

**EARLY STEPS PUBLIC COMMENTS
RELATED TO PROPOSED POLICIES FOR IMPLEMENTATION OF FLORIDA'S
INFANTS AND TODDLERS EARLY INTERVENTION SYSTEM**

The following comments were submitted to the Early Steps State Office during the Public Comment Period (February 21, 2011 through March 22, 2011) via electronic mailbox, postal mail and public hearings. This is a verbatim account of comments submitted. All personally identifiable information, which would make the commenter known, has been removed. Although the commenter is not identified, all comments from a particular individual or entity are kept together. Policies addressed by the comments are shown in bold. When the individual commenting did not identify the specific policy reference for a comment, the policy reference (when known) is added in brackets.

The Early Steps State Office reviewed and considered all comments and made modifications deemed necessary to the policies. Policies have been submitted to the U.S. Department of Education, Office of Special Education Programs (OSEP) for review and approval prior to adoption.

This is provided for informational purposes only. The comments do not necessarily represent the position of the Early Steps State Office.

1. The ES Data System does not current limit the number of units for TRAV or TRAN **[12.6.2]**. In order to have these limits in the data system, ESSO will need to request the addition of these rules. If the rules are put in place, exceptions to records exceeding the number of units or fees can be identified through Exception records, which are already used to document units or fees in excess of Medicaid limits.
2. Proposed policies for an annual evaluation to continue eligibility **[3.1.1]** may need more specific guidance to the field in order avoid loss of Medicaid revenue. Medicaid's billing rules allow an initial multidisciplinary evaluation once per lifetime, and allow up to 3 follow-up multidisciplinary evaluations per calendar year, but only if new concerns present. A funding strategy for these re-evaluations for continued service may need to be developed, or instruction given to perform billable single discipline evaluations, like a speech evaluation, instead of a multidisciplinary team evaluation.
3. The field and the data system will need instruction on removal of the I disposition code from current and future data if the policy is enacted **[12.3.11]**.
4. The field and the data system will need definition and instruction for the proposed S disposition code to identify children who are screened but not evaluated **[12.3.11]**.

My name is XXXXX and I am a deaf mom of a deaf daughter who is 2 half years old. I strongly believe that a Deaf Mentor component to early intervention services is very much needed for families to have access to fluent ASL role models and resources related to language, culture, and education. A Deaf Mentor requires training and hiring qualified individuals. I meet several hearing mothers of deaf/hard of hearing kids and share my experiences growing up as a deaf person. Also, I meet several mothers who want to learn sign language and I volunteer once a week to meet one family and teach them sign language. There are more families out there in Orlando area and I wish I have time and

money to meet all the families and teach them. So, I believe a Deaf Mentor is very much needed for families to have access to fluent ASL (American Sign Language) role models and resources as well.

Language regarding annual IFSP & evaluation is inconsistent. **3.1.11** states that determination of cont. eligibility take place during annual evaluation of the IFSP and states eval can be conducted but **3.5.1** states that evaluation not required for annual eval of IFSP.

In order to track and report information regarding the children found not eligible using the new eligibility criteria, please add a new Disposition Code "S". **[12.3.11]**.

This new code is to include children that were determined to be not Part C/DEI eligible based on developmental screening prior to an initial evaluation.

Thanks for your consideration.

I am responding to the proposed policy change regarding completing an additional evaluation after a Battelle Test that has marked differences in scaled scores for receptive and expressive language skills, but a total language score that does not qualify them for services (example of such are children with verbal apraxia) **[3.1.4]**.. The additional testing will only reiterate the expressive language impairment, the total language score will remain unchanged, and the patient will still not qualify for services. Therefore, administering additional tests due to scaled score discrepancies in language skills is futile, since the scores do not affect the qualification and the test is not paid for under early steps.

Policy **12.3.5K** and Policy **12.3.7** contain duplicative information and I recommend that **12.3.5K** be deleted. Both of these policies state that the interim IFSP date should not be entered into the Early Steps data system as the "initial IFSP date".

My comments on the proposed policies are as follows:

General

Well done! I especially like the summary of changes document. It is very easy to follow.

3.1.11 Guidance

Issue: The summary of change description may be misleading, since the guidance clearly states that the BDI-2 screener "should be used". Suggest changing the language so that it is clear that the BDI-2 Screener is the instrument of choice.

Suggested change in wording: The BDI-2 Screener must be considered first as the screening instrument at the annual evaluation of the IFSP when appropriate for the child's presenting condition(s).

4.2.18. Policy

Issue: Wording is a bit awkward.

Suggested change in wording:

When a child's standard scores on eligibility evaluations do not meet the Early Steps

eligibility criteria and the child is initially made eligible by other documented sources beyond standard scores, the Service Coordinator must explain to the family:

5.6.4. Policy & Guidance

Issue: It is inconsistent with the team-based primary service provider approach to permit service providers to participate in a periodic review by submission of reports via mail and fax. Optimally, the periodic review consists of a discussion involving all members of the IFSP team. By allowing service providers to participate in a periodic review by mailing or faxing in a report, we are perpetuating a medical model of service delivery.

It is suggested that future consideration be given to revising existing 5.6.4 Policy & Guidance to require persons who are delivering services to the child to participate in the periodic review.

Suggested change to existing **5.6.4** Policy:

The periodic review of the IFSP must include the following persons:

- A. The parent(s).
- B. Other family members, advocate(s), or person(s) outside the family, as requested by the parent(s).
- C. The service coordinator.
- D. Persons who are or will be providing services to the child or family.

If conditions warrant, provisions must be made for the participation of:

- D. Persons directly involved in conducting the evaluation and/or assessment.
- E. ~~Persons who are or will be providing services to the child or family.~~

If this recommended change is made to existing policy, changes to **5.6.4** Guidance will need to be made.

5.6.4. Guidance

Issue: Clarification is needed regarding “when the child is served by CMS”, does this mean all Early Steps children or only those served by the CMS Network? Also, further clarification is needed regarding who the “medical professionals” are and what “evaluations and/or assessments” this is referring to. It is recommended that wording be amended to more clearly delineate the requirements of this section.

6.12.4: Policy

Issue: Minor wording change needed for clarity.

Suggested change in wording:

IDEA, Part C funds may only be used beyond a child's third birthday for the following reasons:

7.2.5. Policy

Issue: Existing wording directs parents to orally indicate. I think we want to say that the parents will be given an opportunity to verbally indicate.

Suggested wording change:

No later than the initial IFSP meeting for children referred after age two or the IFSP

periodic review closest to the child's 2nd birthday for all other children, **the parents will be asked to verbally** indicate ~~orally~~ whether they choose to opt-out of LEA notification for their child.

10.3.4 & 10.3.5 Policy

Issue: Phrases "electronic data system" and "provider management system" aren't consistent with references to the Early Steps Data System and the CMS Early Steps Provider Management System in other sections of policy.

Suggest that wording be changed in policy & guidance so that all references to the data system and provider management system are consistent (for example Early Steps Data System and CMS Early Steps Provider Management System),

12.3.11 Guidance

Issue: Minor wording changes needed.

Suggested revision to wording:

Attempts to contact unsuccessful - Children **for whom** ~~who~~ Early Steps personnel have been unable to contact or locate **their families** after making at least three consecutive documented attempts.

In looking at the Use of Insurance policy **1.6.9** and the Informed Notice **Form CMS ES 1064**, the 1064 form needs to be updated to have the same language as the policy below has in A. The 1064 form currently states: ***It is reasonable to expect that we will exceed the lifetime maximum benefit.*** It doesn't say anything about decreasing any other insured benefits.

1.6.9 The **family** may choose not to have their insurance accessed when:

A. Use of insurance would significantly decrease available lifetime coverage or decrease any other insured benefit(s).

B. Use of insurance would increase premiums or lead to the discontinuation of insurance.

My comment is about medical necessity for Medicaid services **[IFSP Form G]**.. It says section added to IFSP Form G to document medical necessity. I would like this to be more clarified as to if it pertains to any service for that child that is paid by Medicaid. Because that's my understanding of what it says that I just need more clarity on, because most services, many services are paid by Medicaid. So it asks where we would want it written on Form D, Form G, but I guess my comment is -- I'm trying not to phrase this as a question -- is I just need more clarity on, I can't answer whether it should be on D or G until I understand -- if you are talking about all services that are paid for by Medicaid. That's what so counter -- . I guess my comment is Early Steps is a developmental program.

Okay. I have a comment. On continuing eligibility **[3.1.11]**. I would like to see an explanation of how this pertains to children who have an established condition as far as the BDI-2 screener. Would those children also be required to have a BDI-2 screener if they had an established condition. Secondly, I would like to see more clarification on if

the BDI screener is used at the annual and the child's eligibility changes. They were originally qualified based on delays in motor and the BDI-2 screener now comes out that they have delays that would make them eligible in the area of communication. Does that change their eligibility for our program and do we change that as their primary eligibility.

I am not clear about the changes regarding re-evaluation at the time of IFSP [3.1.11]. Will we (Primary Service Provider) be able to use the HELP (Hawaii Early Learning Profile) to assess children at the time of Annual IFSP, or will we be completing the Battelle Screener at that time?

Early Steps policy requires that locally developed forms to document parental consent to release personally identifiable include specific topics for *what* information is being shared. Early Steps policy does not require the form to include a category for *how* information is exchanged (mail, phone, fax, email, etc). I recommend adding a letter G. to 8.5.5 to state "Method of communication (phone, mail, fax, email, etc)".

On 3.1.4 under B.2 Scaled scores should have to show a discrepancy of 6 or more points instead of 3 and at least one of the two subdomain scores should have to be a 4 or below. My reason for this is in order to be eligible, a child must score a 78 or below (-1.5 standard deviations) in two areas or a 70 or below (-2.0 standard deviations) in one area. If looking at scaled scores then only one area is being looked at in order to determine eligibility and thus the criteria should be -2.0 standard deviations from the norm. As the mean is 10 and a standard deviation is 3 then there should be a 6 point discrepancy to reach the -2.0 eligibility. Also, since 6 points is two standard deviations, at least one of the scores should have to be 4 as that would show -2.0 eligibility.

On 3.1.11. This is a leap in the right direction. It has been observed that as our LES' providers are self-employed, they are not always in alignment with the purpose and beliefs of the LES. It seems there is difficulty with especially Speech Therapists discharging children once they have age appropriate communication skills. If you look at some of the Exit evaluations as children leave the LES, it would be noted that many are completing age appropriate and even up to 5 year levels and still receiving services in that area, especially if articulation is a concern although not an LES/age appropriate reason to remain in services

On 3.5.1 under C. At first I thought this was a contradiction to 3.1.11 but it seems as though while an evaluation is not needed at the time of the annual an assessment is still required. This is just a little unclear

On 4.2.18. Another leap in the right direction. Just want to express support for the six month window of eligibility

Okay. This is in regards to the eligibility re-evaluation [3.1.11]. My question is why is an evaluation in all five domains not required? My input on that is zero to three years old are always developmentally changing. Some children may regress in certain areas depending on certain delays that may appear between ages zero to three years of age. That's it.

My first comment is we are very excited about the inactive status possibly going away. That has been a thorn in our side as a service coordination team. So thank you for that.

The second thing I'd like to comment on, you specifically in your presentation talked about the medical necessity for Medicaid services [IFSP Form G] and I think you asked a couple of questions about where would it best be placed. I certainly don't want another form. We all I think agree we don't need more forms. I guess I would need further guidance on the purpose of the statement. If it's something that you're only going to do an initial eligibility, then Form D makes sense to me. If it's only required once, if it's required yearly, I think, you know, once we know that type of guidance then it would help determine the form better. If it's needed once, then a Form D makes more sense. If it's needed on an annual basis, then I think a Form G makes more sense. So I think that would be my comments in that. And before we heard your presentation, obviously we were struggling with this one because we were saying exactly what does that mean medical necessity for early intervention services? Because as we know, our model is a developmental educational model which we struggle with all the time because then you've got the Medicaid payor where it's medically necessary. So we're anticipating the guidance and instructions that you've said will be included after discussions with AHCA because obviously as an early steps program, we struggle with medical necessity and how to document that when we're supposed to be the educational developmental model. So thank you for providing more guidance on that. And that's it.

Speaking as a pediatric physical therapist, one of my concerns is obviously the delays that will be shown via testing and how it presents itself. Because delays are not always shown in testing. You can give a standardized test and it doesn't necessarily reflect what the child exactly looks like without a visual look at the child - without a hands-on look at the child. Which definitely needs to take place and be documented. As a therapist, things like muscle tone, posturing, all those things need to be reflected and be considered as part of the child's evaluation as to whether they qualify [3.1.4]. So you may have a child that you're considering is delayed only in one domain, but this muscle tone effects everything that that child does. And therefore, he may not qualify. So as a physical therapist, I think there needs to be a broader range of what's looked at when the child is evaluated so that we don't have children that end up slipping through the cracks that sorely or badly would benefit from therapies.

The other issue that I would like to discuss, again being a therapist, but also a home-based therapist, is the travel log [12.6.2]. The travel log has been a thorn in our side for many years. Not that we don't want to complete or provide information. We do. Here in Broward County we provide a flat-rate -- we receive a flat-rate fee and in our documentation we put time in and time out. We've had attempts to use the original travel log which is very cumbersome. Not in the sense that we have to carry it around, but cumbersome in the sense of documentation. And it was a frustrating source to most of the therapists in this county. So much so, that for me personally I lost staff who refused to ever come back to the Early Step system because of a travel log. So again, if this is thrown at us at a force-based level, I can guarantee you, having done this for 20 years, that there will again be people who will back out because they can provide services to children in many other ways besides the Early Steps program over an issue of a travel log.

My first comment is on policy 3.1.4 (B) which talks about the additional testing

requirement for children 24 to 30 months and then it's specific to expressive and receptive language. Just a point of clarification, that only applies to that domain. And then I'm looking at the last item on D-5 in that same area which again then is speaking about communication domain. My comment is that the way this is worded and laid out is very confusing. When you start with language and end with language but have a bunch of other issues in between that, I think those need to be consolidated and reworded. And I wouldn't start with the 24 to 30 months on language in the beginning of that because it looks like you're only talking about at that age group for all of these six-month re-evals.

My next comment is on Section **3.1.11**. It talks about determination of continuing eligibility must take place during the annual evaluation of the FSP. That's not the terminology we utilize. We talk about the annual review of the FSP. And we think that needs to be clarified in that section.

We also find it confusing on **3.5.1 C** that says an evaluation is not required for the annual evaluation of the FSP. On one hand it sounds like we're talking about all children do have to have some kind of an -- maybe you mean assessment versus evaluation. Not sure there. Because we're talking about the Battelle Screener. But those seem to be very confusing and contradictory.

On policy **4.2.18** related to the role of the service coordinator explaining to the family, my comment is that it's really a recommendation that the new public awareness material that's being developed include this language to help support the information that the service coordinator is going to be providing to the families.

On the medical necessity [**IFSP Form G**] issue, my comment is that the clarification from AHCA needs to be provided immediately so we know what that guidance is going to look like for medical necessity.

On policy **6.12.1**, the policy states the IFSP team should consider whether the continued provision of services is required or likely to be required for the child to maintain appropriate developmental progress. In light of the new requirement for an annual evaluation or assessment [**3.1.11**], however we're going to word that, I think this policy needs clarification and might relate to what Michelle was speaking to. Not just using a test score. But I think this statement here is going to need some clarification and some guidance on that.

On the travel log issue on **12.6.2**, I strongly support and recommend that those areas using a flat rate not be required to use the natural environment travel log. That's it.

I'm XXX, speech language pathologist ... I have some questions or requests for clarification on Policy **3.1.4** in terms of continued eligibility past the initial six months. If we could just get, perhaps, some additional information. It seems a little vague to me as to what is administered at the end of the six months and then what the -- when they're referring to must meet Florida's eligibility criteria at the second evaluation as stated in **3.1.4 (A)**. Is that again using -- would that be using a discipline specific evaluation or would that be a re-administering of Battelle for meeting eligibility? On this policy, as well as on the annual re-evaluation tool, if the policy could give some guidance as to who would be performing the additional assessment -- or I'm sorry, the rescreen, the re-evaluation tool and how often. I'm sorry, I know it says annually, but really, who would be doing it, who would be paying for it, what the reimbursement rate would look like for something like that or is it envisioned being part of a session?

And then I'd like to comment again on **6.12.1** in terms of asking an FSP team when considering closing a child from Early Steps to discuss terminating. It talks about the team needs to consider whether the child -- whether continued provision of services is required or likely to be required for the child to maintain appropriate developmental progress. I'm not sure how we would make those kinds of decisions as clinical professionals. Again, I heard earlier talking about the rapid rate of change in children of this age, what we would be using to determine whether or not they are going to maintain developmental progress and what that would look like. I think everything else has really been said. Just the -- and just I think some further clarification just on the -- there's a -- it's -- I don't know if it's an attachment.

Under **definitions**, under the **scaled score**, if we could just clarify what that is telling us in terms of determining eligibility and sub-domain scaled scores.

Oh, I'm sorry, can I add one more thing? The policy here states 24 to 30 months **[3.1.4]**. The policy states 20 to 30 and your handouts say 24 to 36. So I don't know -- It should be 36? Okay. So it's 24 to 36 months. And prior to 24 months, additional testing is not required to determine eligibility using clinical judgment I guess is the clarification.

Good afternoon. I'm XXX. And I the only thing that I found so far is I think for Policy **3.1.11** -- actually, let me rephrase that, **3.5.1**. It states letter C under the guidance and procedure section, states that an evaluation -- it stated before an evaluation is conducted only for the initial IFSP to establish eligibility. And now it will read an evaluation is not required for the annual evaluation of the IFSP.

I think there should be some clarification there because if you look at **3.1.11**, which I referenced a few minutes ago, we're talking about doing an evaluation -- is it that one? Yes, to continue looking at eligibility. So if we're -- typically the IFSP and the evaluation and assessment process sometimes is done together. But if we're determining eligibility, again looking at evaluating that, then the IFSP, at some point the only way we would continue with an IFSP is to look through that. So perhaps maybe calling that assessment of the IFSP will no longer be necessary if the child is determined eligible -- as the child is determined ineligible. Excuse me. And the only other area that I wanted to make a comment on is -- sorry.

I swiped XXX of her documents and so I'm trying to see where I wrote on hers versus mine. But it's basically about a child having to be, additional tools needing to be used for 24 to 36 months **[3.1.4]**. If it could be clarified. I'm not sure if it is in the policy right now. Unfortunately I haven't read through the entire, all the changes. But making sure that there is a difference stated between established condition and a child coming in for just developmental delay. So if children coming with established conditions, if we're still looking at that as an automatic eligibility criteria, then we need to clarify that an annual evaluation is not necessary for the 24 to 36 months olds. And that's it. Thank you.

Good afternoon. I'm XXXX. And I wanted to speak to the proposed policy change regarding **IFSP Form G** and the requirement that medical necessity be documented for the children who receive Medicaid services. I'm sorry -- I'm not finding that policy number. Form G. That is the only descriptive I have. My concern is that the whole issue of medical necessity is something of a third rail for early intervention because it's a legal definition typically used by managed care and managed care is typically going to trump any other definition anyway as we see from the denials we're already receiving here in Broward County from the Medicaid HMO's. The whole issue of Early Steps being so

reliant on insurance reimbursement is a bit of a contradiction anyway because it's so much involved with a medical program. Whereas we know Early Steps is intended to be an educational developmental program.

The only Florida standard that I can find, manual that I find that is at all applicable is rather obviously our Medicaid EI Waiver Program. Which although it defines the eligibility for EI services as children with DD and established conditions -- albeit the manual is outdated with some of our policy changes -- at least we know that the early intervention services are right and appropriate for our children. Unfortunately the reimbursement isn't sufficient for our providers to continue participating, were that the fee schedule for therapists. So we revert to the EI Medicaid Therapy Manual which again defines medical necessity in the most predictable medical language. And as best I can tell in reviewing the language, it is not consistent or appropriate for most of our Early Steps population. So we don't have a common definition of medical necessity. It makes it I think, therefore, very hard for anyone to define medical necessary on the IFSP form because we don't know whose standard is right and appropriate.

And again, an HMO, a managed care organization, is going to make their own rules about that anyway. So I think that's something of a fool's mission right now if we don't get a great deal more clarity about what definition applies and if we don't have a great deal more teeth with our Medicaid HMO's, particularly we're anticipating reform to go statewide. And of course if reform goes statewide, we don't even know that we are going to have our waiver programs. Another whole issue that we'll save for another day because that's just too horrible to think about. So I would like to see at least postpone implementation of the changes to Form G until such time as we have more clarity and a little bit more insight into what Florida's Medicaid programs are going to look like by the new fiscal year. Thank you very much.

Related to policies **3.1.4** and **3.1.11** and the requirement for determination of continued eligibility, California has the language below to ensure that if parental consent is not obtained to conduct any evaluation necessary to determine continued eligibility, then eligibility is determined to be not established and participation in Part C is ended. It is recommended that similar language be included in the Florida policies.

(2) If pursuant to subdivision (b) herein, the early intervention official requests a determination of the child's continuing eligibility for the early intervention program, and the parent refuses to consent to a multidisciplinary evaluation to establish the child's continuing eligibility, continuing eligibility has not been established and the child shall no longer be eligible for early intervention program services. The early intervention official shall provide the parent with written notice ten working days before the early intervention official proposes to discharge the child from the early intervention program. The notice must be in sufficient detail to inform the parent about the action that is being proposed, the reasons for taking such action; and, all procedural safeguards available under the early intervention program, including the right of the parent to request mediation or an impartial hearing on the child's ongoing eligibility for the early intervention program.

For your consideration:

3.1.4 Guidance/Procedures

Consider changing 78 to 77.5. While the rationale behind the use of 78 was because a score of 77.5 is not a possible score, I think there has been an unintended consequence

that practitioners think it is our policy to "round up" on scoring.

3.1.4 Policy

Consider completely deleting Section D based on input from OSEP that criteria for continuing eligibility cannot eliminate Informed Clinical Opinion/Professional Judgment. I also suspect that having a more stringent criteria for continuing eligibility after initial eligibility determination will lead to increased disputes/complaints.

3.1.11 Guidance/Procedures

Consider changing should to may in section A and adding [Progress monitoring data may also be used for re-determining eligibility.](#)

Attachment: **IFSP instructions for Form D** pp 29-33 Guidance/Procedures

Final sentence in last paragraph for How to Use This Information needs clarification. Consider elaborating that initial eligibility information needs to be repeated on all subsequent IFSPs [as well as the additional information used to support re-determination of eligibility at annual IFSPs.](#)

6.13.1 Policy

Consider changing At the periodic or annual meeting to evaluate the IFSP, the IFSP team may decide to end early interventions services and close the child/family to Early Steps. This [decision](#) should be made whenever the child is functioning comparable to same age peers, [no longer needs early intervention services, or no longer meets the eligibility criteria for Early Steps.](#)

7.2.5 Policy

Consider changing "orally" to "verbally."

7.8.1 Guidance/Procedures

Section A Consider adding to #1 prior to parentheses "unless the child is not medically stable enough for eligibility evaluation."

Section B Consider adding to #1 For children [determined eligible for Early Steps](#), conduct a review.... And consider adding clarification that this would be considered either a periodic or annual IFSP meeting. Consider adding a timeline to #2 of The receiving service coordinator should: Conduct an IFSP periodic review [shortly](#) after family arrives.

8.5.2 Guidance/Procedures

Consider adding information that explains how the written notice can be provided to parents, such as on the actual consent form.

Thank you for the opportunity to review and comment. Overall, the policies are clear, concise and well-written! Great job!

Component: 3.0 First Contacts/Evaluation/Assessment – including child find activities

There is lack of attention to the social-emotional needs of infants and toddlers eligible for referral and entitled to evaluation by the State of Florida's Local Early Steps Programs

(ESP) [3.1.4]. To paraphrase from the current provisions of the Child Abuse Prevention and Treatment Act (CAPTA): ... SEC. 106. (b) (2) (A) (xxi) provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case (*any case with verified findings*)* of child abuse or neglect to early intervention services funded under part C of the Individuals with Disabilities Education Act.

There is lack of attention to the social-emotional needs of infants and toddlers in both the interagency agreement between the Department of Children and Families (DCF)/Department of Health (DOH) and intra-agency agreement between the DOH, Children Medical Services (CMS), ESP/DOH, CMS, Child Protection Team (CPT) referral processes. The referral forms/screening processes to ESP from CPT and DCF in the current agreements do not emphasize/recognize developmentally appropriate signs or symptoms of infants and toddlers living under abusive/neglectful and traumatic conditions (see forms below); abusive/neglectful and traumatic conditions which are more often than not chronic in nature. Regardless of the caregiving provided to the infant/toddler; removal from the home/primary caregiver is a traumatic event and as such should be identified and appropriately evaluated by a team of qualified clinicians with particular experience evaluating the development of infants and toddlers. Policy/Guidance needs to be developed to direct the participants involved in child find activities related to infants/toddlers referred or being referred pursuant to the federal laws containing the IDEA Part C and CAPTA provisions to utilize an appropriate screening tool such as the Brief Infant-Toddler Social and Emotional Assessment (BITSEA) to screen children with a substantiated report of abuse and/or neglect. Infants/toddlers referred to ESP without an appropriate screening of their social-emotional needs utilizing a tool such as the BITSEA should be screened using an appropriate screening tool such as the BITSEA. Guidance should be provided regarding infants/toddlers being evaluated by ESP as a result of a referral by DCF or CPT for an eligibility evaluation to include a domain, social-emotional domain, specific evaluation tool such as the Infant-Toddler Social and Emotional Assessment (ITSEA). All infants and toddlers in shelter/foster care referred to the ESP should be provided with a domain specific evaluation addressing the social-emotional domain such as the ITSEA. A well-developed social-emotional foundation is a key to future learning and overall development; early identification of social-emotional problems within this group of children will ameliorate the probability of early social-emotional concerns resulting in disability or developmental delay later in life.

**(information inserted to reflect Florida's definition of a substantiated case)*

Component: 5.0 - Guidance/Policy 5.6.4

Under Guidance for Policy 5.6.4 confusion may arise as a result of using the term “dual role” in relation to evaluator and direct service provider. “Dual Role” has consistently referred to the Primary Service Provider also performing the tasks required of a Service Coordinator. For example:

Component: 5.0 - Guidance/Policy 5.6.4

Under Guidance for Policy 5.6.4 confusion may arise as a result of using the term “dual role” in relation to evaluator and direct service provider. “Dual Role” has consistently referred to the Primary Service Provider also performing the tasks required of a Service Coordinator. For example:

Component: 4.0 Service Coordination

4.3.2 Average caseload ratios for those performing a dual role (PSP and service coordinator) must not exceed the state established caseload ratio specified in the Early Steps contract.

Component: 6.0 Early Intervention Services and Supports – Guide 6.2.2The PSP may also function in a dual role as the service coordinator when enrolled as both a service coordinator and a direct service provider.

Component: 10.0 Personnel Development and Standards - Handbook

10.4.9 An individual (licensed or non-licensed) who meets the service coordinator requirements may dually enroll.

Please retain consistency, and correct inconsistent use of, the use of the term “Dual Role” to mean that which is reflected in Component 6.0: **6.2.2**The PSP may also function in a dual role as the service coordinator when enrolled as both a service coordinator and a direct service provider.

I am submitting the following comments to the proposed changes to Early Steps policy documents during this public comment period:

3.1.4 Policy – B. 1. Screening and/or evaluation?

B.2. Scaled scores??? Sub-domains??? Although the definitions are available, the info is confusing.

D. “beyond” standard scores?? Do you mean “other than”??

D.2. What if parent doesn’t give consent? Do you terminate?

D4. Wording is much too complicated and I am not even sure what it is you are trying to say.

D5. Do you mean a standardized tool rather than “protocol”?

Guidance/Procedures- B. Standard scores of any tool or specific? B.3. Not clear what this means

C. “beyond”?? Using attesting tool or not?

3.1.11 Guidance/Procedures- A. What is the purpose of the BDI-2 screener at the annual eval of the IFSP? Is it strictly for eligibility? Are you now going to use the Screener to determine if the child continues to need services or are you going to continue to show progress notes? Or both?

B. Don’t you mean “screening tool indicates” rather than the “screener”?

3.5.1 Guidance/Procedures – B. It is confusing to use the term “early intervention services” here. It causes confusion with the Medicaid program title.

C. Very confusing using the term “evaluation” twice. Needs to be explained clearly.

E. This wording concerns me because it implies that only one domain has to be evaluated if it is the only one concern (e.g., PT). All domains must be evaluated if billing Medicaid.

F. Are you leaving the option to the providers? or do you want them to use a testing instrument which will produce a score?

G. What instrument are you using for the secondary screening for ASD? Are you leaving this up to the provider? The rest of G. seems to state that the LES can evaluate a child, I

suppose, using an ADOS, which requires a team, and can make a diagnosis??? Are there qualified personnel conducting the ADOS in order to make a diagnosis?

4.2.18 Summary of Change- Do you mean “other than” rather than beyond? Still confusing.

5.5.3 and 5.6.4 Guidance/Procedures and Summary of Change – Do you need to reword to ensure that providers and the LESs Understand that an Medicaid service (screening, eval or session) must be a face-to-face service, and cannot be conducted by phone, fax, etc., and be billed to Medicaid. Although you state no change to policy, this does change policy from what was previous stated.

IFSP Form D – Isn’t the evaluation to also identify delays and needs associated with those delays? Shouldn’t the form also state that?

IFSP Form G – Should read: **Medical Necessity:** If your child is a Medicaid recipient, the services to be reimbursed by Medicaid must meet the Medicaid definition of medical necessity. The following provides documentation of the medical necessity of your child’s services, if applicable:

Thank you for the opportunity to review the proposed policy changes.

Please accept the following as public comments to be considered for the Operations Guide:

1. Add- **10.6.3**- CMS enrolled ITDSs and EI providers may provide guidance during a ITDS mentorship.
2. Add- **10.6.3**- Multiple ITDSs/EI providers may oversee a mentee during the mentorship process, however, one provider must serve as the primary mentor.
3. Revise- **10.6.3.(3b)**-...and must provide a clear Level II background screening prior to beginning an Early Steps Mentorship.
4. Revise- **10.6.3.c**- change "within 14 calendar days" to "within 30 calendar days."

HRAs and FSAs are not true “insurance” yet many companies are moving to high deductible plans with HRAs set up to potentially cover the deductible and or to pay for other benefits. We have not been able to find policy that covers these hybrid types of plans. Operationally, it would be difficult to identify these on a claim by claim basis as the provider could send in only the EOB stating that the claim was applied to the deductible. Please consider updating policies regarding this issue. Thank you.