



PHPG



The Pacific Health Policy Group

STATE OF VERMONT
VALUE-BASED PURCHASING (VBP) PROJECT

REPORT ON VALUE-BASED PURCHASING WITHIN
INTEGRATED FAMILY SERVICES (IFS)

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INTRODUCTION TO OVERALL VBP PROJECT AND THIS REPORT

The State of Vermont, Department of Vermont Health Access, contracted with the Pacific Health Policy Group (PHPG) to identify the major programs for which the Agency of Human Services (AHS) procures direct care (as opposed to administrative) services from another entity, examine these programs regarding their utilization of value-based purchasing (VBP) methodologies, and make recommendations to strengthen VBP within these programs.

As an initial task of this project, PHPG submitted a Draft Report to DVHA in December 2014 that contained the following working definition of value-based purchasing programs:

Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.

The Draft Report also provided detailed descriptions of the following core features of VBP programs, and a framework for analysis of AHS programs (referred to as a VBP tool) that includes specific elements within these core VBP areas:

- Rate-setting
- Quality Oversight
- VBP Incentive and Performance Measurement Characteristics (i.e., measures, incentive structure, target of incentive, and quality improvement support/resources)
- Support by the VBP Sponsor
- External Factors that may Influence VBP Success

In January 2015, the State modified their request and selected Integrated Family Services (IFS) for PHPG in-depth review regarding its base payment approach and current and potential utilization of VBP. PHPG used the information and tools provided in the Draft December 2014 PHPG Report to serve as a pilot for this in-depth work and to further inform the development of the VBP report and tool.

This Draft IFS Report begins with a program description of IFS, including the program background and current operational structure. Section II provides PHPG findings regarding incorporation of the core features of VBP programs identified above into the IFS model and implementation. Section III provides PHPG recommendations and options for VBP program development within IFS, as well as key considerations related to these options. Section IV includes the VBP checklist completed by PHPG during our review of IFS, which guided the development of the findings and recommendations. Section V. includes primary supporting materials referenced in this Draft IFS Report, and provides lists of other documents reviewed and interviews conducted to inform the Draft IFS Report assessment and findings.

SECTION I: INTEGRATED FAMILY SERVICES (IFS) PROGRAM DESCRIPTION

Background and Overview

Children's Medicaid and other State and federal services to help families fall in five departments and over eleven different divisions of the Vermont Agency of Human Services (AHS). These State administrative structures and the associated State funded community programs have traditionally operated in isolation. State Departments / Divisions historically have developed separate and distinct children's programs, including separate Medicaid State Plan options, Medicaid waivers, and procedures and rules for managing sub-specialty populations within various programs. However, with the inception of the Vermont Global Commitment to Health 1115 Medicaid Demonstration in 2006, other more recent changes at the federal level and research advances in how child development impacts health throughout the lifespan, these silo structures no longer need to exist.

In 2010 AHS began the Integrated Family Services (IFS) initiative to focus on the creation of an integrated and seamless continuum of care for pregnant women and children up to the age of 22 years old with developmental, mental health and/or substance abuse needs and their families. The mission of IFS is to bring state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of Vermont's children, youth and families. The premise of IFS is that giving families early support, education and intervention will produce more favorable outcomes at a lower cost than the current practice of waiting until circumstances are bad enough to access high end funding streams, which often results in out of home or out of state placement.

The specific service delivery goals and objectives of IFS are as follows:

❖ Goals

- Improve early intervention
- Promote efficient and quality healthcare delivery
- Promote flexible service delivery to best meet individual needs
- Develop successful model for potential application statewide

❖ Objectives

- Enhance integration and collaboration across providers and State divisions through the care planning and delivery process
- Improve cost effectiveness, flexibility and fiscal sustainability through payment reform
- Evaluate program effectiveness at achieving goals and objectives

IFS State and Local Operational Structure

State-level Overview

IFS is designed to be collaboration between the following AHS Programs, Departments and their Divisions that support child and family services:

- Department of Vermont Health Access (DVHA)
- Department of Mental Health (DMH): Child, Adolescent and Family Division; Jump On Board for Success (JOBS) Program
- Department of Disabilities, Aging And Independent Living (DAIL): Development Services (DS) Division; Vocational Rehabilitation Division (DVR); JOBS Program
- Department of Health (VDH): Maternal and Child Health Services Division; Alcohol and Drug Abuse Programs (ADAP)
- Department for Children and Families (DCF): Family Services Division; Child Development Services Division
- Agency of Human Services (AHS) Cross-departmental Programs/Structures: Field Services; State Interagency Team; Blueprint for Health

Children's Medicaid services provided through the Agency of Education are not included in the IFS model.

State-level administration of IFS has been re-structured over the last six months to provide improved oversight and functioning. It is now overseen by a recently formed IFS Management Team, which is organizationally positioned within the AHS Secretary's Office. The Management Team is comprised of a new full-time IFS Director (who was hired at the end of December, 2014), the AHS Director of Systems Integration (approximately 95 percent time on IFS), and the AHS Director of Special Projects (approximately 75 percent time on IFS). Each of these members has clearly defined roles and responsibilities to facilitate the advancement of IFS goals and operations. (See Section V, Attachment 1: IFS Management Team).

IFS also now has the following state-level groups to focus on specific aspects of the initiative, with membership spanning all the AHS divisions serving children and families: IFS Senior Leadership Team, IFS Implementation Team, IFS Financing and Payment Reform Work Group, and the soon-to-be-formed IFS Accountability and Oversight Work Group, IFS Community-Based Prevention and Promotion Work Group, and IFS Data and Technology Work Group. In addition, an IFS Stakeholder Group comprised of representatives from relevant AHS divisions and community partners was formed specifically to help guide the program re-design for a time-limited period (December 2014 through February 2015). Collectively, the IFS Management Team and these IFS groups have developed a clear vision and mission, decision making process, readiness guidelines for new regions, governance models, and a draft strategic plan for 2015 to 2010 that includes a 2015-2016 work plan. (See Section V, Attachment 2: IFS Strategic Plan and Work Plan).

Local Level Overview

Currently, IFS is being implemented in two geographic catchment areas of the state (Addison County and Franklin/Grand Isle Counties) through grant agreements between the AHS and DMH/ DAIL Designated Agencies (DA) in each of the two regions and the Parent Child Center (PCC) in Addison County.¹ The grant agreements with Counseling Services of Addison County (CSAC) and Addison County Parent Child Center (ACPCC), the IFS providers in Addison County, began in July 2012, and the grant agreement with Northwestern Counseling & Support Services (NCSS), the IFS provider in Franklin/Grand Isle (F/GI), began in April 2014. It should be noted that, unlike Addison County, in F/GI County both DA and PCC services are provided by NCSS. These sites are considered “early implementer regions,” in that their experience is intended to inform future deployment of IFS statewide.

The local governance and programmatic parameters of IFS are described in the grant agreements between AHS and the IFS Providers in the two early implementer regions, as well as the September 12, 2014 IFS Provider Manual. Section V, Attachment 3 contains relevant excerpts from the IFS Provider Manual used during this review.

The grant agreements between the State and IFS providers clearly denote that IFS is a partnership between the IFS sites and the State to develop and test the program infrastructure through implementation. This includes the design / augmentation of service guidelines, screening and assessment tools, quality oversight practices, documentation and reporting requirements, incentive payments, and outcomes.

IFS Providers also must create and submit to the State a comprehensive local governance agreement for the regional integrated system of care. The written governance agreement must be signed, at a minimum, by the Designated Agency, Parent Child Center, Department for Children and Families –Family Services Division, VDH – Maternal and Child Health Services local designee, AHS Field Director and Local Interagency Team Coordinator.

Each local governance agreement must clearly identify a provider or entity who will serve as lead on administrative functions for the local partnership. This includes, unduplicated and accurate billing for the local provider network; receive, manage and disburse, according to local agreements, any incentive/shared savings payments from the State, on behalf of the local partnership; and ensure State and federally required data are reported as needed and available for State or federal review as requested. The identified administrative entity/fiscal agent must, at a minimum, demonstrate the following:

- An operational HIPAA compliant electronic billing system
- Written Internal Fiscal Controls
- Adherence to AHS & CMS IT security and privacy standards

¹ The IFS grant agreement is one segment of a much larger, comprehensive AHS Master Contract agreement for all services provided by each of these providers.

- Enrollment as a Medicaid provider in good standing
- Maintenance of an MCO grievance and appeals tracking system
- Complete an annual independent audit of its financial records
- Generate and/or collate encounter data reports electronically (date of service, type of service, provider, recipient)

SECTION II: SUMMARY OF FINDINGS REGARDING FEATURES RELATED TO VBP DESIGN WITHIN IFS

This Section provides PHPG findings regarding the following features of IFS that could affect VBP design and implementation:

- Base Payment Model and Rate-setting
- Quality Oversight
- Specific VBP Components within the IFS Model
- Support by the VBP Sponsor
- External Factors that may Influence VBP Success

Base Payment Model and Rate-Setting

Overview

The IFS Provider Manual Section 10.4 describes the general provisions for provider payment (see Section V, Attachment 3), which are presented below. As noted in this Manual, the IFS reimbursement approach is meant to accomplish the following objectives:

- Promote flexibility in service delivery to meet the needs of program participants and promote early intervention/prevention
- Reduce paperwork demands created by and serving only Medicaid fee-for-service billing
- Facilitate documentation based on best clinical practice, quality and outcomes
- Shift focus of program reviews from volume and adequacy of billing documentation to clinical appropriateness, quality and efficacy
- Establish a predictable funding mechanism for providers
- Promote a seamless and integrated health and human service delivery system in each region
- Enable schools, providers and State staff to collaborate and identify the best use of clinical resources for their service region

To achieve these objectives, IFS providers receive revenue from three State sources: 1) Medicaid claims payments for direct care services, 2) quarterly managed care investment payments, and 3) quarterly grant payments for State general fund and/or other non-Medicaid funds. This review regarding VBP focuses on only the Medicaid claims payments for direct services, which is currently called the **IFS PMPM/Case Rate**. **For purposes of this Report, this payment methodology is referred to as the IFS Case Rate** since it is not truly a per member per month (PMPM) methodology, in that providers are only reimbursed for children served in a given month rather than on a total member population basis. In this vein, PHPG suggests that the State similarly revise their language regarding the current IFS methodology to accurately reflect that it is a case rate reimbursement and not a PMPM payment.

Case Rate Payment Construct – IFS Populations and Caseload Calculations

IFS is an agreement for the regional delivery of an integrated and seamless continuum of the services for pregnant women and children up to the age of 22 years old and their families residing in the IFS early implementer geographic regions (i.e., Addison County, Franklin/Grand Isle Counties).

The IFS target population also includes children with developmental disabilities (DD) from birth up to age 18 in Franklin/Grand Isle County. In Addison County, IFS includes children with DD through age 21. Young adults between the ages of 18-22 may be served through IFS or Developmental Disabilities Services (DDS). Individuals 18-22 who currently receive DDS funding will continue to receive DDS funding. Individuals 18-22 with DD may apply for DDS and, if approved, will be the responsibility of DDS. If they are not found eligible to receive DDS funding, they can apply for services through IFS.

IFS providers are expected to serve a minimum caseload for the target population each year. The minimum caseload is determined by examining each provider's Medicaid claims for IFS services to determine the average number of member months and average number of persons served for the target populations over the previous three years. The State and the provider then negotiate the minimum caseload to be included in the IFS provider agreement, based on any expected changes during the agreement period due to new policy or funding initiatives (e.g., new provisions for insurance coverage of autism services that could impact the number of children requiring services).

Case Rate Payment Construct – Services included in IFS

The Case Rate is a monthly rate established for each provider for reimbursement of all Medicaid-covered services provided to the target population. Services are expected to be provided as a coordinated continuum of care/services across multiple types of providers and settings. The goal is to improve the health and well-being of pregnant/postpartum women, infants, children and young adults so that progress on maternal and child health and safety, family stability, and optimal healthy development through the transition to adulthood is achieved.

IFS services include EPSDT outreach and health promotion, prevention, and early intervention services; treatment and support services; and the management of admissions to residential, emergency beds and inpatient psychiatric hospitalization, as well as discharge planning and service coordination from those facilities. Any residential placement request is subject to coordination with and prior approval by the Act 264 Case Review Committee.

The specific Medicaid services within each IFS provider's Case Rate differ, based on the array of services provided by that particular provider (i.e., Designated Agencies versus Parent Child Centers) as well as local governance and system of care agreements. The following Table provides an overview of the Medicaid services included in the IFS Case Rate. Prior to IFS, providers were given a capped budget allocation and reimbursed for these services on a fee-for-service basis.

SERVICE UTILIZATION AND BUDGET ALLOCATIONS USED TO ESTABLISH IFS CASE RATE*						
MEDICAID SERVICE	DEPARTMENT BUDGET ALLOCATION	MEDICAID AUTHORITY	STATE PLAN PROVIDER RESTRICTIONS	IFS PROVIDER		
				NCSS	CSAC	ACPC
Developmental Therapy [limited to DCF-CIS allocation (if any); does not include LEA contract services]	DCF/CDD	State Plan	LEA and/or DCF Part C & H designated providers	X		X
Extended Services for pregnant women (CIS)	DCF/CDD	State Plan	VDH-DCF designated	X		X
Targeted Case Management for children 0-12 months, pregnant & postpartum Women (CIS)	DCF/CDD	State Plan	DCF designated	X		X
Targeted Case Management for 1-5 year olds (CIS)	DCF/CDD	State Plan	DCF designated	X		X
Specialized Rehabilitative Services	DMH	State Plan	DMH designated	X	X	
	DMH (Non-Categorical)	State Plan	DMH designated	X	X	
	DMH Autism	State Plan	DMH designated	X	X	
	DMH/JOBS	State Plan	DMH designated	X	X	
	DMH/YIT	State Plan	DMH designated	X	X	
Children's Emergency Service (Access)	DMH/Access	State Plan	DMH designated	X	X	
Intensive Family Based Services (IFBS)	DCF/FSD	State Plan	DMH and DCF designated	X	X	
	DCF/VCRHYP	State Plan	DCF designated		X	
Substance Abuse Treatment	ADAP	State Plan	ADAP designated	X	X	
Targeted Case Management 0-22 years old with Developmental Disabilities (Bridge)	DAIL/DS	State Plan	DAIL designated	X	X	
Home Provider [GC/MH waiver and Individual Service Budgets (ISB's)]	DMH	GC - DMH specialized program & ISB	DMH, DAIL and DCF designated	X	X	
Respite (GC/MH waiver)	DMH & DCF	GC - DMH specialized program & ISB	DMH, DAIL and DCF designated	X	X	
Transportation (GC/MH waiver)	DMH & DCF	GC - DMH specialized program & ISB	DMH, DAIL and DCF designated	X	X	
EPSDT Outreach & Referral (MH Pediatric Collaborative)	DMH	EPSDT	DMH and DCF designated	X	X	
DAIL DS Program Services (GC/DS waiver)	DAIL/DS	GC - DS specialized program	DMH and DAIL designated	0-18**	0-21	

*Services in the IFS agreement but not reimbursed through the IFS case rate are not included in this Table (e.g., non-Medicaid, MCO investments)
 ** Individuals 18-21 requesting services are given a choice to enter either the IFS or the Adult Developmental Disability Service system

Children whose services are provided under the IFS Case Rate payment may be eligible for additional service benefits if the following conditions are met:

- Service claims are not duplicative of services or any other supports provided under the IFS cap, have been included in the integrated treatment plan, AND are not in the IFS provider grant agreement work specifications
- Service claims from other provider ID's are for a specific set of services provided under a separate local agreement, such as with the schools or through other State funded contracts and/or providers not part of the local governance agreement

IFS providers are required to electronically submit encounter data to the State for all services delivered using the DMH Monthly Service Report (MSR). Minimum required encounter data elements include client name, Medicaid ID, date of referral, date of first contact, and for each service delivered: date of service, place of service, type of service, and person delivering service. Section V, Attachment 4 includes DMH - MSR service type reporting codes for encounter data (based on 2011 documentation).

The IFS regional fiscal agent must submit the MSR no later than the last day of the month following the reporting month. These data have sufficient detail to be utilized for IFS quality oversight /monitoring, outcomes and potential future adjustments to the rate methodology as needed. **However, it appears that there are no dedicated State resources for reviewing these data on behalf of IFS.**

Case Rate Payment Construct – Rate Setting Methodology

IFS provider payment rates are constrained by a cap on the total reimbursement a provider can receive in a given year across all children and youth served. In essence, this cap is determined by the broader annual funding appropriations process, in which the General Assembly approves expenditures for each AHS Department and for the specific service programs within the purview of the Department. Typically, the expenditures approved do not change from year to year unless there is a specific proposal to do so. These annual expenditure authorizations create a cap on the amount that each Department may spend for the services they oversee. As a result, funding for IFS early implementer sites is limited by each Department's approved budget for the service types that are included in IFS, and historical allocations of these statewide funds for the IFS services delivered by each IFS provider. As such, **annual budgeting to determine the Medicaid allocation for IFS services is conducted separately by each of the Departments participating in IFS.**

In addition, the IFS rate setting process has not altered the base funding policies that govern the provider Medicaid allocation within specific Departments. For example, DCF uses a regional allocation formula, while DMH uses an annual provider review of financials, cost and budget to determine each provider's future allocation; other programs such as DCF-IFBS may use a procurement process. As such, **each IFS provider's Medicaid allocation and resulting IFS rates differ based on their unique historical budget allocation and expenditure levels under their contracts with each separate Department involved in IFS.**

To develop the IFS provider's unique monthly Medicaid rate, each AHS Department involved in IFS identifies the Medicaid services under their purview that are within the provider's IFS agreement, and their specific annual allocations available for those services, the region and for the target population expected to be served by the IFS provider. Claims data are used to validate historical member month totals across all allocations in the aggregate for each IFS provider to determine caseload targets. The total Medicaid allocation is divided by the minimum Medicaid caseload expectation for the provider to determine the final IFS case rate. As such, Case rates are not based on any one group of services being bundled into a claim; rather, rates are based on an overall global aggregate budget for the year and meeting a minimum caseload target. In addition, there is no case mix adjustment for the rates; the same member month rates are paid for children and families requiring minimal services packages as for those requiring intensive service packages.

Case Rate Payment Construct – Provider Payment Methodology

Annually, IFS providers and the State agree on each IFS provider's overall operating budget and billable caseload expectations. The provider case rates are based on 100% of the total annual allocation and billable caseload. The total IFS annual allocation per provider is defined in their grant agreement and a maximum billing amount is loaded into the Medicaid Management Information System (MMIS). Each IFS provider is paid using beneficiary based claims that are processed monthly through the MMIS, using the provider's unique case rate and annual payment limit on file.

The billing agent for each of the two IFS early implementer regions (CSAC and NCSS) submits claims for each Medicaid-eligible individual served each month that include the provider number responsible for the service; HP then reimburses the rate on file for that provider. The billing agent cannot submit more than one claim per local provider for each Medicaid-eligible individual they serve each month.

In order for a claim to be submitted the following conditions must be met:

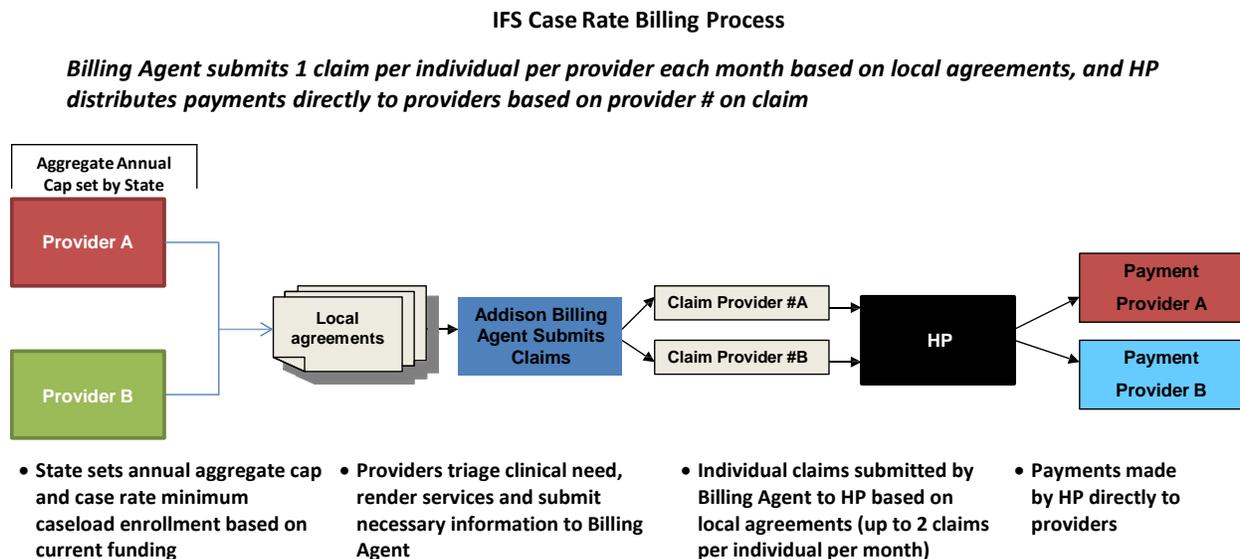
- The client must be a Medicaid beneficiary
- The client must be an active case for the rendering provider agency
- Provider service logs must substantiate performance of at least one activity or visit per month. Activities include any allowable state plan, EPSDT and/or home and community based waiver service, including but not limited to collateral contacts, service coordination, psychosocial rehabilitation, consultation and education, family, individual or group counseling or allowable EPSDT outreach and administration activities.

Any individuals, including physicians, serving as direct service staff under the IFS capitated rate cannot concurrently provide private services of a similar nature to an IFS client and bill for those services as a fee-for-service private practitioner under the Medicaid program.

For children who have private coverage, third party payers must be billed for all services covered in the commercial payer's covered benefit plan. If services are delivered to a Medicaid beneficiary that are not

in the primary payer’s covered benefit package, but allowable under the Global Commitment to Health Medicaid waiver, the case rate may be billed.

The following provides a graphic description of the IFS Case Rate billing process:



For caseload tracking purposes, providers must continue to submit monthly claims even if the aggregate annual cap level is reached; however, the claim will not be reimbursed once the maximum aggregate cap for that provider is met.

Federal Title XIX regulations do not allow these IFS providers to deny or limit services to Medicaid beneficiaries even if their annual aggregate cap is reached. That said, there are provisions in the CSAC and ACPCG grant agreements which allow for these providers and the State to review and revise the contractual cap and case rate should unforeseen exceptional circumstances occur that are out of the provider’s control that are on such a scale that is not accounted for in their caseload trends (e.g., natural disaster, adverse community events, significant and previously unreported child maltreatment and custody). However, it should be noted that any increases in the funding amounts within an IFS grant agreement would most likely need to be approved by the General Assembly or re-allocated by each Department using funds currently allocated to providers outside of the IFS program.

In addition, according to language in the CSAC and ACPCG IFS grant agreements, if the provider incurs verifiable service costs that, as a result of the pilot, are not reimbursable, but would be reimbursable under practices in place for non-pilot sites at the time the services were provided, the provider may request a review and payment by the State. The request must be submitted to the AHS Secretary and be accompanied by documentation of the expense, the services delivered, and the reason the costs are above and beyond the IFS aggregate annual cap and/or the case rate.

Providers are required to conduct annual reconciliation of actual financial experience to the grant and

report this information to the State, including:

- a monthly operating statement of income, expenditures and associated operating losses/surpluses that encompasses all revenues received (including IFS Case Rates, Managed Care Investments, Federal Grants, first party, third party, donations, etc.) and the associated expenses;
- a statement of total caseload served;
- a calculation of total per-member per-month expenses, revenues, and grant-funded revenues; and
- an annual financial audit report.

Subsequent grant agreements are level funded to the previous year's value plus or minus any legislatively identified increases or decreases. The IFS Provider Manual indicates that an iterative process ensues between providers and the State to define how any prior-year surpluses will be reinvested into services, **although it is unclear if this provision has been implemented by any or all of the AHS Departments responsible for the budgets of the services included in the IFS Case Rate. In addition, to be true to the IFS model, this process would ideally be performed across all Departments rather than by each separate Department involved in IFS.**

Findings regarding VBP Elements within the Case Rate Payment Model

VBP programs must be designed to work in concert with the effects of their underlying base payment model. As described in the Draft PHPG December 2014 Report, there are three primary models for provider payment: fee-for-service, bundled payments, and population-based payments (see Section V, Attachment 5: Base Payment Models).

The IFS Case Rate is primarily a bundled payment model in that providers are paid a fixed dollar amount for a defined set of Medicaid services delivered within a month for each beneficiary served by the provider, and they assume financial risk for the cost of services for the IFS population. On a positive note, this bundled payment approach gives the providers the flexibility to decide what Medicaid services should be delivered, rather than being influenced or constrained by more granular fee schedule amounts. However, this type of payment model also may create an incentive to underserve the target population. **Strong Valued Based Purchasing must also include provisions for State oversight and personnel resources to monitor service utilization data and/or an appeals process to ensure that the children and families receive the services needed.**

PHPG also reviewed the specific financial and caseload assumptions used to create the IFS model to assess key components related to VBP design, including but not limited to:

- Rates that are reasonable to assure enrollee access to care
- A rate setting process that aligns with the State budgeting timelines and methods
- A payment model design that supports the objectives of the program

The IFS rate setting model is based on a three year caseload average and the previous year's

expenditures for the specific providers, services and populations involved in the IFS program. However, as previously noted, the IFS rate setting process has not altered the base funding policies from the specific Departments governing the Medicaid allocation. **While current operational realities may warrant the variations in contracts, caseload and service utilization assumptions within each IFS provider's case rate, this makes it difficult to compare results across sites and to develop a consistent rate-setting methodology for deployment of the IFS model statewide.**

The IFS rate setting process must align with State budgeting timelines and methods, in that the aggregate annual IFS provider budgets are derived from separate and discrete budgeting processes across AHS divisions. **However, there are no unified or coordinated annual IFS budgeting or rate setting processes for these children's services across AHS. As a result, the administrative functions associated with funding (e.g., data reporting, fiscal accountability) remain segmented. This limits the ability of IFS to truly function as an integrated program for children and family services at the State and local levels.** This issue is tangentially identified in the IFS Work Plan for 2015 - 2016, which includes action steps to explore expansion of the services within the IFS bundled payment and how the financing and management system aligns with the system of care and not just specific programs (see Section V, Attachment 2).

Nevertheless, the case rate model that enables each separate IFS provider to manage to a target appears to support the programmatic goals of the IFS program. The case rate is designed to support service flexibility based on need, establish a predictable funding mechanism for providers, and promote collaboration across providers in each region to identify the best use of clinical resources for their service region.

Provider feedback indicates that all of these objectives are being met. Providers indicate that the case rate model has enabled them to redefine job descriptions, change their intake systems, and modify their service notes to better align with the IFS focus of meeting the holistic needs of children, youth and families. Providers also verbally report an increased ability to provide more early intervention services, to provide additional non-billable services (e.g., consultation to other providers, assessment of community after-school programming, parenting groups), and to better provide necessary treatment services to more children (e.g., substance abuse services). CSAC has provided data that show an increase in the number of direct service hours, more timely first contact, and a decrease in the number of crises interventions. Providers also indicate that the level of cooperation among local providers has been significantly enhanced due to the new IFS governance structures.

In summary, the case rate appears to be a good fit for the goals of the IFS program, as implemented in the two early implementer regions. However, in order to ensure that this is a sound model that preserves service access and can systematically be deployed in other sites, there would need to be a more unified IFS budgeting process within AHS, and development of a consistent methodology for population and service inclusion/exclusions in the provider rate-setting process that incorporates both a system of re-basing utilizing standardized data and a quality performance component.

Quality Oversight

PHPG reviewed the IFS model to assess key quality oversight components related to VBP design, including but not limited to:

- Quality oversight structures;
- Monitoring for potential unintended consequences and mitigating the risks of potential fraud, abuse and waste; and
- Quality performance measurement.

Quality Oversight Structures

The IFS Provider Manual includes several activities related to Quality Oversight, including state-level auditing and monitoring, provider quality improvement projects, risk mitigation strategies, and performance and outcome measurement. However, IFS Quality Oversight at the state level is still under development, and there is no organized framework for quality oversight activities. This could be the role of the recently formed IFS Management Team which is jointly responsible for data and accountability, and the AHS IFS Director who is Chair of the soon-to-be-formed IFS Accountability & Oversight Work Group. (See Section V, Attachment 1).

According to the IFS Strategic Plan, an objective for 2015-2016 is to hold IFS grantees to common population indicators and performance measures. The 2015 - 2016 IFS Work Plan contains specific goals and tasks to accomplish this objective, including putting systems in place to measure and monitor performance that use consistent practices and processes across IFS for performance improvement and reporting. (See Section V, Attachment 2).

As indicated in the IFS Provider Manual, IFS recently created a state-level cross-departmental IFS team to conduct site visits and chart reviews at the two provider sites. The site visits were conducted in January and February, 2015. Over twelve state staff representing all AHS divisions involved with IFS participated in the site visits, using the opportunity to cross-train about each other's existing quality performance requirements as well as to assess provider adherence to the requirements within the IFS program.

To conduct IFS site visits, the State has developed an IFS Chart Review Form with review items that relate to timeliness of care, appropriateness of care, and evidence-based practices (see Section V, Attachment 3 for an example of items included in the site visit reviews). The IFS Provider Manual includes nine "appropriateness of care" measures (see Section V, Attachment 3) and eight of these measures are included in the January 2015 IFS Chart Review Form.

The Chart Review Form items also reflect the IFS core elements that must be present in all client records, and items related to specific best practice guidelines developed by each specific state program within the IFS purview. IFS leadership indicate that it is the goal to eventually develop one set of

evidence-based practices for IFS sites that reflect an integrated system of care and still maintain elements unique to specific populations where needed.

The IFS Provider Manual also indicates that IFS Providers also are required to identify at least one area for quality improvement per fiscal year, which may include but are not limited to:

- i. *Practice Improvements*, such as use of electronic medical records, data registries, panel management tools, utilization review processes, triage and follow-up protocols, etc.
- ii. *Care Related Improvements*, such as family engagement strategies, trauma informed practice, health promotion activities, positive youth development, clinical guidelines (depression, ADHD, Autism, etc).

While not identified as a formal quality improvement project, CSAC's SFY14 Final Report presented information that their Appropriateness of Care Measure Data indicated that they were not seeing clients for a face to face contact within the targeted 5 business days frequently enough. As such, they redesigned their entire intake system. Since that change in May, 2014, they have seen about 93% of clients within 5 days.

Risk Mitigation

The IFS Manual September 2014, Section 11: Reporting, Program Integrity and Quality Oversight includes defined risk areas and mitigation strategies (see Section V, Attachment 3). The Manual identifies risks related to case rate model, including aggregate budget payments for which the provider would not otherwise be entitled; enrollment inflation and "cherry-picking"; and underutilization (i.e., providers failing to provide enrollees members with medically necessary health care services on a timely basis).

The Manual discusses mitigation strategies to address each of these risk areas, most of which are inherent in the federal and state laws and regulations governing the IFS providers (e.g., Medicaid provider certification, MMIS verification of Medicaid beneficiary enrollment, grievance and appeal rights, and bottom-line accountability for geographic service provision).

The IFS payment model also includes a provision that the State will recuperate 10% of a provider's annual Case Rate allocation if it is determined that the provider has not met minimum caseload expectations for the previous fiscal year. While it is not clear if the State has or intends to implement this element, this approach may not be financially sound due to the fact that providers only receive monthly payments for individuals actually served. As such, if providers fail to serve the minimum caseload, they are already reducing their revenues below those expected. Given that providers involved in these pilots are often the only agencies available to serve a region or target population, penalties in the absence of corrective action planning and strong quality improvement structure could ultimately limit access to necessary services rather than promote value and quality. Risk should be shared between the providers and State; however penalties in the absence of a strong VBP design and other incentives may be counterintuitive.

In addition, the Manual indicates that the State routinely monitors grievance and appeal trends and conducts chart reviews and consumer satisfaction surveys to monitor for appropriateness of enrollment activities and consumer satisfaction with provider services and member assessment of outcomes (see Section V, Attachment 3). **However, the State IFS structure currently does not have a systematic process in place to monitor these untended consequences and/or to collect and report statewide or regional data on service utilization, grievances and appeals, or consumer satisfaction specifically for IFS. As such, risk mitigation is currently weak in the IFS oversight structure. A more comprehensive monitoring and evaluation approach should be considered before deployment of the model in additional sites.**

Quality Performance Measurement

To date, no unified State-level baseline data are being collected or reported for IFS service utilization measures, population indicators or performance measures, primarily due to a lack of alignment across divisions and a lack of staffing available to perform this function for the IFS program. The IFS Work Plan for 2015 – 2016 identifies this issue by including an action step to “produce semi-annual reports to provide state & local data to drive decision-making.” (See Section V, Attachment 2).

Currently, multiple documents contain IFS performance and outcome measures that, for the most part, do not align with each other. These documents include the September 2014 IFS Provider Manual (which contains outcome measures for quality oversight, as well as outcome measures associated with the shared savings incentive that has not been implemented), the SFY15 Grant Agreement with CSAC, the CSAC SFY2014 IFS Report, and the January 2015 IFS Strategic Plan.

The most recent document, the 2015 IFS Strategic Plan, is based on the January 22, 2015 IFS stakeholder meeting, in which participants reached broad agreement on specific population indicators used to measure change at a whole-population level, and headline performance measures to be included in all IFS grants in the future. In addition, in late January 2015, IFS State leadership met with the IFS Providers to identify initial performance and outcome measures for NCCSS and CSAC to report to the IFS Management Team within the near future for purposes of legislative reporting to the legislature, other interested stakeholders and potential new IFS regions. Section V, Attachment 6 contains a cross-walk comparison of the outcome measures contained in these various documents.

As indicated in the PHPG IFS Leadership interview and email correspondence that summarized the February 2, 2015 meeting with providers, the whole of the IFS Measure Set is still developing under the auspices of the soon-to-be formed IFS Accountability & Oversight Work Group. In its entirety, the IFS Measure Set is intended to include the headline performance measures in the 2015 IFS Strategic Plan and appropriateness of care measures included in the IFS Provider Manual. Different data/performance measures from the Measure Set will be used depending on the purposes and audiences. While progress has been made toward identifying some of the data collection needs around each of these measures, the data collection is not yet standardized for most of them; until this occurs, any data reports will include the data collection specifications for each measure.

The IFS Provider Manual indicates that the goal is to review measures quarterly and report them annually, and periodically update them as the IFS initiative progresses. It also indicates that the State will establish baseline indicators on all measures for all regions and the baseline will guide how benchmarks are determined for each local provider network. In addition to the above measures, the IFS Provider Manual indicates that the State will create community profiles for each region which will be provided to local provider networks on a regular basis to gauge overall population health, demographics, and trends in health conditions and service needs.

It is important that the data collected and reported regarding provider performance be carefully chosen to ensure alignment with the goals of the IFS project and with the inherent risks associated with a case rate model.

VBP Incentive Structure and Measurement Model

The specific purpose of the PHPG VBP Project is to review the VBP structure within each AHS prioritized program to assess alignment with characteristics of effective VBP programs. As presented in the Introduction to this Draft Report, the following definition of Value-based Purchasing was derived from the national literature and is used in this project:

Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use.

Provider Manual Section 10 implies that providers are able to retain prior-year surpluses, as long as they are reinvested into eligible services. This provides a financial incentive for providers to ensure efficient care and to focus on improving the outcomes related to the services under their financial agreement. However, it is unclear if this provision has been implemented by any or all of the AHS Departments responsible for the budgets of the services included in the IFS case rate. In addition, as previously noted, it is unclear whether the State is adequately monitoring the encounter data to identify any reduced service provision to the children and families seen by the provider, which is an inherent risk in a case rate approach.

The IFS design, as described in Section 10 of the Provider Manual, also included a shared savings incentive (see Section V, Attachment 3) which would have rewarded providers for performing well on metrics related to out-of-home placements (i.e., Private Non-medical Institution utilization, non-hospital-based emergency placements, and DCF substitute care allocations for the region), psychiatric hospitalizations and emergency room utilization. Under this approach, the percentage decrease in expenditures associated with reductions in utilization would be shared back with the IFS providers equal to the percentage of the drop in utilization. However, this incentive structure is somewhat duplicative of the shared savings approach within the Vermont Medicaid Shared Savings Program (VMSSP) that was implemented in January 2014 in that emergency room and psychiatric hospitalization utilization are included in the cost of care calculations for the Accountable Care Organizations (ACO) participating in

the VMSSP. Moreover, shared savings incentives are not recommended for small sample sizes given the unreliability of projected cost calculations. As such, this IFS shared savings incentive approach has not been implemented. **As IFS moves forward with strengthening the VBP aspect of the model, any incentive structures should be designed and reviewed for alignment within the context of the broader incentive programs that have been implemented or are being planned under the State Health Care Reform efforts.**

PHPG did not identify any other VBP components within the IFS operational model, and none that include performance metrics. As such, further assessment of these VBP metrics was not warranted for this Report.

Support by the VBP Sponsor

Effective VBP programs include actions and resources that engage the providers in efforts to improve their performance and the overall performance of the program model, such as:

- Provider engagement in VBP program design and measure selection
- Data use, performance feedback and transparency with providers
- Implementation flexibility
- State-level resources to help provider improvement

Provider Engagement in VBP Design and Measure Selection

It is clear from all the documentation that IFS is meant to be jointly designed and implemented by the State and local partners. IFS providers report that they were involved in the design phase of the overall IFS initiative and provided direct feedback and edits to information through meeting participation, review of methodology and focused feedback sessions to review the IFS Manual as it was developed. Providers currently report that they feel their “State partners have been incredibly open and inclusive throughout the IFS program design and implementation.”

Data Transparency with Providers

Sponsors of strong VBP programs review the incentivized measures with providers prior to implementation; provide routine performance (data-driven) feedback to providers; and have staff, data collection and reporting systems that support monitoring VBP programs. As previously noted in Section II, none of these elements currently exist in the IFS State-level infrastructure.

Implementation Flexibility

Strong VBP models give providers flexibility regarding how to implement changes and to innovate on their own terms. Providers are given broad parameters within the overall IFS program regarding staffing, service delivery and local governance arrangements. They report that this is the primary benefit of the IFS program.

State-Level Resources to Help Provider Improvement

In effective VBP programs, the VBP sponsor provides resources to support provider efforts to improve their performance, such as technical assistance on comparative benchmarking; infrastructure support; clinical data feedback loops; quality improvement support and coaching, and additional staffing support (e.g., care managers).

The IFS Work Plan for 2015 – 2016 includes an action step to “establish an IFS learning community that includes collaborating partners and others interested in integration and fosters relationship-building within and across IFS regions, including families and practitioners, for the purposes of connecting, learning and sharing expertise.” (See Section V, Attachment 2).

External Factors

Effective VBP programs ensure that the external factors that can influence VBP success are aligned to support the VBP program goals and providers. These external factors include structural alignment for providers across multiple incentive programs; alignment of provider performance measures and reporting across different programs; ensuring that current regulations and laws support the VBP design; taking into account there State regulations, and programmatic and /or funding policies that may impact VBP program design and effectiveness; and VBP sponsor accounting for VBP funding needs (IT, staffing and Incentive payments) in the State budget process. Each of these is briefly reviewed below as a precursor to State implementation of a VBP program within IFS in the future.

Alignment of Multiple VBP Incentives for the Same Provider Network

Providers report that other programs that have an incentive structure, such as VCRHYP, do not align with the IFS model. As such, CSAC has chosen to not participate in the VHCRIP Incentive Pool.

Alignment of Multiple Measures from Different Programs

The goal of IFS is to have one unified set of measures; however providers report that the State has not met that objective and there is poor alignment across divisions. For example, the Provider Grant Agreement contains separate performance measures and provider implications for each of the AHS Divisions and programs represented in the Agreement.

In addition, the IFS providers have identified a list of twelve separate data bases or other reporting mechanisms required by the State for provider data reporting. Each of the programs associated with the reporting mechanisms have their own unique set of measures. This creates a disincentive for providers to streamline operations and also makes it extremely difficult to obtain holistic data for the IFS initiative. Reporting requirements include:

1. Monthly Service Report (MSR) – DMH and DAIL

2. Substance Abuse Treatment Information System (STATIS) - ADAP
3. Jump on Board for Success (JOBS) – VR and DMH
4. Runaway Homeless Youth Management Information System (RHYMIS) – Vermont Coalition for Runaway and Homeless Youth Programs (VCRHYP)
5. Bright Futures Information System (BFIS) – DCF early childhood
6. Early Intervention – Part C of IDEA
7. Reach-Up—Access
8. Tracking what used to be “waiver” kids - DMH
9. Youth in Transition (YIT)
10. Home-based Applied Behavioral Analysis (ABA)
11. Consultation services such as Pediatric Practices, non-open case consults
12. DCF/MH data

Regulatory and Legal Support for the VBP Program Design

The Global Commitment to Health enables flexible payment mechanisms for the Medicaid program, such as the IFS bundled payment model and future VBP program implementation.

Federal and State Programmatic and /or Funding Policies and Regulations that Could Impact VBP Program Design and Effectiveness

Providers indicate that the current effectiveness of the IFS Model is negatively impacted due to the fact that many of the requirements of the State departments and their programs do not align with the IFS model. Examples include:

- IFS providers must still develop a Plan of Care based on the child or youth rather than the family due to Medicaid billing requirements and State concerns related to HIPAA.
- JOBS requires that the IFS providers can only bill for JOBS services if the service is provided by the 2.2 FTEs funded through the JOBS program; this restricts providers from receiving credit for other youth who receive employment support services via staff who are not funded by JOBS.
- The DCF Child Development Division still requires submission of fee-for-service data.
- VCRHYP requires that outcomes are tracked separately for VCRHYP youth.

Additionally, as noted in previous Sections, different AHS Departments and programs currently use multiple databases and reporting systems, which negatively impacts the ability to submit, collect and monitor data for IFS in its entirety across involved Departments and programs. The State is in the process of designing and implementing a new Medicaid Management Information System (MMIS), and a unified Health Services Enterprise (HSE) platform. The HSE/MMIS projects provide an opportunity to streamline and standardize data submission and reporting requirements for specialized Medicaid programs (i.e., programs administered by DAIL, DMH, DCF, VDH and Agency of Education). As such, AHS/DVHA has contracted with the Pacific Health Policy Group (PHPG) and BerryDunn to conduct an 18-month project MMIS Specialized Program Project (SPP) to assess opportunities for modernizing client reporting systems across the AHS Specialized Programs and support the State in reducing redundancies

and maximizing efficiencies for data collection and reporting across these Programs. Data submission, collection and reporting for IFS should benefit from this project.

Furthermore, a new federal initiative called the Excellence in Mental Health Act Medicaid Pilot Program will soon become available that is designed to increase access to community mental health and substance use treatment services while improving Medicaid reimbursement for these services. The Secretary of the Department of Health and Human Services (DHHS) is responsible for designing and administering the program, which will involve a prospective payment system for comprehensive defined services, and will be made available for up to eight states to participate in a two year pilot program beginning in September 2017. Criteria for mental health clinics to be state-certified to participate in the program and guidance for establishing the prospective payment system must be issued by DHHS no later than September 1, 2105. DHHS will award planning grants to States by January 1, 2016 for purposes of developing proposals to be one of the eight pilots. Based on current information available about the Excellence in Mental Health Act pilot program, this may be an excellence opportunity for Vermont's mental health system. As such, the State should ensure that the IFS structure and processes are in alignment with the federal pilot program's goals, objectives and design. ²

VBP Sponsor Accounting for VBP Funding Needs in the State Budget Process

Currently the State budgeting process does not include allocation of additional resources to support the IFS infrastructure needs or future incentive payments.

² A more detailed summary of the current information available about the federal pilot program is available at: <http://www.thenationalcouncil.org/wp-content/uploads/2015/04/ExAct-CCBHC-Fact-Sheet-3-2015.pdf>

SECTION III: OPPORTUNITIES AND RECOMMENDATIONS FOR IFS VALUE-BASED PURCHASING (VBP) DESIGN

The IFS Initiative represents a unique blending of health and human service providers into an integrated continuum of care. The premise of IFS is that giving children, youth and families early and comprehensive support, education and intervention will produce more favorable outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access *high end* and safety net funding streams which often result in enhanced care management, more costly and chronic interventions, and out of home or out of state placement.

To establish an integrated approach to care, it was recognized that payments, incentives, quality oversight and program integrity practices must transition from volume-based fee-for-service and be designed to promote provider alignment, seamless and integrated prevention, and earlier intervention. In order to accomplish, this IFS reimburses a continuum of Medicaid behavioral health, mental health, nurse home visits, and developmental and case management services through a single case rate for each unique provider involved in the local governance agreement.

As noted in the findings, the IFS initiative currently does not operate with VBP elements, in that there are no performance measures linked to financial consequences. However, it is clear that the IFS framework was designed to permit such an undertaking. Outlined below are several key areas to consider in enhancing the project with a VBP approach to provider contracting.

Value-Based Purchasing: Base Payment Model

The IFS case rate approach gives the providers the flexibility to decide what services should be delivered, rather than being constrained by fee codes and amounts. However, this type of payment model also may create an incentive to provide fewer services to the target population. As such, it is imperative that the State have the personnel resources to monitor service utilization data to ensure that the children and families receive the services needed. This is especially important since there are no outcome measures being systematically measured that could indicate inadequate service delivery.

Value-Based Purchasing: Rate Setting

To ensure successful program deployment statewide, it may be prudent for the State to explore revisions to the rate-setting and payment methodology to ensure efficiency and equitable funding redistributions among providers based on data, as well as a value-based component based on performance data. It would be important that any re-basing of current funding take into account the fact that the current budgeting across AHS departments and subsequent IFS rate setting process is based on legislative allocations and historical trends for the specific providers involved, which may not accurately reflect current demographics for the target population, expected need and cost for services.

Additionally, the State currently is contemplating participation in the new opportunity provided under the federal Excellence in Mental Health Act Medicaid pilot program, as described at the end of Section II. As such, any revisions to the current IFS rate setting methodology and processes for case rate administration should be considered within the context of the pilot program payment guidelines that will be issued by DHHS in September 2015.

Other aspects for strengthening the rate setting model include, but are not limited to:

1. Incorporate additional service-level encounter data into the rate setting methodology.
 - a. Transition providers to submit encounter claims, including service-level detail under national healthcare code and transaction regulations, through the MMIS. This will likely be a required element under the Excellence in Mental Health Act pilot program. Note: Opportunities for transitioning encounter information from the MSR and other disparate systems to the AHS HSE/MMIS are currently being examined as part of the modernization of AHS IT systems. (See description at end of Section II).
 - b. Until such time, use the details available in the MSR to develop benchmark pricing models for calculations of the case rate.
 - c. Develop written technical documents for documenting the methodology used and if advanced by the State, a process and schedule for re-basing.
 - d. Assess the need for incorporating other elements such as outlier policies and/or risk adjusting case rates.
2. Incorporate standardized cost data into the rate setting methodology.
 - a. Assess the standardization and alignment of information in cost reports currently submitted by some IFS providers.
 - i. Incorporate existing cost data into the model for calculations of the global budget allocation and case rate.
 - ii. Include any data used in the detailed methodology technical documents recommended above, as well as any proposed process and schedule for re-basing.
 - b. For providers that currently do not submit cost reports, assess the viability of transitioning these providers to submitting standardized cost reports, and the possible mechanisms for submitting these reports.
3. Standardize services and target group of Medicaid enrollees that are included in the case rate.
 - a. Establish a common baseline that identifies specific services and providers that must be part of the local governance agreement in each region. Limit variations to allowing additional service types and/or providers above the base so to encourage integration and collaboration among providers in the community
 - b. Identify claims-based elements to be able to track eligible beneficiaries.
 - c. In the short term, the State could allow for each unique variation, as requested by local teams, while creating further incentives for those regions that choose a more

comprehensive approach to delivery reforms and local governance. However, this approach is more burdensome for the State to administer and may increase complexity which could detract from the transparency of the model. As such, an integrated approach across all providers may be the ultimate goal.

It is important to note that all of the above options would require a unified and coordinated approach to annual budgeting and rate setting for children's programs across AHS departments, as well as an enhanced infrastructure at the State level to focus on fiscal accountability and quality oversight.

Value-Based Purchasing: Quality Oversight & Risk Mitigation

IFS Quality Oversight at the state level is still under development. The model itself allows for a broad framework of measurement types (access, cost and quality). While work groups have been formed to create a unified framework for IFS data reporting and accountability, it is doubtful that that this will provide the dedicated staff needed to review and report statewide or regional data on service utilization, grievances and appeals, or consumer satisfaction specifically for IFS. As such, dedicated State resources for comprehensive monitoring and evaluation should be identified before deployment of the IFS model in additional sites.

The current development agenda for the Health Service Enterprise (HSE) and the State Innovation Model are fully supportive of developing these processes and IFS can continue to benefit from its alignment with these efforts.

Value-Based Purchasing: Incentives & Measurement Model

As defined in the literature and for this project, value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.

The only current VBP-related incentive within the IFS model is the provision that enables providers to retain surpluses, as long as they are reinvested into eligible services. While this incentivizes efficient service delivery and improving the outcomes related to the services under the financial agreement, it is unclear if this provision has been implemented. It also is unclear whether the State is adequately monitoring for under-utilization which is an inherent risk in a bundled payment approach that includes an agreement to retain savings achieved under the cap.

Options for developing a more robust value-based purchasing component within IFS should be contemplated within the context of the funding streams and contractual expectations of many of the IFS providers. State and federal-matching funds comprise a majority of their revenue, which is controlled by

the annual legislative budgetary process, and their funding typically does not include inflationary factors. Furthermore, these providers serve vulnerable populations and are contractually obligated to hold bottom-line accountability and a no-reject policy for serving members of their community. As such, financial fragility of providers, and ability/willingness to take financial risk, should be taken into account as the following value-based purchasing options are considered.

1. Creation of an incentive pool separate and distinct from current provider allocations to incent specific provider performance measures. However, such an incentive structure would need to be designed within the context of the broader payment reform initiatives being undertaken through Vermont's broader health care reform activities (e.g., VMSSP). It should be noted that without a new funding allocation specifically for this purpose, this option would require taking funds from existing allocations.
2. Create a quality performance withhold approach which would retain some percentage—typically 10% to 15%—from case rate payments to be at risk for performance. At the end of a performance period, the providers would be eligible to receive the withheld amount assuming they meet a defined quality benchmark. This option could be linked with the ability to develop and successfully implement a Corrective Action Plan within a specific time period past the performance period in order to earn back the withheld amount.
3. Create a reward or penalty structure that would use historical performance to either adjust upwards or downwards prospective case rates based on performance. Again, this option could be linked with the ability to develop and successfully implement a Corrective Action Plan within a specific time period in order to earn back any penalty.

Value-Based Purchasing: Support by Sponsor

Providers report strong support for their efforts and local flexibility in service delivery under this model; however, they also note that critical data feedback loops on performance and outcomes for their region have not yet been developed. The flexibility and the open dialogue regarding goals, outcomes and project design provides an excellent foundation if VBP elements were to be introduced into the IFS model. In addition, the iterative and respectful relationship between the State and its early implementer sites provides an ideal opportunity for the creation of a strong learning system and continuous improvement models.

Options for consideration, but are not limited to:

1. Dedicated State resources for data collection and dissemination
2. Implement a more formal and consistent learning collaborative process for providers to share successful strategies and to discuss data driven feedback
3. Dedicate resources to support provider efforts to improve their performance

Value-Based Purchasing: External Factors

Providers report multiple areas across AHS programs that are misaligned or continue to require budgeting, reporting, performance standards or other incentives that create unnecessary burden in the local practice setting. The goal of IFS is to have one unified set of measures for IFS, incentive programs that are aligned and complementary, and a common approach to providers working with the same family or target population.

Providing more clear and consistent feedback from the state level, creating an incentive for more comprehensive models, dedicating State-level resources to make IFS fully functional as a program in and of itself, and adopting the learning collaborative model may collectively and systemically tackle this problem.

Summary and Conclusion

In exchange for flexibility to serve clients without service restrictions, prior authorizations, diagnostic or age restrictions, and multiple and diverse claims processes and reporting requirements, providers must ensure no duplication of services, commit to investments in health promotion, family wellness and prevention and work with community teams to identify and address the health of whole populations.

IFS behavioral health and human services providers operate under an annual aggregate Medicaid cap that is developed using a global budget process that involves a state review of all services and sources of public funding, including Medicaid, Title V, Title IV-E and any other state or federal child and family funding stream supporting the provider. While the aggregate cap is the basis for monthly IFS Medicaid payments, local providers cannot deny or otherwise terminate services to Medicaid clients based solely on reaching the aggregate financial cap and they must adhere to clinical standards and best practice guidelines. Providers must work together to define their local system of care and plan for gaps.

While the IFS case rate does not include a financial incentive or other components of VBP design, it appears to be successful at supporting an increase in direct care services, service delivery flexibility based on need, reduced paperwork, and increased collaboration across providers in each region to identify the best use of clinical resources for their geographic area. Evidence presented suggests that despite the lack of a value based financial incentive, the movement away from a volume-based fee for service model to the case rate model has supported the system change and improvement in the delivery systems that were hoped for at the outset of the IFS project. This could be a result of the fact that the IFS providers are non-profit community agencies whose mission, and state mandate, is to serve target low-income and disabled populations within a specific geographic region under a budgetary process that caps funding based on available state resources rather than need; as such, the flexibility provided by the bundled payment model is enough of an “incentive” to restructure their activities to better achieve the IFS goals.

It also should be noted that the early implementer regions represent providers who are highly motivated for change, requested participation and who have adopted a culture of continuous quality improvement. It is possible that settings such as these do not need financial penalties or rewards to promote positive practice improvements. If IFS is to expand beyond these early implementer sites, it is unclear if practice changes will be as robust absent a financial reward in providers' settings that are not invested in the desired change that the IFS approach offers.

Regardless of the VBP aspects within the IFS model, it is clear that improvements in alignment across AHS Departments regarding budgeting, reporting and performance standards are needed if IFS is to succeed in expanding beyond the early implementer regions. This work should begin by aligning the target populations, services and budgets across the two early implementer regions. Without this alignment, the IFS model has limited internal validity which impedes the ability to expand to other sites.

This alignment for the provider grants must be accompanied by dedicated State IFS resources that span AHS Departments to support a unified budgeting process for IFS services and implementation of a strong framework for quality oversight and performance. The recent restructuring of the IFS State-level administration and the development of new cross-departmental teams and work-groups provides a good foundation for taking these next steps. Although systematic data is not yet available, initial indications are that IFS is achieving its goal of providing the flexibility through bundled payments that enables providers to serve individuals based on their needs and to promote community infrastructures that support integrated care. Providing the State resources necessary to strengthen this model would be a sound investment for AHS.

**SECTION IV:
VBP CHECKLIST FOR IFS**

VALUE-BASED PURCHASING PROGRAM CHECKLIST				
AHS Program Name: <i>Integrated Family Services (IFS)</i>			Bolded Text = Areas for Improvement	
SECTION I: PAYMENT MODEL AND RATE SETTING				
Review Element	Yes	No	N/A	Rationale/Reference Material
Does the payment model incentivize the desired behavior or systems change?	X			Provider feedback and preliminary data from CSAC indicate that the bundled payment model is enabling them to meet IFS objectives.
Does a risk arrangement exist between the provider and State?	X			Providers work under a capped model and may not deny or limit services to Medicaid beneficiaries because the annual Medicaid cap is reached (IFS Manual Section 2.2).
Does the VBP sponsor have access to financial, caseload and service information needed to establish rates?	X			The model relies on actual claims history, provider costs, revenue projections and legislative allocations for children’s services.
Does the VBP sponsor have written documentation of the rate setting process?	X	X		The IFS Provider Manual Section 10 describes the rate setting process, and spreadsheet analyses of provider budgets, caseloads and final rates were created for each region. However, the details of the final agreed upon rates are not transparent or consistent across sites.
Does the rate setting model include reasonable caseload and service utilization assumptions?	X			Rate setting is based on actual expenditure trends in region and for the specific providers involved.
Does the VBP sponsor’s rate setting process include provisions for budget adjustments and subsequent year budgeting that align with State budgeting timelines and methods?	X			Aggregate annual provider budgets are derived from the budgets approved by the legislature for each relevant AHS division.
Are the rates reasonable to assure enrollee access to needed services?	X	X		Rates are based on actual expenditure trends in the region and for the specific providers involved. However, there is no method to determine if the historical allocations are too high or too low based on the target population and expected need for services.
SECTION II: QUALITY OVERSIGHT				
Is there a well-defined and operational quality oversight structure?		X		The IFS Provider Manual identifies quality oversight mechanisms which includes a cross-departmental IFS team for regional oversight. With the exception of recently conducted site visits, there currently is no State-level IFS capacity to monitor outcomes, program integrity and oversee quality improvement monitoring specifically for IFS.

VALUE-BASED PURCHASING PROGRAM CHECKLIST				
AHS Program Name: <i>Integrated Family Services (IFS)</i>			Bolded Text = Areas for Improvement	
SECTION II: QUALITY OVERSIGHT, continued				
Review Element	Yes	No	N/A	Rationale/Reference Material
Does the quality oversight structure allow for monitoring of potential unintended consequences?	X	X		See above response.
Does the quality monitoring structure include monitoring for potential fraud, waste and abuse?	X	X		See above response.
Does the quality oversight design include a mix of measures (process, quality, patient experience of care and outcome)?	X			There are multiple documents that include process, quality, patient experience and outcome measures.
Is there agreement on what constitutes positive change within performance measures?		X		Currently, multiple documents contain desired outcomes with little consistency across the items in these documents. Recent meetings have produced some common performance measures, but measurement construction is still under development.
Is the data gathering reliable and valid?			X	Data are not routinely being collected or reported at this time.
Are the data easily obtainable for the provider and the State?		X		Relevant data are contained in multiple databases owned by separate state departments/divisions.
Are the quality measurement data sensitive enough and reported with enough frequency to measure change quarterly, yearly or within the contract period?		X		Data are not routinely being collected or reported at this time.
SECTION III: VBP INCENTIVE STRUCTURE & MEASUREMENT MODEL				
Is a financial incentive model being employed?		X		A shared savings and caseload incentive are documented in the IFS Provider Manual Section 10 but have not been implemented.
Is the incentive large enough to compensate the provider for the effort required to obtain the reward?			X	IFS does not include financial incentives linked to performance measures at this time.
Does the VBP structure incentivize the desired behavior or systems change?			X	See above response.
Does the VBP model reward achievement and improvement?			X	See above response.

VALUE-BASED PURCHASING PROGRAM CHECKLIST				
AHS Program Name: <i>Integrated Family Services (IFS)</i>			Bolded Text = Areas for Improvement	
SECTION III: VBP INCENTIVE STRUCTURE & MEASUREMENT MODEL, continued				
Review Element	Yes	No	N/A	Rationale/Reference Material
Does the incentive structure mitigate the negative impact of de-resourcing low-quality providers who may be most in need of resources to be able to improve quality?			X	The IFS financing structure is based on individual provider payments and the model does not include a pooled incentive that is shared across multiple providers.
Does the incentive structure mitigate any possible unintended consequences or “cherry picking” of clients to gain reward and/or lower provider costs?			X	The agencies involved are required by law to serve the populations involved and cannot deny services to those who qualify in their geographic region.
If the program uses an “absolute attainment” threshold, is there sufficient motivation for providers to continue to improve once the threshold is attained?			X	This incentive structure has not been implemented, nor does the current program documentation provide any detail about how the incentives would be structured or measured.
If the program uses a “relative incentive structure” does it mitigate against providers allocating resources to improvement on a measure that may not yield the greatest clinical benefit and which may lead to overtreatment of patients?			X	See above response.
If the VBP program uses a “fixed incentive pool” does it include a mechanism that assures that if more providers succeed they do not get penalized by smaller incentives?			X	See above response.
Does the VBP program avoid use of “100%” attainment thresholds that may promote over utilization of services?			X	See above response.
Are the VBP data sensitive enough and reported with enough frequency to measure change quarterly, yearly or within the contract period?			X	See above response.
Does the VBP model include an “appropriateness of care” measure?			X	IFS does not include performance measures linked to financial incentives at this time. However, see response for similar question in Section II: Quality Oversight.
Is there agreement on what constitutes positive change within VBP measures?			X	See above response.

VALUE-BASED PURCHASING PROGRAM CHECKLIST				
AHS Program Name: <i>Integrated Family Services (IFS)</i>		Bolded Text = Areas for Improvement		
SECTION III: VBP INCENTIVE STRUCTURE & MEASUREMENT MODEL, continued				
Review Element	Yes	No	N/A	Rationale/Reference Material
Does the VBP design include a mix of measures (process, quality, patient experience of care and outcome)?			X	See above response.
Do the VBP measure denominators have proper inclusion and exclusion criteria?			X	IFS does not include performance measures linked to financial incentives at this time.
Are the VBP measure numerators valid, useful and supported with evidence?			X	See above response.
Is the VBP data gathering reliable and valid?			X	IFS does not include performance measures linked to financial incentives at this time. However, see response for similar question in Section II: Quality Oversight.
Are the VBP data easily obtainable for the provider and the State?			X	See above response.
SECTION IV: SUPPORT PROVIDED BY THE VBP SPONSOR				
Were providers engaged in the design of the VBP program?			X	There is no VBP program within IFS at this time.
Is there alignment between provider characteristics, scope of practice and VBP program objectives?			X	See above response.
Were measures reviewed with providers prior to implementation?			X	Measures related to VBP have not been implemented.
Does the VBP sponsor provide routine performance (data-driven) feedback to the provider?		X		No routine or standardized data about provider performance has been provided by the State.
Does the VBP sponsor have staff, data collection and reporting systems that support monitoring VBP programs?		X		There are no dedicated resources within AHS for the IFS Program regarding data collection and reporting systems.
Do providers have flexibility on how to implement changes and to innovate on their own terms?	X			Providers are given broad parameters within the program regarding staffing, service delivery and local governance arrangements.
Does the VBP sponsor have resources to support provider efforts to improve? (e.g., TA on comparative benchmarking; infrastructure support; clinical data feedback loops; quality improvement support /coaching; additional staffing support, such as care managers).		X		There are no dedicated resources within AHS for these types of provider support.

VALUE-BASED PURCHASING PROGRAM CHECKLIST				
AHS Program Name: <i>Integrated Family Services (IFS)</i>			Bolded Text = Areas for Improvement	
SECTION V: EXTERNAL FACTORS				
Review Element	Yes	No	N/A	Rationale/Reference Material
If multiple VBP incentives exist for the same provider network, are they aligned?		X		Providers report that other programs that have an incentive structure, such as VCRHYP, do not align with the IFS model.
If providers are being tracked on multiple measures from different programs, are they aligned?		X		Providers report that there is poor alignment of measures across divisions.
Do current regulations and laws support the VBP program design?	X			The Global Commitment to Health enables flexible payment mechanisms for the Medicaid program, such as the IFS bundled payment model and future VBP program implementation.
Are there State regulations, and programmatic and /or funding policies that impact the VBP program design and effectiveness?	X			Separate Departmental provider funding approaches do not support an integrated IFS fiscal design. Providers report that many of the reporting requirements of state departments do not align with the IFS model.
Does the VBP sponsor account for VBP funding needs (IT, staffing and Incentive payments) in the State budget process?		X		The State does not allocate any additional resources within the State budgeting process to support the IFS infrastructure needs or future incentive payments.

SECTION V: SUPPORTING MATERIALS

PHPG reviewed a number of documents to inform this Draft Report and also conducted interviews with key IFS State and provider staff.

Primary References

Several of the reviewed documents served as primary references and are attached in this Section for easy examination by the reader. These include the following:

- Attachment 1: IFS Management Team Overview
- Attachment 2: IFS Strategic Plan and Work Plan 2-1-15
- Attachment 3: IFS Provider Manual - September 12, 2014 (Key Excerpts)
- Attachment 4: DMH - MSR Service Type Reporting Codes for Encounter Data (2011 documentation)
- Attachment 5: Value-based Purchasing Base Payment Models (Excerpted from Draft PHPG Task 2 Report for DVHA: Identification of Key Components / Standardized Criteria of Well-Developed VBP Programs, December 16, 2014)
- Attachment 6: Cross-walk Comparison of IFS Outcome Measures within IFS Documents
- Attachment 7: PHPG IFS Interview Protocols

Additional Materials Reviewed

In addition to the above, PHPG reviewed the following IFS materials to inform this Draft IFS Report:

- AHS CSAC Grant FY15 – 01/29/15
- AHS NCSS Grant FY15 – 01/29/15
- AHS ACPC Grant FY15 – 01/29/15
- Integrated Family Service Local Governance Agreements and Partnerships Discussion Brief: September 12, 2014
- Kids Inpatient_FYs and Projections_Jan Report_noEEs (sent to PHPG by Charlie Biss – 01/28/15)
- IFS Common Client Tracking Review From – draft 11/20/14
- IFS QR Chart Form 01/27/15

- Overview of Integrated Family Services – Vermont Agency of Human Services, January 2015
- IFS Stakeholder Meeting notes - 01/27/15
- IFS Measures: 01/30/15 and associated email correspondence on 02/02/15 between Dru Roessle and Shawn Skaflestad, Carol Maloney, Susan Bartlett, Todd Bauman, and Cheryl Huntley
- IFS Services Funding Inside and Outside the IFS Bundled Rate
- DA Draw Down FY15
- Materials submitted to PHPG by Cheryl Huntley, CSAC:
 - IFS System of Care Work Plans
 - Umbrella 12 12
 - Triangle: Addison County Supports and Services System for Integrated Family Services
 - IFS Stories from CSAC
 - Integrated Family Services FY 14 Final Report – CSAC
 - IFS FY 14 Summary Take 3 – CSAC
 - Data Thoughts from NCSS and CSAC
- CIS Statewide Semi-annual Report 2HFY14 update
- CIS Regional Report Summary 7-1-13 thru 12-31-13

Interviews

PHPG conducted telephone interviews with key State and provider staff, who were identified by IFS State leadership, to obtain information regarding IFS implementation. Details regarding these interviews are contained in the Table below. The Interview Guides are included as Attachment 86 of this Section.

Name and Affiliation	Interview Topic	Interview Date
Cheryl Huntley CSAC, Youth and Family Services Director Todd Baumann NCSS, Children’s Services Director	Providers	January 27, 2015
Richard Donahey AHS Central Office Fiscal Operations	Fiscal	January 27, 2015
Charlie Biss DMH, Director of Child, Adolescent and Family Services	State Infrastructure and Quality	January 27, 2015
Shannon Thompson DMH Chief Fiscal Officer	Fiscal	January 28, 2015

Name and Affiliation	Interview Topic	Interview Date
Heather McClain DCF	State Infrastructure and Quality	February 3, 2015
Terri Edgerton and Karen Garbarino DCF Child Development Division	State Infrastructure and Quality	February 3, 2015
Susan Bartlett AHS Director of Special Projects Carol Maloney AHS Director of Systems Integration	Targeted Questions for Clarification	February 5, 2015

ATTACHMENT 1

Integrated Family Services Management Team



IFS Vision: Vermonters work together to ensure all children, youth and families have the resources they need to reach their fullest potential.
IFS Mission: Integrated Family Services brings state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of Vermont's children, youth and families.

<p style="text-align: center;">Susan Bartlett <i>AHS, Special Projects</i></p> <ul style="list-style-type: none"> • Financing and Payment Reform Work Group Chair • Senior Leadership Team Co-Facilitator • Liaison to Secretary • Budget Related Matters • Medicaid and State Plan Coordination 	<p style="text-align: center;">Carol Maloney <i>AHS, Systems Integration Director</i></p> <ul style="list-style-type: none"> • Regional Implementation (Lead) • Senior Leadership Team Co-Facilitator • IFS Advisory Board • Learning Communities • Liaison to SIM and HSE Efforts • Coordinating with Blueprint, Health Care Reform and Other System Reform Efforts • Legislative Liaison • Community Development • AHS Extended Commissioner's work 	<p style="text-align: center;">Cheryle Bilodeau <i>AHS, Integrated Family Services Director</i></p> <ul style="list-style-type: none"> • Child and Adolescent Needs and Strengths (CANS) • Accountability and Oversight Work Group Chair • Quality Case Reviews • Manual Updates and Management • Website Management (with Carolyn) • Implementation Team Facilitator • Professional Development • Practice Model • IFS Newsletter (with Carolyn) • Technical Assistance to Early Implementer regions-Addison and Franklin with Charlie Biss, DMH
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<p>The IFS Management Team all attend:</p> <ul style="list-style-type: none"> ➤ Senior Leadership Team ➤ Implementation Team ➤ Financing and Payment Reform Work Group 	<p>The IFS Management Team is jointly responsible for:</p> <ul style="list-style-type: none"> ➤ Strategic planning ➤ Communication tools and processes ➤ Data and accountability ➤ Regional implementation ➤ AHS departmental engagement ➤ Resource development
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ATTACHMENT 2

**AGENCY OF HUMAN SERVICES ~
INTEGRATED FAMILY SERVICES
*Strategic Plan & Work Plan***

Draft February 1, 2015

How the IFS Approach is Viewed and Measured at All Levels

IFS Vision	Vermonters work together to ensure all children, youth and families have what they need to reach their full potential.			
IFS Mission	Integrated Family Services brings state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of Vermont’s children, youth and families.			
IFS Outcomes	1. Pregnant women and young children thrive/Children are ready for school	2. Families are safe, stable, nurturing and supported	3. Youth choose healthy behaviors/Youth successfully transition to adulthood	4. Communities are safe and supportive
Population Indicators	<ul style="list-style-type: none"> a. % of women who receive first trimester prenatal care b. [children meeting developmental milestones/screenings] c. [% of children ready for school] d. [% of children and youth with a medical home] 	<ul style="list-style-type: none"> a. Rate of child abuse and neglect b. [substance abuse measure?] c. [parents having skills they need to be successful parents] d. [parents having concrete supports in times of need] 	<ul style="list-style-type: none"> a. % of adolescents who feel valued by their community b. % of students with plans for education, vocational training, or employment following high school c. [youth engaging in healthy behaviors – physical activity and nutrition?] d. [a school-aged children indicator] e. [substance abuse measure?] 	<ul style="list-style-type: none"> a. % access to safe and supervised early childhood and out of school care b. [housing indicator] c. [% of families who have experienced homelessness in the past year] d. [% of families who are food insecure]
IFS Performance Measures	<ul style="list-style-type: none"> 1. [% of clients with a plan of care developed collaboratively with families, and that includes needs identified through standardized screenings, assessments, evaluations, and/or care information summary] 2. [% of families that have shown improvement on a standardized assessment tool] 3. [a measure that demonstrates level of satisfaction from family perspective] 4. [measure that demonstrates quality execution of plan of care (e.g., timeliness, appropriateness, evidence-informed)] 			

Introduction of Strategic and Work Plan

- These plans are intended to keep the IFS Management Team, IFS Senior Leadership Team and IFS Implementation Team pulling in the same direction.
- The strategic plan helps to operationalize the IFS’ theory of change (see the document entitled “Building Blocks for Change”), and it provides the big picture to inform the work plan.
- The work plan provides more detail specific to the eight elements of the IFS model. While each element has its own priorities, all eight elements are inter-related. As such, progress in one area will depend in part on progress in other areas.
- Both of these documents will be updated as needed to reflect current conditions, lessons learned and new thinking.
- If you have questions about these plans please contact any member of the IFS management team with your thoughts: Cheryle Bilodeau, IFS/AHS Director, Cheryle.bilodeau@state.vt.us, 802-760-9171; Susan Bartlett, AHS Special Projects, Susan.Bartlett@state.vt.us, 802-917-4852; Carol Maloney, AHS Director of Systems Integration, Carol.Maloney@state.vt.us, 802-279-6677.



Strategic Plan ~ 2015-2020

See the Building Blocks for Change for additional detail

2015-2016	<ol style="list-style-type: none"> 1. Integrated Family Services (IFS) grantees are held to common population indicators and performance measures. 2. State and community partners, in collaboration with people who receive supports & services, work to create effective communications strategies & systems. 3. IFS state & community partners develop a consistent & replicable financing model that connects social, emotional and physical health. 4. State administrators & communities report increased administrative efficiencies & flexible service delivery. 5. IFS’ vision, goals and strategies are clearly communicated.
2017-2019	<ol style="list-style-type: none"> 1. 40% of local regions have implemented the IFS approach 2. IFS regions and state administrators show improved outcomes for Vermont’s children & families. 3. Regional and community-based partners work collaboratively and effectively to use funds flexibility to meet the particular needs of children, youth & families. 4. Planning at the state and regional level is driven by a holistic and collaborative perspective of Vermont’s children, youth & families service delivery system and community supports. 5. Policies cut across AHS department lines in ways that promote seamless children, youth and families service delivery system and build on strengths in each community.
2020	<ol style="list-style-type: none"> 1. 80% of local regions have implemented the IFS approach 2. Families understand & can easily access supports & services they need regardless of geography, income or type of need. 3. Policymakers and service providers use data to drive policy decisions and reallocate resources to most effectively meet the needs of Vermonters.

Work Plan
January 2015 through June 2016

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
ACCOUNTABILITY & OVERSIGHT			
1. There is a system in place to Measure Performance	a. Population Indicators are established: <ul style="list-style-type: none"> i. Stakeholder meetings convened ii. SLT and I-Team review indicators iii. Indicators are confirmed b. Performance measures are established: <ul style="list-style-type: none"> i. Stakeholder meetings convened ii. SLT and I-Team review indicators iii. Indicators are confirmed 	June 2015	IFS management Team, Dru, Kim and Carolynn
2. There is a system in place to monitor performance	a. Quality Case Reviews are conducted in active IFS regions: <ul style="list-style-type: none"> a. Case Review in Addison to be held on 1-29-15 b. Case Review in Franklin to be held on 2-18-15 b. Each active IFS region utilizes a client satisfaction survey that ensures there is room for additional regional input	Feedback on quality case reviews is provided to regions within 60 days of date of case review.	Accountability and Oversight Work Group with representation from IFS regions
3. There are consistent practices and processes across IFS with the intent of improving performance	a. Consider how to use AHS strategies (RBA Turn the Curve, Agency Improvement Model (AIM) & Plan-Do-Study/Check-Act (PDSA/PDCA)) to improve IFS performance—build on what we are already doing		Accountability and Oversight Work Group
4. Multiple systems and modalities are utilized to communicate performance			Accountability and Oversight Work Group
5. Training is created and offered to constituents to teach performance			Accountability and Oversight Work Group

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
FINANCING & PAYMENT REFORM			
<p>1. A system is in place to ensure statewide consistency in IFS agreement regarding what is included in bundled payments</p>	<p>a. Finance WG creates a plan for review by SLT b. Explore options regarding expanding bundle c. Identify what are the Medicaid funding sources? (MMIS Special Projects Grant) d. Clear decision making process for funding. e. Make sure VT is following formal legal regulations & processes f. Make sure any changes are appropriately reviewed</p>		<p>Financing and Payment Reform Work Group</p>
<p>2. Funding for developmental services is included in IFS bundles in a way that ensures services can respond to individual clients' needs</p>			
<p>3. There is a clear intercept model with identified services and supports for children's mental health, children's dev. disabilities, children's special health needs, Family Services support service funding and CIS</p>	<p>a. Integration opportunities are identified for each dept./division, language is consistent & common understanding b. How do we make sure whatever is created is not just a program list? c. How the financing and management system aligns with the system of care and not just a program. d. System of care should be defined in the document somewhere, if this language is used. e. Need to add in language around VBP and the finance group's work.</p>		
<p>4. IFS payment reform meets the health needs of CYF and are reflective of other health care reform efforts underway in VT</p>	<p>a. Linkages/connections between and among social, emotional and physical health are clearly identified</p>		

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
5. Funding distribution across the state is evaluated and an equitable funding formula is utilized	a. Individual budgets in the regions are shifted to an outcome-based model.		
COMMUNITY-BASED PREVENTION & PROMOTION			
1. Ensure the family voice is represented in all teams			Community-Based Prevention and Promotion Work Group
2. Alignment is created between IFS with school, community, and transition-age youth programming	a. Collaborative meeting with Washington County Youth Service Bureau partners, IFS Mgt. Team & DCF Family Services Division b. Align AHS & AOE related to Multi-Tiered Systems of Support (MTSS) c. Align AHS & AOE related to Align Positive Behavior Interventions (PBIS) d. Align AHS & AOE related to Strengthening Families framework e. Align current home visiting services, standards and guidelines		Community-Based Prevention and Promotion Work Group
3. Consistent and streamlined transitions for children, youth and families involving IFS, schools, nonprofit organizations, etc.	a. Make sure we look at transition from child to adult services b. Agree on screening & assessment tools to be used in IFS regions i.e. trauma assessment c. Create a consistent and common assessment process (i.e. CANS /Child & Adolescent Needs & Strengths) across disciplines to determine children, youth and family needs for services and to track individual and aggregated progress		Community-Based Prevention and Promotion Work Group
4. IFS supports community development that focuses on promoting a safe and caring environment to	a. Establish a way to assess and evaluate community needs for: <ul style="list-style-type: none"> i. Prenatal ii. Parent education as it related to IFS iii. Early childhood 		Community-Based Prevention and Promotion Work Group

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
encourage healthy child, youth and family development			
5. There is a core identification of IFS services that are evidence-informed and outcome-driven.	a. Explore ways to connect or integrate various current frameworks & approaches, including but not limited to: <ul style="list-style-type: none"> i. MTSS & Strengthening Families Framework can help in this area ii. Trauma-informed frameworks e.g. Adverse Childhood/Family Experiences iii. Gender-informed practices iv. Vt Family-Based Approach (Dr. Hudziak) v. Placement Stability Project vi. MTSS 		Community-Based Prevention and Promotion Work Group
6. Expansion of autism services both within the DAs and statewide with private providers	Increase coordination between DVHA autism staff & IFS e.g. Autism/Applied Behavior Analysis (ABA) <i>Q: Is this an appropriate action step related to this outcome? What's missing?</i>		Community-Based Prevention and Promotion Work Group
7. Services in the IFS bundle meet the health needs of CYF and are reflective of other health care reform efforts underway in VT	a. Increase collaboration/integration between primary care and IFS b. Ensure integration of IFS and Help Me Grow c. Collaboration with substance treatment community		Community-Based Prevention and Promotion Work Group
8. Single, integrated family plan that represents all services, including Integrated Family Services Plan and Individualized Education Plan (IEP) when appropriate			Community-Based Prevention and Promotion Work Group
DATA & TECHNOLOGY			

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
1. Integration (ask if integration is the correct term) of databases with a shared reporting capacity	a. Common tools & processes including eligibility IT system		Data and Technology Work Group
2. Integrated case management system			Data and Technology Work Group
3. Resources as they relate to IT and data are used efficiently	a. Produce semi-annual reports provide state & local data to drive decision-making		Data and Technology Work Group
LEADERSHP & GOVERNANCE			
1. There is a demonstration of AHS' commitment to reform for children, youth and families (CYF) & Secretary's support and vision for IFS			
2. There are documents that clearly lay out what is required at the state and regional level for expansion of IFS	a. Finalize Readiness Plan with input from regions		
3. There is clarity regarding decision-making authority and process.	a. Be clear on who will lead which processes related to governance b. Formalize which decisions are made at state level & which can be left to regions to make (re. money, service delivery, governance, etc.)		
4. Department staff are able to articulate their role in moving IFS forward	a. Clarify role of Dept. staff in moving IFS forward		
5. Clear roles and responsibilities of	a. Improve consistency statewide by clarifying scope, goals, roles &		

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
teams and boards operating within IFS	responsibilities including but not limited to State Interagency Team (SIT) and Local Interagency Teams (LIT) [keep legislatively-mandated requirements re. participation & scope in mind] b. Clarify IFS Advisory Board role c. Consider any new teams at the state and/or local level that may be needed to ensure integration along the continuum of services d. Improve functioning of trauma-focused teams at the local and state levels e. Clarify the relationship between IFS, Designated Agencies and Specialized Services Agencies		
6. Effective internal functioning	a. Clarify and agree on Mgt. Team's, Sr. Leadership Team's and Implementation Team's roles & responsibilities b. Clarify and agree on Mgt. Team's, Sr. Leadership Team's and Implementation Team's roles & responsibilities c. Clarify what the Management Team & SLT need from each other in order to function well as a team (Habits of the Heart/group norms) d. Consistent meetings with senior managers based on agreed-upon schedule		
<i>Q: What outcome does this action step reflect?</i>	Stay up-to-date with/knowledgeable about other system reform efforts/initiatives & their connections to IFS, including Early Learning Challenge (ELC) grant, health care reform (Health & Human Services Enterprise, Blueprint and Accountable Care Organizations), VT-FACTS and DCF/Family Services Division's efforts to improve the child safety system		
Family-centered approach is embedded throughout IFS, including Strengthening Families			

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
Agreed-upon approach that invites creative thinking and promotes positive changes in practice and behavior	a. Review Diana Whitney's Appreciative Inquiry approach		
STATE & LOCAL SERVICE DELIVERY STRUCTURE			
1. Determine the most appropriate mechanism within IFS to address grievances, appeals and fair hearings			
b. There is consistency among IFS regions in terms of service delivery	<ul style="list-style-type: none"> a. Align service delivery & financial elements in two pilots b. Common foundation for a consistent continuum of supports & interventions region to region including but not limited to governance agreements c. Align statewide & regional service delivery d. Codified roles and responsibilities of state and local partners 		
High-quality service delivery according to adopted frameworks	Enhance the capacity to meet professional development & technical assistance needs related to implementing the IFS model by...TBD		
<i>Q: What is the desired outcome related to preparation & development [the "doing"]?</i>			
Regions provide data to state IFS team(s) needed for preparation of annual reports, planning purposes, etc.	1. Streamline & align (and clarify) regional reporting requirements		
<i>Q: What outcome would this reflect?</i>	<i>Q: Would having a coordinated planning document be helpful in ensuring service integration at the local level?</i>		
Community partners (e.g. Designated Agencies, probation and			

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
parole, housing, Parent Child Centers) are integrated into IFS local governance & service delivery structure			
HUMAN RESOURCES & ORGANIZATIONAL CULTURE			
	Update AHS training curriculum to reflect integration, teamwork and Strengthening Families framework		
	Coordinate System of Care (how do we make this broader than system of care?) trainings (State Interagency Team)		
	Clarify what the Management Team & SLT need from each other in order to function well as a team (Habits of the Heart/group norms)		
	Consistent meetings with senior managers based on agreed-upon schedule		
Organizational elements of integration are in place	Equip IFS teams with skills related to team building, conflict resolution, groups' approach to problem-solving, interpersonal communication, etc.		
	<ul style="list-style-type: none"> a. Provide regular opportunities for IFS stakeholders to gather as a community b. Promote use of common language consistent with AHS c. inaugurate new Waterbury space in a formal way d. Recognize & celebrate success on an ongoing basis 		
	Consider changes in job descriptions to reflect decisions being made		
1. Establishment of a forum for learning from each other and sharing information	a. Establish an IFS learning community that includes collaborating partners and others interested in integration and fosters relationship-building within and across IFS regions, including families and practitioners, for the purposes of connecting, learning and sharing expertise		

GOAL	ACTION STEPS	COMPLETION DATE	LEAD TEAM/WORK GROUP
COMMUNICATIONS			
1. Broad stakeholders are kept informed of IFS' activities & progress	<ul style="list-style-type: none"> a. A bi-monthly newsletter is disseminated <ul style="list-style-type: none"> i. Management team, Kim and Carolynn work together to put together inaugural newsletter ii. Carolynn collects e-mail addresses and puts newsletter into Mailchimp for dissemination b. Regular & easily understandable reports on IFS progress c. Use social media (electronic communication) e.g. weekly field memo d. Have diverse communication tools and strategies to appeal to different audiences e. Consider an IFS blog (questions that come in are triaged as needed & answered) 		After inaugural newsletter Cheryle and Carolynn will be the lead with support from Mgt Team
2. IFS is marked to a broad audience	<ul style="list-style-type: none"> a. Clear materials that describe IFS to multiple audiences: <ul style="list-style-type: none"> i. Logo ii. Letterhead iii. Website 		
3. Basic information on IFS is easily accessible to stakeholders	<ul style="list-style-type: none"> a. Team will review IFS manual and make necessary edits to ensure it reflects: <ul style="list-style-type: none"> a. Whole population language b. The continuum of community resources encompassed in the IFS model b. Expectations of IFS regions 	June 2015	Cheryle Bilodeau, Carolynn Hatin, Laurel Omland and Kim Friedman

Implementation of Work Plan

Element	Modality	Chair	Members
Accountability and Oversight	Work Group	Cheryle Bilodeau	Dru Roessle Melissa Bailey Daniel Hal
Financing and Payment Reform	Work Group	Susan Bartlett	Carol Maloney Cheryle Bilodeau Heather McLain
Community-Based Prevention and Promotion	Work Group	Carol Maloney	
Data and Technology	Work Group		
Leadership and Governance			
State and Local Service Delivery Structure			
Human Resources and Organizational Structure			
Communications	Embedded across all work groups		

ATTACHMENT 3

Relevant Excerpts regarding IFS VBP Assessment from the IFS Provider Manual, September 12, 2014

SECTION 1: INTRODUCTION

1.2 Federal and State Authorities

The State of Vermont has partnered with the Centers for Medicare and Medicaid Services (CMS) to develop and operate an innovative and comprehensive health reform model under Section 1115 Demonstration authority. The majority of Vermont's Medicaid program operates under the Global Commitment to Health Demonstration, with the exception of its Children's Health Insurance Program (CHIP), individuals enrolled in Vermont's Section 1115 long-term care Demonstration (Choices for Care) and Vermont's Disproportionate Share Hospital (DSH) program. More than 95 percent of Vermont's program participants are enrolled in the Global Commitment Demonstration. The State has requested that all Medicaid and CHIP programs be consolidated under the Global Commitment to Health Demonstration authority.

The Global Commitment Demonstration operates under a managed care model that is designed to provide flexibility with regard to the financing and delivery of health care in order to promote access, improve quality and control program costs. The Agency of Human Services (AHS), as Vermont's Single State Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) and member Departments of the AHS are responsible for operation of the managed care model for all age groups, disability types and home and community based services.

The Global Commitment's Special Terms and Conditions (STCs) provide authority and guidance regarding operation and oversight of the Demonstration. Per the STCs, Vermont operates its managed care model in accordance with federal managed care regulations, found at 42 CFR 438. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews and approves the IGA annually to ensure compliance with the STCs.

Pursuant to the Global Commitment STCs, the State is responsible for meeting Medicaid managed care program integrity requirements for the Global Commitment participants and DVHA continues to be responsible for meeting traditional program integrity requirements for populations not enrolled in Global Commitment Demonstration. While DVHA has opted to use a combination of program integrity processes aligned with both managed care and traditional regulations (42 CFR 438 and 42 CFR 455) for Global Commitment participants, the STCs provide that external reviews of DVHA's program integrity and audit functions should be based solely on managed care requirements (42 CFR 438) for the Global Commitment population.

The special terms and conditions of the Global Commitment to Health 1115 waiver give Vermont considerable flexibilities to promote health care reform, both in service type, delivery structure and reimbursement models. By adopting the concepts and regulatory structure of a Medicaid Managed Care Entity, the State may choose more widespread use of reimbursement strategies that include PMPM, pay for performance, sub-capitated, episodic, prospective, shared savings, bundled and monthly rates and other hybrid models to promote quality and outcomes. The 2013 federal approval package offers the

following authorities: STC #5 and STC#28 and waiver authority #6 allow for reimbursements outside the traditional State Plan, STC #28 allows for payments not bound by Upper Payment Limit (UPL) and STC # 15, 22 and 37 along with Section II, Program Description, allows for a service delivery and payment structure that would otherwise be used in a private Medicaid MCO. Waiver Authorities # 1, 2, 8 allow the State to create flexible models across the State and work with designated provider systems to deliver specialty and other services.

The Medicaid State Plan in combination with the non-State plan services authorized in the Global Commitment to Health Demonstration Waiver guide the types of covered services that must be provided by the AHS/DVHA. However, for children under the age of 21 and their families, federal EPSDT statutes mandate that outreach and education regarding prevention and healthy child development be provide to families along with any medically necessary service needed to ameliorate or prevent form worsening any condition, disability or illness, regardless of whether or not those services appear in the Medicaid State Plan. Federal EPSDT requirements can be found at 42 U.S.C. §§ 1396d(r) (5), 1396d (a). Service level requirements includes all benefits that fall within the federal definition of medical assistance as described in Section 1905(a) of the Social Security Act.

This manual is specific to children and family services funded through each of the six AHS departments and includes adherence to the federal Medicaid EPSDT mandate and its relationship to the Title V children with special health needs, Title IV-E child welfare and IDEA part B and C mandates.

SECTION 2: PROVIDER PARTNERSHIPS AND LOCAL GOVERNANCE

2.1 Eligible Providers

An entity is considered eligible for participation in the integration of family services (IFS) when it is an enrolled Vermont Medicaid provider and a DMH/DAIL Designated Agency (DA) or Specialized Services Agency (SSA) or DCF designated Parent Child Center (PCC), a contractor of DCF-FSD, VDH or other AHS department, office or unit to provide direct care, outreach and administrative services identified in this manual in a specific geographic catchment area. If any such provider subcontracts services to be performed on their behalf, it is the responsibility of that provider to ensure that the subcontractor adheres to the requirements set forth in this manual.

Entities must agree to comply with Medicaid and all appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, and the standards, procedures, outlined in this manual and in State or federal law.

2.1.1 Service provider staff, contractors, and interns

- a. Medicaid State Plan services must be provided directly by a licensed practitioner of the healing arts or prescribed and supervised by a licensed practitioner recognized in the Medicaid State Plan or under Vermont rules and working within the scope of their Practice Act.
- b. Students/interns providing services must be supervised by a qualified staff of the provider agency/entity, and is subject to all provider agency/entity policies and procedures. The provider agency/entity and the supervising healthcare professional must assume responsibility for the work performed.

- c. The service must have been delivered by the provider agency itself or sub-contractor with that agency, or an entity otherwise authorized by AHS and provided by a qualified staff member who based on his/her education, training, or experience is authorized by the provider agency and for Medicaid State Plan services, Medicaid and Vermont rules as competent to provide the service.

The provider agency must ensure background checks are up to date and that CMS suspension; exclusion and debarment lists are checked on a periodic basis for all employees and subcontractors. Subcontracted provider policies must be consistent with background checks of the provider.

Use of sub-contracted service providers are at the discretion of the provider agency. Sub-contracts with entities or individuals providing direct services on behalf of any provider in the local governance agreement must be available for review by Title XIX auditors. Sub-contracts require provisions showing:

- a. With whom the sub-contract is made, including provider requirements and credentials;
- b. What Title XIX services the sub-contractor will provide under the sub-contract;
- c. The staff member(s) responsible for supervision over the clinical practices of the sub-contractor (with the exception of contract physicians).

2.2 Community Partnerships & Local Governance

The underlying infrastructure of the IFS is based on the premise that all providers come together locally to create formal working agreements, define roles and responsibilities and create a local system of care that will promote population health, prevention, early intervention and intensive home and community based treatment commiserate with EPSDT and other best practices, in a unified and outcome driven manner for children and families. Providers will work together and adhere to individual overall aggregate budget caps.

In exchange for flexibility to serve clients in the most cost effective, clinically appropriate manner feasible, using a global budget process that provides an aggregate annual Medicaid cap, local providers agree they will not deny, wait list or otherwise terminate services to Medicaid clients based solely on reaching their aggregate financial cap and that they will adhere to clinical standards and best practice guidelines promoted by the State. Savings resulting from local efforts will be tracked by AHS and discussion of provider incentives will be ongoing with early implementer sites.

Providers are expected to collaborate to ensure the delivery of a continuum of preventive, prenatal care for pregnant women and other EPSDT services for children and families with developmental, mental health and/or substance abuse needs. Providers are asked to create administrative mechanisms and agreements that support unduplicated billing, meaningful use of electronic health records and federal reporting. Outcomes agreed to in the State of Vermont grant award are considered collective responsibility of all signatories involved in the local governance agreement and include tracking population health as well as impact of target services on the population served (See Section 11: Reporting and Quality).

Providers will create and submit to the State a comprehensive governance agreement for the integrated system of care. The written governance agreement will be signed, at a minimum, by the Designated Agency, Parent Child Center, Department for Children and Families –Family Services Division, VDH – Maternal and Child Health Services local designee, AHS Field Director and Local Interagency Team Coordinator and sent to the AHS Director of Integrated Family services for review and final approval.

It is the intention of the State that local district offices of the State, which have direct service delivery obligations, are equal partners and equal signatories to the local governance agreements. State employed staff that carry caseloads, participate in treatment planning meetings and/or prior authorize direct support services or contracts for children and families in their assigned region, are considered equal partners, equally responsible and equally accountable to the parameters set forth in the local governance agreement.

Recognizing the inherent differences between non-profit and State systems, the State IFS team will work with IFS Implementers to identify and ensure that conflict of interest, equity of power and problem resolution mechanisms are defined at the Central Office level and are accessible for any issues arising from State staff that are also part of the local provider governance agreement.

Local Governance agreements will, at a minimum, clarify local structure and operating practices including but not limited to the following information:

General Governance

- Process for modifications and yearly review of governance model
- Clear definition of roles and responsibilities of each party
- Clear decision making processes including resolution of governance disagreements
- Implementation of an agreed upon process for strategic planning and achievement of outcomes including agreements regarding mutual accountability for performance measures
- Coordination with other State initiatives as they pertain to IFS and other related AHS funded services and providers (e.g., primary prevention activity, The Vermont Blueprint for Health, School Based services, Building Bright Futures, etc.)
- Accountability to ensure active engagement and participation of families, other service providers and community stakeholders in the governance structure and decision making processes.

System and Service Delivery

- Clinical intake, assessment, triage and utilization review of clients to ensure that clients are served in a timely and integrated manner
- Roles, responsibilities and continuous quality improvement model for the local system of care and services for children and families, including representation on required State and local councils and committees
- Participation in ongoing review and evaluation of local IFS service system, program model(s) and performance, which includes the entire system of care/services for pregnant/postpartum women, children and families

- Involvement in any corrective action needed to improve quality of the IFS service system and/or the outcomes for children and families in the catchment area.
- Establishment of strategic goals that are in concert with the purpose and performance measures of the contract and reflect community needs and resources as well as align with the State of Vermont's Strategic Plan

Budget, Billing and System of Care Investments

- Defining local agreements and processes to ensure:
 - Non-duplication of direct services for any given client/family. Duplicative services are defined as same service type being delivered in the same timeframe and working on the same treatment plan goals. For example, two therapy providers working on anger management without the knowledge of the other or clear clinical need for two interventions. Duplicative billing is not the same as concurrent billing described in Section 10.1
 - Non-duplication of billing. (See 10.1 for allowable concurrent billing)
 - Local dispute resolution around service delivery, billing and governance model
 - Clear process for decisions regarding the use of any savings or incentives shared by the State
 - Fiscal and practice liability agreements

2.3 Administrative Entity/Fiscal Agent Requirements & Role

Each local governance agreement will clearly identify a provider or entity who will serve as lead on administrative functions for the local partnership. This includes, unduplicated and accurate billing for the local provider network; receive, manage and disburse, according to local agreements, any incentive/shared savings payments from the State, on behalf of the local partnership; ensure State and federally required data is reported as needed and available for State or federal review as requested.

The identified administrative entity/fiscal agent must, at a minimum, demonstrate the following:

- An operational HIPAA compliant electronic billing system
- Written Internal Fiscal Controls
- Adherence to AHS & CMS IT security and privacy standards
- Enrollment as a Medicaid provider in good standing
- Maintenance of an MCO grievance and appeals tracking system
- Complete an annual independent audit of its financial records
- Generate and/or collate encounter data reports electronically (date of service, type of service, provider, recipient)

SECTION 3: GENERAL PROGRAM REQUIREMENTS

3.9 Grievance and Appeals

Each provider receiving Medicaid funding and responsible for providing services identified in the Vermont Medicaid State Plan and/or the covered services charts in the CMS approved Special Terms and Conditions of the Global Commitment to Health 1115 demonstration waiver must maintain compliance with Vermont's Medicaid Managed Care grievance and appeals rules. Local networks must have processes and agreements in place to ensure that all necessary notices are provided to beneficiaries and that quarterly grievance and appeal reporting by the identified local Administrative entity/fiscal entity to the State is timely and accurate.

3.10 Local System of Care, Strengthening Families and Bright Futures

The local governance agreement defining roles and responsibilities of providers will serve as the foundation for a clearly articulated and transparent local system of care. Providers are expected to work together with the AHS Field Services Director and as part of a Local Interagency Team to develop a written description of the provider network that includes all IFS and EPSDT related activities and the activities of other AHS partners, such as, but not limited to: Building Bright Futures Regional Councils, The Blueprint for Health Community Health Teams and other AHS and State initiatives. Local system of care planning should involve the AHS Field Director.

SECTION 10: REIMBURSEMENT METHODOLOGY, INCENTIVES, EXCLUSIONS AND BILLING INSTRUCTIONS

The State of Vermont has created an alternative reimbursement approach in order to achieve the following objectives:

- Promote flexibility in service delivery to meet the needs of program participants and promotion of early intervention/prevention and a full continuum of EPSDT services in each region of the State
- Reduce paperwork demands created by and serving only Medicaid fee-for-service billing
- Facilitate documentation requirements based on best clinical practice, quality and outcome driven oversight
- Shift focus of program reviews from volume and adequacy of billing documentation to clinical appropriateness, quality and efficacy
- Establish a predictable funding mechanism for providers
- Promote a seamless and integrated health and human service delivery system at the local level
- Enable schools, providers and State staff to collaborate and identify the best use of clinical resources for their service region

To achieve the objectives outlined above, three types of payments have been created:

10.1 IFS PMPM/Case Rate

This is a monthly rate established for reimbursement of all Medicaid-covered services outlined in this manual. Member month rates are based on agreed upon annual allocations for all covered services per

provider, divided by the minimum Medicaid caseload expectation for that provider. The same member month rates will be paid for minimal services packages as for intensive service packages. The goal of the funding model is to ensure that beneficiaries get a package of early periodic screening diagnostic and treatment (EPSDT) and outreach services commensurate with their functional needs within an overall annual aggregate cap on reimbursements. PMPM/Case rates are **not** based on any one group of services being “loaded” into a claim; they represent a global aggregate budget divided by minimum caseload.

The total annual allocation per provider will be defined in their grant agreement with the State and based on local governance and system of care agreements. The maximum billing amount per provider will be loaded into the MMIS.

- a. Children whose services are provided under the IFS capitated pmpm payment may be eligible for additional service benefits if the following conditions are met:
 - i. Service claims are not duplicative of services or any other supports provided under the IFS cap; have been included in the integrated treatment plan AND; are not in the IFS provider contract work specifications
 - ii. Service claims from other provider ID’s are for a specific set of services provided under a separate local agreement such as with the schools or through other State funded contracts and/or providers not part of the local governance agreement (See Section 7 and 8).
- b. The designated administrative entity (See Section 2) will submit no more than one claim per local provider for each Medicaid-eligible individual they serve each month. For example, if an enrollee has three providers in their integrated treatment plan, then three providers may each submit one claim.
- c. Claims will indicate the provider number responsible for the service; HP will reimburse the rate on file for that provider
- d. For caseload tracking purposes, providers will continue to submit monthly claims rates, even if the aggregate annual cap level is reached, however the claim will not be reimbursed once the maximum aggregate cap for that provider is met.
- e. In order for a claim to be submitted the following conditions must be met;
 - i. The client must be a Medicaid beneficiary
 - ii. The client must be an active case for the rendering provider agency
 - iii. A case will be considered active if provider service logs substantiate performance of at least one activity or visit per month. Activities include any allowable State Plan, EPSDT and/or home and community based waiver service, including but not limited to, collateral contacts, service coordination, psychosocial rehabilitation, consultation and education, family, individual or group counseling or allowable EPSDT outreach, education and administration activities as described in this manual or subsequent State guidance.
- f. Medicaid as secondary payer. For children who have private coverage, third party payers should be billed for all services covered in the commercial payers covered benefit plan. If services are delivered to a Medicaid beneficiary that are not in the primary payers covered benefit package,

but allowable as described in this manual and under the Global Commitment to Health 1115 Medicaid authority, the case rate may be billed

- g. A PMPM claim will be recouped for any of the following circumstances
 - i. No service was delivered in the month billed
 - ii. The client was not a Medicaid beneficiary during the month billed
 - iii. The client was deceased on or before the first day of the month for which services were billed
- h. PMPM claims over six months old that have not already been billed will not be approved for filing except in the instances outlined below. Claims over two years old are not allowed under federal law:
 - i. The State has created a situation which made it difficult or impossible to submit the claim and/or adjustment with the allowed time
 - ii. HP is at fault (documentation required) for the claim and/or adjustment not being processed in a timely manner;
 - iii. Retroactive eligibility;
 - iv. The agency has been over paid and a recoupment is needed
- i. Any individuals, including physicians, serving as direct service staff under the IFS capitated rate may not concurrently provide private services of a similar nature to an IFS client and bill for those services as a fee-for-service private practitioner under the Medicaid program.
- j. Activities with the primary purpose of education, such as academic tutorial, typically provided in an educational setting by professional educators and teaching clients the vocational skills needed for a specific job (i.e. vocational trainer/job coach activities) or other vocationally-related services are excluded from the IFS capitated rate. Excluded vocational activities include:
 - Vocational Placement
 - Work Adjustment Training
 - Job Placement/Performance evaluation
 - Vocational Workshop
 - Vocational Counseling
 - Vocational Support Group
 - Vocational Program Administration

10.2 Managed Care Investments

The use of Managed Care investment authorities is at the sole discretion of the State of Vermont. The State will determine whether or not any activities governed by the local governance agreement and subsequent provider grant agreements will be supported with MCO investment funds. Managed care investments are not considered Medicaid covered benefits and are paid to providers from the State's accounting system on a quarterly basis.

10.3 Other Federal Grants (Non- Medicaid)

Any federal Non-Medicaid funds considered part of the local governance agreements will be paid to providers from the State's accounting system on a quarterly basis. Federal dollars must be spent on deliverables contained in provider grant agreements for those funds.

10.4 General Payment Provisions

All expenditures will be reported electronically to the DMH - IFS cost center for all participating providers. Annually, providers will reconcile actual financial experience to the grant. This will include:

- a. a monthly operating statement of income, expenditures and associated operating losses/surpluses. The statement will encompass all revenues received (including IFS Case Rates, Managed Care Investments, Federal Grants, first party, third party, donations, etc.) and the associated expenses;
- b. a statement of total caseload served; and
- c. a calculation of total per-member per-month expenses, revenues, and grant-funded revenues
- d. Annual financial audit report

Subsequent grant agreements will be level funded to the previous year's value plus or minus any legislatively identified increases or decreases. An iterative process will ensue between providers and the State to define how any prior-year surpluses will be reinvested into services.

10.5 Incentive Payments

10.5.1 Caseload Payments

Annually, providers and the State will agree on overall operating budget and billable (minimum) and target caseload expectations. Provider PMPMs will be based on 100% of the total annual allocation and billable caseload. The State will determine if minimum and target caseload expectations were met within three months of the end of the fiscal year. If the minimum expectations are not met, the State will recoup 10% of the annual allocation.

10.5.2 Caseload Definition

Caseload target counts will be determined based on the sum of the following:

- a. Number of pmpm claims for unique beneficiaries
- b. Number of EPSDT contacts with unique organizations, groups or families, as measured by encounter data submitted through the MCIS for Consultation and Education services to an organization or group related to
 - i. Seeking out eligible families and informing them of the benefits of prevention and the health services and assistance available,
 - ii. Helping families understand healthy development and using health resources, including their own skills (talents) and knowledge, effectively and efficiently

EPSDT contacts may include informational sessions, a manual based or other curriculum based training related to healthy development, access to care and health coverage and skill building.

Contacts made on behalf of an identified child must be coded as collateral contact within the array of services provided under the integrated treatment plan and are not allowed as EPSDT outreach and education.

Three or more EPSDT contacts within one quarter with the same organization or family group for EPSDT outreach and education describe in this section will only be counted as one for purposes of caseload target calculations.

10.5.3 Shared Savings payments are currently suspended pending further State discussion: The State will create a three year average expenditure report by region for beneficiary utilization of the following services:

- a. Private Non-Medical Institution (PMNI)
- b. Inpatient psychiatric hospitalization under 21
- c. Emergency room visits under 21
- d. Non hospital based emergency placements (e-beds; hospital diversion)
- e. DCF Substitute Care allocations for the region

Verifiable reductions in expenditures in these areas will be credited to providers at the close of each fiscal year. The percentage decrease equal to the percentage drop in utilization, up to twenty percent will be shared back with the local provider network in the fourth quarter of the subsequent fiscal year. Shared savings will be reinvested into the local system of care based on local provider governance agreements and must be used to support program and activities that enhance the protective factors listed in the “Strengthening Families” – Bright Futures framework outlined in Section 1 and 2 of this manual.

SECTION 11: REPORTING, PROGRAM INTEGRITY AND QUALITY OVERSIGHT

11.1 Encounter data and other reporting

State Plan and home and community based service detail must be provided to the State through electronic reporting (MSR) and will provide information for utilization and outcome tracking. The focus of reporting and program integrity is quality of care, consumer satisfaction including grievance and appeals, client and population health and performance-based deliverables. Data must be collected and providers monitored to meet the following Medicaid Managed Care regulatory requirements:

- a. Confirm that contracted services were delivered (42 CFR 438 Subpart H-Program Integrity) – this includes ensuring that capitated funds are used for children’s health promotion, early intervention, family support and treatment in alignment with EPSDT expectations.
- b. Ensure that appropriate services were provided (42 CFR 438.204/240) – this includes ensuring that providers utilize best practices in treatment and caregiver support given the youth’s age, environmental circumstances, diagnosis and natural support network.
- c. Determine quality of services provided (42 CFR 438.204/240) – this includes measuring progress and ensuring that expected outcomes are achieved

Provider reporting elements will be submitted electronically using the DMH-MSR activity reporting system and include the reporting elements listed in Attachment B.

11.2 Program Integrity

The State uses the following terms in defining fraud and abuse:

Medicaid Managed Care Fraud: any type of intentional deception or misrepresentation made by an entity or person in a capitated program, or other managed care setting with knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.

Medicaid Managed Care Abuse: practices in a capitated MCO, PCCM program, or the managed care setting, that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards of contractual obligations for health care.

11.2.1 Risk Areas & Mitigation Strategies (42 CFR 438 Subpart H-Program Integrity)

Risk areas defined for IFS included, but are not limited to the following.

- a. Inaccurate or Misleading Local Governance Agreements: The incentive may be receipt of global aggregate budget payments for which the provider would not otherwise be entitled this may involve such things as falsification of health care provider credentials, falsified or inadequate provider network; falsification, deliberate non-compliance with local or State agreements.
 - i. Mitigation Strategies: All participating providers must be enrolled Medicaid providers in good standing. The enrollment process includes verification of certifications and licensees and review of federal suspension and debarment lists. In addition, the State Departments of DMH, DCF, DAIL and VDH maintain separate designation and certification requirements for all providers serving vulnerable populations. Lastly, the State Agency of Human Services, Director of Integrated Family Services must sign off on all local governance and provider network agreements prior to authorizing a implementation site or final grant agreement.
- b. Enrollment: Activities designed to overinflate caseloads, create incentives for enrollment as well as abuses such as enrolling ineligible individuals, enrolling nonexistent individuals, enrolling nonexistent or ineligible family members, “cherry-picking” or selecting healthier segments of the enrollment population, disenrolling undesirable members, failing to notify the State of deceased members.
 - i. Mitigation Strategies: All members are verified in the MMIS as actively enrolled as a Medicaid recipient prior to provider payments being disbursed. In addition, providers designated by DMH, DAIL and DCF to serve vulnerable populations must serve all clients in their region who meet State criteria without regard to the nature or severity of their diagnosis, ‘cherry picking’ is discouraged by the nature of the State laws that define the priority and target populations for these provider networks. Other safeguards include enrollee grievance and appeal rights and access to legal aid and healthcare ombudsmen services. The State routinely monitors grievance and appeal trends and conducts chart reviews and consumer satisfaction surveys to monitor for appropriateness of enrollment activities.

- c. **Underutilization:** This type of fraud/abuse may occur when an organization or local governance network shows a pattern of failing to provide enrollees members with medically necessary health care services on a timely basis (e.g., untimely first contact with clients, untimely assignment of a primary care physician, delay in reassigning a PCP upon an individual's request, discouragement of treatment using geographic or time barriers, failure to serve individuals with cultural or language barriers, defining "appropriateness of care" and/or "experimental procedures" in a manner inconsistent with standards of care, cumbersome appeal processes for enrollees or providers, ineffective grievance process, inadequate prior authorization "hotline", unreasonable prior authorization requirements, delay or failure of the PCP to perform necessary referrals for additional care, or routine denial of claims).
 - i. **Mitigation Strategies:** The State requires assessment and integrated treatment planning for all individuals identified as part of the IFS/EPSTDT initiative. Additionally, the State requires that each network have a clinical review process that involves interagency teaming to review cases for prioritization and assignment. In all cases State staffs assigned to local regions are part of that planning team (i.e., Medical Social Workers from the Children with Special Health Needs Program, and Social Worker staff from the Department of Children and Families). These processes make it difficult for any one provider to limit, discourage or otherwise provide sub-standard treatment response without immediate detection or complaints to the State by key stakeholders. Other safeguards include enrollee grievance and appeal rights and access to legal aid and healthcare ombudsmen services. The State routinely monitors grievance and appeal trends and conducts chart reviews and consumer satisfaction surveys to monitor for satisfaction with provider services and member assessment of outcomes.

11.3 Quality Oversight and Outcomes

11.3.1 Dissemination of Best Practice Guidelines

Providers are expected to implement best practice guidelines that support the Bright Futures and Strengthening Frameworks and promote growth in key areas associated with family wellness, resiliency, assets and protective factors and clinical care guidelines.

11.3.2 Provider Quality Improvement

Providers will identify at least one area for quality improvement per fiscal year. Multiple years may focus on the same or similar areas for improvements that are implemented, tested and adjusted. Areas of quality improvement include but are not limited to:

- iii. **Practice Improvements** such as use of electronic medical records, data registries, panel management tools, utilization review processes, triage and follow-up protocols, etc.
- iv. **Care Related Improvements** such as family engagement strategies, trauma informed practice, health promotion activities, positive youth development, clinical guidelines (depression, ADHD, Autism, etc.) Positive Youth Development

11.4 Audits and Monitoring

A cross departmental IFS team will be assigned to each region and designated to monitor outcomes, program integrity and in collaboration with Field Services Directors, oversee quality improvement monitoring. The monitoring team will conduct at least one site visit and chart review annually and as needed participate in check in calls or meeting with providers to assess progress and provide technical assistance. The team will employ consistency in methodologies for tracking the utilization of intensive services used to determine shared savings incentives across all regions of the State. *Audits tools and methods will be developed with early implementer sites and a separate guideline developed as tools are finalized through these early projects.* Table one on the following page and table two provides a snapshot of audit elements and standards related to performance deliverables, adequacy of network and appropriateness of care.

11.5 Outcome Measurement

IFS outcome measures will be reviewed and periodically updated as the initiative progresses. Initial measures were chosen based on the following factors:

- a. Being considered reasonably valid measures of those IFS services that are targeted at improvement of enrollee health
- b. Using data that are already collected in a reliable/consistent manner;
- c. Obtainable in a timely manner at a reasonable cost.

All measures will use administrative data that is captured electronically. In addition, the measures will be reviewed quarterly and reported annually. Except where noted the estimated degree of data completeness is 100%. Data for the entire population that meet the criteria will be included. As a result, no sampling techniques will be used. Baseline indicators on all measures will be established for all regions and that baseline will guide how benchmarks are determined for each local provider network.

In addition to outcome measures, community profiles for each region will be created and provided to local provider networks on a regular basis to gauge overall population health, demographics, and trends in health conditions and service needs.

IFS Outcome Measures and their corresponding AHS statutory outcome area are defined below and in the charts on the following pages.

11.5.1 Children Live in Stable and Supported Families

- a. *Child Safety Interventions*: Number of Child Safety Interventions (Investigations and Assessments) as defined by DCF-FS) during a given measurement period (TBD)
- b. *Child Substantiations*: Percentage of Child Safety Interventions (as defined above) that resulted in a family being opened for ongoing services by DCF-FSD).
- c. *EFS Out of Home Placements*: Number (percentage) of MEDICAID youth age 21 yrs or younger that received EFS (as defined by EFS*) that required an out of home placement during a given measurement period (TBD)
- d. *Family Reports of experience of care*: Percentage of families that agree with the following: we got the help I needed, we received services that were right for us, Staff treated us with respect, and the services that we received made a difference. (Measurement period TBD).

- e. *Inpatient Psychiatric Admissions*: Percentage of all Medicaid youth age 21 years or younger with psychiatric hospital admission during the measurement period.
- f. *Inpatient Psychiatric ALOS*: Average length of stay of psychiatric hospital admissions for all Medicaid youth age 21 years or younger during a given measurement period (TBD).
- g. *Inpatient Psychiatric Readmissions*: Percentage of all Medicaid youth age 21 years or younger with psychiatric hospital readmission during the measurement period.

11.5.2 Pregnant Women and Young Children Thrive

- a. *OnePlan Goals*: Percentage of children Birth-6 years old or pregnant and postpartum women who achieve 1 or more of their goals as defined annually in their OnePlan during a given measurement period.
- b. *Prenatal/Postpartum Care*: Prenatal care = the percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment. Postpartum care = the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
- c. *Well-Child Visits (first 15 months of life)*: Percentage of beneficiaries who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life: zero, one, two, three, four, five, six or more.
- d. *Well-Child Visits (third, fourth, fifth, and sixth year of life)*: Percentage of beneficiaries who were three to six years of age during the measurement year who received one or more well-child visits with a primary care practitioner (PCP) during the measurement year.

INTEGRATED FAMILY SERVICES - PROGRAM PERFORMANCE & ADEQUACY OF NETWORK MEASURES					
Audit Element	Standard	Evidence/Source of Information	How Frequent	Who	Required Data Elements
Timely First Contact	<u>Emergent</u> : Within 24 hours <u>Birth – 3 yrs</u> (includes pregnant women): 2 business days from date of referral <u>3 and above</u> : 5 business days	<i>Administrative data in MSR (date of referral and date of first contact)</i>			Type of referral Date of referral Date of first contact
Timely First Visit	TBD	<i>Administrative data in MSR (date of referral and date of first visit)</i>			Date of first visit
Provider license and/or certifications	Appropriate licenses and certifications	<i>Administrative data in MMIS</i>			Provider license and/or certifications
Provider Availability	30 minutes or 30 miles	<i>Geographic Mapping of Providers</i>			Provider zip code
Appeals	Denial	<i>Grievance & Appeal</i>			Contained in

	procedures are followed and monitored	<i>Database</i>			Grievance & Appeals Manual
Grievance	Grievance procedures are followed and monitored	<i>Grievance & Appeal Database</i>			Contained in Grievance & Appeals Manual
Program Enrollment	Only those enrolled are served.	<i>Administrative data in MMIS</i>			Program Enrollment

INTEGRATED FAMILY SERVICES – APPROPRIATENESS of CARE MEASURES

MEASURE	DESCRIPTION	HOW MONITORED	WHO DOES ACTIVITY	HOW FREQUENTLY	TARGET
REFERRAL1	A. Percent of clients (greater than three years of age) that received initial contact within 5 <i>business</i> days of referral. B. Percent of clients prenatal to six that received initial contact within 5 <i>calendar</i> days.	Report from EMR	Report from DA/PCC	BIANNUAL	100%
EVALUATION 1	Percent of clients with initial assessments and plan of care completed within 90 calendar days of referral.	Report from EMR	Report from DA/PCC	BIANNUAL	100%
EVALUATION 2	Percent of clients with at least one standardized* screening or assessment tool used to develop the plan of care.	Report from EMR	Report from DA/PCC	BIANNUAL	100%
EVALUATION 3	Percent of clients that had all 11 core information elements included in the summary and planning documents.	Client Record	Chart review	BIANNUAL	100%
PLAN OF CARE 1	Percent of clients with documented discussion of care goals. May include direct note, goal that is client directed, sign off by parent/guardian or language of goals clearly indicate involvement by client and family	Client Record	Chart review	BIANNUAL	100%
PLAN OF CARE 2	Percent of clients with a plan of care that addresses needs taken from the screening, evaluation and core information summary.	Client Record	Chart review	BIANNUAL	100%
PROGRESS1	Percent of clients that have shown improvement on a standardized* assessment tool.	Report from EMR	Report from DA/PCC	BIANNUAL	100%
PROGRESS2	Percent of clients that have evidence of service coordination in their record.	Client Record	Chart review	BIANNUAL	100%
TRANSITION - DISCHARGE	A. Percent of clients (greater than three years of age) that	Report from EMR(?)	Report from DA/PCC	BIANNUAL	100%

PLAN 1	had transition or discharge plans developed 30 days or more prior to transition or discharge date. B. Percent of clients (pre-natal to three years of age) that had a transition plan, meeting and notification to schools and state at least 90 days before transition.				
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IFS MANUAL ATTACHMENT B: IFS CORE DOCUMENTATION, DATA ELEMENTS AND REPORTING REQUIREMENTS

1.1 Core Documentation/Chart Elements

All IFS core elements must be present in all client records, this includes all items and requirements noted in section 3.6 and 3.7 of this manual:

- a. Referral & Intake information
- b. Screening Tools or information
- c. Evaluation Tools & on-going assessment information
- d. Integrated Family Plan of Care
- e. Progress notes
- f. Transition or discharge plan

Sample forms are included in this attachment which contains all core elements required for IFS data collection. IFS does not require the use of specific forms, however, all data represent on the sample forms in this manual must be present in local records and must be easily transmitted to the state, as needed, in an electronic format, for oversight, federal and State reporting, audit and outcome measurement. Current forms include a plan summary document, early implementers are in the process of refining full treatment plan formats and any revisions will be included in subsequent manual drafts.

1.2 Documentation of Services Provided

Electronic documentation of services provided is required. Agencies working towards automation of records must seek prior approval for submitting data to the State in a manner that is not an electronic extract. The provider must be able to produce specific encounter data using activity (currently MSR) coding schema, as noted in this manual must, from the EHR if requested by the state. *This is a temporary solution until a more modern IT data storage and sharing solution is defined and available.*

1.3 Encounter and Other Data Reporting

Minimum encounter data elements should be present or easily reported from the electronic health record, these include: client name, Medicaid ID, date of referral, date of first contact. For each service delivered: date of service, place of service, type of service, person delivering service. *This is a temporary code schema until the State defines final encounter data needs.*

IFS MANUAL ATTACHMENT C: BEST PRACTICE GUIDELINES IN THE REQUEST FOR AND MANAGEMENT OF OUT-OF-HOME SERVICES FOR CHILDREN AND FAMILIES

ATTACHMENT 4

DMH - MSR Service Type Reporting Codes for Encounter Data (2011 documentation)

A01 = Service Planning & Coordination
B01 = Community Supports
B02 = Community Supports
B03 = Family Education
C01 = Employment Assessment
C02 = Employer & Job Development
C03 = Job Training
C04 = Ongoing support to Maintain Employment
D01 = Respite (by the hour) – Not for MH Adult
D02 = Respite (by the day or overnight) – Not for MH Adult
E01 = Clinical Assessment
E02 = Individual Therapy
E03 = Family Therapy
E04 = Group Therapy
E05 = Medication & Medical Support & Consultation Services
F01 = Consultation, Education & Advocacy
F02 = ADAP – Individual Consultation & Education for Professional Staff
F03 = ADAP – Group Consultation & Education for Professional Staff
F04 = ADAP – Individual Consultation & Education for Participants
F05 = ADAP – Group Consultation & Education for Participants
G01 = Emergency / Crisis Assessment, Support & Referral
H01 = Supervised / Assisted Living (by the hour)
H02 = Staffed Living
H03 = Group Treatment / Living
H04 = Licensed Home Providers /Foster Families
H05 = Unlicensed Home Providers /Foster Families
H06 = ICF / MR – Not for MH Adults
I01 = Transportation
J01 = ADAP – Intensive Outpatient
J02 = ADAP – Follow-up for Intensive Outpatient
K01 = Partial Hospitalization – Not for DS use
L01 = Day Services – Not for DS use
X01 = Hold for DA use for non- DMH-reportable service activities
If not specifically required by a program it can also be: blank or zero

ATTACHMENT 5

**Value-based Purchasing Base Payment Models
Excerpted from PHPG Task 2 Report for DVHA:**

*Identification of Key Components / Standardized Criteria of Well-Developed VBP Programs, December 16, 2014
(Edited March 4, 2015)*

PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING			
Payment Model	Operational Definition	Effects on Providers	Rate-Setting / Payment Mechanisms
<i>Fee-for-Service (FFS)</i>	<p>Health care providers are paid for each service they render (e.g., an office visit, test, procedure or service).</p> <p>Payments are issued retrospectively, after the services are provided.</p> <p>FFS is the best approach where the principal or sole problem is underuse of a service, in that it ensures that individuals receive that service (assuming that the fee level is adequate).</p>	<p>Incentivizes providers to provide more treatments and individual units of care regardless of whether that care is efficient or effective because payment is dependent on the quantity of care, rather than quality of care.</p> <p>Pays providers for doing things to sick people, rather than getting and keeping people well.</p> <p>Financially penalizes health care providers for providing better quality services since providers frequently lose revenues and profits if they keep people healthy, reduce errors and complications, and avoid unnecessary care.</p> <p>Puts the provider at risk for the number and cost of processes within each service covered by a separate fee, but nothing else.</p> <p>Providers lose revenue if they perform fewer services or lower-cost services, but their costs of delivering the remaining services generally do not decrease proportionately, which can cause operating losses for the providers.</p> <p>Is considered a barrier to coordinated care, or integrated care because it rewards individual clinicians for performing separate treatments.</p>	<p>Payers set rates based on the costs of providing the service, based on a percentage of what other payers reimburse for equivalent services, and/or based on negotiations with providers.</p> <p>Payment rates may be updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate.</p>

PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING			
Payment Model	Operational Definition	Effects on Providers	Rate-Setting / Payment Mechanisms
<p>Bundled Payments</p> <p><i>Variants include:</i></p> <ul style="list-style-type: none"> • Episode-based Payment • Episode-of-care Payment • Global Bundled Payment • Case rate • Evidence-based Case Rate • Prospective Payment Systems 	<p>Health care providers are paid a fixed dollar amount based on the expected costs for a clinically defined episode or bundle of related health care services as needed by an individual for a particular condition or treatment.</p> <p>Bundles can be defined in different ways, cover varying periods of time (e.g., one year for a chronic condition, the period of the hospital stay), and include single or multiple health care providers of different types (e.g., hospital only, hospital and ambulatory provider).</p> <p>If the goal is to control over-utilization of certain kinds of services, then a single payment for all services controlled by a particular provider could be used. If the goal is to better coordinate decisions among multiple providers, then gain-sharing or bundled payments for those providers could be used.</p> <p>Also frequently called a Case Rate (i.e., there is a single payment for the case rather than multiple fees for each of the specific services provided within that case.)</p> <p>Prospective Payment System (PPS): Health care providers are paid based on a predetermined, fixed amount for a particular service, based on the classification system of that service (i.e., diagnosis-related groups for inpatient hospital services or case mix adjusted payments for home health services). For example, CMS uses separate PPSs for</p>	<p>Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.</p> <p>Reduces the incentive for the provider to overuse or provide unnecessary services within an episode of care.</p> <p>May provide incentive to provide the lowest level of care possible, not diagnose complications of a treatment before the end date of the bundled payment, or delay care until after the end date of the bundled payment.</p> <p>Does not provide incentive to control the number of episodes that the person experiences.</p> <p>Gives healthcare providers the flexibility to decide what services should be delivered, rather than being constrained by fee codes and amounts.</p> <p>Episode-base Payments without Provider Bundling:</p> <ul style="list-style-type: none"> • There is no financial incentive for multiple providers involved in the same portion of an individual’s overall episode of care to coordinate their activities in a value-maximizing way. • There is a financial incentive for each provider to shift costs onto other providers involved in separately-paid portions of the individual’s overall episode of care. 	<p>The amount of the bundled payment should be prospectively defined (i.e., established before the care actually occurs).</p> <p>Historical expenditures are typically used to determine the initial bundled payment rates.</p> <p>The bundled payment rate can be set at an amount estimated to increase, decrease, or maintain historical expenditure levels.</p> <p>The definition of a bundled payment is largely comprised of three components:</p> <ol style="list-style-type: none"> 1) Service inclusion criteria 2) The episode time window 3) Inclusion and exclusion criteria regarding plan enrollees 4) Provider inclusion criteria <p>Defining when a bundle begins and ends and what services are included can be challenging when considering chronic conditions. In the case of chronic diseases, it has been suggested that an “episode” should defined as all care that occurs during a fixed period of time (e.g. a year).</p> <p>Severity adjustment for payment amounts is important (i.e., the payment level for a particular type of episode should be higher if the individual has more complex needs).</p> <p>In bundled provider models, providers are encouraged to create joint arrangements for accepting and dividing up the bundled payment among themselves.</p> <p>The design of bundled payment programs affects the costs of payment administration, including costs to both providers and payers.</p>

PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING			
Payment Model	Operational Definition	Effects on Providers	Rate-Setting / Payment Mechanisms
	reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.		More complex bundled payment designs are likely to incur higher administration costs.
<p>Population-based Payments</p> <p><i>Variants Include:</i></p> <ul style="list-style-type: none"> • Total Cost of Care Payment • Comprehensive Care Payment • Global Payment • Capitation • Condition-Adjusted (or Specific) Capitation • Risk-Adjusted Global Fee • Partial Capitation 	<p>Health care providers are prospectively paid a set amount for all of the healthcare services needed by a specified group of people for a fixed period of time, whether or not that person seeks care (as opposed to bundled payments which are based on an individual receiving care).</p> <p>Traditional Capitation: The methodology to determine the amount paid per individual is the same for all individuals, regardless of how well or sick the individual is or how many services are provided.</p> <p>Condition-Adjusted (or Specific) Capitation or Risk-Adjusted Global Fee: The methodology to determine the amount paid per individual is adjusted based on the relative health and other characteristics of the individuals within the group that may affect the level of services needed (e.g. age, race, sex, location).</p> <p>Partial Capitation Payment: The provider receives a fixed dollar amount to cover the costs of a pre-defined set of services (e.g. payments for carve outs for high-cost items such as specific drugs or medical devices, like prosthetics) that a specified group of people may receive in a given time period, but other</p>	<p>Providers have incentive to consider the cost of treatment.</p> <p>There is no incentive to provide more services simply to increase revenues.</p> <p>Gives healthcare providers the flexibility to decide what services should be delivered and the upfront resources to deliver them, rather than being constrained by fee codes and amounts, or waiting for uncertain, after-the-fact shared savings payments to be made.</p> <p>The provider has an incentive to ensure that quality care is delivered because they are responsible for providing some or all of the remedial services that may be needed with no added compensation.</p> <p>If the provider delivers inefficient, high-cost care, then depending on the structure of the arrangement, it may be held responsible for some of the additional costs incurred.</p> <p>Encourages providers to focus on preventive health care, as there is greater financial reward in illness prevention than in illness treatment.</p>	<p>The amount of the payment should be adjusted based on the types and severity of conditions, and other characteristics of the individuals being cared for.</p> <p>Payments should be set at adequate levels to provide good-quality care.</p> <p>Special provisions should be established for unusually high-cost cases, such as outlier payments, reinsurance, etc., to avoid having a few expensive cases cause financial problems for providers who are doing a good job of managing typical cases.</p> <p>Theoretically, a provider contracting for a population-based payment is not required to submit claims. Rather the provider is accountable for managing the total cost and quality of care.</p> <p>If the payer requires claims submission, a provider contracting for a population-based payment does not need to establish claims-payment systems to directly pay other providers delivering care. Rather, the payer could still process claims from other providers using its existing claims-processing system, essentially treating the population-based payment as a debit account. The provider contracting for a population-based payment would be responsible for keeping total costs within the payment amount.</p>

PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING			
Payment Model	Operational Definition	Effects on Providers	Rate-Setting / Payment Mechanisms
	services continue to be paid on a fee-for-service or other basis.		

ATTACHMENT 6

Outcome Measures across Multiple IFS Documents

IFS Provider Manual – Outcome Measures (p 61-62)	IFS Strategic Plan & IFS Stakeholder Meeting (1/22/15)	Measures to be Reported by CSAC and NCSS as of February 2015 (denoted by *) & Measures in CSAC SFY14 IFS Report	Shared Savings Incentive Measures - IFS Provider Manual (p. 56))
<p>IFS outcome measures will be reviewed and periodically updated as the initiative progresses. Initial measures were chosen based on the following factors:</p> <ul style="list-style-type: none"> d. Being considered reasonably valid measures of those IFS services that are targeted at improvement of enrollee health e. Using data that are already collected in a reliable/consistent manner; f. Obtainable in a timely manner at a reasonable cost. <p>All measures will use administrative data that is captured electronically. In addition, the measures will be reviewed quarterly and reported annually. Except where noted the estimated degree of data completeness is 100%. Data for the entire population that meet the criteria will be included. As a result, no sampling techniques will be used. Baseline indicators on all measures will be established for all regions and that baseline will guide how benchmarks are determined for each local provider network.</p>	<p>Population Indicators: IFS will use population indicators to gauge progress at a whole-population level in Vermont. IFS is not solely accountable for these indicators; many partners working together will contribute to our collective achievement of these indicators.</p> <p>Headline Performance Measures to include in IFS Grants: IFS will use headline performance measures to measure quality and impact across all IFS grants in communities. Although other performance measures will be included in IFS grants, these headline performance measures are meant to be the best proxy for whether or not people served are better off and to discern the quality of care provided. These measures pertain to the services provided by the IFS grantees and any sub-contracted services. While all of the indicators and performance measures below will be considered by the IFS AO Work Group before finalizing, brackets indicate that there is meaningful work still to be done to hone and finalize.</p>	<p>Measures to be reported by IFS Providers as of 2015: In late January 2015, IFS State leadership met with the IFS Providers to identify initial performance and outcome measures for NCSS and CSAC to report to the IFS Management Team within the near future for purposes of legislative reporting to the legislature, other interested stakeholders and potential new IFS regions.</p>	<p>AHS would create a report of up to a five year average utilization for each of these services by region and a percentage value of verifiable reductions in utilization would be calculated. The percentage decrease in expenditures associated with reductions in utilization will be shared back with the IFS providers equal to the percentage of the drop in utilization. This payment would be capped at 20% of the five year average. The savings would be shared back with the local provider network in the fourth quarter of the subsequent fiscal year. Shared savings must be reinvested into the local system of care based on local provider governance agreements and must be used to support program and activities that enhance the protective factors in children and strengthen families.</p>
		Total number of children and youth served *	
		Number of children and youth served by age	
		Top ten primary diagnostic disorders	
		<u>Number of children and youth served who have a diagnosis commonly associated with trauma</u>	

IFS Provider Manual – Outcome Measures (p 61-62)	IFS Strategic Plan & IFS Stakeholder Meeting (1/22/15)	Measures to be Reported by CSAC and NCSS as of February 2015 (denoted by *) & Measures in CSAC SFY14 IFS Report	Shared Savings Incentive Measures - IFS Provider Manual (p. 56))
		<u>(PTSD and Reactive Attachment Disorder) *</u>	
		Total hours of service by service type and by diagnosis	
		Number of hours spent caring for children and youth served who have a diagnosis commonly associated with trauma (PTSD and Reactive Attachment Disorder) *	
		Staff turnover and staff morale	
11.5.1 Children Live in Stable and Supported Families	Families are safe, stable, nurturing, and supportive		
<i>h. Child Safety Interventions:</i> Number of Child Safety Interventions (Investigations and Assessments) as defined by DCF-FS) during a given measurement period (TBD)	<u>Rate of child abuse and neglect</u>		
<i>i. Child Substantiations:</i> Percentage of Child Safety Interventions (as defined above) that resulted in a family being opened for ongoing services by DCF-FSD).			
<i>j. EFS Out of Home Placements:</i> Number (percentage) of MEDICAID youth age 21 yrs or younger that received EFS (as defined by EFS*) that required an out of home placement during a given measurement period (TBD)			DCF Substitute Care allocations for the region
<i>k. Family Reports of experience of care:</i> Percentage of families that agree with the following: we got the help I needed, we received services that were right for us, Staff treated us with respect, and the services that we received made a difference. (Measurement period TBD).	[parents having concrete supports in times of need] IFS Headline Measure: [a measure that demonstrates level of satisfaction from family perspective]	Percentage of people served who report receiving the help they needed * Percentage of people served who report being treated with respect by staff * Percentage of people served who report the services they received made a difference * Number of complaints and grievances	

IFS Provider Manual – Outcome Measures (p 61-62)	IFS Strategic Plan & IFS Stakeholder Meeting (1/22/15)	Measures to be Reported by CSAC and NCSS as of February 2015 (denoted by *) & Measures in CSAC SFY14 IFS Report	Shared Savings Incentive Measures - IFS Provider Manual (p. 56))
<p><i>l. Inpatient Psychiatric Admissions:</i> Percentage of all Medicaid youth age 21 yrs or younger with psychiatric hospital admission during the measurement period.</p>		Rate of inpatient hospitalization *	Inpatient psychiatric hospitalization under 21
<p><i>m. Inpatient Psychiatric ALOS:</i> Average length of stay of psychiatric hospital admissions for all Medicaid youth age 21 yrs or younger during a given measurement period (TBD).</p>			
<p><i>n. Inpatient Psychiatric Readmissions:</i> Percentage of all Medicaid youth age 21 yrs or younger with psychiatric hospital readmission during the measurement period.</p>			
		Number of crisis interventions *	Emergency room visits under 21 Non-hospital based emergency placements (e-beds; hospital diversion)
		Number admitted to residential care *	Private Non-Medical Institution (PMNI)
	[parents have skills they need to be successful parents]		
<p>11.5.2 Pregnant Women and Young Children Thrive</p>	<p>Pregnant women and young children thrive/Children are ready for school</p>		
<p><i>e. OnePlan Goals:</i> Percentage of children Birth-6 years old or pregnant and postpartum women who achieve 1 or more of their goals as defined annually in their OnePlan during a given measurement period.</p>	<p>IFS Headline Measure: [measure that demonstrates quality execution of plan of care (e.g., timeliness, appropriateness, evidence-informed)]</p>		
<p><i>f. Prenatal/Postpartum Care:</i> Prenatal care = the percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment. Postpartum care = the</p>	<p>% of women who receive first trimester prenatal care</p>		

IFS Provider Manual – Outcome Measures (p 61-62)	IFS Strategic Plan & IFS Stakeholder Meeting (1/22/15)	Measures to be Reported by CSAC and NCSS as of February 2015 (denoted by *) & Measures in CSAC SFY14 IFS Report	Shared Savings Incentive Measures - IFS Provider Manual (p. 56)
percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.			
g. <i>Well-Child Visits (first 15 months of life)</i> : Percentage of beneficiaries who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life: zero, one, two, three, four, five, six or more.	<u>[% of children and youth with a medical home]</u>		
h. <i>Well-Child Visits (third, fourth, fifth, and sixth year of life)</i> : Percentage of beneficiaries who were three to six years of age during the measurement year who received one or more well-child visits with a primary care practitioner (PCP).			
	<u>[children meeting developmental milestones/screenings]</u>		
	<u>[% of children ready for school]</u>		
	Children succeed in school]/Youth make healthy choices/Youth transition successfully to adulthood		
	% of adolescents who feel valued by their community		
	% of students with plans for education, vocational training, or employment following high school		
	[youth engaging in healthy behaviors – physical activity and nutrition?]		
	[a school-aged children indicator]	Number of children placed on an IEP Number of children with a 504 plan	
	[substance abuse measure?]	Number of families with a member who was abusing substances such that it interfered with family functioning (in last six	

IFS Provider Manual – Outcome Measures (p 61-62)	IFS Strategic Plan & IFS Stakeholder Meeting (1/22/15)	Measures to be Reported by CSAC and NCSS as of February 2015 (denoted by *) & Measures in CSAC SFY14 IFS Report	Shared Savings Incentive Measures - IFS Provider Manual (p. 56))
		months)	
	Communities are safe and supportive		
	% access to safe and supervised early childhood and out of school care		
	[housing indicator]		
	[% of families who have experienced homelessness in the past year]	Number of families who were homeless or staying with family or friends due to not having a residence of their own (in last six months)	
	[% of families who are food insecure]		
	IFS Headline Measure: [% of clients with a plan of care developed collaboratively with families, and that includes needs identified through standardized screenings, assessments, evaluations, and/or care information summary]		
	IFS Headline Measure: [% of families that have shown improvement on a standardized assessment tool]	Number of children/families that have achieved one or more goals in the last six months	

ATTACHMENT 7

IFS Value Based Purchasing Project: PHPG Interview Questions

Provider Interview Questions

Is the incentive for the IFS initiative large enough to compensate you for the effort required to obtain the reward?

Do the IFS quality, outcome and incentive measures align with the behavior or systems change that is required in the IFS initiative?

Has the IFS model changed your behavior or delivery system? Please describe.

Does the State provide you with routine performance (data-driven) feedback?

Are the data that you are required to report to the State easily obtainable for you?

Were you engaged in the design of the IFS initiative?

Is there alignment between your scope of practice and IFS initiative objectives?

Do you have other incentives, from other contracts, that align or hinder the IFS incentive system?

Are you being tracked on other quality or performance measures from different contracts? If so, please describe the measures and target population.

Are there funding policies (State or local) that impact the IFS initiative design or its effectiveness?

Quality and Outcome Measures (for State Staff Interviews)

What information has been collected on the appropriateness of care and provider network adequacy measures that are outlined in the IFS Manual?

Providers are required to identify at least one area for quality improvement per fiscal year. Has this process begun and, if so, what is the process for reporting on those areas to the State?

Are the data used in the measurement methodology easily obtainable for State?

Could the State share with us the methodology, including the inclusion and exclusion criteria for each of the outcome measures listed below:

- 1) Child Safety Interventions: Number of Child Safety Interventions (Investigations and Assessments) as defined by DCF-FS) during a given measurement period

- 2) Child Substantiations: Percentage of Child Safety Interventions that resulted in a family being opened for ongoing services by DCF-FSD).
- 3) EFS Out of Home Placements: Number (percentage) of MEDICAID youth age 21 yrs or younger that received EFS (as defined by EFS*) that required an out of home placement during a given measurement period
- 4) Family Reports of experience of care: Percentage of families that agree with the following: we got the help I needed, we received services that were right for us, Staff treated us with respect, and the services that we received made a difference.
- 5) Inpatient Psychiatric Admissions: Percentage of all Medicaid youth age 21 yrs or younger with psychiatric hospital admission during the measurement period.
- 6) Inpatient Psychiatric ALOS: Average length of stay of psychiatric hospital admissions for all Medicaid youth age 21 yrs or younger during a given measurement period.
- 7) Inpatient Psychiatric Readmissions: Percentage of all Medicaid youth age 21 yrs or younger with psychiatric hospital readmission during the measurement period.
- 8) OnePlan Goals: Percentage of children Birth-6 years old or pregnant and postpartum women who achieve 1 or more of their goals as defined annually in their OnePlan during a given measurement period.
- 9) Prenatal/Postpartum Care: Prenatal care = the percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment. Postpartum care = the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
- 10) Well-Child Visits (first 15 months of life): Percentage of beneficiaries who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life: zero, one, two, three, four, five, six or more.
- 11) Well-Child Visits (third, fourth, fifth, and sixth year of life): Percentage of beneficiaries who were three to six years of age during the measurement year who received one or more well-child visits with a primary care practitioner (PCP) during the measurement year.

Please describe the staff, data collection and reporting systems that support state level monitoring of the regions.

Please describe efforts to support provider improvement efforts. (For example: TA on best practices; benchmarks; infrastructure support; clinical data feedback loops; quality improvement support and coaching; and additional staffing support, such as care managers).

Does the IFS initiative provide routine performance (data-driven) feedback to the provider?

Have you identified any current regulations and laws that support or hinder the IFS program design?

Have you identified any State funding policies that impact the IFS program design and effectiveness?

Fiscal Questions (for State Staff Interviews)

The IFS Manual indicates that the shared savings incentives are currently suspended. Is that still the case?

Were any payments made to providers prior to the suspension of the shared savings model?

- If so, which regions and what was the amount of payment made?
- If not, have other incentives been implemented to replace the shared savings model?

Does the State still track utilization and expenditures for the services identified as the shared savings targets?

- f. Private Non-Medical Institution (PMNI)
- g. Inpatient psychiatric hospitalization under 21
- h. Emergency room visits under 21
- i. Non-hospital based emergency placements (e-beds; hospital diversion)
- j. DCF Substitute Care allocations for the region

Does the State have written documentation of the caseload and rate setting assumptions used in each of the two regions (i.e., what programs were included and which were excluded in each area)? If not, could you describe for us the assumptions used in each region?

What process does the State use to reconcile payments and costs to determine if additional provider payments will be made at the end of the year?

Were additional provider payments made at the end of any fiscal year for either region?

Please describe the process for establishing annual budget targets for service provision in the regions and the expected target population.

Please describe the process for establishing annual budget targets for state staffing, IT needs and provider incentives to support the initiative.

Have you identified any State funding policies that impact the IFS program design and effectiveness?

Outstanding Questions (for AHS IFS Leadership Interview)

1. Please confirm that the list below accurately represents the groups supporting IFS.

IFS Senior Leadership Team
IFS Implementation Team
IFS Financing and Payment Reform Work Group
IFS Community-Based Prevention and Promotion Work Group
IFS Data and Technology Work Group
IFS Accountability and Oversight Work Group
IFS Stakeholder Group

2. Please clarify the membership on the IFS Stakeholder group.

3. Please confirm the start date of the first IFS grant agreements in Addison County, was it July 2012?

4. We understand that the shared savings model was suspended; however, page 64 of the current CSAC grant describes a shared savings model. Has another approach been substituted?

5. What is the intent of the target caseload in the caseload incentive design?

6. The IFS provider manual describes the measurement methodology for outcome measurement to be 100% of target population (excerpt below) is this still the intent?

Manual Excerpt: Measures will be reviewed quarterly and reported annually, and will be periodically updated as the IFS initiative progresses. Except where noted, the estimated degree of data completeness is to be 100%. Data for the entire population that meet the criteria will be included; as a result, no sampling techniques will be used. The State will establish baseline indicators on all measures for all regions and that baseline will guide how benchmarks are determined for each local provider network.

7. Have the community profiles described in the IFS provider manual (excerpt below) been created? If so, how is “regular basis” defined? Who produces these measures?

Manual Excerpt: The State will create community profiles for each region which will be provided to local provider networks on a regular basis to gauge overall population health, demographics, and trends in health conditions and service needs.

8. Is the State monitoring grievance and appeals trends and satisfaction for the early implementer regions (excerpt below)?

Manual Excerpt: The State routinely monitors grievance and appeal trends and conducts chart reviews and consumer satisfaction surveys to monitor for appropriateness of enrollment activities and consumer satisfaction with provider services and member assessment of outcomes.

9. Have providers identified quality improvement areas for local focus as described in the manual (excerpt below)?

IFS Manual Excerpt: In addition, IFS Providers also are required to identify at least one area for quality improvement per fiscal year. Multiple years may focus on the same or similar areas for improvements that are implemented, tested and adjusted. Areas of quality improvement include but are not limited to:

- v. *Practice Improvements, such as use of electronic medical records, data registries, panel management tools, utilization review processes, triage and follow-up protocols, etc.*
- vi. *Care Related Improvements, such as family engagement strategies, trauma informed practice, health promotion activities, positive youth development, clinical guidelines (depression, ADHD, Autism, etc.*

10. Does the state monitor for the potential unintended consequences and risk mitigation as described in the IFS manual?

11. Is there capacity and staffing dedicated to the quality oversight structure? For example, does the State have data collection and reporting systems or dedicated staff in place to support provider performance feedback and/or technical assistance?

12. Please verify the membership (departmental affiliation or subject matter focus) for the team that conducted the most recent provider site visit?

13. Please clarify whether there is a year-end budget reconciliation process for providers.

14. Please clarify the outcome and strategic plan documents recently received and the relationship to the measurement system described in the manual.

- Is there a written description of each measurement methodology (inclusion/exclusion criteria; definition of population)?
- Will the population measures recently described augment or replace the IFS outcome measures?
- How does the measurement approach relate to the measures described in provider contracts?
- Are the appropriateness and quality measures described in the manual still accurate?

15. Are there State or Federal regulations and policies that impact the VBP program design and effectiveness?

16. Does the IFS initiative have a process for identifying annual funding needs in the following areas?

- State infra-structure (IT, staffing and incentive payments)
- Provider direct services (caseload and service utilization trends)