State of Vermont
Agency of Human Services

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Integrating Family Services Initiative:

IFS Provider Manual

Revised for FY2017

This document is the Agency of Human Services Integrating Family Services (IFS) Medicaid Global Commitment to Health Provider Manual. The rules and regulations outlined in this manual supersede those in previous manuals for DMH Children's Services.

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SECTION 1: About This Manual

1.1 Manual Primary Purposes

The information in this manual is intended to supplement and expand on a region's IFS grant. It includes guidelines and expectations regarding IFS implementation. More detailed, complementary information can be found via links to specific manuals. For example, the Children's Integrated Services manual provides in-depth information regarding provision of early childhood services, supports and other resources as part of IFS.

IFS teams will keep the manual up-to-date to reflect new policy decisions, new laws and regulations, and lessons learned. Given that the manual serves as the Medicaid Global Commitment to Health Provider Manual, it has a strong mental health focus despite the fact that services in the IFS bundle include more than mental health services. The manual will continue to improve, expand and evolve as services for children, youth and families become more integrated to reflect the range of resources, the continuum across ages and the continuum in terms of intensity of services and supports provided by IFS regions.

1.2 Integrating Family Services Overview

Integrating Family Services is an innovative approach, spearheaded by the Vermont Agency of Human Services, to reform how Vermont provides resources that support children, youth (through age 22), their families and their communities. This includes:

- Maternal and child health, which focuses on health promotion, prevention and wellness
- Early childhood through young adult development
- Mental health and social emotional health
- Child and youth safety
- Youth justice
- Child and youth well-being
- Developmental needs and disabilities
- Substance use and abuse
- Special health care needs
- Integration and working partnerships with health care providers

IFS' Vision: Vermonters work together to ensure all children, youth and families have what they need to reach their full potential.

IFS' Mission: Integrating 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.

AHS Act 186 Outcomes

1. Help ensure that families are safe, stable, nurturing, and supported.
2. Pregnant women and young children thrive.
3. Youth choose healthy behaviors.

4. Youth successfully transition to adulthood.

Section 1.3 IFS Guiding Principles

1. Promote the well-being of Vermont's children, youth and families. Policies, services and service providers are sensitive and responsive to the unique aspects of each family.
2. Build communities' capacity to provide a full range of resources in a flexible and timely way that is responsive to the needs of children and youth (prenatal through age 22) and families.
3. Focus on the individual and the family. Understand the child's needs in the context of his/her family.
4. Ensure that youth and families' voices inform processes, plans and policies.
5. Adopt the Strengthening Families approach. Strengthening Families' five protective factors guide our work.
6. Invest in a skilled, competent and valued workforce. People working with children, youth and families need training, support and adequate compensation.
7. Balance innovation with families' experiences, research and data to inform decisions about how to best use available resources and achieve positive outcomes.
8. Assure continuous quality improvement. Data informs decisions and drives change at the state and local level.
9. Promote a common language, shared decision-making and cross-disciplinary team work.

For more information about IFS, go to http://ifs.vermont.gov

SECTION 2: Local Governance

2.1 Eligible Providers

An entity is considered eligible for participation in Integrating 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.
d. The provider agency must ensure background checks are up to date and that Centers for Medicare and Medicaid Services (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 Local Governance

A comprehensive, written, local governance agreement for an integrated system of care should be in place at all times. The written governance agreement will be signed, at a minimum, by the DA, DCF-FSD District Director, AHS Field Director, and LIT Coordinator. The local governance agreement will, at a minimum, clarify local agreement and operating processes and practices.

General Governance for IFS

1. Modifications to and yearly review of local governance agreement
2. Clearly defined of roles and responsibilities of each party signing agreement
3. Clear description of decision making processes including resolution process of disagreements
4. Clear descriptions, of the advisory nature of this group and, when appropriate, of who has decision making authority
5. Implementation of an agreed upon process for strategic planning and achievement of outcomes
6. Mutual accountability in order to ensure the purpose and performance measures of the grant are being met.
7. 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.).
8. Accountability to ensure active engagement and participation of families, other service providers and community stakeholders in the governance structure and decision making processes.

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 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.

Providers are expected to collaborate to ensure the delivery of a continuum of preventive, prenatal care for pregnant women and other 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.

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

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

2.3 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.
- Local dispute resolution around service delivery, billing and governance model
- Fiscal and practice liability agreements

2.4 The roles of the DA/PCC and SSA in the IFS Region

The role of the SSA is to serve cases that cannot be served by the DA/PCC, typically high-end cases and occasional conflict cases or cases where one child is already being served by the SSA and the family wishes to have another child served without a whole new team/agency.

Referrals should flow through the DA/PCC utilizing the local process to triage cases, to refer to appropriate services, and to achieve the best outcome for the child/family. The DA/PCC has the right of first refusal. Services through the SSA are time-limited with the goal of referring back to

the DA/PCC. Through IFS, the DA/PCC develops strong high-end services with relevant support from the SSA, including consultation from areas of expertise, specialized evaluations, and specialized service wraparound.

The SSA should be a part of the local governance agreement and participate in the local case review team to offer consultation and identify what resources are available through the SSA. The SSA likely contributes to regional outcomes but is not accountable to the outcomes in this region in the same manner as the DA/PCC/DCF. The SSA will continue to have its own outcomes and incentives through a separate grant process.

The DA/PCC will provide activities and services that are:

a. available year-round (unless part of a specific seasonal approach such as summer or after school therapeutic programs);
b. available 24 hours a day 7 days a week **if required** by the client's plan of care;
c. provided in the natural environments of the families and children to the maximum extent possible in order to support family or children's inclusion with typically developing peers. This will often be in the home or a community-based program or community setting;
d. provided by adequately and appropriately qualified and supervised professionals in accordance with established Vermont Medicaid and professional regulations;
e. provided through a centralized intake and referral process either by "one door" or "no wrong door";
f. managed within the regional allocation;
g. identified as medically necessary through a multidisciplinary assessment process;
h. coordinated by a designated lead case manager, service coordinator or care coordinator and;

The DA/PCC will ensure that:

a. specialized consultations are available as needed for children and families who have complex needs;
b. a utilization management plan is developed and implemented locally;
c. proper authorizations and business processes are in place to allow for all providers to communicate effectively with individuals, families and other team members;
d. data is used to guide decision making for both systems improvement as well as monitoring of individualized integrated service plans;
e. local information technology can provide data extracts to the Child Development Division for required data elements and reporting. This may mean the inclusion of additional reporting elements that are not currently captured through MSR; and
f. staff attend as required, state technical assistance meetings and trainings required to meet Federal or State requirements.

2.3 Administrative and Fiscal Requirements
Providers billing the IFS case rate are responsible to ensure unduplicated and accurate billing network; State and federally required data is reported as needed and available for State or federal review as requested.

Each administrative entity 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

3.1 Access to Services

3.1.1 Referrals Response Times*:* All attempts to contact family must be documented as follows:

a. Birth to 3 year olds who are referred to OSEP funded Early Intervention (EI) – Referrals must have evidence of being reviewed by an early intervention team member or supervisor within 2 business days from date of referral and contact made within 5 calendar days.
b. Pregnant/postpartum women and all other children – Referrals must show evidence of having direct contact or attempt at contact within five business days from date of referral.
c. Emergent referrals must have evidence of being addressed within 24 hours or sooner and programs providing urgent care must be available 24 hours a day, 7 days a week.

3.1.2 Availability*:* Family support activities and treatment services will be:

a. available year-round (unless part of a specific seasonal approach such as summer or after school therapeutic programs);
b. available 24 hours a day 7 days a week if required by the clients plan of care;
c. provided in the natural environment (i.e., home, early child care setting) to the maximum extent possible or a community setting that supports the family, child or youth's inclusion with typically developing peers;
d. provided through a centralized intake and referral process either by "one door" (a single centralized point of entry) or "no wrong door" (a consistent intake and shared triage process used by all providers);
e. identified as medically necessary if they are treatment related under Vermont Medicaid.

3.2 Early Education and Population Based Interventions

Providers are expected to promote wellness, resiliency and family education and awareness in healthy childhood development. These activities may take the form of population based initiatives, e.g., healthy eating, family support and wellness fairs, etc. as well as be targeted consultation and education activities with child care providers, pre-schools and/or other community based or faith based groups that support families and their children.

3.3 Screening and Assessment

The use of standardized screening and/or evaluation tools is expected. At least one standardized screening and/or assessment tool will be used in order to develop the plan of care. The most appropriate tools for the presenting issue and age should be used, it is not expected that every tool listed by the State is used for every assessment. However, all assessments should address family needs as well as the identified child or youth.

Initial assessments may be brief in nature to provide family support, preventative interventions, immediate early intervention and/or brief treatment. However, families that have any of the

characteristics listed below should receive a complete battery of multi-dimensional assessments and treatment plan services. A treatment plan in place within 90 days of initial assessment for families who have:

- multiple and complex needs and/or
- a clear need for support longer than 3 months and/or
- repeatedly requested additional support and services after discharged

The local provider network will ensure that specialized consultations are available as needed for children and families who have complex needs and that the process for access and referral is based on the same standards regardless of which provider identifies the need for more specialized consultations.

The Intake and Assessment process for families who have more intensive needs should include, but not be limited to:

a. Review of relevant information from other sources, such as the family, health care provider, child care provider, schools, other State agencies or programs, or others involved with the child and family;
b. Communication of the screening results to the family, the rest of the team and if requested by the family, the referral source;
c. Identification, provision and/or arrangement of subsequent specialized assessments or access to additional expertise as needed;
d. Facilitation of family connections with center-based or other community resources that promote learning and educational success for all family members; development of life skills such as self-care, parenting and child care, food security, money management; and addressing mental health, relationship or safety issues; and/or environmental concerns;

When treatment planning is warranted, plan development, a summary of intake data, assessments and additional information will include:

a. What the family wishes to accomplish including hopes and dreams;
b. History of the presenting concern;
c. Individual and family strengths that will contribute to outcomes;
d. Psychosocial history and developmental milestones;
e. Medical history;
f. Mental status;
g. Developmental needs;
h. Individual and family needs or deficits voiced or identified as a result of assessment;
i. Diagnosis or impression from information gathered and assessment(s) ;
j. Clinical formulation or interpretive summary of information gathered and assessment(s); and
k. Care plan, family support and treatment recommendations

Progress Monitoring using the CANS (Child and Adolescent Needs and Strengths)
The CANS (5-22) must be utilized for each child who is:

- 5-22 years old,
- who are receiving more than one service, and
- are in DCF custody.

3.4 Integrated Family Plan
For families who have multiple needs and whose providers span several disciplines, the integrated family plan will outline the core set of services, supports and family goals and identify who is acting as the lead service coordinator. Elements of the integrated family plan must meet the IFS core requirements (Attachment B) and include:

- identification of child and family strengths and capabilities
- evidence that the goals are meaningful to and have been developed in partnership with families
- goals that are specific, measurable, achievable, relevant, time-bound; and identification of who is responsible for providing services.

The activities and strategies to achieve the goals and outcomes will clearly define work and expectations between the service provider(s) and the family on behalf of the child. Services provided to family members must meet a collateral need of the identified client and support overall healthy development of the child or youth as indicated in best practice research (i.e., environmental/lifestyle modifications, obtainment of parenting strategies to support success, access to information, developmental education, skill building).

3.5 Lead Service Coordinator
The identified lead service coordinator is responsible for, at a minimum: assisting individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed medical, social, educational and other related services and supports for a specific individual, as well as monitoring progress, needed plan of care changes and transitions. Any services and supports that are part of the integrated family plan may be coordinated through formal (provided by the human services system including Family Services Social Workers for children in State custody) or informal (available through the strengths and resources of the family or community) resources.

Roles and Responsibilities of a Lead Service Coordinator

a. Serving as a single point of contact in supporting caregivers to obtain the resources and services they need;
b. Participating in and facilitating the family's involvement in the development, review and evaluation of the integrated plan
    i. Planning for and facilitating planning meetings including: the initial meeting, annual and 6-month reviews (for children under 6 years old) and transition meetings
    ii. Including the family's service providers on the individual child/family team (including school personnel, health care

providers, juvenile justice, family support, mental health, human services, and others at family request);

c. Promoting and facilitating communication between team members including the family;

d. Coordinating and/or performing screenings, initial or ongoing assessments, eligibility, progress and/or service coordination and program planning as needed

e. Consulting with and providing synthesis of information to parents/caregivers;

f. Ensuring the provision of year round services as needed and especially for pregnant/postpartum women and children from birth to age 6 and their families;

g. Utilizing specialized consultation or assessment expertise as needed;

h. Ensuring services are delivered and/or supported within the child care setting when child care is part of a child/family's plan; and

i. Providing written notification to families of the reduction or termination of benefits or services.

3.6 Documentation of Services Provided

Electronic documentation of services provided is required, agencies transitioning to electronic records must obtain prior agreement from the State on how information will be stored and transmitted. Documentation must be of sufficient clarity (i.e., acronym free or clearly defined) and clinical content to ensure eligibility for payment. Auditors must be able to read documentation, especially any documentation kept in paper format. The provider must be able to produce specific encounter data using activity (currently MSR) coding schema, as noted in this manual from the EHR if requested by the State. All electronic records must be HIPAA compliant.

For families who require treatment intervention and/or family support beyond consultation and education and population based strategies, the following items must include all IFS core elements (Attachment B) and be present in the client file:

a. Participant Name and Medicaid ID
b. Referral & Intake information
c. Screening Tools or information
d. Evaluation Tools & on-going assessment information (including assessment provider name and dates completed)
e. Integrated Plan of Care (including time frame of the plan, service type and frequency, responsible providers name, family and licensed clinician signature and dates completed)
f. Progress notes (which may be a weekly or monthly summary at the providers discretion) to include:
    i. Summary of major content or intervention themes consistent with treatment goals;
    ii. Observations made of the individual or responses to interventions;
    iii. Assessment of progress toward treatment goals;

iv. Ongoing needs for continued intervention and next steps.
v. Performance goals/outcomes for individual clients served.
vi. A summary of services provided and dates (this summary may be electronically available as part of the EHR and does not need to be duplicated as a separate document each month)

g. Transition or discharge plan

Psychiatrist or Psychiatric Nurse Practitioner with specialized training in child, youth and family services is required for the initial treatment plan development for the three groups of children listed below. The periodicity of review and oversight thereafter will be based on Psychiatrist or Psychiatric Nurse recommendation:

1. Children receiving psychiatric and/or medication management services
2. Children returning directly from a psychiatric inpatient setting
3. Children who have a co-occurring physical health and emotional/behavioral condition for whom the supervising clinician determines a review and consultation is needed

3.7 Transitions and Discharge planning

In thinking about IFS as a continuum of care, transition and discharge planning take on new meaning. In the past with programs that were separate a transition plan or discharge plan would need to occur, however, with IFS serving children 0-22 a transition or discharge plan would only be indicated for the value of information sharing to ensure continuity of care. To this end, a transition or discharge plan should be developed when a child/youth:

- requires services or providers outside the local network
- they are moving to another region
- they have completed services
- they have chosen to discontinue services
- services have been terminated

Plans should include the following components and be done with the family and family team whenever possible:

- Teaming efforts that occurred for the child/youth
- Reason for discharge or transition
- Condition at last contact
- Referrals made, if clinically indicated

Timelines:

A transition plan will be developed with the family and the family's team no less than 30 days prior to the transition date. Discharge summaries will be developed with the family and the family's team whenever possible. Plans will be made available to the family and the family's team.

Settings:
For a child who is in an out-of-home treatment setting, the local team shares equal responsibility with the facility or out of home treatment provider for discharge planning with the family. This includes settings such as:

i. out-of-home community home provider placements;
ii. private non-medical institutions/residential programs (in and out of state);
iii. hospital diversion/emergency beds;
iv. inpatient psychiatric hospitalization; and
v. arrangements with other providers

For children birth to age three, Part C Federal regulations require:

i. notifying schools of a child's potential eligibility for Part B pre-school special education at least 6 months prior to the child's 3rd birthday and documentation of the date of the notification; and
ii. with parental consent, convening a transition conference at least 90 days prior to the transition date and documentation of the date the conference was convened.

3.8 Confidentiality (Privacy and Security)
All entities involved in supporting families and their children shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of their work. Providers will follow federal and State law relating to privacy and security of individually identifiable health information as applicable; including AHS rule No. 08-048; the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations; V.S.A. Title 9, Ch. 62 pertaining to social security numbers; 42 CFR Part 2 for alcohol and drug abuse treatment information. Providers will assure that all of its employees and subcontractors understand the sensitive nature of the information that they may have access to and sign an affirmation of understanding regarding the information's confidential and non-public nature.

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.

SECTION 4: IFS System of Care: Outreach, Education, Administration and Early Childhood Screening and Surveillance

4.1 Outreach, Education and Administration

Outreach, Education and Administration related to early periodic diagnosis and treatment services is provided though several mechanisms. (1) Through a partnership with schools and school nurses as defined by the Vermont Department of Health, Maternal and Child Health programs and DVHA (2) through other community providers designated by the Integrating Family Services Initiative and Child Development Division for early childhood providers and the Department of Mental Health for mental health providers working in the home and community and especially co-location in pediatrician's offices. EPSDT Outreach provided by school nurses in cooperation with VDH has separate and distinct policies and procedures and is not the focus of this document. Please see VDH for school nurse partnerships and subsequent EPSDT administrative claiming. For purposes of outreach and education being provided by other community providers the requirements outlined below apply.

The integration of child and family services is designed to address two mutually supportive Federal EPSDT components:

1. assuring the availability and accessibility of required health care resources, and
2. helping Medicaid recipients and their parents or guardians effectively use them.

4.1.1 Target Group

Children and families who are Medicaid-eligible or potentially eligible must be given priority for services that are deemed medically necessary. Special focus should be given to high risk populations including but not limited to:

a. families who do not have homes;
b. families living in rural areas;
c. children whose families are considered "low income", i.e., are unemployed, or below poverty guidelines;
d. families/children who have witnessed crime, including domestic violence;
e. families with a history of child abuse and neglect;
f. child and families impacted by incarceration
g. at risk prenatal, maternal, newborn or child health conditions, e.g., preterm birth, low birth weight infant, infant mortality due to neglect, infants/children who have been exposed to toxic substances during pregnancy;
h. children under 3 years of age who need early intervention services because the child:
    i. is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in 1 or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development; or

ii. has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

All direct services that are Medicaid-reimbursable must to billed to Medicaid.

4.1.2 Outreach and Educational Components, Activities and Goals

4.1.2.1 EPSDT components should be designed to manage a comprehensive program of prevention and treatment, to systematically:

a. Seek out eligible families and inform them of the benefits of prevention and the health services and assistance available,
b. Help families understand healthy development and use health resources, including their own talents and knowledge, effectively and efficiently,
c. Assess the child's needs through initial and periodic examinations and evaluations, and
d. Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly
e. Support program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided.

4.1.2.2 Administrative responsibilities for home and community based EPSDT outreach programs are to:

a. Seek out eligible children (up to age 21) who are eligible or potentially eligible for Dr. Dynasaur/Medicaid or other support services and inform these children and their parents/guardians of the health services and assistance available to them and of the benefits of prevention;
b. Assess children's mental health and developmental needs periodically and as concerns arise;
c. Help children and their families use health care resources effectively and efficiently;
d. Assure that mental health and developmental problems found are diagnosed and treated early, that needed services are provided in a timely and efficient manner, and that duplicative and unnecessary services are avoided.
e. Monitor mental health and developmental status and maintain and/or improve outcomes.
f. Ensure that children have access to a medical and a dental home.

4.1.2.3 EPSDT Outreach, Education and Administrative activities may occur in any home and community based setting and/or service environments such as, but not limited to:

a. **Crisis Services:** Crisis programs provide 24-hour phone response and mobile crisis mental health outreach services. This program can sometimes be an entry point for children in need of mental health, developmental or other health screening and services. As such, it provides an opportunity to identify children and families who are

eligible or potentially eligible for Dr. Dynasaur/Medicaid, inform them of the benefits and services available to them, and assure their success in accessing these services.

b. **Pediatric Collaborative Arrangements:** Many pediatric and family practice physicians in Vermont experience a lack of resources and/or knowledge for assuring that children with mental health and/or developmental disabilities are able to access services and care providers to adequately screen, diagnose, and treat their more specialized needs. This creates unnecessary barriers to children receiving appropriate care. EPSDT Administration and Outreach activities provide coordination of care for Dr. Dynasaur/Medicaid eligible children, especially those with mental health or developmental needs, by a mental health/medical social worker based in pediatric or family practices across the State.

c. **Early Childhood Care and Education Settings:** Early childcare and education programs offer a prime entry point for children and their families to understand healthy development, preventive care, access to health care coverage, providers and health education as well as other necessary resources to support families and their children.

4.1.2.4 The specific goals of the EPSDT Outreach, Education and Administration:

a. To assure that all Dr. Dynasaur/ Medicaid eligible or potentially eligible children and youth accessing the EPSDT program are identified and informed of the benefits available to them.
b. To assure that all Dr. Dynasaur/Medicaid eligible children accessing the EPSDT program have Medical and Dental Homes and are receiving preventive services as defined on the AHS- VDH *Health Screenings for Children & Adolescents* (the EPSDT Periodicity Schedule).
c. To assure that all Dr. Dynasaur/Medicaid eligible children and youth with mental health needs who access the EPSDT program are identified and referred for appropriate services.
d. To assure that all Dr. Dynasaur/Medicaid eligible children referred for covered services are able to access these services.
e. To identify gaps, barriers or duplication of medical/dental/mental health services to the children and youth served by the EPSDT program and develop strategies to improve the delivery and coordination of these services.

4.1.2.5 Activities that may be coded as EPSDT Outreach, Education and Administration include, but are not limited to:

a. Identifying children and families who are eligible or potentially eligible for Dr. Dynasaur/Medicaid.
b. Informing eligible and potentially eligible children and families about the benefits and availability of services provided by Dr. Dynasaur/Medicaid including mental health services covered by Dr. Dynasaur/Medicaid (including preventive treatment and

screening) and services provided through the EPSDT program. All providers are expected to adhere to the EPSDT (Bright Futures) Periodicity scheduled for screenings as published by VDH.

c. Distributing literature about the benefits, eligibility requirements, and availability of the Dr. Dynasaur/Medicaid program, including services outlined on the EPSDT periodicity schedule.
d. Assisting the Medicaid agency to fulfill the outreach objectives of the Dr. Dynasaur/Medicaid program by informing individuals and their families about health resources available through the Dr. Dynasaur/Medicaid program.
e. Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal and well-baby care programs and services.
f. Providing information regarding Dr. Dynasaur/Medicaid managed care programs and health plans to individuals and families and how to access that system.
g. Encouraging families to access the medical/dental/mental health services provided by the Dr. Dynasaur/Medicaid program.
h. Verifying an individual's current Dr. Dynasaur/Medicaid eligibility status for purposes of the Dr. Dynasaur/Medicaid eligibility process.
i. Explaining Dr. Dynasaur/Medicaid eligibility rules and the Dr. Dynasaur/Medicaid eligibility process to prospective applicants.
j. Assisting individuals or families to complete a Dr. Dynasaur/Medicaid eligibility application.
k. Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Dr. Dynasaur/Medicaid application.
l. Providing necessary forms and packaging all forms in preparation for the Dr. Dynasaur/Medicaid eligibility determination.
m. Referring an individual or family to make application for Medicaid benefits.
n. Assisting the individual or family in collecting/gathering required information and documents for the Dr. Dynasaur/Medicaid application.

Time may not be coded as EPSDT outreach, education and administration if it was part of, or occurred at the same time as, any Medicaid State plan service as case management or collateral contact on behalf of a specific client or client related plan of care activity.

4.2 Pre-Natal Care and Support to Pregnant Women

It is important to link at-risk adolescents to pre-pregnancy risk education, family planning, pregnancy testing, and prenatal care. Additionally, all pregnant women should be encouraged to obtain early prenatal care and ensure that they and newborns be cared for in a setting that provides quality services appropriate to their level of risk. Late care or no care is related to increased prematurity rates. Low birth weight is the most important predictor of illness or death in early infancy. Higher costs of care are associated with the need for neonatal intensive care, extended and repeated hospitalizations, and follow up services for infants born at risk. Prenatal care may include, but not limited to nurse midwife services in pregnancy, labor, birth, and the immediate postpartum period.

4.3 Early Childhood Services

4.3.1 Screening, Surveillance and Evaluation

Providers are expected to promote surveillance, early identification and screening for Medicaid eligible and Medicaid enrolled children. The following definitions adopted by the State of Vermont AHS in 2010 should guide activities. All providers are expected to adhere to the EPSDT (Bright Futures) Periodicity scheduled for screenings as published by VDH.

Surveillance/Early Identification: This is the ongoing, longitudinal, cumulative process of recognizing children who may be at risk of developmental delays. Surveillance may occur in primary care practices, childcare settings or other environments applying population-based strategies for early detection of risk or problems.

Screening: This is use of brief and objective standardized tools to identify children at risk of developmental delay. It is a formal process that occurs at defined intervals and points of entry into services and any time a child is identified at risk through surveillance. Screening may occur at a primary care practice, mental health or other early childhood or provider settings.

Evaluation: This is a more complex process aimed at identifying and refining the specific nature of a particular client problem and related complex or confounding factors. Together, this information forms the foundation for specific recommendations and, if appropriate, leads to an individualized integrated treatment plan. An evaluation consists of gathering key information, exploring problem areas, formulating diagnoses, identify disabilities and strengths, and assessing the client's readiness for change.

4.3.2 Family Support

Family Support services focus on increasing child and family access to high quality child development services and safe environments. Using culturally competent, family centered supports, staff provides role modeling, counseling and mentoring aimed at successful development of parent and child life skills. Young adults are encouraged to achieve their health, education, economic, personal, and parenting goals as well as receive assistance to learn about and connect with community resources as needed**.** Allowable **s**ervices are aligned with EPSDT goals and rules and include, but are not limited to:

a. On-going screening and assessment to determine individual and family growth and development status;
b. Assessment and identification of basic needs and mitigation of family risk factors
c. Facilitation of family connections with center-based or other community resources that promote school success; support learning and development of life skills, such as self-care, parenting and child care, meal planning, money management; and addressing mental health, relationship issues, and/or environmental concerns;
    a. Identification of and providing access to job training;
    b. Support and education for parenting;

d. Ongoing support to ensure the child and/or parent has access to health insurance and utilizes their medical and dental home appropriately;
e. Providing health-focused prevention, promotion, and anticipatory guidance based on Growing Up Healthy (http://dcf.vermont.gov/sites/dcf/files/pdf/cdd/dev/GUH.pdf) and American Academy of Pediatrics Bright Futures Guidelines for Health Supervision (3rd edition)

4.3.3 Parent Child Center Services

Parent Child Center base services serve as a community resource and place of expertise on early childhood development and parenting for parents of young children. PCC's will insure that all pregnant women and parents of young children in the community can access their services. The primary goals of this prenatal and early childhood work are aligned with EPSDT and include, but are not limited to ensuring that:

a. parents of young children are actively engaged in their children's learning;
b. parents are socially connected and have support systems in place; and
c. parents have the resources to meet their family's basic needs.

Section 5: IFS Service Delivery

5.1 Early Childhood Intervention and Family Mental Health

Early childhood and family support services are intended to assist children, families, child care providers, and individuals, programs, and/or organizations serving the needs of young children and their families. Services are intended to address parent/child relational concerns, support access to and effective utilization of community services and activities, and develop parents', caregiver's and professional's skills in order to promote and support children's healthy social, emotional, and behavioral development.

a) **Early childhood and family support services** for all age groups are intended to address an event, systems or programmatic challenges, and/or promote the healthy social, emotional, and behavioral development of young children using evidence-based practices or curriculum.

b) **Consultation and education** services delivered must be outcomes-based using a pre- and post-assessment tool, and utilizing the integrated treatment plan. Consultation and education services are considered collateral contacts when they are intended to build the skills or capacity of individuals to improve their ability to meet the social, emotional, and behavioral development of young children identified for services in their care.

c) **Therapeutic Child Care** services are intended to provide outcome-based, planned combinations of intervention, consultation, and education services within high quality child care settings to improve child care staff's and parent's skills and abilities to support optimal social, emotional, and behavioral development of the young children in their care. Therapeutic Child Care services must be delivered in accordance with guidance provided by the Child Development Division which can be found at (http://dcf.vermont.gov/cdd/cis

5.2 Early Childhood and Family Support (birth to age 3)

Early childhood and family support services for children birth to age three are funded by a variety of State and federal resources, including Medicaid, EPSDT, OSEP- IDEA Part C, Title V - Children with Special Health Needs and State general funds. Regardless of fund source, local network providers must ensure that general program requirements outlined in section one are followed, for example, no duplication of services, integrated planning and outcomes. Any early intervention service must be coordinated with Medicaid EPSDT and Title V early childhood efforts in the State. Activities supported with multiple federal funding options must be designed to maximize outcomes and ensure no duplication or overlap of efforts or payments.

Part C Early Intervention must be provided in accordance with Part C of the 2004 IDEA and in accordance with the reauthorized Part C regulations in effect September, 2011 (https://www.federalregister.gov/articles/2011/09/28/2011-22783/early-intervention-

program-for-infants-and-toddlers-with-disabilities), and the State of Vermont Special Education Rules adopted June 1, 2013 and effective July 1, 2013. (http://education.vermont.gov/new/html/pgm_sped.html)

Early Intervention services are provided to children experiencing cognitive, physical, communication, social/emotional or adaptive delay or who have a diagnosed medical condition that has a high probability of resulting in developmental delay. Contractors are required to have available and reference at the Early Intervention site the current federal and state laws, regulations, rules and state policies and procedures, and guidance related to Part C Early Intervention and Part B Special Education for Preschool Children.

Ensure all client-specific information is stored and shared in a secure, HIPAA and FERPA compliant manner as applicable (see Attachment F and http://www2.ed.gov/policy/gen/reg/ferpa/index.html)

Submit resumes of staff to the State to assure the Office of special Education that all Early Intervention staffs meet the Vermont Part C requirement of holding a bachelor's degree in early childhood or a related field.

Early Intervention, OSEP funded through IDEA must be provided in accordance with Part C of the 2004 IDEA and in accordance with the reauthorized Part C regulations in effect September 2011. Providers coordinating both EPSDT funded services with Part C funding must:

a. Have available at the Early Intervention site copies of the current federal and State laws and regulations and State policies and procedures related to Part C Early Intervention and Part B Special Education for Preschool Children.
b. Assure all eligible children will have on file a written plan that meets Part C regulations, specifically 34 CFR §303.342 through §303.345,
c. Assure and document that families are regularly informed of their rights under IDEA, Part C dispute resolution
d. Develop and implement the Regional Child Find Agreement in accordance with the template and requirements in Attachment H of this agreement,
e. Assure that there is a process in place for dispute resolution at the community level, prior to informing the State office or the Interagency Coordinating Council (ICC) of unresolved complaints.
f. Submit the Regional Agreements to the CIS/EI administrator of the Part C Program.

Providers will also coordinate with their DCF Family Services Division district office to ensure early childhood services and support are provided to eligible children under the age of three who have had a substantiated case of abuse and or neglect as defined under the Child Abuse Prevention and Treatment Act (CAPTA). Referrals from the Family Services Division (FSD) will be received in the same manner as all referrals and a developmental screening will be done unless they are referred with a developmental concern or their family is requesting a full evaluation.

a. Children who are “high risk” with an open case with FSD and are referred to early intervention from FSD will go to a developmental screening unless they are referred with a developmental concern or their family is requesting a full evaluation.
b. Efforts to locate and identify eligible homeless children for Part C services

5.3 Early Intervention and Treatment Services (All Age Groups)
The overall goal of IFS and EPSDT treatment services are in alignment and premised on providing the most effective evidence base intervention, as medically necessary, for each individual child and family. Medically necessary services for Medicaid enrollees under the age of 21 are services and benefits that support normal growth and development and prevent, diagnose, detect, treat, ameliorate, palliate or prevent from worsening the effects of a physical, mental, behavioral, genetic or congenital condition, injury or disability. Medically necessary interventions must be reasonable expected to produce the intended results for children and to have expected benefits that outweigh any possible harmful effects.

Any EPSDT intervention and treatment service should:

a. Assist in achieving, maintaining, or restoring health and functional capabilities without discrimination to the nature of a congenital/developmental abnormality;
b. Be appropriate for the age and developmental status of the child;
c. Take into account the setting that is appropriate to the specific needs of the child and family; and
d. Reflect current bioethical standards.

5.4 Medicaid State Plan Services
All services that are medically necessary need to be provided whether or not it appears in the Vermont Medicaid State Plan. See Attachment A for federal EPSDT definitions.

5.4.1 Medicaid State Plan Services for Children and Families included in the IFS Case Rate
Service definitions below are taken from the approved VT Medicaid State Plan which should be referred to for most up to date definitions.

Medicaid State Plan Service	**Medicaid State Plan Definition**	**Target Group Restrictions**	**Provider Restrictions**
Clinic Services Diagnosis and Evaluation Services	A service related to identifying the extent of a patient’s (client’s) condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the client s attitudes, behavior, emotional state, personality	None	DMH Designated

	characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to family background, family interaction and current living situation; an evaluation of the client's social performance, community living skills, self-care skills and prevocational skills; and/or an evaluation of strategies, goals and objectives included in the development of a treatment plan, program plan of care consistent with the assessment findings as a whole.		
Developmental Therapy (CIS portion in sub-capitation payment)	Evaluation and treatment services provided to a child in order to promote normal development by correcting deficits in the child's affective, cognitive and psychomotor development. Services must be specified in a child's Individualized Family Service Plan (IFSP) under Part H of the Individuals with Disabilities Education Act (IDEA) and must be furnished by providers who meet applicable State licensure or certification requirements.	Young children who have an Individualized Family Service Plan recognized under IDEA Part C and H	LEA and/or Part C & H designated providers
Specialized Rehabilitative Services	Basic living skills, collateral contact, service coordination, specialized counseling		DMH Designated
Intensive Family Based Services (IFBS)	IFBS are family-focused, in-home treatment services for children that include crisis intervention, individual and family counseling, basic living skills and care coordination.	None	DMH and DCF designated
Clinic Services - Psychotherapy, individual & family	A method of treatment of mental disorders using the interaction between a therapist and a patient to promote emotional or psychological change to alleviate mental disorder. Psychotherapy also includes family therapy when only one family is being treated.	None	DMH Designated
Clinic Services	A method of treatment of mental disorders, using the interaction between a therapist and two or more patients to	None	DMH Designated

Group Therapy	promote emotional or psychological change to alleviate mental disorders. Group therapy may, in addition, focus on the patient's adaptive skills involving social interaction and emotional reactions to reality situations		
Clinic Services Emergency Care	A method of care provided for persons experiencing an acute mental health crisis as evidenced by (1) a sudden change in behavior with negative consequences for wellbeing; (2) a loss of usual coping mechanisms, or (3) presenting a danger to self or others. Emergency care includes diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. Emergency services are intensive, time-limited and are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources.	None	DMH Designated
Extended Services for pregnant women	Pregnancy-related and post-partum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls. (Home visiting)	Authorized by the Title V agency as part of CIS package	VDH & DCF-CDD designated
Targeted Case Management for children 0-12 months and pregnant and postpartum Women	Services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities	Must be enrolled in the DCF Healthy Babies, Kids, and Families Program (now known as Children's Integrated Services (CIS).	DCF- CDD designated
Targeted Case	Services furnished to assist individuals, eligible under the State Plan, in gaining	Must be enrolled in	DCF-CDD designated

Management for 1-5 years olds	access to needed medical, social, educational and other services. Case Management includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities	the DCF CIS programs and identified by a health professional or community program as at risk of inappropriate health care service utilization, medical complications, neglect, and or abuse.	
Target Group 0-22 years old w/Developmental Disabilities	Services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities.	Persons who do not have access to case management through any other program	DAIL Designated
Clinic Services Chemotherapy (Med-Check	Prescription of psychoactive drugs to favorably influence or prevent mental illness by a physician, physician's assistant, or nurse performing within the scope of their license. Chemotherapy also includes the monitoring and assessment of patient reaction to prescribed drugs.	None	DMH designated

Service	**Special Program (STC) or Federal Definitions**	**Target Group Restrictions**	**Provider Restrictions**

Home Provider	See Manual Section 6	See Manual Section	DMH, DAIL and DCF designated
Respite	See Manual Section 6	See Manual Section	DMH, DAIL and DCF designated
Transportation	Mileage reimbursements or other arrangements necessary due to challenging behaviors for transportation to services pursuant to the integrated family plan when such activities do not meet the definition on non-emergency transportation reimbursement by DVHA.	None	DMH, DAIL, and DCF designated
EPSDT Outreach and Education	See Manual Section 4	None	DMH and DCF designated

CORE Service	**Managed Care Investment or other Federal Funds**	**Target Group Restrictions**	**Provider Restrictions**
Parent Child Center	See Manual Section 4	None	DCF- CDD designated
Early Intervention	See Manual Section 4	None	DCF- CDD designated
Strengthening Families	See Manual Section 4	None	DCF- CDD designated

5.4.2 Vermont Medicaid State Plan Services for Children and Families not included in Case Rate

Services NOT currently included as core services in Case Rate payment
Outpatient Hospital Services
Inpatient Hospital Services
Lab and X-ray
Nursing Facility
Physician Services
Medical/Surgical Services provided by a dentist
Medical Care and any other remedial care (chiropractic, podiatry, optometry, opticians, naturopath, midwife, high tech nursing,)
Behavioral Health provided by non-DA/SSA providers reimbursed by DVHA fund sources
EPSDT Medical, dental and vision services
Family Planning Services
Face to Face tobacco cessation counseling services
Home Health Services

Private Duty Nursing
OT/PT/SLP
Clinic services designated by VDH
Prescription drugs, prosthetics, dentures, eyeglasses
Substance Abuse Services
Private Non-Medical Institutions
School Health Services (IEP related)
Child Sex Abuse and Juvenile Offender Services
ICF/MR
Hospice TB-related Case management
Respiratory Care Services
Pediatric or Family Nurse practitioner
Personal Care Services
Ambulance
Non-Emergency Transportation
Family Services Division - Targeted Case Management (DCF)

SECTION 6: IFS System of Care: Intensive Out of Home Treatment & Support

6.1 Target Group

Out of home treatment and support options are targeted at those children and youth who, absent these services would otherwise meet or be at risk of an institutional level of care or who are at risk of hospitalization. This array of services is provided by or under the supervision of a DMH/DAIL Designated Agency or Specialized Service Agency and/or in consultation with the Family Services Division of DCF or the Local Educational Administration (LEA).

Children who require these types of service Medicaid funded supports are considered to meet the definition of former 1915 (c) waivers for children under 21 who are experiencing a severe emotional disturbance (SED) or multiple co-occurring complex disorders and their families or the home and community based Developmental Services Program (DS), now referred to as "Special Programs" in the 2013 Global Commitment to Health Special Terms and Conditions approved by CMS.

Out of home care is considered an intensive level of care and utilizes some of the most restrictive treatment settings. The goal of all Medicaid funded programs is to service enrollees in the least restrictive environment possible commiserate with their clinical needs. Level of care assessments must take into account; severity of the problem, child and family coping skills, support system strength and availability, level of medical involvement and history or current level of treatment compliance on the part of the child and family. In addition, level of care determinations that focus on symptomology must consider less tangible variables in the child and family's life such as cultural competence, family strengths, underutilization of less intensive supports, need for incarcerated treatment and cognitive functioning considerations.

6.2 Parent/Guardian Financial Expectations when out of home services are used

Families who retain custody of their child will be asked to contribute to cost of their child's needs while in out-of-home placement, taking into account their ability to contribute. Available funds may include:

- *SSI and SSA*: The payee for the child must inform the Social Security Administration of the change in living arrangement. Because SSI is specifically meant to benefit the child and support their needs (it is not a family income supplement) the family is expected to provide for the child's needs related to clothing, hygiene, personal products, transportation and/or contribute commiserate with ability to any required room and board payments.
- *Adoption Assistance Agreement* (AAA). An AAA is a legal contract between the State and the adoptive parents, intended to help families adopt children with special needs, primarily from foster care. If the child is on Adoption Assistance the family is expected to inform the Family Services Division of the change in the child's living situation. The AAA may need to be renegotiated if it does not reflect or did not anticipate the current

needs of the child. The family may be expected to contribute a portion of the child's AAA toward for the child's needs related to clothing, hygiene and personal products, transportation or any required room and board payments.

- *Earned Income*: A family's ability to pay for their child's needs while in out of home care from earned income should be taken into consideration when planning for personal needs and room and board.

6.3 Out of Home Services and Permanency Planning

The family and local team are required to create a viable plan for permanency if the parent/caregiver:

1. Has not been able or willing to participate in the treatment of their child/youth
2. Is not able or willing to put into place necessary parenting strategies and/or activities to support the child in returning to the family home
3. Has made a decision that their child cannot return home, even after all goals are met

6.4 Local Community Resources

Local community resources are at the discretion of the local treatment and support team and do not need prior authorization. These include:

6.4.1 Respite

Respite may be provided in or out of the home for the purpose of providing a planned break for families/caregivers that are caring a child who has complex needs and who cannot be left unsupervised. Respite may be provided by the hour or as an overnight service.

6.4.2 Home Providers

Out of home care is a typically short-term individualized shared-living arrangement for children, offered within a home provider's home that is licensed by the State to serve children and youth. Services are targeted at youth who may require further assessment or who are unable to remain safely with their family due to intensive mental health and/or co-occurring mental health and developmental disabilities. This goal of this service is to provide both the child and the family an opportunity for enhancing coping, social and personal care skills and establishing a care plan to reunite the family under the same roof. Home Care may be referred to as: Therapeutic foster care, Shared parenting or Developmental Home services. Any shared parenting or developmental home provider used as part of an integrated treatment plan for children not in state's custody must contracted by the DA/SSA and adhere to DDAS Home Safety Inspection rules and process.

6.5 Statewide Resources Requiring Prior Authorization

The following out of home intensive treatment services must be prior authorized using the authorization process described for each service. All prior authorization decisions will be issued in writing. Approvals will include date effective, length of the approval period and expectations for progress reporting, continued stay or other criteria it deems necessary to ensure proper clinical and quality oversight. All denials will clearly state the reason for the denial and all

applicable grievance and appeal rights. Best practices expectations are outlined in Attachment C Best Practices in Out of Home Placement Guidelines.

6.5.1 Private Non-Medical Institutions (PNMI*)*

A PNMI is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides medical care to its residents. Facilities must be licensed as a Residential Child Care Facility and be enrolled in the VT Medicaid program. The PNMI Per-diem rate includes a comprehensive spectrum of mental health care services. When a child is being served in a PMNI facility it is expected that home and community based providers will stay actively involved in treatment and discharge planning and will facilitate transitions back to the community (home or home provider) in the most clinically expeditious manner possible.

Prior Authorization is required for any residential program for which the requesting agency or family is seeking Medicaid or other State involvement in payment for services. Services that have not followed these processes are not eligible for State participation in payment. This includes, but is not limited to those out-of-home programs that serve as statewide resources and for whom state DMH, DVHA, DCF, DAIL or VDH have specific provider contracts.

An **out-of-state** facility may be considered only if all in-state options have been exhausted or deemed clinically inappropriate at the sole discretion of the State through the prior authorization process. Any out-of-state provider authorized must be an enrolled Medicaid provider, in good standing, and accept Vermont Medicaid rates.

6.5.1.1 Eligibility

Residential placement is reserved for situations that represent the highest level of severity and acuity. To be eligible for Medicaid funded programs a child must be actively enrolled in the Vermont Medicaid program and be determined to meet medical necessity criteria outlined in this document.

To be eligible for other State and federal funding a child must be a resident of Vermont under the age of 22 and:

- Be in the custody of the Department for Children and Families or on Youthful Offender status as determined by a court; or
- On an IEP that includes residential treatment services

6.5.1.2 Exclusions

Absent a clear and specific treatment need residential services will not be authorized. Residential treatment is not appropriate if the sole reason is:

a. As a substitute for detention or incarceration, to avoid or forestall a court appearance
b. For caregiver respite
c. To remove a child or youth from an undesirable living situation
d. Failure of the parents to engage in or allow treatment at a level consistent with the needs of the child, as determined by predominant medical best practice guidelines (i.e.,

American Psychological Association, American Academy of Pediatric Providers; American Academy of Child and Adolescent Psychiatrist etc.)

6.5.1.3 Prior Authorization Processes

Children and youth, for whom prior authorization of residential treatment is sought must be assessed and all treatment information must be reviewed by a representative of the DCF Family Services Division, or a DMH/DAIL Designated Child and Family Service program. DMH and DAIL have delegated authority for eligibility and level of care determinations and treatment planning to local designated and specialized services agencies (See Best Practices in Out of Home planning for local DA/SSA & DCF listings)

6.5.1.4 Assessment and Level of Care Determinations

All of the following conditions must be met and evidence verified, as determined by a licensed professional, under contract with or working as an employee of a designated agency using the assessments and processes described in this document. Evidence that the child:

a. Has a behavioral, cognitive, physical or emotional diagnosis as defined by the currently approved International Classification of Diseases that significantly impairs daily functioning, as demonstrated through standardized assessment scores and that indicates a need for structured out of home services using scales such as the ASEBA.
b. Exhibits a pattern of significant impairment in social, familial, or community functioning; symptomology may include, but not be limited to: chronic behavior problems that pose a risk to self or others such as aggression, running away, substance abuse, destructive acts; demonstrated history that the client is unable to form a therapeutic alliance in the community or access community support needed to progress.
c. Requires twenty-four hours, seven-day week supervision for activities of daily living, medication management and compliance and for the development of positive coping skills for the child or youth, social and interpersonal or other skills needed for emotional well-being.
d. The support system (family, caregiver, significant others in the community) do not currently have a demonstrated ability, knowledge, training or skills to manage safety while participating in therapeutic in home services.
e. A less intensive level of care is not appropriate OR clear documentation that a short term length of stay as part of an early intervention approach will result in long term in-home unification and family success.

6.5.1.5 Authorized Assessments and Required Documentation

All of the following must be present in the medical record and verified as current (completed within the past six months) by the designated agency:

a. Achenbach System of Empirically Based Assessment (CBCL, YSR, ABCL);
b. Written psychological and/or adaptive functioning assessments;
c. Discharge summaries for any inpatient services received in the last 12 months;
d. A current or proposed integrated treatment plan;
e. A document summarizing the clinical information and verifying that out-of-home treatment has been determined medically necessary.

f. Any unusual/extenuating circumstances that may not be evident in other documentation that may support the request for out of home service.

6.5.1.6 Multi-Disciplinary Team Review
All requests for must be reviewed by the Local Interagency Team (LIT) or a clinical sub-committee designated by the LIT to complete clinical reviews and triage. One member of the LIT will be identified and serve as point person and liaison for the State to the family.

If the LIT or its designee agrees with the request and determines that all eligibility, assessment and clinical findings outlined in previous sections of this document have been met, it will forward the referral to the Case Review Committee for final determination and approval.

If the LIT disagrees with the request or feels that further assessment is needed, it will send written notice of its findings to the parent, legal guardian and lead provider involved with the case. Findings may include either a formal request for additional information, with a timeline for response or a notice that the LIT disagrees with the referral and will not forward for prior authorization. All notices of denial will clearly state the reason for the denial and all applicable grievance and appeal rights. If a request for additional information is not responded to within the expected timeframe, the case will be considered withdrawn and notice sent to the parent or legal guardian that the case will be closed.

If the LIT cannot reach consensus or lacks the needed expertise to review the case, it will be sent directly to the Case Review Committee.

6.5.1.7 Case Review Committee (CRC) Determinations
Requests deemed appropriate at the LIT level will be reviewed by CRC. CRC may request additional information or issue written findings.

CRC findings are considered recommendations to the department authorizing final payment. DAIL, DCF, DMH, DVHA will issue final decisions. Written notice of Departmental findings will be sent to the parent, legal guardian and lead provider involved with the case.

Departmental approvals will include date effective, length of the approval period and expectations for progress reporting, continued stay or other criteria it deems necessary to ensure proper clinical and quality oversight.

Departmental denials will clearly state the reason for the denial and all applicable grievance and appeal rights.

6.5.1.8 Procedures for State/Local Communication and Transfer of Case Information
The assigned lead case manager from the LIT will contact the CRC State department representative assigned to their program and notify them of the referral. The referral will be sent electronically and must include:

a. A cover letter outlining the dates and findings of the LIT reviews, the nature of the out-of-home service request, the past history of services to the child and family, and goals of the request.
b. Copies of the notices sent to the parent or legal guardian
c. A signed Child Placement Agreement (for all non-State custody out-of-home placement request)
d. Signed releases, as necessary
e. Requested Financial Support, including any relevant self-pay or private insurance offsets
f. A current or proposed integrated treatment plan
g. Supporting assessments as defined in this document
h. Supporting documentation, including letters from providers not present at LIT or other planning meetings.
i. An individualized education plan (IEP) when applicable.

6.5.1.9 Concurrent Review and continued stay approvals

Continued stay will be reviewed and approved at least every 3 months unless otherwise indicated in the CRC notice of approval/findings. Designated representatives of the CRC with expertise matching the case under consideration will review medical record documentation to determine if:

a. identified goals are being achieved and milestones for transition are being met
b. family and support system skills are increasing such that transition will be successful (even if the child has not yet met all their goals).
c. The family is ready for the child to transition home sooner than original target date.
d. Re-assessments of functioning, risk and severity show evidence of improvement
e. Transition planning is active and within the approved timeframes
f. Family plan meetings with DA/SSA and/or DCF, placement and family are occurring monthly and are productive in the development of a community and family support plan.
g. the family is participating in continued treatment/support services by attending identified treatment sessions at the placement, in the community or home and is helping to identify what ongoing treatment and supports they will need once the child returns home

If there are indications that the child and family are not responding to the therapeutic intervention or the interventions are not effective, the CRC representative will ask the local team to consider different goals or placement options.

6.5.2 Inpatient Psychiatric Hospitalization

Inpatient psychiatric hospital admission represents the highest level of care and is reserved for youth who are determined to be a danger to themselves or others who cannot be stabilized at a lower level of care. Youth whose primary insurance is Vermont Medicaid are assessed by designated Emergency Services (ES) staff from the Vermont Community Mental Health Centers (CMHC) prior to being admitted to a psychiatric inpatient facility. The purpose of assessment

prior to an inpatient admission is for continuity of care, identification of intervention strategies, and appropriate determination for involuntary hospitalization. This includes assessment for less restrictive alternatives and review of any existing crisis plan for the youth. An inpatient psychiatric admission may be recommended or supported by the ES staff when:

a. The youth is in need of hospitalization based on admission criteria, and
b. Community and support system resources are exhausted, and
c. A less restrictive alternative is not available

The ES staff also arranges for transportation and admission to a psychiatric inpatient facility. Children and adolescents who are out-of-state at the time of the admission will be screened by the admitting facility. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission.

Any elective, non-emergency admission must be prior authorized by DVHA

6.5.2.1 Concurrent Review

The admitting facility (provider) will contact the DVHA utilization reviewer within 24 hours or the next business day after admission to begin the concurrent review process. The utilization reviewer will make every effort to accommodate the provider regarding the information gathering (fax, phone, secure electronic transmission), however, the utilization reviewer may request additional information if needed to determine the authorization. Based on information provided, the utilization reviewer will assign authorization in increments of 24 hours up to 7 days based upon the beneficiary's acuity level, unless extenuating circumstances exist and care providers agree to an exception. The utilization reviewer will render an authorization decision to the provider within 24 hours or 1 business day of receipt of the clinical information. It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for additional inpatient days. If the provider does not contact the utilization reviewer to request authorization of additional inpatient days, the authorization will end and the utilization reviewer will generate a payment authorization in the MMIS.

Upon determination that clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day or the change in authorization status. If the provider disagrees with this decision they may request a Secondary Review.

The DVHA expects that beneficiaries will discharge with scheduled follow-up appointments. The discharge plan will contain documentation of these appointments or documentation of the beneficiary's refusal of appointments. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the DVHA to make authorization determinations, the provider is responsible for:

a. Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing supporting clinical information justifying the inpatient admission.
b. Initiating discharge planning at the time of admission, including but not limited to contact with family or guardian, primary care provider (PCP), all outpatient behavioral health treatment providers, the appropriate State liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living, the Department for Children and Families, the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP), and the Local Educational Agency (LEA). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare and identification of expected discharge date.
c. Documentation of the beneficiary's (or guardian's) refusal to sign releases for team members not covered by HIPPA.
d. Active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment resources.
e. Prompt notification to the DVHA utilization reviewer of barriers to active discharge planning including difficulties reaching the treatment team members. The DVHA utilization reviewer can support the provider with initiating and engaging in active discharge planning.
f. Providing the DVHA utilization reviewer with the necessary and pertinent information regarding the need for continued inpatient level of care including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.
g. Contacting the utilization reviewer on or before the last covered day to request authorization for additional inpatient days.

6.5.3 Specialized Residential Treatment for Children who have Behavioral Health Needs (Woodside Juvenile Rehabilitation Center)

Woodside received National accreditation as a treatment facility from the Commission on the Accreditation of Rehabilitation Facilities (CARF) in 2012. Woodside specializes in working with youth who are exhibiting delinquent behavior and who have been determined to need treatment as someone who poses a significant risk to themselves or to others; and who demonstrates behavior that cannot be treated in any less restrictive setting. This includes services to youth who are believe to need immediate treatment due to: a diagnosis or diagnosable condition using current Diagnostic and Statistical Manual of Mental Disorders Criteria; self or other-harming behavior(s) that require significant treatment intervention; and for whom without facility based intervention, there is reason to believe that there will be serious deterioration of the condition. All Woodside placements are reviewed and approved by DCF.

6.5.4 Emergency/Hospital Diversion Beds

Emergency or hospital diversion beds are community-based programs that provide a very high level of care and have the ability to divert youth from in-patient hospitalization. Typically, youth who do not require around-the-clock medical monitoring can be stabilized in a smaller treatment setting. Emergency/Hospital Diversion programs have 24-hour awake night staff, 24-hour psychiatric and in-house crisis back-up, and have the ability to conduct psychological, neurological, and other specialized testing as needed. The typical length of stay in these services is one to ten days.

6.5.4.1 Eligibility & Authorization for Admission

All admissions to emergency/hospital diversion programs must be screened by local ES. The ES is responsible for coordination with the Emergency Bed (E-Bed) or Hospital Diversion Program (HDP) Intake to assure children and youth referred meets criteria for admission.

6.5.4.2 Continued Stay Approvals

All admissions are authorized for payment up to ten days. If a discharge date has not been set prior to the seventh day of authorization the E-bed/diversion program team must request approval for any continued stay beyond the tenth day.

Request for approval of continued stay must include:

a. Psychiatric functioning, risk of harm to self or other, including information needed for independent scoring of the CALOCUS,
b. status of stabilization and whether transitioning to a lower level of care would lead to imminent destabilization,
c. a plan of services and supports upon discharge that is reasonable to maintain stabilization the client at a lower level of care
d. evidence that the continued stay request is not based solely upon lack of available placement at a lower level of care

6.5.4.3 Criteria for Continued Stay

Scores of 4 or more on the following 4 CALOCUS scores coupled with evidence that the provider is actively engaged in interventions to attempt to address the development/ strengthening of skills, manage risk level, increase functioning are considered justification for continued stay:

a. CALOCUS (Dimension I, p.12-13): "**Risk of Harm**" score of 4 or more; and
b. CALOCUS (Dimension II, p.14-15): "**Functional Status**" score of 4 or more; and
c. CALOCUS (Dimension IV, p.19): "**Recovery Environment – Supports**" score of 4 or more; and
d. CALOCUS (Dimension VI, p.23): "**Treatment Acceptance & Engagement – Parent/Caregiver**" score of 4 or more. Scores of 3 or lower requires more justification for why the child needs to remain at this level of care. The following two areas must be considered:
    a. **Return to baseline for this child? :** Has the child returned to his/her baseline level of functioning? Child may be chronically unstable; this alone does not necessitate e-

bed level of care, rather it would need to be addressed in community plan, possibly with additional resources. AND

b. **Recommendations for next phase of treatment are available.** E-bed program has gathered adequate information to make recommendations for discharge plan. If the child was to discharge before 10th day, what is likelihood the child would maintain stability/baseline or would risk of harm increase?

If the receiving team is actively working to put appropriate plan in place with incorporation of e-bed recommendations then continued stay may be warranted to maintain gains made and support long term stabilization of the youth's positive gains.

Extensions may be granted for up to 10 days. Denials of continued stay request must be reviewed by the DMH Medical Director/Child Psychiatrist prior to issuance of denial by DMH.

6.5.4.4 Requests for Continued Stays in excess of 20 days

If the extension request is for more than 10 additional days OR a 2nd request is being made, the Case Review Committee will be consulted for technical assistance. If a 3rd request is made the Case Review Committee must reviewed and provide authorization recommendations to DMH.

Section 7: REIMBURSEMENT METHODOLGY, 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:

7.1 IFS 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. 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 case rate system 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.

b. The designated administrative entity 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 Case Rate 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. Case rate 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

7.2 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.

7.3 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.

7.4 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.

7.5 Incentive Payments

7.5.1 Caseload Payments
Annually, providers and the State will agree on overall operating budget and billable (minimum) and target caseload expectations. Provider case rates 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.

7.5.2 Caseload Definition
Caseload target counts will be determined based on the sum of the following:
a. Number of case rate 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.

7.5.3 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 8: REPORTING, PROGRAM INTEGRITY AND QUALITY OVERSIGHT

8.1 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 CRF 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.

8.2 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.

8.2.1 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 Integrating 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/EPSDT 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 form 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.

8.3 Quality Oversight and Outcomes

8.3.1 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.

8.3.2 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:

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.) Positive Youth Development

8.4 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 on a biannual basis 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.

8.5 Outcome Measurement

Vermont statute Act 186 (2014) establishes outcomes and indicators that are intended to align programs and strategies across the state toward the same ends. Population Indicators will be available to IFS regions annually through an AHS Scorecard. This information will be used by IFS Regional Governance Teams to inform how they target supports and services. IFS regions are not solely responsible for bending the curve on population indicators; rather there will be performance measures IFS regions have and the thought is those measures will positively impact trend data in whole population health. An entire community is responsible for population level indicators.

IFS performance measures, as stated in the grant, will be reviewed and periodically updated as the initiative progresses. The measures will be reviewed annually. Data for the entire population that meet the criteria will be included.

IFS Manual Attachment A: EPSDT Excerpts

Core EPSDT Elements
§5124(B)(1) "You [the states] must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F."

§5122 F. "Limitation of Services—the services available…are not limited to those included in your State [Medicaid] plan…. the services must be necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . . and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You [the states] make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental."

"42 CFR 440.230 allows you [the states] to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that all services included in §1905(a) of the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided."

EPSDT Scope of Benefits (42 U.S.C. §§ 1396d(r) (5), 1396d (a) ***includes all benefits that fall within the federal definition of medical assistance*** (as described in Section 1905(a) of the Social Security Act).

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Laboratory and X-ray services
- Nursing facility services for adults
- EPSDT services (including periodic screening services for recipients under age 21 and Medicaid covered services necessary to correct or ameliorate a diagnosed physical or mental condition)
- Physician services
- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist (with limitation)
- Nurse-midwife services
- Pediatric nurse practitioner or family nurse practitioner services
- Home health services for persons eligible to receive nursing facility services

Services optional for adults: **mandatory under EPSDT, regardless of whether or not they appear in a State plan**, when necessary to correct or ameliorate an illness or condition:

- Case management services
- Dental services, including orthodontia and dentures
- Prescribed drugs
- Physical therapy, occupational therapy and related speech and language services
- Eyeglasses
- Home health care services (includes nursing services, home health aides, medical supplies and equipment, physical therapy, occupation therapy, speech pathology, audiology services)
- Private duty nursing services
- Clinic services (including services outside the clinic for eligible homeless persons)
- Prosthetic devices
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home or other setting) recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Intermediate care facility for the mentally retarded services
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, certified pediatric or family nurse practitioner legally authorized to perform under State law
- Hospice care
- TB-related services
- Respiratory care services
- Personal care services
- Primary care case management services
- Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary of the Department of Health and Human Services.

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

IFS does not require the use of specific forms, however, all data required 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.

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.

CORE Service	**Medicaid State Plan Definition**
Clinic Services Diagnosis and Evaluation Services	A service related to identifying the extent of a patient's (client's) condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the clients attitudes, behavior, emotional state, personality

	characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to family background, family interaction and current living situation; an evaluation of the client's social performance, community living skills, self-care skills and prevocational skills; and/or an evaluation of strategies, goals and objectives included in the development of a treatment plan, program plan of care consistent with the assessment findings as a whole.
Developmental Therapy (CIS portion in sub-capitation payment)	Evaluation and treatment services provided to a child in order to promote normal development by correcting deficits in the child's affective, cognitive and psychomotor development. Services must be specified in a child's Individualized Family Service Plan (IFSP) under Part H of the Individuals with Disabilities Education Act (IDEA) and must be furnished by providers who meet applicable State licensure or certification requirements.
Specialized Rehabilitative Services	Basic living skills, collateral contact, service coordination, specialized counseling
Intensive Family Based Services (IFBS)	IFBS are family-focused, in-home treatment services for children that include crisis intervention, individual and family counseling, basic living skills and care coordination.
Clinic Services - Psychotherapy, individual & family	A method of treatment of mental disorders using the interaction between a therapist and a patient to promote emotional or psychological change to alleviate mental disorder. Psychotherapy also includes family therapy when only one family is being treated.
Clinic Services Group Therapy	A method of treatment of mental disorders, using the interaction between a therapist and two or more patients to promote emotional or psychological change to alleviate mental disorders. Group therapy may, in addition, focus on the patient's adaptive skills involving social interaction and emotional reactions to reality situations
Clinic Services Emergency Care	A method of care provided for persons experiencing an acute mental health crisis as evidenced by (1) a sudden change in behavior with negative consequences for wellbeing; (2) a loss of usual coping mechanisms, or (3) presenting a danger to self or others. Emergency care includes diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. Emergency services are intensive, time-limited and are intended to

	resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources.
Extended Services for pregnant women	Pregnancy-related and post-partum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls. (Home visiting)
Targeted Case Management for children 0-12 months and pregnant and postpartum Women	Services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities
Targeted Case Management for 1-5 years olds	Services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities
Target Group 0-22 years old w/Developmental Disabilities	Services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services; development (and periodic revision) of a specific care plan; referral and related activities; monitoring and follow-up activities.
Clinic Services Chemotherapy (Med-Check	Prescription of psychoactive drugs to favorably influence or prevent mental illness by a physician, physician's assistant, or nurse performing within the scope of their license. Chemotherapy also includes the monitoring and assessment of patient reaction to prescribed drugs.
CORE Service	Special Program (STC) or Federal Definitions
Home Provider	
Respite	
Transportation	Mileage reimbursements or other arrangements necessary due to challenging behaviors for transportation to services

	pursuant to the integrated family plan when such activities do not meet the definition on non-emergency transportation reimbursement by DVHA.	
EPSDT Outreach and Education to providers		
EPSDT Outreach and Education to families		
CORE Service	Managed Care Investment or other Federal Funds	
Parent Child Center		
Early Intervention		
Strengthening Families		

IFS Manual Attachment C: Best Practice Guidelines in the Request for and Management of Out-of-Home Services for Children and Families

Vermont's system of care for children and families is designed to provide community-based treatment and support services with the goal of supporting a child/youth's progress and success within the context of his/her family and community. Coordinated and integrated service planning is one key to accomplishing this goal. Local Interagency Teams (LITs), established in State statute, are expected to meet with families of children with clinical, functional, behavioral and/or development disabilities to plan for the most effective support and treatment options for supporting healthy development. This coordinated service planning results in an Integrated Family Plan (previously known as, a coordinated family plan).

The system of care is guided by the philosophy that children, youth and their families achieve better outcomes when they can remain in their home and communities. The system of care relies on research showing that community-based interventions are crucial for a child, youth and family's long-term success (Haogwood, Burns, Kiser, Ringeisen, and Schoenwald, 2001). In 2001, the Surgeon General of the United States issued a report called *Mental Health: A Report of the Surgeon General.* This report had a number of important findings, including that:

- Clear coordination between residential staff and community providers, particularly schools, medical care or community clinics is necessary to transfer gains from a residential setting back into the community; and
- Coordinated aftercare services are essential to support the skills gained during a residential or out-of-home placement; that can only be accomplished through collaboration between the community team, the out-of-home therapeutic provider and the family

For some children, short-term, residential placement or out-of-home treatment is an important step towards long-term success in the home and community. The IFP may include a recommendation for out-of-home treatment. Any use of out-of-home services should be designed to treat and support both the child and their family with a goal for the child to return home as quickly as possible.

Out-of-home treatment must be designed to address specific clinical and functional needs and ***is not a substitution for***:

- detention or incarceration or to avoid or forestall a court appearance
- caregiver respite
- removal of a child or youth from an undesirable living situation
- failure of the parents to engage in or allow treatment at a level consistent with the needs of the child, as determined by predominant medical best practice guidelines (i.e., American Psychological Association, American Academy of Pediatric Providers; American Academy of Child and Adolescent Psychiatrist etc.)

Out of home care is not considered a treatment option for children whose sole diagnosis is developmental disability. However, for children with a developmental disability and a co-occurring emotional, behavioral, medical or mental health condition(s) out-of-home treatment may be considered as an intervention in the treatment of the co-occurring disorder.

Contributing factors for a needed out-of-home placement are generally related to multiple child and family issues and stressors. Thus interventions are expected to address multiple domains of child and family living including, but not limited to: living conditions; food security; medical and developmental status; severity of the problem, child and family coping skills, support system strength and availability, level of medical involvement and history or current level of treatment compliance on the part of the child and family. In addition, services and supports must give attention to cultural competence, family strengths, underutilization or lack of access to less intensive supports.

It is the policy of the State of Vermont to support children in their family home and in their community. Out of home placements are expected to be short-term commiserate with medical necessity. When return home becomes impossible, even after treatment gains and goals have been obtained, the family and providers must address a plan for permanency outside of the treatment milieu.

This document provides guidelines and expectations for persons and families involved in requesting and working with out of home services as part of an integrated treatment plan.

1.1 Out of Home Service Types - Levels of Restrictiveness

Out of home services are designed specifically to (1) address the treatment needs of children and youth and (2) build the capacity of family members so that the child can return home**.** Out of home services involve several levels of care from least intensive and intrusive to the most restrictive. Each is outlined in brief below.

Overnight Respite – This is considered a planned break for families and is the least restricted form of out of home support. Overnights are typically 24 to 48 hours, in some cases overnight respite may take place during a school vacation and be longer in duration. In all cases, there is no expectation that the child or youth is receiving specialized treatment services or expertise above and beyond what they receive at home. Overnight respite can be compared to a planned vacation. Respite is not typically a Medicaid funded activity unless it is related to hospice care; respite is available in limited amounts through many community organizations.

Foster Care, Kinship Care, and Developmental Home: These services are employed when a child or youth cannot stay with their parent or caregiver and need a safe, stable family environment to grow. These options may be long term, however if it is clear that the young person will not or cannot stay connected to their family of origin, then permanency planning needs to be part of the planning associated with these out of home options.

Emergency/Hospital Diversion Programs: Emergency or hospital diversion beds are community-based programs that provide a very high level of care and have the ability to divert youth from in-patient hospitalization. Typically, youth who do not require around-the-clock medical monitoring can be stabilized in a smaller treatment setting. Emergency/Hospital Diversion programs have 24-hour awake night staff, 24-hour psychiatric and in-house crisis back-up, and have the ability to conduct psychological, neurological, and other specialized testing as needed. The typical length of stay in these services is one to ten days. These same programs also provide assessment services

Therapeutic Foster Care/Shared Parenting: Out of home care is a typically short-term individualized shared-living arrangement for children, offered within a home provider's home that is licensed by the State to serve children and youth. Services are targeted at youth who may require further assessment or who are unable to remain safely with their family due to intensive mental health and/or co-occurring mental health and developmental disabilities. This goal of this service is to provide both the child and the family an opportunity for enhancing coping, social and personal care skills and establishing a care plan to reunite the family under the same roof. Home Care may be referred to as: Therapeutic foster care, Shared parenting or Developmental Home services. Any shared parenting or developmental home provider used as part of an integrated treatment plan for children not in state's custody must contracted by the DA/SSA and adhere to DDAS Home Safety Inspection rules and process.

Residential and Group Home Treatment (PNMI) A PNMI is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides medical care to its residents. Facilities must be licensed as a Residential Child Care Facility and be enrolled in the VT Medicaid program. The PNMI Per-diem rate includes a comprehensive spectrum of mental health care services. When a child is being served in a PMNI facility it is expected that home and community based providers will stay actively involved in treatment and discharge planning and will facilitate transitions back to the community (home or home provider) in the most clinically expeditious manner possible.

Inpatient Hospitalization: Inpatient psychiatric hospital admission represents the highest level of care and is reserved for youth who are determined to be a danger to themselves or others who cannot be stabilized at a lower level of care. Youth whose primary insurance is Vermont Medicaid are assessed by designated Emergency Services (ES) staff from the Vermont Community Mental Health Centers (CMHC) prior to being admitted to a psychiatric inpatient facility. The purpose of assessment prior to an inpatient admission is for continuity of care, identification of intervention strategies, and appropriate determination for involuntary hospitalization. This includes assessment for less restrictive alternatives and review of any existing crisis plan for the youth. An inpatient psychiatric admission may be recommended or supported by the ES staff when:

a. The youth is in need of hospitalization based on admission criteria, and
b. Community and support system resources are exhausted, and

c. A less restrictive alternative is not available

1.2 Considerations in Pursuing Out of Home Services

Out of home services may be necessary to build skills, lessen symptomology of underlying problems and enhance the functional abilities of the child/youth. Building on skills and abilities that will contribute to the success of the child/youth's to return home. However, recent research related to impact of child's environment and exposure to toxic stress also require a focus on modifications to the home environment and/or family skills that will support a successful return given the synergistic nature of caregiver/child interactions. It is important that a systems approach be used; that is, the child/youth's behavior is not treated as "the problem," but that overall family functioning is the focus which includes the child/youth's specific treatment/support needs. For children who have a developmental disability the intent of placement is not to treat the disability but to achieve skills to mitigate the co-occurring mental health, behavioral or other functional needs.

Treatment planning and decision-making processes should always include **Active family involvement.** The team must respect and support family engagement and use planning as an opportunity to model good problem solving, conflict resolution and planning skills. It is essential:

- that the family actively participates in planning and decision making and attends team meetings
- for the family to attend meetings and treatment sessions and to have family visits once the child is placed out of the home;
- for the family to be included as an important contributor to the progress their child makes; and
- for the family to acquire skills to help the child learn new behaviors and coping mechanisms.

Any treatment plan must ensure that **both community-based and** out of home service providers are able to **measure progress and outcomes** and those providers have the skills and systems in place to incorporate methodologies and tools to gauge progress. Progress should be evidenced by a measurable reduction in symptoms and/or behaviors to the degree that indicates responsiveness to the treatment as well as the ability to generalize skills in home and community settings

The **providers and other team members** engage with the family in a collaborative and respectful relationship and are able to adjust approaches to the strengths, needs and culture of the family. The providers and other team members contribute their expertise and knowledge to ensure the most positive outcomes.

All t**reatment plans must reflect activities needed to support a successful return to in-home supports. P**lans should clearly define the goals and objectives that need to be addressed to

return the child to his/her home. Any out of services used should be considered a component of the overall plan and not the plan in in its entirety.

Considerations should be given to the following components of out of home care when matching the specialized focus and expertise of the out of home provider against the needs of the child and family.

Structured milieu – The milieu offers the child positive peer interaction consistent with the child's diagnosis and clinical goals within the structured environment.

Level of staff training and credentials – The staff and contractors involved in care meet the DCF licensing guidelines. The staff should be credentialed and have training and expertise in treating children and their families.

Best Practice - The program should be expected to implement evidence-based practices when available, to address the child's and family's needs and incorporate the values of the Vermont system of care into its operations.

Certification – The program is licensed as either a residential program or a foster home from the Department for Children and Families (DCF) is required for all Vermont out-of-home placements. For all out of state residential programs a residential treatment license in good standing from the appropriate State licensing entity for their place of business. Certification from a nationally recognized accreditation organization is preferred for all residential programs.

For children with a developmental disability and co-occurring condition, not in state's custody, all shared parenting/developmental home placements must be contracted by the DA/SSA and adhere to DDAS Home Safety Inspection rules and process.

Additional training - Staff should be trained in basic care, first aid, universal precautions, de-escalation and management of aggressive behavior and ongoing improvements in skills needed for best practices.

Integrated Family Plans & In Home Transitions - The out of home service provider should conduct or participate in regular team meetings to update plans as needed based on progress and barriers. Goals should be realistic and achievable matching the child's and family needs in the context of their home and community. An integrated plan should build on what has been accomplished in the out-of-home setting and contain steps to transition those gains to the home and community setting and outline any new or enhanced skills that will need to be worked on in home to support the child and family once the child returns. Short -term and long-term goals across settings must be clearly connected and build on each other. Improvement cannot be measured in isolation of the home setting, but, rather, build on skills that complement each other in all settings and allow for the child's successful reintegration into the family. Plans must support clear communication among all parties in establishing, refining

and accomplishing goals. Transition planning for eventual in home success should begin at the time of admission.

Education – A child will receive a *free and appropriate public education* regardless of living situation. If the child is living out of his/her school district, the team maintains a connection to the sending school and works with that school to establish an educational transition plan in conjunction with the transition plan to home. Additionally, if the child is in a facility, the facility can provide or has access to special education services to maintain a child's Individualized Education Plan.

Final Transition plan – As mentioned above, the in home transition plan must start at referral and intake for out of home services. One of the first questions should be "What environments are we preparing the child to be successful in and what skills does that success require?" As return home becomes more imminent and target dates for discharge are established, a final plan must be established that includes community connections, establishes continuity of care and education and allows for the child and family to practice in home skills and plan to support successful reunification and provide aftercare until community based providers and other natural support systems are in place.

1.3 Key Components for Assessment and Planning Prior to Request for Out of Home Service Approval

1.3.1 Comprehensive evaluation

Comprehensive assessments should be available or completed that enable the treatment planning team to determine:

- Clarify diagnosis and/or behavioral concerns
- Appropriateness and effectiveness of current or proposed medication trials
- Appropriateness of treatment planning and goals
- Reliable indicators of progress

1.3.2 Local Interagency Teams

Local Interagency Teams (LITS) represent multi-disciplinary expertise from child and family serving agencies in a given region of the state. LIT's can be accessed for expertise, brainstorming and review of local resources that may be available. If a treatment team is considering a residential facility as the provider of out of home services, LIT must be the first step in a State required prior approval process. At a minimum reviews by LIT's must include representatives from:

- The family and any guest the family wishes to invite;
- Department for Children and Families;
- Department of Disabilities, Aging and Independent Living
- Department of Education

- Department of Mental Health
- Department of Vermont Health Access
- Vermont Federation of Families

It is the responsibility of the Local Interagency Team (LIT) to collaborate with the family to assess the initial and ongoing need for out-of-home treatment. This includes:

A. Clinical review and ensuring the child/youth profile meets the level and severity of acuity required for prior approval of requests including, but not limited to a review of:

   - The child's current (within 6 months) clinical and functional assessments
   - The strength of the family support systems and family treatment needs.
   - Current child and family progress and safety issues.

B. Determining proposed length of stay such that the stay addresses those goals and objectives that can **only** be achieved in an out-of-home setting. Out of home stays should not be extended to address goals suitable for home and community based intervention.

C. Ensuring the plan included the provision of family treatment and support needed for the family to gain skills and adopt parenting strategies that meet the needs of their child/youth in the family home

Unless it is contra-indicted because of court/DCF involvement the family or caregiver should be involved in all LIT planning processes.

1.3.4 Family Role and Responsibilities
The family is responsible for full engagement in:

- meetings and planning out-of-home treatment and goals;
- providing emotional and financial support to meet the child/youth needs
- soliciting extended family and community supports for the child and themselves
- programs to increase their capacity to effectively parent the child at home;
- planning for the child's reintegration into family and community
- permanency planning if reunification is not possible, .

Families who retain custody of their child will be asked to contribute to cost of their child's out-of-home placement, taking into account their ability to contribute. Conversations regarding ability to contribute should start at the first suggestion that out of services are being considered as part of the integrated treatment plan. A family's ability to pay should be based on non-Medicaid or federally reimbursed costs related to care which may include, a child's personal care and clothing needs, room and board, transportation home or for any other extra-curricular activities that the child may engage in that are not part of the treatment cost. The discussion

regarding families contributing to the out-of-home placements should always focus on how the expenditures and goals will support the child returning to their care.

1.4 Integrated Family Plans
Individualized and integrated family plan should be clear regarding goals and objectives and indicate how each of the following considerations will be addressed:

A. How the lead agency (i.e., DA/SSA, DCF, Schools, etc.) will remain actively involved including the identification of who will be the lead in communicating with the out of home provider regarding progress and planning and with CRC regarding continued stay reviews and discharge;

B. The support, treatment, skill building, psycho–education and/or other supports the family will receive during the out-of-home treatment period and what how those will generalize to the child's transition home;

C. Clearly defined clinical goals for home, community and out-of-home treatment;

D. Clearly defined method and schedule to monitor progress assess outcomes and determine when the child and family are ready for transition;

E. A description of how the child is to be transitioned back into his/her home and community when appropriate;

F. A proactive discussion regarding the possibility that the family may decide the child's return to the family home is not possible. This includes an agreement that the family will participate in the identification of and plan for successful kinship placement or plan for permanency and;

G. A Child Placement Agreement signed by involved parties.

1.5 Post placement in out-of-home services
If prior approval is granted, the Case Review Committee (CRC) will review and approve continued stay at least every 3 months, unless otherwise indicated in the CRC notice of approval/findings. Local teams and the lead agency assigned to the case must ensure the appropriate documentation is available. This includes, but is not limited to demonstrated evidence of the following:

1. Identified goals are being achieved and milestones for transition are being met
2. Family and support system skills are increasing such that transition will be successful (even if the child has not yet met all their goals).
3. The family is ready for the child to transition home sooner than original target date.
4. Re-assessments of functioning, risk and severity show evidence of improvement
5. Transition planning is active and within the approved timeframes

6. Family plan meetings with DA/SSA and/or DCF, placement and family are occurring monthly and are productive in the development of a community and family support plan.
7. The family is participating in continued treatment/support services by attending identified treatment sessions at the placement, in the community or home and is helping to identify what ongoing treatment and supports they will need once the child returns home

1.6 Placement effectiveness

If either the CRC continued stay review, the family or local treatment team believe that there are indications that the child and family are not responding to the therapeutic intervention or the interventions are not effective, the team must consider different goals or placement options.

1.7 Permanency Planning

The family and local team are required to create a viable plan for permanency if the parent/caregiver:

1. Has not been able or willing to participate in the treatment of their child/youth;

2. Is not able or willing to put into place necessary parenting strategies and/or activities to support the child in returning to the family home;

3. Has made a decision that their child cannot return home, even after all goals are met

1.8 Agencies Designated to Review and Coordinate Out of Home Requests

Contact information for agencies designated to coordinate placements can be found at: http://mentalhealth.vermont.gov/DAlist

1.9 VT Authorities governing out of home services and prior authorization processes.

3 V.S.A. § 835 (8 V.S.A. § 835) - Provides State agencies generally with the authority to adopt and compile procedures. Procedures are practices that have been adopted by an agency -- and are not required to go through the administrative procedures process for rulemaking**.**

18 V.S.A. § 7401(14),(15),(17) – Deals specifically with the powers and duties of the Commissioner of Mental Health. This provisions is the authority/responsibility of the Department of Mental Health to provide services to children and adolescents with severe emotional disturbances in the context of a system of community mental health agencies and to coordinate those services with those agencies as well as other departments as required by Chapter 43 of Title 33 (Act 264); § 8907 Authorizes the Commissioner of Mental Health and the Commissioner of Disability Aging and Independent Living to designate community agencies to provide mental health and developmental services;

Chapter 43 of Title 33 - Act 264 - Establishes the interagency system of care and coordinated services planning under the authority of the Secretary of AHS, applicable AHS departments, as well as the Department of Education.

Vermont Medicaid Rule 7103 - Defines medical necessity and demonstrates the guidelines take into the requirements for providing medically necessary services to children pursuant to EPSDT.

Medicaid Rule 7102 - Authorizes the requirement for prior authorization process for certain Medicaid services.

Medicaid Rule - 12-2-201:10 - Vermont Administrative Code for authorizing the requirement for prior authorization process for certain Medicaid services.

Medicaid Rule 12-7-4:7411 - Authorization and payment for private non-medical institutions (Residential programs) and how prior authorization is required for payment of services at PNMIs

§ 5106. Powers and duties of commissioner – Requires Department for Children and Families/Family Services to, in part, supervise and assist a child who is placed under the commissioner's supervision or in the commissioner's legal custody by order of the court. To place a child who is in the commissioner's legal custody in a family home or a treatment, rehabilitative, detention, or educational facility or institution subject to the provisions of sections 5292 and 5293

§ 4903. Responsibility of department – Instructs DCF/FSD to provide aid and services to the extent necessary for the purpose of permitting children to remain in their own homes.