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ABSTRACT

This paper considers the use of parental fees and private insurance as sources of funding for early intervention services under Part H of Public Law 99-457, the 1986 amendments to the Education of the Handicapped Act. First, relevant legislative authorities are cited including the Maternal and Child Health Service Block Grant (1981) and guidelines to relevant sections of P.L. 99-457, Part H. The role of the financial counselor on the team developing services is stressed and a full job description provided. The paper then addresses sources of payment especially private insurance; the calculation of family financial responsibility (sample forms and tables provided), illustrated by three sample vignettes; and options for implementing payment for services identifying advantages and disadvantages of six progressive levels: (1) totally free care; (2) Medicaid is charged, but not private insurance nor parents; (3) Medicaid and private insurance are charged, and parents may need to pay for deductibles and co-insurance; (4) Medicaid and private insurance are charged and parents are charged for deductibles and co-insurance on a sliding scale; (5) Medicaid, private insurance, and clients are charged on a sliding fee scale; and (6) Medicaid, private insurance, and clients are charged on a sliding fee scale and parents have the additional option of paying privately for additional services. (DB)

Carolina Institute for Child and Family Policy

USE OF PARENTAL FEES IN P.L. 99-457, PART H

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FOREWORD

This contribution to the Carolina Policy Studies Program (CPSP) series of reports on the implementation of Part H of P.L. 99-457 is comprised of three independent papers on financing services. These papers are aimed primarily at state level administrators and are intended to present public policy perspectives on the complex task of financing services for infants and toddlers with handicaps and their families. The papers were originally prepared for a small policy conference held in Chapel Hill, N.C., to explore major financing issues to guide our future work on implementation of the law, and have since been substantially revised and updated for this report.

This paper, **Use of Parental Fees for P.L. 99-457, Part H**, was prepared by Peter van Dyck, M.D., M.P.H., Director of the Division of Family Health Services in the Utah Department of Health. He has had extensive experience in addressing issues related to financing services. This paper focuses primarily on use of parental fees as a source of funding for Part H services. It is impossible to completely separate parental payment for services from the use of private insurance. This paper provides meaningful insights into this important topic.

The second paper, **State Financing of Services Under P.L. 99-457, Part H**, was written by Richard Clifford, Associate Director of CPSP, and is the initial report of the CPSP case study of six states' efforts to implement the financial provisions of the law. It describes the sources and funding mechanisms used in the six states, and makes recommendations regarding state response to the requirements of Part H. It should be noted that the other two papers were prepared because of the authors' extensive experience in particular aspects of financing services, and are not related to the case studies reported in the **State Financing** paper.

The third paper, **The Massachusetts Experience with Medicaid Support of Early Intervention Services**, was written by Karl Kastorf, Part H Coordinator in Massachusetts. As indicated by the title, the paper provides an overview of how one state has successfully integrated use of the federal Medicaid program into a plan for financing Part H services on a statewide basis. Many states have found it difficult to maximize use of this potentially large and important source of federal and state financial support for Part H services. It is hoped that the Massachusetts experience will be helpful to other states as they develop and refine their own strategies.

We greatly appreciate the time and expertise shared with us by the many participating staff members in the six case study states. Their willingness to spend substantial amounts of time with us, both personally and in gathering reports, memoranda and other documents to enable us to conduct the case studies, has been invaluable. We have come to respect them for their work on a tremendously difficult task. As you will see from the Clifford paper, we have questions about the possibility of truly fulfilling the intent of the financing provisions of the law. If it is possible, it will only be because of the dedicated work of the Part H Coordinators and their colleagues across the country.

This is the first time the Carolina Policy Studies Program has relied on state personnel to independently prepare policy papers for this series. Dr. Van Dyck has demonstrated his substantial knowledge and understanding of the complexities of integrating parent fees into a system of financing Part H services. His paper should be helpful to state and local personnel working to fully implement P.L. 99-457, Part H. Kathleen Bernier, a colleague here at CPSP, had responsibility for editing this paper for inclusion in this series and her work is greatly appreciated.

Richard M. Clifford
March, 1991

The use of parental fees generates a charged discussion whenever approached and is a particularly sensitive issue when the services being discussed are linked, directly or indirectly, with the education system or a state or local educational agency. While there is a history in most health agencies of charging parents for certain services, the education system has rarely -- if ever -- charged for the delivery of services. Yet, in a fiscal environment where there is never enough revenue and always more need than can be met, it would seem prudent to investigate and evaluate all potential sources of revenue, especially if services are to be expanded or added. It must be remembered that a lead agency under Part H of P.L. 99-457 is responsible for providing appropriate early intervention services statewide to all who meet the eligibility criteria. It is very difficult to conceive that financing early intervention services is possible exclusively from public funds, and a lead agency must be particularly careful that a limitation in funding does not result in either essential services being denied to families or the quality of services being decreased.

RELEVANT LAWS

The Maternal and Child Health Service Block Grant, P.L. 97-35, passed in 1981, says, in Section 501(b)(1)(D), ". . . if any charges are imposed for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services."

In 1988, P.L. 100-360, the Medicare Catastrophic Coverage Act, was signed into law. Section 1903(c) was amended to read, "Nothing in the Medicaid Statute shall ... prohibit ... payment for covered services furnished to a handicapped infant, toddler or child because such services are included in an IEP established by Part B ... or in an IFSP pursuant to Part H."

In the Education of the Handicapped Act Amendments of 1986, P.L. 99-457, Part H, Section 672 reads, in part, "(2) Early Intervention Services are developmental services which -- (A) are provided under public supervision, [and] (B) are provided at no cost except where Federal or State law provides for a system of payments by families, including a schedule of sliding fees."

The Department of Education published guidelines on Thursday, June 22, 1989, for Early Intervention Programs for Infants and Toddlers with Handicaps, and Section 303.521 further clarifies the issue of fees.

Section 303.521 **FEES**

(a) **General**. A state may establish consistent with Section 303.12(a)(3)(iv), a system of payments for early intervention services, including a schedule of sliding fees (Section 303.12(a)(3)(iv) ... at no cost, unless ... Federal or State law provides a system of payments by families, including a schedule of sliding fees.)

(b) **Functions not subject to fees**. The following are required functions that must be carried out at public expense by a State, and for which no fees may be charged to parents:

(1) Implementing the child find requirements in Section 303.321;

(2) Evaluation and assessment, as included in Section 303.322, and including the functions related to evaluation and assessment in Section 303.12.

(3) Case management, as included in Sections 303.6 and 303.344(g).

(4) Administrative and coordinative activities related to--

(i) The development, review, and evaluation of IFSPs in Sections 303.340 through 3030.346; and

(ii) Implementation of the procedural safeguards in Subpart E, and the other components of the statewide system of early intervention services in Subparts D and F.

All of this has a further caveat stated in Section 303.520(b)(3) of the same guidelines. The policies must "include an assurance that -- (i) Fees will not be charged for the services that a child is otherwise entitled to receive at no cost to parents; and (ii) The inability of parents of an eligible child to pay for services will not result in the denial of services to the child or the child's family."

While it may seem, at first glance, that this does not leave much opportunity for parental fees, it should be noted that the actual provision of early intervention services is not included in the guidelines as an exception. It seems clear that the law, then, allows for the charging of parental fees, no matter whether the lead agency is under the auspices of health, education, or some other entity.

FINANCIAL COUNSELING

Both the Maternal and Child Health Service Block Grant and P.L. 99-457 imply or state specifically that (1) clients under the poverty level

are to receive services without charge, and (2) that if fees are charged, they be pursuant to a public schedule of charges related to a sliding fee scale. I feel there is a third component which, while not required except perhaps under case management in P.L. 99-457, is just as essential. That is the element of **financial counseling**.

The financial counselor has an integral role on the team that provides services to clients. The counselor works or consults with clients to substantiate, correct or complete income, expense, and insurance information, compute the client's portion of financial obligation, inform the client as to the extent of responsibility for medical expenses, identify potential alternate sources of payment for services, manage changes in the client's financial status, and handle problems regarding the client's financial situation. A financial counselor may perform other duties, such as accepting and reviewing application and registration forms, acting as an information and referral source, and being the point of contact with the system for the client.

This interface, or buffer, if you will, between the specific early intervention service and Medicaid, private insurance, and other fee-for-service providers or clinics is sorely lacking at the present time -- yet much needed. Parents uniformly request additional assistance in these financial areas. It should be emphasized that the purpose of the financial counselor is to be a facilitator for the client, and not an obstructor or "bureaucrat." An example of a full job description, labeled PDQ Health Resource Specialist 19, is shown in Figure 1.

FIGURE 1

SAMPLE

PDQ
HEALTH RESOURCE SPECIALIST 19

1. 15% Accept inquiries from potential clients and the public regarding FHS services. Determine at the time of initial contact the nature of the person's inquiry or problem, for the purpose of providing appropriate information or referring inquirer to the right source for information, services, or financial assistance. Provide information or refer client to a service agency or source of payment inside or outside FHS. If the referral is within FHS, ensure that Application/Registration forms are sent or given to the client. If the referral is outside FHS, take all appropriate action to ensure that client is placed in contact with the outside agency. Continue to update a list of resources available for referral.

2. 20% Accept Application/Registration forms from clients; review forms for completeness; evaluate income and expense information for determination of financial eligibility and assignment of percentage of client responsibility for the medical bills; identify missing information and potential problems in submitted Application/Registration forms; handle difficult cases referred by a Health Resource Specialist 17;

3. 30% Work or consult with clients to substantiate or correct income, expense and insurance information on forms; obtain missing information; recompute client percentage of financial obligation if necessary; identify other potential sources of payment; inform clients of the extent of their responsibility for payment of medical expenses generated in FHS clinics or by referral to other providers; work with clients on an ongoing basis to ensure payment of client's portion of the bill, manage changes in client's financial status, ensure compliance with FHS financial policies, and handle problems arising in clients' financial situations; handle difficult cases referred by a Health Resource Specialist 17.

4. 25% Help coordinate the FHS Accounts Receivable system. Act as liaison with FHS billing agent. Work with clinic staff in operation of the Accounts Receivable System, as directed, to ensure smooth operations, including staffing, training and other activities. Work with staff to ensure that encounter and authorization forms are initiated for client services. Check encounter and authorization forms for completeness and accuracy, and process forms in accordance with FHS policy and procedures.

5. 10% Under direction of a Health Resource Specialist 23, assist in implementation of policies and procedures that ensure maximum reimbursement from third party payers and clients. Procedures may include those designed to obtain prior approval from third party payers, ensure proper coding of clinical services for billing purposes, etc.

SOURCES OF PAYMENT

There are several reasons a state may want to institute an accounts receivable and billing program. It is my experience that in programs for Children with Special Health Needs, 30% to 35% of all clients are either on Medicaid or Medicaid eligible. This is particularly important for early intervention services with the passage of the new Medicaid mandates in 1989. Beginning April 1, 1990, all states had to cover children up to age six whose family income is less than 133% of the official poverty level. In addition, changes in Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandated that all abnormalities found during a screening which require medical care and qualify for federal matching must be covered by the state Medicaid agency. This new mandate has at least doubled, and in some states tripled, the number of children served in Part H programs that are eligible for Medicaid. The changes also mandate the breadth and depth of services to be available. As a result, physical therapy, speech and hearing, psychological, and other services, that were previously only partially covered by Medicaid, will now be more readily available.

In our clinics in Utah, approximately 60% to 65% of clients have some form of private insurance. Private insurance usually pays quite well for medical providers providing medically necessary services in out-patient settings, as long as the service is provided by a medical professional. The type of out-patient setting, be it early intervention clinic, hospital out-patient clinic. health department or educational class room, does not seem to make a difference.

As I work with various states and my own Legislature, I sense that legisiative intent is swinging towards evaluating all potential sources of revenue for programs provided by state agencies. Our Legislature, in

fact, has intent that prohibits the Utah Department of Health from unfairly competing with the private sector; therefore, our public schedule of charges must be similar to the communities'. As recently as February, 1990, the Department of Health was directed by the Legislature to explore the use of parental fees in early intervention services, in spite of the knowledge that maximum efforts were already being made in collecting from Medicaid and private insurance. It was their conviction that, although the return may be relatively small, all revenue sources should be utilized. They also felt that many parents in the state could appropriately share the expenses of their children's care.

CALCULATING FAMILY FINANCIAL RESPONSIBILITY

Forms that are currently used in the state of Utah for programs providing health services to assess a client's ability to pay, based on family size, existing medical expenses, and gross income, are presented in Figures 2, 3, and 4. Figure 2 shows an Application For Services form that is used to collect demographic information and to get permission to release information. Figure 3 presents a Registration Form used to collect financial information regarding both Medicaid and insurance and to determine the portion of the cost of care to be paid by the client. Figure 4 provides an illustration of a Sliding Fee Schedule that relates the percent of financial responsibility a client must assume to family size and monthly income.

In order to determine the percent of financial responsibility a client must assume using the Sliding Fee Schedule in Figure 4, the family's net monthly income must be calculated. The Financial Information section of the form presented in Figure 3 shows that unusual

FIGURE 2

Program _____
Clinic _____

UTAH DEPARTMENT OF HEALTH
Family Health Services Division
P.O. Box 16650
Salt Lake City, Utah 84116-0650

☐ New ☐ Update
001801

APPLICATION FOR SERVICES

Instructions:
1. Complete both the Application and Registration pages of this form.
2. Type or print. Do not fill in shaded areas.
3. Read the release section below and sign the form at the bottom.

Person to Receive Services

Name _____ (Last) _____ (First) _____ (Middle)

Birthdate ___ / ___ / ___ (MO / DAY / YR) Sex ____ Race _____ Hispanic? Yes ☐

Social Security Number _ _ _-_ _-_ _ _ _ Language Spoken in the Home _____

Address _____ (Street) Home Phone _____

_____ (City) _____ (County) ____ (State) ____ (Zip) Work Phone _____

Parent or Guardian Name _____ (Last) _____ (First) _____ (Middle)

Spouse Name _____ (Last) _____ (First) _____ (Middle)

Referred By: _____ (Name) _____ (Agency)

_____ (Address) _____ (Phone)

Problem, Condition, or Reason for Application: _____

Services Requested: _____

Release

- I apply for and consent to those health services which Family Health Services Division, Utah Department of Health prescribes, performs, or authorizes.
- I understand that in order to provide these services, the Family Health Services Division must collect confidential and personally identifiable information. This information will be available to various staff, agencies, and others in order to provide agreed upon services. I understand that information collected and released to others will be, in the best professional judgment of Family Health Services Division staff, necessary to provide these services.
- I acknowledge receipt of a more complete description of my rights and obligations, including a description of the use of the Utah Registry for the Handicapped.
- I authorize insurance, Medicaid or Medicare benefits to be paid to the Family Health Services Division or its authorized agent, and for Family Health Services Division or its authorized agent to release information to insurance companies, Medicaid and Medicare as necessary to process claims. I understand that I may be liable for all or a portion of the bill, specified as Personal Financial Responsibility (PFR), and that interest may be charged on accounts unpaid 60 days after billing date.

Signatures _____ (Patient, Parent, or Guardian) _____ (Family Health Services Worker)

Date _____ Date _____

Rev. 2/12/91

FIGURE 3

Account # _____ __

Date ____ / ____ / ____
MO DAY YR

UTAH DEPARTMENT OF HEALTH
Family Health Services Division

REGISTRATION FORM

☐ New ☐ Update

002007

Client Name _____ Birthdate __ / __ / __
Last First Middle

Responsible Party

Name _____
Last First Middle

Address _____ City _____

County _____ State _____ Zip _____ Phone _____

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Relationship to Client _____

Employer _____ Address _____ City _____

State _____ Zip _____ Phone _____ Title/Occupation _____

Insurance Co. _____ Phone _____

Address _____ City/State _____ Zip _____

Member # _____ Group/Policy # _____

Secondary Insurance _____ Phone _____

Address _____ City/State _____ Zip _____

Name of Insured _____ Relationship to Client _____
Last First Middle

Member # _____ Group/Policy # _____

Employer _____ Address _____ City _____

State _____ Zip _____ Phone _____ Title/Occupation _____

Medicaid # _____

Financial Information (This information is used to determine what portion of the cost of care is to be paid by the client)

Number of dependent children living in household _____
(if pregnant, include the unborn child)

Number of other dependent persons living in household _____
(including self, head of household, spouse and other adults)

Total Family Size _____

Average Gross* **Monthly** Income for Family

Gross salary & wages (first wage earner)	$ _____
Gross salary & wages (other wage earner(s))	$ _____
Other income (includes pensions, compensation, insurance, income from property, rentals, contracts, interest, dividends, royalties, alimony or child support, public assistance grants, etc.):	$ _____
*Income Before Deductions — Total Monthly Income	$ _____

Unusual **Monthly** Expenses for Family

Medical Bills	$ _____
Medical insurance	$ _____
Child support or alimony	$ _____
Child day care costs	$ _____
Total	$ _____

Net Income $ _____ **Personal Financial Responsibility** _____ %

Program Code _____ Chart # _____ Program Code _____ Chart # _____ Referral Code _____

Rev. 2/11/91

I have reviewed the Personal Financial Responsibility determination by FHS and understand my obligation.

Client, Parent, or Guardian Signature Date FHS Worker Date

FIGURE 4

UTAH DEPARTMENT OF HEALTH
FAMILY HEALTH SERVICES DIVISION
SLIDING FEE SCHEDULE, 1991
MONTHLY INCOME RANGES

CLIENT FINANCIAL RESPONSIBILITY		0%	20%	40%	60%	100%
% OF FEDERAL POVERTY GUIDELINE		0% TO 133%	133% TO 150%	150% TO 185%	185 % TO 225%	>225%
FAMILY SIZE	FEDERAL POVERTY GUIDELINE ($)	M O N T H L Y I N C O M E ($)				
1	552	0 734	735 828	829 1021	1022 1241	1242 AND UP
2	740	0 984	985 1110	1111 1369	1370 1665	1666 AND UP
3	928	0 1235	1236 1393	1394 1717	1718 2089	2090 AND UP
4	1117	0 1485	1486 1675	1676 2066	2067 2513	2514 AND UP
5	1305	0 1736	1737 1958	1959 2414	2415 2936	2937 AND UP
6	1493	0 1986	1987 2240	2241 2763	2764 3360	3361 AND UP
7	1682	0 2237	2238 2523	2524 3111	3112 3784	3785 AND UP
8	1870	0 2487	2488 2805	2806 3460	3461 4208	4209 AND UP
EACH ADDITIONAL	188	250	283	348	424	424

Note: The FHS fee schedule is based on official poverty levels published in the Federal Register Feb. 20, 1991, pp. 6859-6861. When new poverty guidelines are published the fee scale will be changed as required in federal law, Title V of the social Security Act, and in accord with guidelines published by the Department of Health and Human Services, Office of the Secretary.

monthly expenses, including medical bills and medical insurance premiums, are subtracted from total gross monthly income to yield net income. This net income is then linked with family size, as seen in Figure 4, and a percent of financial responsibility the client must assume is ascertained.

Three vignettes might be helpful to illustrate the process:

1. A two-parent family has a one-year-old child with Down syndrome who is presently in need of early intervention services. During the birth and first year of life, $10,000 in medical bills (an annualized average monthly bill of $833) were incurred for the child's care. The family's total yearly income is $18,000 (monthly gross income of $1,500). The family has no insurance.

The net income is derived by subtracting the monthly expenses of $833 from the monthly income of $1,500. The result is $667, and, as seen in Figure 4, this family of three will be eligible for services without charge.

2. A two-parent family has a premature baby who, upon discharge from the hospital, clearly has unresolved vision and hearing problems. Early intervention services are recommended. Upon discharge the family's medical expenses total $40,000. Private insurance has paid 80%, leaving a $8,000 charge (an annualized average monthly bill of $667) for the clients. Medical insurance premiums have cost them $1,800 during the last year ($150 per month). Together the parents earn $24,000 ($2,000 per month).

Net income is $1,183, the total monthly income of $2,000 minus the total unusual monthly expenses of $817. Again, the expenses bring the family income below the schedule for imposing fees and the family is eligible without charge for early intervention services.

3. A two-parent family has an infant six months old who is beginning to show signs of cerebral palsy. The baby was premature and spent two weeks in the hospital, incurring a $10,000 bill. Private insurance paid 80%, leaving the parents with $2,000 co-insurance payment (an annualized average monthly bill of $167). Insurance premiums are $300 per month. Total family income equals $30,000 per year ($2,500 per month).

Net income is derived by subtracting the average monthly bill ($167) and the monthly insurance premium ($300) from the $2,500 monthly income. The monthly net income is $2,033. Using the Sliding Fee Schedule in Figure 4, it can be seen that the parents of this family of three are responsible for 60% of the outstanding costs incurred for early intervention services. (Go down column 1 to Family Size of 3, across the row to the Monthly Income cell that includes $2,033 -- the fourth cell, $1718-$2089 -- and up to the corresponding percentage of Client Financial Responsibility.)

There are several points which should be emphasized regarding this example:

1. This family's private insurance will pay for most health-related services such as psychology, speech therapy and audiology. It also pays for physical therapy.

2. P.L. 99-457 only allows charges to the family for direct early intervention services, so the family is only responsible for 60% of the charges for services that insurance will not pay.

3. If, in the future, expenses become larger or surgery becomes necessary, the financial status would be recalculated. At that time the family's financial responsibility might be decreased.

OPTIONS FOR IMPLEMENTING PAYMENT FOR SERVICES

In discussion of the issue of charging for early intervention services, I see six progressive levels:

1. Totally free care, no third parties or clients are charged.
2. Medicaid is charged, but not private insurance and not parents.
3. Medicaid is charged, private insurance is charged, and parents may need to pay deductibles or co-insurance.
4. Medicaid and private insurance are charged, and clients are charged only for deductibles and co-insurance. Payments for deductibles and co-insurance are on a sliding fee scale, thereby lessening the burden to the client.
5. Medicaid, private insurance, and clients are charged on a sliding fee scale (including deductibles and co-insurance).
6. Medicaid, private insurance and, clients are charged on a sliding fee scale, and, in addition, parents have the option of paying privately for a package of services or additional services.*

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* Although some states at present may have no private early intervention programs or restrict early intervention

The scope of this paper does not allow the consideration of Options 1 and 2. A discussion of the advantages and disadvantages of each of the remaining options will therefore begin with Option 3.

OPTION 3. Medicaid is charged, private insurance is charged, and parents may need to pay deductibles or co-insurance.

Advantages:

1. This payment option provides additional revenues to early intervention programs and might allow for Medicaid federal matching revenues.
2. It may increase services or increase reimbursements to providers and clients.
3. It allows for more complete capturing of financial and service data, so calculating a true cost of early intervention services might be possible.
4. It closely follows other programs that are health related and currently bill for services.
5. It may enhance Title XIX and private insurance payments by having a published schedule of charges which is applied consistently.

Disadvantages:

1. The agency or provider must have an accounts receivable and billing system.

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programs from being for profit, this added option of parents being able to purchase services privately should be considered.

2. A consistently applied schedule of charges must be developed.

3. Clients must pay 100% of co-insurance or deductibles required by private insurance.

4. Services would count towards limits in private insurance policies on services such as psychology and speech and hearing.

5. Services would count towards a lifetime cap limit on dollars imposed by some private insurance companies.

When private insurance is billed, the client will be responsible for cost sharing, since most insurance plans contain requirements for either deductibles or co-insurance. The deductible is a set dollar amount that the family must pay annually towards the cost of incurred medical expenses before the insurer begins to pay out benefits. The purpose of such a deductible is to keep the premium cost down and discourage unnecessary use of medical services. Co-insurance is the specified percentage of covered expenses which must be paid by the family after the deductible has been met. The vast majority of plans pay only 80% of covered expenses, while the family is expected to cover the remaining 20%. Most traditional health benefit plans limit out of pocket liability for co-insurance and deductibles. Once the family has paid out a specified amount, the plan will pay 100% of covered expenses (Fox & Neiswander, 1987).

OPTION 4. Medicaid and private insurance are charged, and clients are charged only for deductibles and co-insurance. Payments for

deductibles and co-insurance are on a sliding fee scale, thereby lessening the burden to the client.

Advantages:

1. This option is more fair to clients.
2. It limits the liability of clients based on family size, expense and ability to pay.
3. It allows families, many of whom wish to pay something, to pay according to their ability.
4. It more completely captures financial and service data.

Disadvantages:

1. This option decreases revenue to early intervention programs, although minimally.

Because deductions in co-insurance are applied on a sliding fee scale, this method is more fair to clients than that presented in Option 3.

OPTION 5. Medicaid, private insurance, and clients are charged on a sliding fee scale (including deductibles and co-insurance).

Advantages:

1. This option has all the advantages listed for Option 4.
2. Further, it increases revenues to early intervention programs.
3. It increases the completeness of financial and service data.
4. It more fairly spreads the cost of early intervention services among those who can afford it.

5. It may coincide with legislative intent to maximize revenues or to specifically charge parents who can pay.

Disadvantages:

1. Having parents pay for what may be a significant portion of early intervention services is a disadvantage for many families.

If parents pay as part of the system, they can be included in general overall financial and service data, and, in addition to advice on finances from a financial counselor, they may also receive help with coordination and linkage. In other words, case management could be available for all early intervention services received, whether public or private.

OPTION 6. Medicaid, private insurance and clients are charged on a sliding fee scale. In addition, parents have the option of paying privately for a package of services or additional services.

Advantages:

1. This payment option allows parents more freedom of choice.
2. It allows parents to purchase in a free-enterprise system additional or different services.
3. It increases revenues to early intervention providers by allowing those able to pay to do so.

Disadvantages:

1. This option might be considered unfair to the disadvantaged or those with fewer resources.

2. It would make capturing financial and service data more difficult unless all services and payments were recorded for those paying privately.

CONCLUSION

At a recent meeting of parents, called for the single purpose of discussing feasibility of parent fees, there was minimal resistance displayed. All present recognized the necessity of expanding services, and, if charging those who can pay some fair and equitable amount will allow such expansion, many are supportive. There were several warnings expressed by parents which we all could take to heart:

"Parents are willing to help with fees if the revenue goes to extend the programs and not to enable or allow a state agency to cut funding."

"[A parental fee schedule] must take into account the family's medical bill -- not just the salary -- and the extent of other medical expenses in the family."

"Generally okay if it reflects services provided to a child and the family's ability to pay and not just the flat fee."

"We should be allowed to buy early intervention services privately or to add to services that are already being provided."

"A financial counselor would be a great addition to the system. This is one of the most difficult areas for us to access successfully."

State agencies, as well as many health and education professionals, have an extreme reluctance to bill private insurance and parents. There are several reasons for this, including :. (1) it is not easy nor inexpensive to set up an accounts receivable and billing system, (2) a public schedule of charges must be developed and consistently applied, (3) financial responsibility in a sliding fee scale must be developed and consistently applied, (4) education has traditionally provided "free" services to handicapped children (and this is not a requirement of Part H), and (5) there is the perception by some that if services are delivered through an education agency, they are, therefore, not reimbursable by Medicaid or private insurance.

In most states, the Title V agency responsible for services for Maternal and Child Health and Children with Special Health Needs (formerly Crippled Children's Services) programs has a history of billing Medicaid. In many instances, private insurance has been billed as well. In the 20 or so states where the lead agency is a health agency, early intervention may be perceived as more a health-related service than an education-related service. Given the previous history of billing experience, it seems logical to assume that the process would be easier to implement in these states. It would seem advantageous in those states where a health agency is not the lead agency to form an alliance with a health counterpart in order to collaborate on a successful billing system. It at least deserves exploration and evaluation.

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