COMMONWEALTH of VIRGINIA

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November 1, 2016

The Honorable Thomas K. Norment, Jr.,
The Honorable Emmett W. Hanger, Jr.
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Item 315.FF. of the 2016 *Appropriation Act*, required the Department of Behavioral Health and Developmental Services (DBHDS) to *"develop a plan to implement a performance based contracting system for funds provided by the department to the Community Services Boards."*

Please find enclosed the report in accordance with Item 315.FF. Staff at the department are available should you wish to discuss this request.

Sincerely,

Jack Barber, M.D.

Cc: Joe Flores
Susan Massart
Michael Tweedy

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November 1, 2016

The Honorable S. Chris Jones, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Jones:

Item 315.FF. of the 2016 *Appropriation Act*, required the Department of Behavioral Health and Developmental Services (DBHDS) to *"develop a plan to implement a performance based contracting system for funds provided by the department to the Community Services Boards."*

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November 1, 2016

The Honorable Richard D. Brown
Office of the Secretary of Finance
Patrick Henry Building
P.O. Box 1475
Richmond, VA 23218

Dear Secretary Brown:

Item 315.FF. of the 2016 *Appropriation Act*, required the Department of Behavioral Health and Developmental Services (DBHDS) to *"develop a plan to implement a performance based contracting system for funds provided by the department to the Community Services Boards."*

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November 1, 2016

The Honorable William A. Hazel, Jr., M.D.
Office of the Secretary of Health and Human Resources
Patrick Henry Building
P.O. Box 1475
Richmond, VA 23218

Dear Secretary Hazel:

Item 315.FF. of the 2016 *Appropriation Act*, required the Department of Behavioral Health and Developmental Services (DBHDS) to *"develop a plan to implement a performance based contracting system for funds provided by the department to the Community Services Boards."*

Please find enclosed the report in accordance with Item 315.FF. Staff at the department are available should you wish to discuss this request.

Sincerely,

Jack W. Barber, MD
Interim Commissioner

Cc: Joe Flores
Susan Massart
Michael Tweedy

Performance-Based Contracting Implementation Plan (Item 315.FF)

November 1, 2016

DBHDS Vision: A Life of Possibilities for All Virginians

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Performance-Based Contracting Implementation Plan

Preface

Item 315.FF of the 2016 Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to develop a plan to implement performance-based contracting (PBC) for funds provided to community services boards (CSBs). DBHDS shall submit its plan for consideration to the Secretary of Health and Human Resources, the Secretary of Finance, and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2016.

> *FF. The Department of Behavioral Health and Developmental Services shall develop a plan to implement a performance based contracting system for funds provided by the department to the Community Services Boards. The department shall work with the boards to define performance and outcome measures; describe data collection, analysis and reporting requirements and processes; and identify a funding mechanism and the estimated costs, including any incentives and disincentives, of implementing the system. The department shall submit the plan for consideration to the Secretary of Health and Human Resources, the Secretary of Finance, and the chairmen of the House Appropriations and Senate Finance Committees by November 1, 2016.*

Performance-Based Contracting Implementation Plan

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Performance-Based Contracting Implementation Plan

Introduction

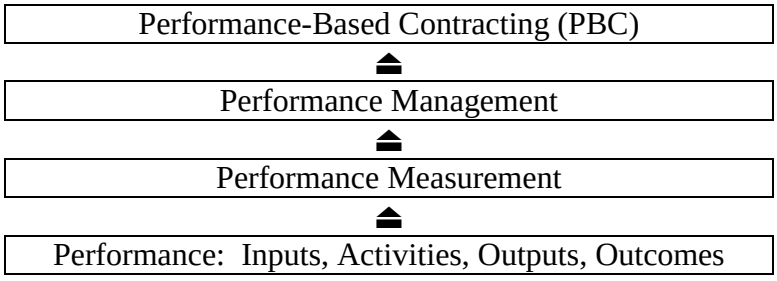
In accordance with Item 315.FF of the 2016 Appropriation Act, the Department of Behavioral Health and Developmental Services (DBHDS) convened a performance-based contracting (PBC) workgroup to assist it in developing a plan to implement PBC. Workgroup membership is listed in Appendix A. The workgroup met on June 29, August 12, September 1, and September 14 to review and comment on plan drafts and accepted the implementation plan at its last meeting.

This plan provides background information about PBC, describes PBC initiatives in other states, identifies principles for implementing PBC in Virginia, discusses the requirements for enhanced data collection and analysis associated with full PBC implementation, presents a timeline for implementation, and describes the three phases of the proposed implementation plan. The plan provides a conceptual framework for implementing PBC, but the framework and many aspects of the plan may need to be revised as it is implemented. For example, once measures have been modeled, some proposed measures may not be the most practical or effective measures, and they would need to be replaced by other more feasible and effective measures.

Background Information About Performance-Based Contracting

In preparation for developing a plan to implement PBC, DBHDS staff gathered background information about PBC for the workgroup. The managerial motivation behind all performance-based strategies is the phrase that "what gets measured gets done." PBC reflects this motivation. By attaching contract compensation to performance achievements, PBC encourages contractors to achieve desired outcomes in a timely manner. PBC gives service contractors considerable discretion throughout the service process, expecting them to use innovative and quality customer services to further enhance service outcomes.

Several articles describe building on performance measurement and management techniques by adding the critical factor of financial incentives that reward organizations for good performance and sometimes penalize them for failing to achieve outcomes. The focus of PBC can be on inputs, activities, outputs, or outcomes. As PBC has evolved over the past two decades, there has been an increasing emphasis on outcomes. The relationship of these approaches is displayed in the following graphic. As an organization moves up the hierarchy of performance reform, performance improves. Each set of activities is the foundation for the next, while they become increasingly complex. Measuring performance requires certain skills and capacities; PBC requires those same skills and capacities, plus additional ones.



The graphic above shows that PBC is more complex than performance measurement or management, suggesting that mastering this practice depends on first having a handle on these more basic practices. If government agencies attempt to jump levels without developing the necessary foundation, they risk policy and organizational failure. Some extremely critical prerequisites for effective performance-based contracting at the contractor level include (1) a rich database of performance information and the capacity to use the data to analyze trends and (2) sufficient organizational size and capacity that can facilitate PBC. Thus, with a relatively large budget and experienced, knowledgeable staff, an organization can minimize fiscal problems and lack of expertise or capacity that could make the shift to performance-based contracting difficult or problematic for smaller organizations. When an organization does not have enough capacity or resources to operate under PBC, its chances of success can be improved significantly by collaborating with other organizations to share administrative and managerial capacity and resources. This may be particularly important for small contractors or providers.

When government agencies and service providers use PBC as a vehicle for collaborating on program goals, both parties benefit. In comparison to line-item contracts, PBC gives government more control over outcomes, which can be specified and tracked. Providers develop expertise in managing these contracts and take ownership of the outcomes they produce. Currently, PBC is being used increasingly as a preferred contracting approach over traditional fee-for-service (FFS) or grant funding methods in a variety of human service areas. Examples include employment, rehabilitative, child welfare, adoption, addiction, and behavioral health services. However, despite this growing popularity, until recently the effectiveness of PBC compared with FFS was still unclear. Human services may not always be compatible with performance measurement due to their ambiguous performance and high provider discretion. Relying on imperfect surrogate measures leaves service contractors room for gaming (for example, client selection), misreporting, or cheating, while high provider discretion helps contractors gain potential benefits. One possible way to minimize gaming would be to change performance measures periodically before contractors learn ways to game them. Another way could be taking selection into consideration and adjusting performance measures for client severity level. Thus, human services bring challenges to PBC that may produce unintended consequences, such as "rewarding A while hoping for B."

For example, one review in 2003 of Maine's addiction treatment system found that PBC gave providers financial incentives to treat less severe clients in order to improve performance outcomes. A later review of the program found that PBC had no positive effect on program performance in the areas of time to treatment, level of client participation, length of stay, and completion of training. On the other hand, a 2013 study of employment services in Indiana found that PBC promoted better employment results and shorter time to employment, the two measured performance incentives, while the impact on two unmeasured employment areas, working hours and wages, was trivial.

In various ways, PBC can reward achievement of outputs (e.g., widgets or units of services), quality (e.g. timeliness, reliability, or conformity), or outcomes (e.g. results, impacts, or accomplishments). These ways include cash incentives such as bonuses or increases in allocations, cash disincentives such as penalties or reductions or delays in payments, and non-monetary incentives or disincentives. Some of these ways are described below.

- Cash incentives or disincentives can be implemented using additional appropriations or by withholding a specified percentage of current allocations for this purpose. A common percentage is one percent, although a few states have used higher percentages.

- Cash incentives can be tied to quality improvements, for example a specified increasing percent of state and federal block grant funds spent on evidence-based practices such as 25 percent in year one, 50 percent in year two, and 75 percent thereafter. Alternatively, organizations that exceed the goal for an outcome could receive financial rewards proportional to the size of their over-performance, such as increases of ½, ¾, or one percent.

- Cash disincentives can be implemented by applying percentages to an organization's underperformance on output, quality, or outcome measures. For example, organizations achieving less than the goal for an outcome could receive a range of percentage reductions depending on the proportional size of the underperformance, for example, reductions of ½, ¾, or one percent.

- Non-monetary incentives or disincentives could include public recognition, such as posting data on dashboards or conducting formal ceremonies, or relief from or imposition of additional administrative requirements.

PBC also can link the extension or renewal of the contract to achievement of outputs, quality, or outcomes based on achieving specified outcomes or attaining several milestones over time to achieve a final outcome, for example, achieving different types of accomplishments such as input, activity, or process milestones.

Incentives form the backbone of performance-based contracts. These contracts define work in measurable and mission-related terms, contain performance standards, include quality assurance plans for measuring contractor performance against those standards, and provide financial incentives and penalties based on performance measurements. The Rockefeller Institute of Government's report on New York City's welfare-to-work performance-based contracting system states that over the 15-year course of this initiative, the city learned four basic lessons.

1. How contracts are constructed is critical. While an initial emphasis on placement appeared to work really well, over time it became clear the placements were not sticking. Consequently, subsequent contracts refocused on job retention.

2. Information technology systems are critical to doing PBC well.

3. Different contractors behave differently when given the flexibility of a bottom-line approach to payment. The city had to identify the different strengths among contractors and manage contracts in a way that played to contractors' different strengths.

4. Contracts have to be flexible enough to evolve with lessons learned.

An Urban Institute study of performance contracting in six states (Florida, Illinois, Maine, Minnesota, North Carolina, and Oklahoma) identified six positive attributes of performance contracting. Performance contracting:

1. Involves contractors in developing performance standards and outcome targets (all states);
2. Provides feedback on performance or requires corrective action plans (all states except Maine);
3. Monitors performance with regular reporting (Illinois, Minnesota, North Carolina, and Oklahoma);
4. Can show performance results based on data reported by providers (Illinois, Minnesota, North Carolina, and Oklahoma);
5. Provides comparative performance data to contractors (Illinois and Minnesota); and
6. Allows a hold-harmless clause in first year contracts (Maine and Oklahoma).

The study found that states that tied payments to outcomes tended to show results more quickly. Finally, the study identified the following lessons learned from performance contracting.

1. Work with service providers to formulate client outcomes, indicators, and targets. Try to standardize indicators and data collection procedures for particular service areas.
2. Get input from providers on the design of payment schedules.
3. Gain commitment and trust from providers by including a hold-harmless clause for the first year.
4. Monitor and report back to providers regularly on their performance and how it compares to that of similar providers.
5. Work closely with providers to identify difficulties in service provision and learn about changes in the client population that will affect performance.
6. Set quarterly targets and monitor them; this is a good practice for providers who are paid with a grant contract, especially in the absence of milestone payments.
7. Provide consistent communication and feedback on performance; this helps to promote accountability and maintain contractor motivation.
8. Offer public congratulations or rewards in the absence of financial incentives for performance; these may be appropriate ways to encourage contractors with higher-than-average performance.
9. Use data from providers to publicize internally and externally the results of programs; include comparisons of results achieved by contractors providing similar services and explanatory information where appropriate.

An Open Minds analysis of PBC in six states in 2009 identified the following critical competencies required for success in a PBC environment:

1. Contracting skills,

2. Unit costing capability,
3. Systems to measure and analyze data,
4. Mechanisms to quickly address an inability to meet performance standards, and
5. Leadership.

Performance-Based Contracting Initiatives in Other States

A number of other states have implemented various versions of PBC over the past 15 years. Appendix B contains descriptions of initiatives in Alaska, Delaware, Maine, North Carolina, Pennsylvania, Washington, and Tennessee.

Principles for Performance-Based Contracting in Virginia

Based on the background information and descriptions in Appendix B of PBC initiatives in other states, the following principles should guide the implementation of PBC in Virginia.

1. Work with representatives of CSBs through the PBC Workgroup to develop the implementation plan. Engage CSB representatives in subsequent PBC implementation.
2. Involve CSBs in developing performance standards, outcome targets, and payment schedules. Standardize indicators and data collection procedures for particular service areas.
3. Select measures that CSBs have an ability to meaningfully influence or affect.
4. Phase in PBC over a reasonable time period with sufficient years to enable modeling and adjusting performance measures and incentives or disincentives. Gain commitment and trust from CSBs by including a hold-harmless clause for at least the first implementation phase.
5. Use data from CSBs to publicize internally and externally the results of PBC. Monitor and report back to CSBs regularly on their performance, compare results achieved by similar CSBs, and include explanatory information where appropriate. Whenever possible, use existing CSB data rather than establishing additional data collection and reporting requirements.
6. Produce and use accurate, valid, and timely or near real-time data to implement PBC; this is critical to effective implementation.
7. Employ relatively small financial incentives or disincentives. Incentives do not need to be large to affect performance, and large penalties have negative and unjustifiable effects on service availability.
8. Identify and implement a small number of meaningful measures to monitor and manage performance. A large number of measures will impede the effectiveness of PBC by

diffusing focus and accountability. The small number should reflect or be proxies for other subsidiary or related criteria or factors.

9. Include a continuous quality improvement focus in PBC implementation to support enhanced service quality and guard against adverse unintended consequences.

10. Work closely with CSBs to identify difficulties in service provision or local circumstances or conditions that could affect services, such as accessing jails or assistance or cooperation from other public or private service providers, and learn about changes in populations that CSBs serve that may affect their performance.

11. Maintain consistent communication and feedback on performance to help promote CSB accountability and success.

12. Use public recognition and rewards to encourage CSBs with higher-than-average performance in addition to financial incentives for improved performance.

PBC Requirements for Enhanced Data Collection and Analysis

DBHDS derives the overwhelming proportion of current data for the performance or outcome measures in its community services performance contracts from the Community Consumer Submission (CCS 3) application, which extracts 78 data elements from local CSB electronic health records about individuals and the services that they received. The CCS 3 Extract Specifications, at http://www.dbhds.virginia.gov/library/community%20contracting/occ-ccs3-extract-specifications-v731-july-2016.pdf, define these data elements. While this data extract has supported effective execution of the performance contract, there are some accuracy, reliability, and completeness concerns about the extract. In addition, it is several months old when DBHDS receives it. Many CSBs have difficulty accessing the data in the exact form in which it is transmitted to DBHDS, and they receive little or no feedback on their data from DBHDS. CCS 3 data could be used to model some PBC measures, but far more accurate, reliable, complete, and near real-time data should be used to implement more sophisticated measures, any financial incentives, and especially any penalties or disincentives associated with PBC. The current CCS 3 extract application has a variety of limitations:

- the metrics are not aligned with emerging national quality or performance standards;
- there is little capability in the current design to support measuring outcomes;
- the current measures do not facilitate comparisons with national measures, peer CSBs, trending over time, or epidemiological assessments;
- current measures are not oriented to CSB clinical business practices;
- data are not uniquely identified transactions but are cumulative;
- data latency can approach six weeks, making it less useful for addressing performance issues; and
- data transmission and validation processes are manual and offer no feedback to or learning loops for CSBs.

While the current CCS 3 application is adequate for existing performance contracting purposes, the application would need to be completely rewritten to make it even minimally useful for full PBC implementation. The high cost of this effort is not justified by the poor return such an investment would produce. Other options for obtaining the high quality and near real-time data needed for full PBC implementation, such as are providing one electronic health record system to all 40 CSBs, are extremely costly or not practical, given the total integration of the 10 administrative policy and two policy-advisory CSBs into their local government information technology operations.

DBHDS is developing a proposal to replace CCS 3 that will produce this more accurate, reliable, complete, and timely data. The proposed replacement would be a performance management analytical warehouse and operational data store (ODS) that would:

- support local processes and outcome performance management;
- develop more balanced clinical, business, and performance contract assessments;
- leverage current technologies to mitigate severe data latency;
- leverage and be consistent with national quality standards, such as National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), and Clinical Quality Measures (CQMs);
- establish direct and secure communications with CSBs; and
- drive adoption of meaningful use outcome measures and business metrics that support CSB operations and inform DBHDS.

Appendix F contains a pictorial depiction of this analytical warehouse and ODS. Compared with the current CCS 3 process where CSBs submit monthly extracts to DBHDS, the analytical warehouse and ODS establish an intermediary level to which CSBs would submit real-time EHR data. DBHS could access and analyze this data constantly and provide feedback about it to CSBs. Development and implementation of this analytical warehouse and ODS is critical to full implementation of PBC in phases two and three. These phases rely on timely, accurate, valid, and reliable data from CSBs that can be analyzed and manipulated to produce meaningful and effective performance measures that will improve services received by individuals. As the experience of other states demonstrates, real PBC cannot be fully implemented in the absence of high quality data. DBHDS' proposal for developing and implementing this analytical warehouse and ODS estimates the total cost at $15.1 million of state general funds. This cost includes:

- procurement and implementation of an analytical warehouse and ODS,
- development of core business metrics and measures and NQF or CQM outcomes reporting,
- all incremental DBHDS information technology expenses for loading, warehousing, and reporting the data, and
- coordination with local contract service providers and health information technology implementation costs.

Timeline for Implementing Performance-Based Contracting

PBC implementation would be phased in over six years from FY 2018 through FY 2023. Phase three would be completely dependent on developing the analytical warehouse and ODS described in the preceding section and implementing it by the end of phase two. Full implementation of phases two and three also would be contingent on sufficient appropriations for the analytical warehouse and ODS and for proposed incentive payments.

Phase One of Performance-Based Contracting Implementation

In the last half of FY 2017, DBHDS and CSBs would identify and develop the initial set of PBC measures using existing reporting requirements, data, and measures. This process would continue into the first half of FY 2018. Once the measures were established, DBHDS and CSBs would model them in the second half of FY 2018 and fine tune or revise them based on the results of modeling to produce the final phase one measures for implementation in FY 2019.

Several states described in Appendix B included some **administrative measures** in their implementations of PBC. DBHDS already has some administrative performance measures in its community services performance contracts with CSBs, and these could be used as part of PBC implementation. Exhibit E in the contract conditions the receipt of subsequent semi-monthly disbursements of state general and federal block grant funds on submission of complete and accurate mid-year and end-of-the-fiscal year Community Automated Reporting System (CARS) financial reports and monthly CCS 3 extracts. Applicable provisions in Exhibit E are attached as Appendix C. If extracts or reports are not received by the due dates, DBHDS delays future semi-monthly disbursements. Exhibit I in the contract contains several measures about the timeliness, completeness, and accuracy of those reports and authorizes imposition of a financial penalty for non-compliance. Exhibit I is attached as Appendix D. Possible administrative measures that could be implemented in phase one include:

1. Submit CCS 3 monthly submissions and CARS reports by the due dates in Exhibit E of the performance contract,
2. Meet the administrative performance standards in Exhibit I of the performance contract, and
3. Submit a CPA audit or management letter by the due date in Exhibit E of the contract.

Several **service-related measures** that are currently being monitored or are required by the performance contract should be considered for inclusion in phase one implementation.

1. **Percent of adults discharged from state hospitals to the CSB who were readmitted to a state hospital within 30 days of discharge**. For each CSB, the measure would calculate the percent of all adults for whom the CSB is the discharge CSB identified in AVATAR, the state hospital information system, who were discharged by a state hospital to the CSB and were readmitted within 30 calendar days of discharge from the state hospital. The specific steps that would be used to calculate the percent are contained in

Appendix G. This measure represents an outcome instead of a process measure, e.g., meeting a target admission rate. The performance measure for each CSB would be based on the increase or decrease in the percent compared with the percent in the previous reporting period.

2. **Percent of adults discharged from state hospitals to the CSB who were readmitted to a state hospital within 90 days of discharge**. For each CSB, the measure would calculate the percent of all adults for whom the CSB is the discharge CSB identified in AVATAR who were discharged by a state hospital to the CSB and were readmitted within 90 calendar days of discharge from the state hospital. The specific steps that would be used to calculate the percent are contained in Appendix G. This measure also represents an outcome measure rather than a process measure. The performance measure for each CSB would be based on the increase or decrease in the percent compared with the percent in the previous reporting period.

3. **Percent of individuals** in the Department of Justice (DOJ) Settlement Agreement population who met the criteria for enhanced case management services and **who received at least one face-to-face developmental case management services contact per month**. This measure is in section 4.e.5.) of the contract body and section III of Exhibit B in the performance contracts with CSBs. The specific steps that would be used to calculate the percent are contained in Appendix G. A possible benchmark based on DOJ Settlement Agreement expectations might be 90 percent. However, the actual benchmark would be identified as a result of modeling the measure in the first year of phase one, and it would need to be consistent with requirements in the DOJ Settlement Agreement.

4. **Percent of individuals** in the DOJ Settlement Agreement population who met the criteria for enhanced case management services and received at least one face-to-face developmental case management services contact per month **who received at least one of those contacts every other month in their residence**. This measure is in section 4.e.5. of the contract body and section III of Exhibit B in the performance contracts with CSBs. The specific steps that would be used to calculate the percent are contained in Appendix G. A possible benchmark based on DOJ Settlement Agreement expectations might be 90 percent. However, the actual benchmark would be identified as a result of modeling the measure in the first year of phase one, and it would need to be consistent with requirements in the DOJ Settlement Agreement.

5. **Average annual utilization rate for residential crisis stabilization programs** for CSBs operating these programs. This measure is in section 4.a.2.) of the performance contract body, which requires 75 percent. The specific steps that would be used to calculate the rate are contained in Appendix G. A possible benchmark for this measure might be 75 percent, given the requirement in the performance contract. In FY 2016, the statewide average utilization rate was 70.47 percent. Individual CSB utilization rates ranged from 48.63 to 84.97 percent. Five of the 16 CSBs operating these programs met or exceeded the 75 percent rate, and seven more achieved a 70 percent rate. However, the actual

benchmark would be identified as a result of modeling the measure, including CSB clinical business practice considerations, in the first year of phase one.

6. **Percent change in the CSB's utilization of total adult state hospital bed days used by adults on the extraordinary barriers to discharge list (EBL)**, expressed as a rate of adult bed days per 100,000 of the adult population. For each CSB, the measure would calculate the adult bed days used by adults on the EBL for whom the CSB is the case management CSB. The specific steps that would be used to calculate the percent change (increase or decrease) are contained in Appendix G. The performance measure for each CSB would be based on the increase or decrease in the bed day utilization rate compared with the rate in the previous reporting period. Because of concerns about numerous legal and service availability variables that affect EBL discharges, the need for clearer definitional parameters, and the significance of EBL bed day usage, this measure should be modeled in the first year to determine if it is viable or needs to be redefined.

As part of developing and implementing the selected measures, DBHDS and CSBs would create clear and detailed definitions and establish performance measure benchmarks or standards for them based on the results of the modeling activity and research to identify any national measures where applicable.

Phase Two of Performance-Based Contracting Implementation

In phase two (FY 2020 and FY 2021), DBHDS and CSBs would continue to monitor and refine the phase one measures and identify and develop additional PBC measures using existing reporting requirements, data, and measures. The most meaningful phase one measures, those that serve as proxies for several measures, would be retained in phase two, and other phase one measures would be discontinued. For example, measure 4 might be retained and measure 3, which is incorporated in measure 4, might be eliminated. The goal would be to end up with two to three phase one measures; perhaps measures 1, 2, and 4. Depending on the accuracy and reliability of the selected phase one measures, financial incentives might be attached to some or all of them in phase two, contingent on the availability of state funds for this purpose.

Additional measures for phase two would be identified in the first half of FY 2020, and once the measures were established, DBHDS and CSBs would model them in the second half of FY 2020 and fine tune or revise them based on the results of modeling to produce the final phase two measures for implementation in FY 2021. Also in phase two, DBHDS in collaboration with CSBs would develop and implement the critically important analytical warehouse and ODS to produce the near real-time, more sophisticated and transparent, and higher quality data without which it would be difficult to implement more meaningful performance measures or to support attaching financial consequences to them.

Several additional **service-related measures** that are currently being used or monitored should be considered for inclusion in phase two implementation. Depending on the experience of DBHDS and CSBs with the bed utilization incentive projects being piloted in FY 2017, measures

7 and 8 may need to be moved to phase three. The bed utilization incentive project methodology is described in Appendix E.

7. **Percent change in the CSB's utilization of total adult state hospital bed days**, expressed as a rate of adult bed days per 100,000 of the adult population. The specific steps that would be used to calculate the percent change (increase or decrease) are contained in Appendix G. The performance measure for each CSB would be based on the increase or decrease in the bed day utilization rate compared with the rate in the previous quarterly or annual fiscal year reporting period.

   However, the actual performance benchmark or standard would be identified as a result of modeling the measure in the first year of phase two. A possible incentive might be based on the results of the bed utilization incentive projects being piloted in FY 2017. Potentially, CSBs reducing their bed day utilization rate from the previous rate would be eligible for a small incentive payment.

8. **Percent change in the CSB's utilization of total adult state hospital beds**, expressed as a rate of adult beds per 100,000 of the adult population. The specific steps that would be used to calculate the percent change (increase or decrease) are contained in Appendix G. The performance measure for each CSB would be based on the increase or decrease in the bed utilization rate compared with the rate in the previous quarterly or annual fiscal year reporting period.

   However, the actual performance benchmark or standard would be identified as a result of modeling the measure in the first year of phase two. A possible incentive might be based on the results of the bed utilization incentive projects being piloted in FY 2017. Potentially, CSBs reducing their bed utilization rate from the previous rate would be eligible for a small incentive payment.

9. **Intensity of engagement in adult mental health case management services**, which is a mandated service. For each CSB, the measure would calculate the percent of adults (age 18 or older) with serious mental illness admitted to the mental health services program area during the previous 12 months who received one hour of mental health case management services within 30 days of admission and who received at least three additional hours of mental health case management services within 90 days of admission. Several other state PBC initiatives described in Appendix B identified similar engagement measures.

   If this measure is retained as a result of the modeling activity in the first year of phase two, the actual benchmark or incentive payment would be identified and implemented as a result of this modeling. This measure has been approved by the DBHDS and Virginia Association of Community Services Boards (VACSB) Quality and Outcomes Committee, but contacts may be a more meaningful measure instead of hours; contacts are the units used for billing Medicaid for targeted case management services.

10. **Intensity of engagement in child mental health case management services**, which is a mandated service. For each CSB, the measure would calculate the percent of children (0 through 17 years of age) with serious emotional disturbance admitted to the mental health services program area during the previous 12 months who received one hour of mental health case management services within 30 days of admission and who received at least two additional hours of mental health case management services within 60 days of admission. Several other state PBC initiatives described in Appendix B identified similar engagement measures.

    If this measure is retained as a result of the modeling activity in the first year of phase two, the actual benchmark or incentive payment would be identified and implemented as a result of this modeling. This measure has been approved by the DBHDS and VACSB Quality and Outcomes Committee, but contacts may be a more meaningful measure instead of hours; contacts are the units used for billing Medicaid for targeted case management services.

11. **Intensity of engagement in substance use disorder outpatient services**. For each CSB, this measure would calculate the percent of adults admitted to the substance use disorder services program area during the previous 12 months who received 45 minutes of substance use disorder outpatient services after admission and who received at least an additional 1.5 hours of substance use disorder outpatient services within 30 days of admission. Several other state PBC initiatives described in Appendix B identified similar engagement measures.

    If this measure is retained as a result of the modeling activity in the first year of phase two, the actual benchmark or incentive payment would be identified and implemented as a result of this modeling. This measure has been approved by the DBHDS and VACSB Quality and Outcomes Committee.

As part of developing and implementing the selected phase two measures, DBHDS and CSBs would create clear and detailed definitions and establish benchmarks or standards for them based on the results of the modeling activity and research to identify any national measures where applicable.

Phase Three of Performance-Based Contracting Implementation

In phase three (FY 2022 and FY 2023), DBHDS and CSBs would continue to monitor and refine phase two measures. The most meaningful phase two measures, those that serve as proxies for several measures, would be retained in phase three, and other phase two measures would be discontinued. For example, measure 7 might be retained and measure 8, which is related to measure 7, might be eliminated. The goal would be to end up with three or four phase two measures; perhaps measures 7, 9, 10, and 11. Depending on the accuracy and reliability of the retained phase two measures, financial incentives may be attached to them in phase three, contingent on the availability of state funds for this purpose.

In phase three, DBHDS and CSBs would use enhanced data from the analytic warehouse and ODS to develop and implement more meaningful performance measures linked to national quality standards. For example, DBHDS and CSBs could use this enhanced data to develop an access measure for outpatient services. Measures also might include some that will be used by Medicaid managed care organizations (MCOs) for managed long terms services and supports (MLTSS). As part of phase three implementation, DBHDS and CSBs would need the flexibility to incorporate or adapt measures that MCOs might require CSBs to meet, for example as part of MLTSS implementation, rather than developing stand-alone measures unique to CSBs.

Depending on the accuracy and reliability of phase three measures, financial incentives and disincentives might be attached to some or all of them. If a CSB were identified as a candidate for a financial disincentive or penalty, DBHDS would require the CSB to develop and implement a corrective action or quality improvement plan before applying the disincentive or penalty. If the CSB implemented the plan successfully, the disincentive or penalty would not be imposed.

Phase three measures might include some of the following integrated primary health and behavioral health care measures:

- **Adult Body Mass Index (BMI) Screening and Follow-Up:** Percent of individuals receiving services who are 18 years old or older with a BMI documented during the current service contact or during the previous six months of the current episode of care and who had a BMI outside of normal parameters and for whom a follow-up plan was documented during the contact or during the previous six months of the current episode of care (Centers for Medicare & Medicaid Services [CMS] 061);
- **Child and Adolescent Major Depressive Disorder (MDD) Suicide Risk Assessment:** Percent of individuals receiving services who are six through 17 years old with a diagnosis of MDD who had a suicide risk assessment completed using the Columbia standard assessment instrument during the visit in which a new diagnosis or recurrent episode was identified (CMS 177);
- **Adult Major Depressive Disorder (MDD) Suicide Risk Assessment:** Percent of individuals receiving services who are 18 years old or older with a diagnosis of MDD who had a suicide risk assessment completed using the Columbia standard assessment instrument during the visit in which a new diagnosis or recurrent episode was identified (CMS 161);
- **Depression Remission at 12 Months:** Percent of individuals receiving services who are 18 years old or older with newly diagnosed or existing major depression or dysthymia and an initial PHQ score of greater than nine who demonstrated remission at 12 months, defined as a PHQ score of less than five (CMS 159); or
- **Initiation and Engagement in Substance Use Disorder Treatment:** Percent of individuals receiving services who are 13 years old or older admitted to the substance use disorder services program area with a substance use disorder diagnosis who:
  - initiated treatment within 14 days of admission, and
  - initiated treatment and received two or more additional substance use disorder services within 30 days of the first treatment visit (CMS 137).

As part of developing and implementing the selected phase three measures, DBHDS and CSBs would create clear and detailed definitions and establish benchmarks or standards for them based on the results of the modeling activity and research to identify any national measures where applicable.

Linkage to the Community Services Performance Contract

Section 37.2-508 of the Code of Virginia and State Board Policy 4018 (CSB) 86-9 establish the community services performance contract as the primary accountability and funding mechanism between DBHDS and CSBs. The State Board policy is available on the DBHDS web site at http://www.dbhds.virginia.gov/library/state%20board/adm-sbpolicies4018.pdf. The current contract contains CSB performance measures in Exhibit B, and it is available on the web site at http://www.dbhds.virginia.gov/library/community%20contracting/17%20pc%20contract%20final%20may2017.pdf. Because the contract is the mechanism through which DBHDS provides state and federal block grant funds to CSBs and holds CSBs accountable for the provision of services and achievement of performance measures, PBC should be incorporated into the performance contract. DBHDS proposes inserting applicable provisions and requirements related to phase one of PBC implementation in Exhibit H of the FY 2018 performance contract and including successive PBC implementation phases in subsequent fiscal year contracts.

Conclusion

Item 315.FF of the 2016 Appropriation Act requires DBHDS to develop a plan to implement performance-based contracting (PBC) for funds provided to CSBs. DBHDS must submit its plan to the Secretaries of Health and Human Resources and of Finance and the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2016. DBHDS convened a workgroup that included CSB representatives to assist it in developing this plan.

This plan provides background information about PBC, describes PBC initiatives in seven other states, identifies 12 principles for implementing PBC in Virginia, proposes development of a $15.1 million analytical warehouse and ODS to address the requirements for enhanced data collection and analysis associated with full PBC implementation, presents a six-year timeline for implementation, and describes three phases of proposed PBC implementation. The plan provides a conceptual framework for implementing PBC, but the framework and many aspects of the plan may need to be revised as it is implemented. For example, once measures have been modeled, some proposed measures may not be the most practical or effective measures, and they would need to be replaced by other more feasible and effective measures.

PBC implementation would be phased in over six years from FY 2018 through FY 2023. Phase one would use existing data to jump start initiation and minimize initial implementation costs. Phase two would add more meaningful measures, develop and implement the analytical warehouse and ODS needed for the next phase, and pilot the use of financial incentives. Phase three would add national integrated primary and behavioral health care measures to capture more sophisticated outcome measures, continue the use of financial incentives, and pilot the use of

financial disincentives. Full implementation of phases two and three would be contingent on sufficient appropriations for the analytical warehouse and ODS and for incentive payments. The implementation of PBC presents significant challenges to DBHDS and CSBs, but it also offers exciting opportunities to increase service accountability, improve service quality, and expand service availability to improve the quality of life for individuals receiving mental health, developmental, or substance use disorder services.

Performance-Based Contracting Implementation Plan

Appendix A: Performance-Based Contracting Workgroup Membership

Name	Organization
James F. Bebeau, L.P.C.	Danville Pittsylvania Community Services Executive Director
David A. Coe	Colonial Behavioral Health Executive Director
Jennifer M. Faison	VACSB Executive Director
Mike Forster	VACSB Data Management Committee Chairperson
Paul R. Gilding	DBHDS Director of Support Services
Stacy H. Gill, L.C.S.W.	DBHDS Director of Community Behavioral Health Services
John P. Lindstrom, Ph.D.	Richmond Behavioral Health Authority Chief Executive Officer
Nathan T. Miles	DBHDS Budget and Financial Analyst
Beverly D. Rollins	DBHDS Director of Administrative Community Operations
Joel B. Rothenberg	DBHDS Community Contracting Director
Melissa Constantine	VACSB Quality and Licensing Committee Chairperson
Joseph J. Scislowicz	Chesapeake Integrated Behavioral Healthcare Executive Director
Allen Wass	DBHDS Business Analytics Center of Excellence Director

Appendix B: Performance-Based Contracting Initiatives in Other States

A number of other states have implemented various versions of PBC over the past 15 years. This section summarizes the efforts of selected states.

Delaware Performance-Based SA Treatment Contracting Model

This model included 11 substance use disorder (SUD) treatment program sites and focused on the following performance measures:

- Capacity utilization;
- Active participation by individuals receiving services in treatment targets, for example, minimum number of sessions per individual per month; and
- Program treatment completion as defined by the state.

The state did not require programs to adopt specific clinical techniques but offered technical assistance and training in evidence-based practices. Features of the model included:

- Programs meeting all targets could earn up to five percent above their base rate for the month;
- Programs could receive bonus payments for individuals completing treatment;
- Some provider organizations passed along incentive payments to clinicians; and
- Provider organizations missing target utilization rates, defined as sessions per month, were subject to financial penalties: having monthly payments reduced or not being eligible for other financial incentives based on individual participation and treatment completion.

In the first year (2002), programs were required to maintain an 80 percent utilization rate each month to earn base payments for the month. After 2002, the utilization rate increased to 90 percent. Between 2001 and 2006, average utilization increased from 54 to 95 percent; the average rate of individuals who met participation requirements increased from 53 to 70 percent; and only one program failed to meet requirements. Successful programs:

- Extended hours of operation,
- Made facility enhancements,
- Offered salary incentives for counselors, and
- Used two evidence-based services: motivational interviewing and cognitive behavioral therapy.

North Carolina Center Point Human Services

Center Point is a local management entity covering mental health, developmental disability, and substance abuse services for Forsyth, Stokes, and Davie Counties. It administers state and county funding. It established the following provider performance benchmarks.

Mental health service benchmarks are:

- 70 percent of individuals discharged from inpatient care receive one billable contact within seven days of discharge,
- 70 percent of individuals discharged from inpatient care receive a second billable contact within 14 days of discharge, and
- 77 percent of individuals maintain stability by avoiding re-admission to a state facility within 180 days of discharge.

Substance abuse service benchmarks are:

- 95 percent of new individuals receive an admission assessment within 48 hours of referral, and
- 75 percent of new individuals receive a second billable contact (treatment initiated) within 14 days.

Maine Performance-Based Contracts Without Linkage to Compensation

Since 1997, all Department of Health and Human Services (DHHS) contracts are performance-based, but there is no direct tie between contractor compensation and performance; the contracts link renewals and extensions to performance. Contractors continue to be compensated using cost reimbursement contracts. DHHS uses a developmental approach that allows contractors to become familiar and comfortable with collecting and reporting performance data. An evaluation of DHHS' use of performance-based contracting for substance abuse services found that contractor behavior was influenced by the design of the contract. Achievement of output and outcome performance increased when tied to contract renewal, and the greater the proportion of a contractor's operating budget that came from PBC, the greater the performance. Maine established performance standards in 15 areas:

1. ACT Team
2. Community Integration
3. Crisis Services
4. Daily Living Skills
5. Day Support Services
6. Information and Referral
7. Intensive Community Treatment
8. Medication Services
9. Outpatient Services
10. Peer Services
11. Recreation/Social/Leisure
12. Residential Services
13. Respite Services
14. Supported Housing
15. Warm Lines

Examples of mental health outpatient encounter standards include:

1. Numbers served: unduplicated numbers of individuals served and unduplicated numbers of individuals age 60 and over served;
2. Timely access to services: waiting time from service eligibility determination to receipt of services; and
3. Employment: number of individuals employed full- or part-time.

Tennessee TennCare Performance-Based Contract With Penalty

Tennessee uses behavioral health measures from the HEDIS with the contractor's HEDIS result for the prior reporting period as the baseline. Contractors are eligible for a $0.03 per member per month payment for member months from the preceding calendar year for each audited HEDIS measure for which significant improvement is demonstrated using the NCQA minimum effect size change methodology. HEDIS measures include:

- Antidepressant medication management,
- Follow-up care for children prescribed attention deficit hyperactivity disorder medication, and
- Community tenure/hospital readmission for mental illness.

There are various penalties related to program issues such as:

- Failure to comply with licensure and background check requirements, penalty: $5,000;
- Failure to provide an approved service in accordance with timelines specified in the contract or with reasonable promptness, penalty: cost of services not provided plus $500 per day per occurrence for each day;
- Failure to comply with corrective action plans, penalty: $500 per calendar day for each day the corrective action is not completed;
- Failure to provide a written discharge plan for discharge from a psychiatric inpatient or residential treatment facility, penalty: $1,000 per occurrence;
- Failure to comply in any way with encounter data submission requirements, penalty: $25,000 per occurrence; and
- Failure to comply with requirements regarding documentation for CHOICES members, penalty: $500 per plan of care/member file that does not include the required elements.

Pennsylvania Performance-Based Contract With Bonus

The Pennsylvania Department of Public Welfare's Health Choices Behavioral Health (HCBH) Program provides medically necessary mental health, drug and alcohol, and behavioral services on a county or multi-county basis. It provides financial and non-financial incentives for HCBH primary contractors to meet quality goals. The Department uses six specific core quality performance indicators for financial incentives:

1. Follow-up from psychiatric inpatient discharge at seven days, ages 6-20,
2. Follow-up from psychiatric inpatient discharge at seven days, ages 21-64,
3. Follow-up from psychiatric inpatient discharge at 30 days, ages 6-20
4. Follow-up from psychiatric inpatient discharge at 30 days, ages 21-64,
5. Readmissions to psychiatric inpatient hospitalization within 30 days following discharge from psychiatric inpatient hospitalization, ages under 21, and
6. Readmissions to psychiatric inpatient hospitalization within 30 days following discharge from psychiatric inpatient hospitalization, ages 21-64.

In 2008, primary contractors earned a performance incentive payment based on their performance in the previous year compared to the 2006 baseline. Contractors below the 50th percentile received no payment, and those above the 50th percentile received a payment based on the contractor's ranking. Contractors were eligible to receive an additional incentive payment if they showed improvement. Contractors below the 50th percentile were eligible to receive up to a 25 percent improvement award, and those above the 50th percentile were eligible for an improvement payment between two and 25 percent based on the amount of improvement. Incentive payment amounts were equivalent to one-half of one percent of the contractor's capitation revenue earned, and they could not exceed 105 percent of capitation payments.

A 2011 update of the HCBH program identified three dimensions of performance:

1. **access** performance measures compare the number of people served to the number of people eligible for HCBH services,
2. **quality of process** measures provide information about the quality of service delivery processes critical to effective and appropriate behavioral health services, and
3. **consumer satisfaction** measures gather feedback from consumers and family members about key aspects of service delivery and related outcomes.

Results for all three dimensions provide information on the HCBH program's performance and form the basis to develop quality improvement strategies. The Department also uses the following performance indicators for HCBH-eligible individuals:

1. Percentage of adults receiving services who have serious mental illness (SMI) and no co-occurring substance abuse diagnosis,
2. Percentage of adults receiving services who have SMI and co-occurring SUD diagnosis,
3. Percentage of African-American adults receiving any mental health service,
4. Percentage of African-American adolescents receiving any substance abuse service,
5. Percentage of African-American adults receiving any substance abuse service,
6. Percentage of adults receiving any mental health service,
7. Percentage of adolescents receiving any substance abuse service,
8. Percentage of adults receiving any substance abuse service,
9. Annual older adults (65 years old or older) receiving any service per 1,000 eligible older adults,
10. Annual older adults (65 years old or older) receiving services per 1,000 eligible older adults for selected service categories,
11. Percentage of individuals under 21 years old who had an encounter of at least one day in a residential treatment facility,
12. Percentage of individuals under 21 years old with cumulative residential treatment facility bed days of 120 or greater,
13. Percentage of psychiatric inpatient discharges who are readmitted within 30 days post discharge who are under 21 years old,

14. Percentage of psychiatric inpatient discharges who are readmitted within 30 days post discharge who are ages 21-64,
15. Percentage of psychiatric inpatient discharges who are readmitted within 30 days post discharge who are 65 years old or older,
16. Percentage of individuals discharged from a residential treatment facility with follow-up services within seven days post discharge,
17. Percentage of individuals discharged from a psychiatric inpatient facility with follow-up services within seven days post discharge who are under 21 years old,
18. Percentage of individuals discharged from a psychiatric inpatient facility with follow-up services within seven days post discharge who are ages 21-64,
19. Percentage of individuals discharged from a psychiatric inpatient facility with follow-up services within seven days post discharge who are 65 years old or older, and
20. Percentage of adults discharged from non-hospital substance abuse residential rehabilitation with follow-up services within seven days post discharge.

Washington Department of Social and Health Services

As part of its efforts to develop legislatively mandated (2013) PBC, the Department analyzed the effects of an array of case-mix adjustments on two measures of access:

1. Substance Use Disorder(SUD) Treatment Penetration: the percentage of members with an indication of a SUD treatment need who received treatment in the measurement year, and
2. Mental Health (MH) Service Penetration: the percentage of members with a mental health service need who received services in the measurement year.

Case-mix variables included age, gender, race/ethnicity, criminal justice involvement, homelessness, residence in an institution or residential care setting, population density of the service area, physical condition/disease burden, alcohol use disorder relative to drug use disorder, and presence of co-occurring mental health need or substance use disorder.

The analysis examined regional variations. SUD penetration rates ranged from 23.0 to 37.6 percent and MH service penetration rates ranged from 42.3 to 54.4 percent for different regions. The analysis concluded that well-designed payment systems should not reinforce existing incentives for managed care organizations to achieve favorable risk pools. If performance incentives are passed through health plans to their contracted providers, well-designed performance payment models should create incentives for providers to engage high-risk clients who may be less able to adhere to standards of care. In addition, payment models should account for access-to-care challenges faced by rural and frontier regions of the state and avoid reinforcing regional resource disparities.

Alaska Division of Behavioral Health

The Alaska Division of Behavioral Health (DBH) in the Department of Health and Social Services has been implementing PBC over a long period of time through several evolutions; it has been working on a performance management system since 1998. In 2008, it began a performance-based granting initiative. Alaska classified providers by type: multi-program, urban, rural, and substance abuse residential providers. The state developed three methodologies for assessing performance in phase one:

1. Grant Performance Methodology:
   a. Complete grant review and progress scores for each provider,
   b. Separate providers into the provider category types,
   c. Rank order the providers in each group, and
   d. Providers with a score lower than 70 percent received a 3.51 percent funding decrease;

2. Unit Cost Methodology:
   a. Calculate total clients served by priority population in each provider in FY 2007,
   b. Administrative managers calculate total grant funding in FY 2007,
   c. Unit cost calculated by dividing funding by clients served,
   d. Average cost was rank-ordered within each provider type to determine the simple average across all providers, and
   e. Providers that exceeded 1.5 times the average unit cost received a 1.5 percent funding decrease; and

3. Residential Utilization Methodology:
   a. Rates of residential utilization were calculated by dividing total bed days provided in FY 2007 by available bed days (total beds purchased x total days in the year), and
   b. Providers with a residential utilization rate of over 85 percent were returned one percent of any unit cost funding decrease to that provider.

In phase two, Alaska developed provider and regional measures for data quantity and quality submitted by providers (minimal data set) and outcomes using the client status review (CSR) of life domains. In FY 2015, treatment and recovery providers started with their FY 2014 final award amounts for each competitive group (adults with SMI, children with serious emotional disturbance, adults with SUD, and youth with SUD) and performance-based funding points reflecting provider performance were applied as adjustments to those amounts. For each group, the total funding remained the same, but each provider's percentage of the total changed, thus reflecting the competitive aspect of this process. Each provider's change in its percentage of the total funds for the group reflected how well it did in comparison to other providers. The performance measures are listed below.

1. Compliance Measures:
   a. Grant review and progress report - DBH staff score, and

b. Annual household income data element - percent of clients with missing or bad data;

2. Access or Engagement Measures:
   a. Average number of days from intake to first treatment service,
   b. Percent of clients served within 30 days of program enrollment, and
   c. Percent of clients not served within 135 days of enrollment;
3. Outcome (Effectiveness) Measures that are based on CSRs:
   a. CSR Health Domains: poor mental health days - percent who improved or stayed the same or poor substance abuse days - percent who improved or maintained abstinence;
   b. CSR Quality of Life Domains: percent who improved or stayed the same;
   c. CSR Client Satisfaction: percent who were satisfied with quality of services; and
   d. CSR Client Satisfaction: percent who were satisfied with improved quality of life.

Possible performance-based funding points ranged from -1.50 to + 1.00 in quarter increments, e.g., 0.25, 0.50, and 0.75 for each measure. Overall, of 69 providers, 61 percent received increased funding ranging from $75 to $42,632 with an average of $4,972 and 39 percent received funding decreases ranging from $11 to $48,948 with an average of $7,735. Thus, Alaska's performance-based funding initiative has evolved over a period of years from a focus on activities and outputs to more of an emphasis on outcomes.

Appendix C: Exhibit E Performance Contract Process Excerpts

The following requirements for submission of CARS reports, CCS 3 extract submissions, and CPA audits are excerpted from Exhibit D in the Community Services Performance Contract at http://www.dbhds.virginia.gov/library/community%20contracting/17%20pc%20contract%20final%20may2017.pdf.

08-19-16: CSBs submit their complete CCS reports for total (annual) FY 2016 CCS service unit data to the IS&T in time to be received by this date. This later date for final CCS service unit data allows for the inclusion of all units of services delivered in that fiscal year that might not be in local information systems in July.

08-31-16: CSBs submit their CCS monthly consumer, type of care, and service extract files for July to the IT&S in time to be received by this date.

08-31-16: CSBs send complete FY 2016 end of the fiscal year performance contract reports electronically in CARS to the IS&T in time to be received by this date.

IS&T staff places the reports in a temporary data base for OSS and OFGM staff to access them. The OSS Community Contracting Director reviews services sections of the reports for correctness, completeness, consistency, and acceptability; resolves discrepancies with CSBs; and communicates necessary changes to CSBs. OFGM CSB Financial Analysts review financial portions of reports for arithmetic accuracy, completeness, consistency, and conformity with state funding actions; resolve discrepancies with CSBs; and communicate necessary changes to CSBs.

Once they complete their reviews of a CSB's reports, the OSS Community Contracting Director and OFGM CSB Financial Analysts notify the CSB to submit new reports reflecting only those approved changes to IS&T. CSBs submit new reports to correct errors or inaccuracies no later than **09-16-2016**. The Department will not accept CARS report corrections after this date. Upon receipt, the process described above is repeated to ensure the new reports contain only those changes identified by OFGM and OSS staff. If the reviews document this, OSS and OFGM staff approves the reports, and IS&T staff processes final report data into the Department's community services database.

Late report submission or submitting a report without correcting errors identified by the CARS error checking program may result in the imposition by the Department of a one-time, one percent reduction not to exceed $15,000 of state funds apportioned for CSB administrative expenses. See Exhibit I for additional information.

08-31-16: CSBs submit their 4th quarter FY 2016 Exhibit B Quarterly Performance Measures Reports to the OCC in time to be received by this date.

During September and October, CSB Financial Analysts prepare EDI transfers for payments 7 and 8 (October) and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts for payment 7 for CSBs with signed contracts that submitted their final FY 2016 CCS consumer, type of care, and service extract files by the

due date and whose FY 2016 end of the fiscal year CARS reports and 4th quarter FY 2016 Exhibit B Quarterly Performance Measures Reports were received in the Department by the due date. Payments 7 and 8 shall not be released without a contract signed by the Commissioner and receipt of those CCS extract files, complete CARS reports as defined in item 2.a. of Exhibit I, and Exhibit B Reports.

09-30-16: CSBs submit their CCS monthly consumer, type of care, and service extract files for August to the IT&S in time to be received by this date.

During October and November, CSB Financial Analysts prepare EDI transfers for payments 9 and 10 (November), and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts for CSBs whose complete CCS submissions for the first two months of FY 2016 and the completed contract signature page were received from the CSB.

10-31-16: CSBs submit CCS monthly consumer, type of care, and service extract files for September to the IT&S and their 1st quarter Exhibit B Quarterly Performance Measures Reports to the OSS in time to be received by this date.

During November and December, CSB Financial Analysts prepare EDI transfers for payments 11 and 12 (December), and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts. Payments shall not be released without receipt of September CCS submissions and 1st quarter Exhibit B Quarterly Performance Measures Reports.

11-30-16: CSBs submit their CCS monthly consumer, type of care, and service extract files for October to the IT&S in time to be received by this date.

12-01-16: A. CSBs that are not local government departments or included in local government audits send one copy of the audit report for the preceding fiscal year on all CSB operated programs to the Department's Office of Budget and Financial Reporting (OBFR) by this date. A management letter and plan of correction for deficiencies must be sent with this report. CSBs submit a copy of C.P.A. audit reports for all contract programs for their last full fiscal year, ending on June 30, to the OBFR by this date. For programs with different fiscal years, reports are due three months after the end of the year. Management letters and plans of correction for deficiencies must be included with these reports.

B. Audit reports for CSBs that are local government departments or are included in local government audits are submitted to the Auditor of Public Accounts by the local government. Under a separate cover, the CSB must forward a plan of correction for any audit deficiencies that are related to or affect the CSB to the OBFR by this date. Also, to satisfy federal block grant sub-recipient monitoring requirements imposed on the Department under the Single Audit Act, a CSB that is a local government department or is included in its local government audit shall contract with the same CPA audit firm that audits its locality to perform testing related to the federal Mental Health Services and Substance Abuse Prevention and

Treatment Block Grants. Alternately, the local government's internal audit department can work with the CSB and the Department to provide the necessary sub-recipient monitoring information.

If the CSB receives an audit identifying material deficiencies or containing a disclaimer or prepares the plan of correction referenced in the preceding paragraph, the CSB and the Department shall negotiate an Exhibit D that addresses the deficiencies or disclaimer and includes a proposed plan with specific timeframes to address them, and this Exhibit D and the proposed plan shall become part of this contract.

During December CSB Financial Analysts prepare EDI transfers for payment 13 (1st January), and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts for CSBs whose FY 2016 end of the fiscal year performance contract reports have been verified as accurate and internally consistent, per items 2.b. through d. of Exhibit I, and whose CCS monthly extracts for October have been received. Payments shall not be released without verified reports and CCS submissions for October.

12-30-16: CSBs submit their CCS monthly consumer, type of care, and service extract files for November to the IT&S in time to be received by this date.

During January and early February, CSB Financial Analysts prepare EDI transfers for payments 14 through 16 (2nd January, February), and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts for CSBs whose monthly CCS consumer, type of care, and service extract files for November were received by the end of December. Payments shall not be released without receipt of these monthly CCS submissions and receipt of audit reports with related management letters and plans of corrections (A at 12-01-16) or sub-recipient monitoring information and plans of corrections (B at 12-01-16).

01-31-17: CSBs submit their CCS monthly consumer, type of care, and service extract files for December to the OIST and their 2nd quarter Exhibit B Quarterly Performance Measures Reports to the OSS in time to be received by this date.

02-16-17: CSBs send complete mid-year performance contract reports and a revised Table 1 in Exhibit H to the IS&T electronically in CARS within 45 calendar days after the end of the second quarter in time to be received by this date. IT&S staff places the reports on a shared drive for OSS and OFGM staff to access them. The offices review and act on the reports using the process described for the end of the fiscal year reports. When reports are acceptable, IS&T staff processes the data into the community services data base.

During late February, CSB Financial Analysts prepare EDI transfers for payment 17 (1st March), and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts for CSBs whose monthly CCS consumer, type of care, and service extract files for December and 2nd quarter Exhibit B Quarterly Performance Measures Reports were received by the end of January; payments shall not be released without these monthly CCS submissions and Exhibit B Reports.

During March, CSB Financial Analysts prepare EDI transfers for payments 18 and 19 (2nd March, 1st April) and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts for CSBs whose complete FY 2017 mid-year performance contract reports were received by the due date. Payments shall not be released without complete reports, as defined in item 2.a. of Exhibit I.

02-28-17: CSBs submit their CCS monthly consumer, type of care, and service extract files for January to the IS&T in time to be received by this date.

03-31-17: CSBs submit their CCS monthly consumer, type of care, and service extract files for February to the IS&T in time to be received by this date.

During April and early May, CSB Financial Analysts prepare EDI transfers for payments 20 through 22 (2nd April, May) and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts for CSBs whose mid-year performance contract reports have been verified as accurate and internally consistent, per items 2.b. through d. of Exhibit I, and whose monthly CCS consumer, type of care, and service extract files for January and February were received by the end of the month following the month of the extract. Payments shall not be released without verified reports and these monthly CCS submissions.

04-28-17: CSBs submit their CCS monthly consumer, type of care, and service extract files for March to the IS&T and their 3rd quarter Exhibit B Quarterly Performance Measures Reports to the OSS in time to be received by this date**.**

During late May, CSB Financial Analysts prepare EDI transfers for payment 23 (1st June), and, after the OSS Community Contracting Director authorizes their release, send transfers to the Department of Accounts for CSBs whose monthly CCS consumer, type of care, and service extract files for March and 3rd quarter Exhibit B Quarterly Performance Measures Reports were received by the end of April. Payments shall not be released without these monthly CCS submissions and Exhibit B Reports.

05-31-17: CSBs submit their CCS monthly consumer, type of care, and service extract files for April to the IS&T in time to be received by this date.

During early June, CSB Financial Analysts prepare EDI transfers for payment 24 (2nd June) and, after the OSS Community Contracting Director authorizes their release, send the transfers to the Department of Accounts, after the Department has made any final adjustments in the CSB's state and federal funds allocations, for CSBs whose monthly CCS consumer, type of care, and service extract files for April were received by the end of May. Payments shall not be released without these monthly CCS submissions.

06-30-17: CSBs submit their CCS monthly consumer, type of care, and service extract files for May to the IS&T by this date.

07-31-17: CSBs submit their CCS consumer, type of care, and service extract files for June to the OIST in time to be received by this date.

08-11-17: CSBs submit their complete Community Consumer Submission (CCS) reports for total (annual) FY 2017 service units to the IS&T in time to be received by this date. This later date for final CCS service unit data, allows for the inclusion of all units of services delivered in the fiscal year that might not be in local information systems in July.

08-31-17: CSBs send complete FY 2017 end of the fiscal year performance contract reports electronically in CARS to the IS&T in time to be received by this date. If the CSB cannot include the minimum 10 percent local matching funds in its reports and a waiver has not been granted previously in the fiscal year by the Department, it shall submit a written request for a waiver of the matching funds requirement, pursuant to § 37.2-509 of the Code of Virginia and State Board Policy 4010, to the OSS with its report.

09-01-17: CSBs submit their 4th quarter Exhibit B Quarterly Performance Measures Reports in time to the OCC be received by this date.

Appendix D: Exhibit I Administrative Performance Standards

The CSB shall meet these administrative performance standards in submitting its performance contract, contract revisions, semi-annual performance contract reports in the Community Automated Reporting System (CARS), and monthly Community Consumer Submission (CCS) extracts to the Department.

1. The performance contract and any revisions submitted by the CSB shall be:
   a. complete, that is all required information is displayed in the correct places and all required Exhibits, including applicable signature pages, are included;
   b. consistent with Letter of Notification allocations or figures subsequently revised by or negotiated with the Department;
   c. prepared in accordance with instructions in the Department-provided CARS software and any subsequent instructional memoranda; and
   d. received by the due dates listed in Exhibit E of this contract.

   If these performance contract standards are not met, the Department may delay future semi-monthly payments until satisfactory performance is achieved.

2. Semi-annual performance contract reports submitted by the CSB shall be:
   a. complete, that is all required information is displayed in the correct places, all required data are included in the electronic CARS application reports, and any required paper forms that gather information not included in CARS are submitted;
   b. consistent with the state and federal block grant funds allocations in the Letter of Notification or figures subsequently revised by or negotiated with the Department;
   c. prepared in accordance with instructions;
   d. (i) internally consistent and arithmetically accurate: all related expense, resource, and cost data are consistent, congruent, and correct within a report, and (ii) submitted only after errors identified by the CARS error checking programs are corrected; and
   e. received by the due dates listed in Exhibit E of this contract.

   If the CSB does not meet these standards for its semi-annual CARS reports, the Department may delay future semi-monthly payments until satisfactory performance is achieved. The Department may impose one-time reductions of state funds apportioned for CSB administrative expenses[1] on a CSB for its failure to meet the following standards in its end of the fiscal year CARS report:

   - a one percent reduction not to exceed $15,000 for failure to comply with standard 2.d; and
   - a one percent reduction not to exceed $15,000 for failure to comply with standard 2.e, unless an extension has been obtained from the Department through the process on the next page.

3. Monthly consumer, type of care, and service extract files shall be submitted by the end of the month following the month of the extract in accordance with the CCS Extract and Design Specifications, including the current Business Rules. The submissions shall satisfy the requirements in section II Data Quality Feedback of Exhibit B and the Data Quality Performance Expectation Affirmations in Appendix E of the CSB Administrative Requirements. If the CSB fails to meet the extract submission requirements in Exhibit E of this contract, the Department may delay semi-monthly payments until satisfactory performance is achieved.
4. If the Department negotiates an Exhibit D with a CSB because of unacceptable data quality, and the CSB fails to satisfy the requirements in Exhibit D by the end of the contract term, the Department may impose a one-time one percent reduction not to exceed a total of $15,000 of state funds apportioned for CSB administrative expenses[1] on the CSB.
5. Substance abuse prevention units of service data and quarterly reports shall be submitted to the Department through the Social Solutions ETO Prevention Data System.

[1] The Department will calculate state funds apportioned for CSB administrative expenses by multiplying the total state funds allocated to the CSB by the CSB's administrative percentage displayed on page AF-1 of the contract.

The CSB shall not allocate or transfer a one-time reduction of state funds apportioned for administrative expenses to direct service or program costs.

Process for Obtaining an Extension of the End of the Fiscal Year CARS Report Due Date

The Department will grant an extension only in very exceptional situations such as a catastrophic information system failure, a key staff person's unanticipated illness or accident, or a local emergency or disaster situation that makes it impossible to meet the due date.

1. It is the responsibility of the CSB to obtain and confirm the Department's approval of an extension of the due date within the time frames specified below. Failure of the CSB to fulfill this responsibility constitutes prima facie acceptance by the CSB of any resulting one-time reduction in state funds apportioned for administrative expenses.
2. As soon as CSB staff becomes aware that it cannot submit the end of the year CARS report in time to be received in the Department by 5:00 p.m. on the due date, the executive director must inform the Office of Support Services (OSS) Director or Community Contracting Director that it is requesting an extension of this due date. This request should be submitted as soon as possible and it shall be in writing, describe completely the reason(s) and need for the extension, and state the date on which the report will be received by the Department.
3. The written request for an extension must be received in the OSS no later than 5:00 p.m. on the fourth business day before the due date. A facsimile transmission of the request to the OSS fax number (804-371-0092), received by that time and date, is acceptable if receipt of the transmission is confirmed with a return facsimile memo from the OSS no later than 5:00 p.m. on the third business day before the due date. Telephone extension requests are not acceptable and will not be processed.
4. The OSS will act on all requests for due date extensions that are received in accordance with this process and will notify the requesting CSBs by facsimile transmission of the status of their requests by 5:00 p.m. on the second business day before the due date.

Appendix E: State Hospital Bed Utilization Incentive Methodology

The general principles for an incentive plan are outlined below and will require the Region to identify specific thresholds for the incentive payments based upon CSB bed utilization. These same principles apply to all of the Regions that received one-time funds.

Example Incentive Plan

Up to $800,000 of the one-time funds used to establish an incentive for the reduction of overall bed utilization for adult and geriatric individuals from the Region who are in Western State Hospital, Piedmont Geriatric Hospital, and Catawba Hospital.

Population Included in the Calculation of Bed Utilization Rates

Adult and geriatric civil (TDO, CMA, and involuntary) and NGRI individuals

Time Period for Incentive Payments

First period from July through December 2016
Second period from January through June 2017

Bonus Payment:

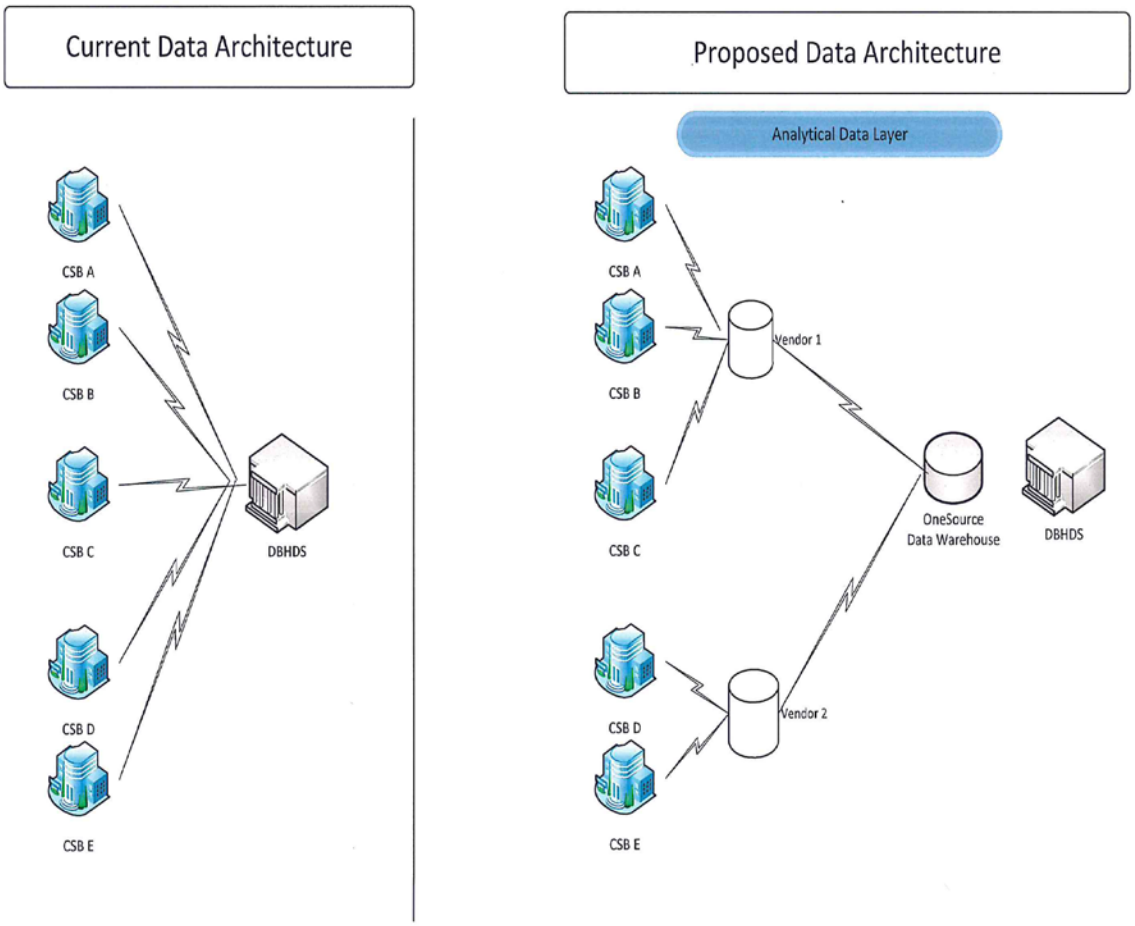
The Region will establish a target threshold of bed utilization per 100,000 population. Any CSB that maintains an average bed utilization at or below the target threshold for the time period will receive a 25,000 bonus payment at the end of each incentive period, i.e., December 2016 and June 2017.

Incentive Payment:

Option A: Any CSB who achieves and sustains a 10 percent reduction in its bed utilization per 100,000 population for the last four months of the first six month period will receive a payment of $30,000. Any CSB who sustains a 10 percent reduction in its bed utilization per 100,000 population for five out of the six months of the last six month period will receive a payment of $30,000.

Option B: Any CSB who received a bonus payment and who also achieves and sustains a five percent reduction in its bed utilization per 100,000 population for the last four months of the six month period will receive a payment of $30,000. Any CSB who sustains a five percent reduction in its bed utilization per 100,000 population for five out of the six months of the last six month period will receive a payment of $30,000.

Appendix F: Analytical Warehouse (ODS) Pictorial



Appendix H: PBC Service-Related Measure Calculations

This appendix contains the specific calculations for each measure with the data sources used in the calculations.

Phase One Service-Related Measures

1. **Percent of adults discharged from state hospitals to the CSB who were readmitted to a state hospital within 30 days of discharge**.

   For each CSB, the measure would calculate the percent of all adults for whom the CSB is the discharge CSB identified in AVATAR, the state hospital information system, who were discharged by a state hospital to the CSB and were readmitted within 30 calendar days of discharge from the state hospital. For the specified quarterly or annual fiscal year reporting period, the following steps would be used to calculate the percent.

   a. Search AVATAR data in the data warehouse to identify the adults discharged from any state hospital to each discharge CSB and the dates of their discharges. State hospitals in this measure mean Catawba Hospital (CH), Central State Hospital (CSH), Eastern State Hospital (ESH), Northern Virginia Mental Health Institute (NVMHI), Piedmont Geriatric Hospital (PGH), Southern Virginia Mental Health Institute (SVMHI), Southwestern Virginia Mental Health Institute (SWVMHI), and Western State Hospital (WSH). Adults mean individuals ages 18 or older who were admitted as adult civil, adult civil TDO (temporary detention order), geriatric civil, or geriatric civil TDO admissions.

   b. Using AVATAR discharge dates and unique consumer identifiers in the data warehouse (data warehouse IDs), search the AVATAR data to identify any of those individuals who were readmitted as adult civil, adult civil TDO, geriatric civil, or geriatric civil TDO admissions to any state hospital within 30 days of the discharge dates.

   c. Divide the number of individuals identified in step b by the number of individuals identified in step a to calculate the percent for each CSB.

2. **Percent of adults discharged from state hospitals to the CSB who were readmitted to a state hospital within 90 days of discharge**.

   For each CSB, the measure would calculate the percent of all adults for whom the CSB is the discharge CSB identified in AVATAR who were discharged by a state hospital to the CSB and were readmitted within 90 calendar days of discharge from the state hospital. For the specified quarterly or annual fiscal year reporting period, the steps in the first measure would be used to calculate the percent but modified to use 90 calendar days.

3. **Percent of individuals** in the Department of Justice (DOJ) Settlement Agreement population who met the criteria for enhanced case management services and **who received at least one face-to-face developmental case management services contact per month**. For the specified quarterly or annual fiscal year reporting period, the follow steps would be used to calculate the percent.

a. Search CCS 3 type of care records to identify individuals with a 920 consumer designation code for enrollment in the Medicaid ID waiver and service records for these individuals to identify the individuals who received developmental case management services (200 program area ID code and 320 service code).

b. For the individuals identified in step a, search CCS 3 consumer records to identify those who met the enhanced case management criteria (data element 90).

c. For the individuals identified in step b, search CCS 3 service records to identify those individuals who received a face-to-face developmental case management service within the past 30 days by using codes 07, 09, or 11 in service subtype (data element 64) and service through dates (data element 62).

d. Divide the number of individuals identified in step c by the number of individuals identified in step b to calculate the percent for each CSB.

4. **Percent of individuals** in the DOJ Settlement Agreement population who met the criteria for enhanced case management services and received at least one face-to-face developmental case management services contact per month **who received at least one of those contacts every other month in their residence**. For the specified quarterly or annual fiscal year reporting period, the same steps used in the third measure would be used to calculate the percent, but a new step d would be inserted after step c to search CCS 3 service records for these individuals to identify the individuals who received at least one contact every other month in their residence by using codes 01 or 15 in service location (data element 65) to identify the services provided in their residence. Then, the number of individuals identified in the new step d would be divided by the number of individuals identified in step c to calculate the percent for each CSB.

5. **Average annual utilization rate for residential crisis stabilization programs** for CSBs operating these programs. This measure is in section 4.a.2.) of the performance contract body, which requires 75 percent. For the annual reporting period, the following steps would be used to calculate the rate.

a. Multiply the residential crisis stabilization bed capacity identified in CARS by 365 days to calculate the total annual available bed days.

b. Divide the number of bed days reported in CCS 3 service records for the fiscal year by the total available bed days calculated in step a.

6. **Percent change in the CSB's utilization of total adult state hospital bed days used by adults on the extraordinary barriers to discharge list (EBL)**, expressed as a rate of adult bed days per 100,000 of the adult population. For each CSB, the measure would calculate the adult bed days used by adults on the EBL for whom the CSB is the case management CSB. For the specified quarterly or annual fiscal year reporting period, the following steps would be used to calculate the percent change (increase or decrease).

a. Search the AVATAR warehouse data to identify all of the adult civil, adult civil TDO, and adult EBL not guilty by reason of insanity (NGRI) and geriatric civil, geriatric civil TDO, and geriatric EBL NGRI bed days used at CH, CSH, ESH, NVMHI, PGH,

SVMHI, SWVMHI, or WSH by adults who are on the EBL for whom the CSB is the case management CSB.

b. Divide the CSB's total adult (age 18 or over) population from the current Weldon Cooper Center for Public Service (UVA) Population Estimates by 100,000 to establish the denominator.

c. Divide the total adult bed days in step a by the number in step b to calculate the CSB's EBL bed utilization rate.

d. Using the same process, calculate the utilization rate for the preceding reporting period.

e. Divide the rate produced in step c by the rate produced by step d, multiply the result by 100 and subtract 100 from the result to produce the percent change in the bed day utilization rate for the CSB. For example, dividing 100 bed days in the current reporting period by 110 bed days in the previous reporting period, multiplying the result by 100, and subtracting that result from 100 equals -9.1 percent change.

Phase Two Service-Related Measures

7. **Percent change in the CSB's utilization of total adult state hospital bed days**, expressed as a rate of adult bed days per 100,000 of the adult population. For the specified quarterly or annual fiscal year reporting period, the following steps would be used to calculate the percent change (increase or decrease).

   a. Using the AVATAR data in the DBHDS data warehouse, identify all of the state hospital adult civil, civil TDO, and NGRI and geriatric civil, civil TDO, and NGRI beds days at CH, CSH, ESH, NVMHI, PGH, SVMHI, SWVMHI, or WSH used by individuals for whom the CSB is the case management CSB.

   b. Divide the CSB's total adult (age 18 or over) population from the current Weldon Cooper Center for Public Service (UVA) Population Estimates by 100,000 to establish the denominator.

   c. Divide the total adult bed days in step a by the number in step b to calculate the CSB's bed day utilization rate, for example, 100 bed days/100,000 adult population.

   d. Using the same process, calculate the rate for the preceding reporting period.

   e. Divide the rate produced in step c by the rate produced by step d, multiply the result by 100 and subtract 100 from the result to produce the percent change in the bed day utilization rate for the CSB

8. **Percent change in the CSB's utilization of total adult state hospital beds**, expressed as a rate of adult beds per 100,000 of the adult population. For the specified quarterly or annual fiscal year reporting period, the following steps would be used to calculate the percent change (increase or decrease).

   a. Using the AVATAR data in the data warehouse, identify all of the adult state hospital beds used for adult civil, civil TDO, and NGRI and geriatric civil, civil TDO, and NGRI

admissions at CH, CSH, ESH, NVMHI, PGH, SVMHI, SWVMHI, or WSH by individuals for whom the CSB is the case management CSB.

b. Divide the CSB's total adult population from the current Weldon Cooper Center for Public Service (UVA) Population Estimates by 100,000 to establish the denominator.

c. Divide the total adult beds in step a by the number in step b to calculate the CSB's rate.

d. Using the same process, calculate the for the preceding reporting period.

e. Divide the rate produced in step c by the rate produced by step d, multiply the result by 100 and subtract 100 from the result to produce the percent change in the bed utilization rate for the CSB.

9. **Intensity of engagement in adult mental health case management services:** For each CSB, the measure would calculate the percent of adults (age 18 or older) with serious mental illness admitted to the mental health services program area during the previous 12 months who received one hour of mental health case management services within 30 days of admission and who received at least three additional hours of mental health case management services within 90 days of admission. The calculation would use CCS 3 data from consumer, type of care, and service records.

10. **Intensity of engagement in child mental health case management services**: For each CSB, the measure would calculate the percent of children (0 through 17 years of age) with serious emotional disturbance admitted to the mental health services program area during the previous 12 months who received one hour of mental health case management services within 30 days of admission and who received at least two additional hours of mental health case management services within 60 days of admission. The calculation would use CCS 3 data from consumer, type of care, and service records.

11. **Intensity of engagement in substance use disorder outpatient services**. For each CSB, this measure would calculate the percent of adults admitted to the substance use disorder services program area during the previous 12 months who received 45 minutes of substance use disorder outpatient services after admission and who received at least an additional 1.5 hours of substance use disorder outpatient services within 30 days of admission. The calculation would use CCS 3 data from consumer, type of care, and service records.