CIS Payment Reform: Comments and Responses
January 2020

COMMENT 1

Burlington/Chittenden
Vermont Family Network (Kelly Morrison)

I am writing to express grave concern regarding the CIS payment reform study and the impending fiscal and target utilization changes for the July 1, 2020. The current payment reform and anticipated decrease of $7.6 million to Chittenden County's Children's Integrated Services will significantly impact Chittenden County's CIS supports and services to children and families. These services are vital to the health, safety, stability, early development and education of our very youngest community members and their families. These services have been inadequately funded, impacting agencies' abilities to meet their obligations to our youngest children, even those services that are entitled and mandated by law. As a result of this continued underpayment, children and their families are not receiving the timely, high quality services they are entitled to, and which are needed for good outcomes.

The payment reform study found that, even with the proposed payment reform, there will continue to be an underpayment of $132.24 per child per month to hosting agencies to carry out the contracts set forth by the state, one of which is Early Intervention, an entitlement program that is also federally mandated. Across the state this is an underpayment of $2.4 million dollars to the agencies that host the programs. Simultaneously targets will be increased to 100% of current utilization and Chittenden County CIS will be required to serve more children with even less funding. Also, with these changes there will be increasing scrutiny from the Child Development Division on CIS programs as the relationship between the state and stakeholders transitions from a focus on technical assistance and stakeholder engagement towards an increased focus on compliance as stated in a memo from the Child Development Division's, dated 11/18/19.

More money must be invested into this program in order to re-stabilize agencies and allow for the provision of high quality, timely, services, especially those services mandated by federal law. Investing in young children now saves on services in the future that are less effective and costlier. I urge you to reconsider this proposed payment reform given the negative impacts it will have on Chittenden County's CIS supports and services to young children and families. I urge you to fund this program at the level it takes to do this work as indicated by the payment reform study. We must increase the funds to CIS in order to promote optimal outcomes for our very youngest and their families, make prevention a focus once again, and recognize the promise of every child in Vermont.

Response to Comment 1: The Child Development Division's (CDD) goals in this payment reform initiative are to ensure equity in payment for CIS services across regions, develop a data-driven approach to payment rather than basing payment on historical levels, and in doing so to respond to federal requirements to improve the payment methodology. The payment reform study used cost and utilization data from the provider survey and Vermont-specific wage and benefit data from the federal Bureau of Labor Statistics and other published sources to construct a statewide monthly case rate, as data indicated the cost of service delivery does not vary in any consistent or significant way across regions. This process produced a rate of $633.90 per client per month.

As previously discussed, the outcome of payment reform would be limited to the current budget for CIS bundled services. As such DCF and DVHA are unable to fully fund the case rate of $633.90. -. To address inequities in existing case rates – which vary from $471 to $646 – DCF has proposed a consistent rate of

$501.66, which is the amount permitted by current funding levels that simultaneously ensures reimbursement is paid for the current caseload in each region. The proposed rate change is paired with recalculations of regional contract totals to ensure that these are reflective of the proportion of the statewide CIS caseload that each region serves, again with the goal of providing reimbursement for the current regional caseload. There is no target caseload, but rather a contract total for reach region that allows them to receive reimbursement for their current caseload., CDD anticipates updating these contract totals in future contract cycles, as regions submit additional data regarding population served.

The combination of these two factors (new case rate and adjusted contract totals based on reported population served) rate would result in 4 CIS fiscal agents experiencing an increased contract and 5 fiscal agents experiencing a contract reduction. Chittenden County is one of the regions that would experience a reduction, equaling $216,958.02 over a 12-month period (an estimated 7.6% reduction from current levels); it would not experience a $7.6 million reduction.

CDD intends to continue its commitment to provide technical assistance and engage with stakeholders; those activities are critical to the program's success. It is also critical for providers to submit information on utilization and services that are provided to children and families. That information is needed to continue to evaluate need throughout the state, ensure that payment reform is resulting in desired outcomes, and provide accountability for the use of public funds (i.e., state and federal tax dollars) to support the program. This is consistent with policies that need to be followed related to procurement, contracting, oversight, and monitoring, as indicated in CDD's November 18th communication.

DCF agrees with the commenter's emphasis on the importance of prevention services. To that end, the CIS program is intensely focused on ensuring that needed services are provided to young children and their families, in a high-quality and timely fashion, using payment methods that ensure equity across the state.

COMMENT 2

Barre/Washington
Central Vermont Home Health and Hospice (Kathryn Leffel)

Because there was significant regional variation on data reported to the CIS survey (in part because of differences in regional tracking of services, regional differences in services provided and differences in the interpretation/understanding of what data was being requested), the data being used is inaccurate - the $477 "cost of services" is knowingly inaccurate and borders on fraudulent.

All the agencies providing CIS services operate at a loss on those services. The anticipated rate of $501 starting July 1st will exacerbate this situation. In the Barre region, we are getting paid the same amount to serve more clients, from 103 at the beginning of the calendar year, to 122 this past July, to 152 next July, all for the same amount of money. In the meantime, we are serving an average of 207 clients so we're effectively getting paid $368 per case.

The onus is being placed on the providers of services to advocate for increased funding to meet the need of services we are ALREADY providing. So, not only is the state CIS team knowingly under reporting the cost of services, they are expecting the providers to take further time and money from the field and direct services to advocate for funding to cover the services.

In the context of CIS's constant cycle of crisis, it is not surprising to me that we don't have persuasive and cohesive data to bring to the legislature to ask for more funds – everyone is in a perpetual scramble to survive and serve the needs of a very vulnerable population.

Response to Comment 2: The current statewide cost estimate of $477.68 per child per month was based on the data reported through the provider survey; the analysis of which accounted for incomplete data. DCF and DVHA are aware that this figure does not completely account for unmet needs and therefore did not present this as the 'correct' funding level. Rather, the payment reform study found that an appropriate rate would be $633.90 per child per month. However, due to existing funding levels, the proposed rate is $501.66. The rate of $477.68 was shared in part to illustrate that the rate development methodology did not simply rely on provider- reported cost data, but rather incorporated other data (e.g. wage data, adjustments for best practice caseloads, etc.) to arrive at the final finding of $633.90.

Contract totals were calculated based on what each region reported their average monthly caseload to be, with contracts reflecting what proportion of the statewide CIS population this equates to (e.g. if a region serves 10% of the statewide CIS caseload based on their monthly reports, their contract total is 10% of the available CIS bundled services funds). DCF and DVHA will have additional utilization data in time for the January 1, 2021 contracts, so the intent is to use that information to adjust reimbursement. The analysis of the provider survey, coupled with provider submission of more detailed and robust utilization and encounter data, will result in better information for policymakers (including the Legislature) to support budget decisions.

COMMENT 3

Morrisville/Lamoille
Lamoille Family Center (Carol Lang-Godin)

We appreciate the modest increase we received through this process, and that the reimbursement rate is now rationally based. However, we are acutely aware that the rationale that determined our new rate also determined there is a $130.00 difference between the new rate and what the rate should be. We hope that work is being done to correct this.

COMMENT 4

Morrisville/Lamoille
Lamoille Family Center (Floyd Nease)

We appreciate the modest increase we received through this process, and that the reimbursement rate is now rationally based. However, we are acutely aware that the rationale that determined our new rate also determined there is a $130.00 difference between the new rate and what the rate should be.

Response to Comments 3 and 4: DCF and DVHA appreciate the support for the payment reform study as well as the proposed contract rates. The payment reform study suggested an appropriate statewide rate of $633.90 per child per month.

Given State budget limitations, however, existing funding does not allow for the full implementation of this rate. To address inequities in existing rates – which vary from $471 to $646 – CDD has proposed a consistent rate of $501.66, which is the amount permitted by current funding. This rate, and contract adjustments to reflect population served, would result in 4 CIS fiscal agents experiencing an increased

contract amount and 5 fiscal agents experiencing a contract reduction. Morrisville/ Lamoille is one of the regions that would experience an increase, estimated to total $47,951 over a 12-month period (an estimated 6.3% increase from current levels).

COMMENT 5

Newport/ St Johnsbury
Northeast Kingdom Learning Services, Inc. (NEKLS) (Michelle Faust)
Umbrella/Kingdom Childcare Connections (Amanda Cochrane)
Caledonia Home Health Care & Hospice (Treny Burgess)
North East Kingdom Community Action (NEKCA) (Jenna O'Farrell)
Northeast Kingdom Human Services (NKHS) (Tomasz Jankowski)

Thank you for the opportunity to comment on the current payment reform proposals related to Children's Integrated Services (CIS). We appreciate the collaborative process used by the State's team and your investment of both time and resources. That said, local partners in the Northeast Kingdom (NEK) have significant concerns about the present proposal. This letter sets forth our belief that the State should delay implementation of reform until the program is sufficiently funded. Alternatively, the State ought to delay implementation until at least January 1, 2021 to allow NEK partners and the State to work together to redefine the program and settle several outstanding issues.

The State Should Not Implement CIS Payment Reform until Sufficient Funding is Appropriated to Pay the Rates Developed by the State's Consultants.

We support the effort to create a standardized and transparent payment methodology for CIS services. Done right, payment reform to standardized rates can help eliminate disparities and arbitrariness in the rates, and it can give service providers confidence as they plan for the future. Also, payment reform can be an excellent tool to illuminate situations where the rates paid by the State are insufficient. Here, the State's consultants have concluded exactly that: the current appropriation for CIS services produces a payment rate below the cost of running the program. Our hope is that the valuable work demonstrating a funding gap will serve as a burning platform for investment. Yet, the State now proposes to standardize and equalize rates prior to any investment. This action would result in a 36% rate cut to the NEK.

A 36% rate cut would require local partners to cut staff, reduce visits, and hinder emerging progress. For example, we believe staff in Early Intervention alone would be reduced from 4 FTEs to approximately 2.5 FTEs in Newport and from 6 FTEs to 4 FTEs in St. Johnsbury. Visits in each region would drop from approximately weekly to 1-2 times per month as staff members carry an increased caseload. We can reasonably expect that the reduction in service would lead to a decrease in the number of children exiting age appropriate by their 3rd birthday and would thereby increase the number of children entering Part B special education. This result would increase costs and demand at the school district level. We believe this would be especially demoralizing now since over the last five years, St. Johnsbury has had the most ongoing improvement across all federal IDEA Indicators, over every other region in our state. From July 2018 through June 2019, St. Johnsbury met 9 of 10 federal compliance indicators. This is largely due to the appropriately staffed and trained personnel who take great pride in their work with families of young children.

This is only one component of the program. Local partners would need to fully analyze the

impact across the entire program, but we can reasonably conclude that it would further reduce FTEs and demoralize staff.

We expect the proposed change to lower staff morale and cause higher rates of burnout and turnover. Staff will be doing more with less. Also, with fewer staff, we will not be able to have staff participate fully with their state and local partners. For example, we anticipate that staff would no longer be able to participate in efforts like the Home Visiting Alliance, CIS Data Workgroup, and various other activities. This will result in a workforce that is more stressed and less connected to our communities. Overall, it is unclear to NEK local partners what benefit the State gains at this time worth that level of disruption and risk in the State's most vulnerable region.

A Rate Cut, if Implemented should be Delayed until January 1, 2021 to Allow for Planning and Analysis.

Our preference is for adequate program funding. Alternatively, we urge the State to delay implementation of the new model from July 1, 2020 until January 1, 2021 if it decides to move forward prior to adequate program funding. The additional six-month delay will let local partners and the State work on three issues:

- redefine the delivery of services under this new payment model,
- explore a geographic adjustment to the case rate in the NEK due to its present rate, unique geography, and demographics, and;[1]
- determine whether Specialized Childcare Grants will continue, since their removal would create additional financial pressures for CIS providers.[2]

The consequences of a major rate cut are not yet fully clear, and time offers the best strategy to develop a mitigation plan and prepare for the future. Also, we believe delaying until January may benefit the State, as a January start aligns with the customary Medicaid payment reform implementation timeline.

Thank you in advance for your consideration. Local NEK partners stand ready to discuss this letter with you. We trust you are ready to work with us in good faith on an appropriate transition strategy that allows payment reform to be a positive experience for all CIS providers.

Response to Comment 5: DCF and DVHA recognize that the Northeast Kingdom region would sustain the largest percentage reduction in current funding under a standardized rate and appreciate the thoughtful response and estimate of potential impact on staffing, services, and the workforce provided in this comment. The outcome of the Legislative appropriations process for State Fiscal Year (SFY) 2021 cannot yet be ascertained; DCF and DVHA will likely not know the budget allocation for CIS until late May at the earliest so the estimated rate is based on an assumption that the CIS budget for SFY 2021 will remain the same as SFY 2020.

[1] The Department of Vermont Health Access has utilized geographic payment adjustments several times during the past few years while setting Medicaid rates. For example, the FQHC PPS payment system uses an urban adjustment for certain health centers in the northwestern portion of the State white the Durable Medical Equipment (DME) fee schedule uses a Provisional Access to Care Adjustment (PACA) in the eastern side of the state. While the sustainability of such adjustments may be uncertain, these transition strategies have been used in the past to address imbalances in a new payment model.

The rationale for selecting July 1, 2020 as the implementation date for the rate change was to allow fiscal agents and subcontractors time for planning and implementation; the previous goal was to institute the change by January 1, 2020 but providers convincingly articulated that this would not provide enough time and CDD agreed. The challenge with delaying implementation until January 1, 2021 is that the federal government approved the current payment methodology through December 31, 2020 contingent on a new data-driven payment model being implemented no later than January 1, 2021. It is not certain that the State could gain continued federal approval for the program if the model change doesn't occur until January 1, 2021, and there would be no time to make necessary refinements to the model that might become apparent during early implementation. It would also delay efforts to ensure statewide equity by instituting increases to regions that have been receiving lower reimbursement for a number of years.

DCF and DVHA share the Northeast Kingdom partners' commitment to "work…in good faith on an appropriate transition strategy that allows payment reform to be a positive experience for all CIS providers." To that end, DCF and DVHA are interested in engaging in discussions with the Northeast Kingdom, and any other regions interested in similar discussions.

COMMENT 6

Burlington/Chittenden
Vermont Family Network (Pam McCarthy)

Process: The CIS payment reform process felt rushed, and not well-executed, especially given the large investment the state has made in hiring Burns and Associates to conduct this work, in addition to the more well-paced payment reform efforts in Mental Health and Developmental Services. DMH and DAIL payment reforms were more inclusive of stakeholders and allowed agencies far more time to do the work required to inform the new rates. It is disturbing that the proposed rate appears to have been submitted to CMS before the data, proposed rate, allocation and utilization changes were reviewed by the participants in the process, and that the December "provider" comment period is actually just a response to AHS/DCF/CDD regarding what appears to be a "done deal." We are also concerned that the "public" comment period will occur next summer right before the proposed rates will be put in place for July 1, 2020. Communication has been less than adequate throughout this process.

Response Rate: CIS contractors were not clearly required to respond to the Burns and Associates provider survey, so responses were inconsistent and incomplete across the 12 regions. This resulted in data with low response rates, and admittedly less than good quality information from which to draw conclusions/set a credible new rate.

Caseload Targets---Disparate Methodologies: Across AHS payment reform efforts and bundled rate implementation, the methodology to determine caseload requirements is not consistent. The proposed CIS caseloads are set at 100% of the reported encounters for FY19. In other AHS payment reforms, caseload targets have been set at a percentage of historic utilization over a three-year period, incorporating room for occasional fluctuations and allowing agencies to earn the revenue necessary for consistent service delivery. With rates set at 100%, there is no allowance for variation based on the time of year, family and community needs/complexities, changes in population, or changes in the services available to provide CIS supports.

Regional Variations:

- Cost----Despite the admittedly sparse data and understanding the impact that had on Burns' conclusions, the consultants determined that there was not much variation across the regions with

regard to wage and mileage costs. There is much to support the differences between the cost of living/providing services in rural areas of Vermont vs. the more urban Chittenden region. Businesses, nonprofits, and families have to spend more for their housing in Chittenden County. Unemployment is exceptionally low in this region, and it is doubly difficult to recruit and retain skilled CIS staff when our wages are not competitive and are insufficient to employees' housing costs. Many of our providers hold second and third jobs outside of CIS in order to make ends meet. Turnover is creating tremendous issues as we attempt to meet heightened contract expectations and increasing family needs/complexities with decreasing funding. We feel that the costs were underestimated in the survey.

- Demographics---As has been noted in many Chittenden CIS conversations with State partners, Chittenden is unique in its diversity of population. Serving New American families in culturally responsive ways requires extra time and expense that are unaccounted for in the CIS payment reform. Additionally, Chittenden's annual rate of population growth, unlike other areas of the state, continues to be stronger than in other parts of Vermont. There does not appear to be any consideration of a commensurate growth in the need for services, or the resources to deliver them. For VFN as the Chittenden CIS-EI provider, this creates enhanced pressure to comply with the high expectations of this legally mandated program for timeliness, quality, and consistency of services, at a time when we are already struggling to meet demands and improve our Determination status.

Reallocation Methodology: The methodology for reallocation of CIS resources seems to assume a similar service mix of EI, ECFMH, Nursing and Family Support, and Specialized Childcare that is proportionally divided across the 12 regions. How do the proposed regional allocations account for demographic factors, regional trends and needs, complementary resources for prenatal to six-year-olds who participate in CIS, waitlists, etc.? With enhanced Universal Developmental Screening and an emphasis on prevention and early intervention in Vermont's early childhood community, the methodology does not seem to reflect unmet need as a factor. It seems unreasonable to expect that we can continue to serve more children with more complicated families sooner and better with less money and less flexibility, especially after over 10 years of level funding for CIS.

Impact:
+Regional---With the new rate and allocations proposed, Chittenden County will receive a 7.5% cut in total funding, a 15.9% rate reduction, and a 9.8% increase in required caseload/utilization. The proposed Chittenden County rate of $501.66 is 79% of the rate per the Burns and Associates rate study. The proposed rate results in a $216,948 reduction in current funding for Chittenden County and a $691,884 shortfall per the Burns & Associates rate study. This is destabilizing to many organizations in the region considering:

- the reduction in funding is coupled with an increase in the required caseload limiting organizations ability to reduce service provision (cost) in alignment with the reduction in funding;
- Chittenden County providers are already subsidizing financial losses for CIS service provision;
- Chittenden County providers continue to struggle to hire and retain staff paying below market compensation and will now have even less resource to address.

The Chittenden region continues to analyze the impact of the proposed funding reduction and increased required service provision to articulate the negative impact to children and families served likely to include increased waitlists and reduction in available providers.

+Organizational---VFN has been serving the lion's share of Chittenden's CIS caseload, with numbers of children, family complexity, staff turnover and state//CIS contractor expectations steadily increasing over

the last 5 years. At the same time, capacity, and Determination status has been decreasing, as has CIS-EI funding, due to efforts to better compensate skilled staff in a way that attracts and keeps them. If the impending payment reform cuts and reallocations are made in Chittenden County, and the bundled funds are distributed as they have been historically among the Chittenden CIS partners, VFN will lose over $80,000 and two positions. Our capacity to serve infants and toddlers and their families according to best practice and contractual expectations will be seriously impacted, at a time when we are already struggling to do all that we are required to do to achieve good outcomes. Because Chittenden County serves over 25% of the state's IDEA Part C eligible infants and toddlers, our performance as a CIS-EI program impacts the state's standing with the Federal Office of Special Education Programs with regard to compliance and quality. As Chittenden goes, so goes the state.

We would like to again suggest that the annual evaluations that CIS-EI programs are required to do for children, but are currently not reimbursed for, again be Medicaid billable. This would help to offset the inadequacies of the proposed rate and reallocations for the regions, especially in Chittenden County.

Conclusion: It appears the proposed rates are a re-allocation of current funds to ensure each region has the same proportionate service mix available for its historical caseload without regard for actual costs, suppressed cost, regional demographics, trends, or needs of children and families. The proposed re-allocation also appears to disregard the current subsidizing of CIS service provision by agencies and, with a funding reduction and utilization increase in Chittenden County, will further increase the financial subsidization required by providers thus further eroding the precarious financial sustainability of many of the providers. Additionally, it seems imperative that the ECFMH services and funds allocation, per the November 21, 2019 memo from Commissioners Schatz and Squirrel, be resolved before finalizing change to new rates and allocations. Finally, rather than re-allocate what DCF has already acknowledged is an insufficient pool of resources resulting in the de-stabilization of some regions, AHS might consider leaving rates and allocations status quo and using the data gathered thus far to educate on the underfunding of CIS services, and make the case for additional investment in prevention and early intervention by the state.

COMMENT 7

Burlington/Chittenden
Howard Center (Sandy McGuire)

PROCESS

Payment reform is happening in many areas of AHS. However, the process of the CIS Payment Reform has been an outlier with regards to pace (hurried) and provider/stakeholder/consumer involvement (limited). It is concerning that the rates were submitted to CMS for approval in advance of the release/review of the data and proposed rate, allocation, and utilization changes. Further, the rates were submitted in advance of the touted "public comment period" in December which in fact turned out to be limited to an opportunity to provide response to the department only.

SURVEY RESPONSE RATE

The provider survey was not required, and some responses were disregarded due to incomplete data. This resulted in a low response rate for most components of the survey, at times as little as one survey response. Data with a low rate of response is vulnerable to skewing and as such can produce false positive or false negatives. As a result, the provider survey data is incomplete and cannot be used accurately to reflect provider costs to deliver services.

CASELOAD TARGETS – DISPARATE METHODOLOGIES

As Payment Reform is taking place across AHS, and bundled (case) rates are being implemented, the methodology to determine caseload requirement is inconsistent. The proposed CIS caseloads are set at 100% of the reported encounters for FY 2019, even in regions receiving a cut in funding. In other areas of AHS reform these targets have been set at a percentage of historic (a three-year period) utilization allowing for periodic fluctuations while better enabling agencies to earn the revenue required to maintain service delivery. Setting rates at 100% of reported caseloads does not allow for any variation based on seasonality, need, population fluctuation, or changes in available services.

REGIONAL VARIATIONS

Despite a low response rate and caution that the data conclusions were flawed due to that, Burns concluded "Provider Survey indicated that there was not extensive variation in wage and mileage costs across regions." However, multiple other indicators reflect the cost of living in urban Vermont to be 18% higher than rural Vermont.[3] Businesses in Chittenden County are impacted by the higher cost of living grappling with higher building and facility costs and an extremely competitive labor market with the lowest regional unemployment rate in the state, less than 2%. As the pool of workers continues to decrease and market compensation increases in response, the issue is further exacerbated for human service providers who pay below market wages due to resource limitations. The current state of underfunding has led to high staff turnover with staff leaving for similar jobs that pay more money and offer more robust benefits. When considering costs, market compensation and benefits (total compensation) of the key regional competitors (UVMMC, State of Vermont, school districts) for clinical and administrative positions is a critical factor. Without consideration of such factors, costs are underestimated and likely disproportionally so for urban regions.

Further, the annual rate of population growth in Chittenden County continues to outpace other areas of the state which are primarily constricting, yet it does not appear any factor to account for similar trend in service need was incorporated. Chittenden County also has the highest percentage of New Americans in the state[4] necessitating culturally appropriate responsiveness, including multiple language interpreters, increased outreach time and staff training, and overall a service delivery model that is more labor intensive requiring more resources.

RE-ALLOCATION METHODOLOGY

The re-allocation methodology appears to presume an identical service mix proportionately (ECFMH, EI, SCCC, Nursing) for all regions based on historical caseload. How does this align demographics, trends, and need/waitlists? Further, the continued resource investment in early identification of children and families results in increased identified need, however there is a lack of corresponding increase in resources to respond to the service needs. It does not appear unmet need was a factor in the proposed re-allocation.

[3] https://ljfo.vermont.gov/assets/Subjects/Basic-Needs-Budgets/2c974b591b/2019-Basic-Needs-Budget-and-Livable-Wage-report-FINAL-1-15-2019-v2.pdf

[4] http://www.ecosproject.com/wp/wp-content/uploads/2017/09/ECOSPlan_CEDSSupplement4_PublicHearingDraft_20180406.pdf

REGIONAL IMPACT

With the current proposal, Chittenden County will receive a 7.5% cut in total funding, a 15.9% rate reduction, and, at the same time, a 9.8% increase in required caseload/utilization. Said differently, Chittenden County must provide more services than currently required to draw down significantly less money overall. The proposed Chittenden County rate of $501.66 is 79% of the rate calculated per the Burns and Associates rate study. The proposed rate results in a $216,948 reduction in current funding for Chittenden County and a $691,884 shortfall per the Burns & Associates rate study. This will be destabilizing for many organizations in the region considering:

- the reduction in funding is coupled with an increase in the required caseload limiting organizations ability to reduce service provision (cost) in alignment with the reduction in funding;
- Chittenden County providers are already subsidizing financial losses for CIS service provision;
- Chittenden County providers continue to struggle to hire and retain staff paying below market compensation and will now have even less resource available.

The Chittenden region is analyzing the inevitable negative impact of the proposed funding reduction and increased required service provision on agencies and ultimately those we serve. It seems unavoidable that there will be a negative impact to the financial sustainability of provider organizations, the demands on staff, and ultimately the children and families served as impact is likely to include increased waitlists and reduction in available providers.

CONCLUSION

In other current AHS Payment Reform initiatives, there is a fundamental change to the payment methodology (moving away from Fee for Service, changing to prospective payment, shift in rules to allow for increased flexibility in service delivery) with some tangible benefit. The CIS Payment Reform initiative has none of these components as it is already a bundled rate and there are no proposed changes to payment mechanics or shift in requirements that provide flexibility or other benefits in service delivery that could benefit clinicians, administrators, or clients. Rather, it appears CIS Payment Reform is fundamentally CIS Funding Reallocation, and, for Chittenden County, a funding cut accompanied with an increase in required utilization.

The proposed statewide rate and re-allocation of current funds appears to provide each region the same proportionate service mix for its historical caseload without regard for actual costs, suppressed cost, regional demographics, trends, or needs of children and families. The proposed re-allocation also appears to disregard the current subsidizing of CIS service provision by agencies and, with a funding reduction and utilization increase in Chittenden County, has the potential to reduce the capacity of continued financial subsidization further destabilizing services and thus further eroding the precarious financial sustainability of many of these providers. Additionally, it seems imperative that the ECFMH services and funds allocation, per the November 21, 2019 memo from Commissioners Schatz and Squirrel, be resolved before finalizing changes to rates and re-allocations. Finally, rather than re-allocate what DCF has already acknowledged is an insufficient pool of resources resulting in the de-stabilization of some regions, AHS might consider leaving rates and allocations status quo while using the data gathered thus far to educate on the underfunding of CIS services.

Response to Comments 6 and 7: This response follows the topic areas outlined in the comments.

- Process: Relative to other payment reform efforts, there are several factors that allowed for or necessitated a more rapid pace for the CIS project:
    1. The CIS initiative does not entail wholesale payment methodology redesign because the program already had instituted a bundled payment.
    2. The DMH and DAIL projects are engaged in broader delivery system reform (e.g., reconfigured payment model, identification and implementation of a standardized needs assessment tool and changes to the assessment process, and potential changes in the relationship between a personal supports budget and the development of an individualized service plan).
    3. CMS approved the CIS payment model contingent on the implementation of an updated, data-driven payment methodology by January 1, 2021.
    4. The existing rate inequity between regions supports developing a new model sooner rather than later.

  In terms of stakeholder input, DCF and DVHA have offered several forums and opportunities for written feedback and questions and will continue to do so prior to implementation of revised rates. The December public comment period was suggested when it was thought that implementation might occur in January of 2020. Now that implementation has been postponed until July, a public comment period will be offered in the Spring of 2020.

  To clarify, a specific rate has not been provided to CMS. Instead, a range of rates was provided that encompasses the lowest and highest current rates. If CMS approves this range, it will allow DCF and DVHA to consider additional provider input, determine what the CIS appropriation is for SFY 2021, and refine the rate as more information becomes available.

- Response Rate: While CDD could not compel providers to complete the survey, state program staff articulated the importance of doing so verbally and in writing on a number of occasions. In addition, Burns & Associates and state program staff responded to multiple provider questions, reminded providers of the importance of participating, worked closely with fiscal agents and subcontractors to validate the data, and ultimately extended submission deadlines for several providers, all in an effort to obtain the most accurate and complete information.

  Recognizing that not all providers submitted a survey and those that did submit a survey did not always complete every form or may have reported erroneous data, the analysis of the survey data sought to report the most accurate results. Specific strategies include the exclusion of providers from calculations when incomplete data was provided (for example, the calculation of administrative rates requires both cost and revenue data so if a provider reported one but not the other, they were not part of this section of the analysis), the exclusion of 'outlier' responses (defined as more than two standard deviations from the mean), and identification of data points that only included responses from a few providers. These strategies increased the reliability of the data.

  Further, the provider survey was only one of the data sources used in the development of the rate models. For example, the wage, benefit, and caseload assumptions for direct care workers – which comprise 60 percent of the total rate – are primarily *not* derived from the provider survey, but from other sources such as the Bureau of Labor Statistics and caseload data previously reported by providers.

  Finally, the comment period is intended to offer an opportunity for providers and other stakeholders to review the assumptions and offer suggestions for potential changes.

- Caseload Targets: Caseload projections are a key component of the rates and contract totals proposed

for July 2020 implementation; they are based on information reported by providers. Regions are not being asked to serve more clients; contract totals are based on the population that each region reported they already serve. The State is structuring contracts in such a way as to ensure that reimbursement can be made for all clients served, rather than setting an expectation that regions regularly continue to be required to serve clients without reimbursement once the contract totals have been drawn down. The State will have additional utilization data in time for the January 1, 2021 contracts, and the intent is to use that information to adjust contracts.

The rate model is intended to reflect the reasonable costs of providing CIS services based on assumed staffing requirements in relation to enrollment levels. For example, the rate model funds one early interventionist for every 30 children enrolled in the CIS program, inclusive of those children who do not receive early intervention services. Providers are only permitted to bill for children whom they serve; if they serve fewer children than anticipated, their payments would be less than projected. The presumption is that providers' costs will be lower when they serve fewer children. Relatedly, providers have flexibility in how they staff their programs. As noted in the example above, the rate model funds one early interventionist for every 30 children, but providers could staff based on one early interventionist for every 32 children, which provides some cushion for minor fluctuations in caseloads.

- Regional Variation: Burns & Associates' analysis of regional variation was not limited to the provider survey. For wages – which account for the single largest cost in the rate models and which should be most affected by the cost of living issues cited – B&A considered Bureau of Labor Statistics data that demonstrated few differences across the State. That documentation was included in the information shared with providers. On this basis, there was not a justification for a regional adjustment factor.

  B&A also considered potential mileage differences, which were primarily evaluated based on the provider survey. In this instance, there were some differences, but the rate model generally reflected the higher reported mileage levels. Thus, if a regional adjustment factor was added, it would likely produce a lower rate for some regions, while maintaining the same rate in others. For this reason, and because mileage comprises less than four percent of the total rates, a regional adjustment factor was not deemed necessary.

- Reallocation: Unmet need was a factor in the analysis of provider survey results and development of the proposed rate. Specifically, caseload assumptions were adjusted downward to reflect unmet needs (that is, individuals not receiving as much services as they could benefit from). As noted above, the rate models fund one early interventionist for every 30 children enrolled in CIS. In comparison, staffing levels reported through the provider survey and current caseload data suggest existing staffing of one early interventionist for every 34 enrolled children. For each service included in the bundled payment, caseloads were lowered (that is, staffing was increased) by about ten percent.

  Regarding service mix, DCF and DVHA are assuming that children and families throughout Vermont should have access to similar services if needed; there does not appear to be a rationale for providing different services or service mixes to families in different parts of the State. However, the CIS model does allow for regional decision-making regarding allocation of funding between different service areas to best match the needs and resources of the region. This flexibility remains in the program regardless of payment reform.

- Regional and Organizational Impact: Based on current funding, CDD has proposed a statewide rate of $501.66. This rate would result in 4 CIS fiscal agents experiencing an increased contract total and 5 fiscal agents experiencing reduced contract total. Chittenden County is one of the regions that would

experience a reduction, equaling $216,958.02 over a 12-month period (an estimated 7.6% reduction from current levels). DCF and DVHA recognize this impact and appreciate the effort that these two commenters are making to develop estimates of the impact on staffing and services. DCF and DVHA are interesting in maintaining open communication as the Chittenden County partners continue to evaluate impact.

COMMENT 8

Washington County
Family Center of Washington County (Joe Ferrada)

This calendar year, our first year in the bundle, you increased our caseload in July by 18.4% and now you are proposing increasing our caseload by another 24.5% starting next July 1st, all without any additional funding thereby decreasing our case rate per client served. And you justify it by telling us that it's what the budget can afford. Regarding the proposed payment of $501.66 you state that it prioritizes each child served. If that's it the case, look at what the current encounter data is telling you - our caseload over the last 3 months is averaging 207 clients which means our payment should increase by 36% starting July 1st, 2020 or else our case rate will be $368.36. Please look at what the current data is telling you - all clients served is different from all client billed - we are not able to bill for all clients served and you all know that. Please pay us for all clients served in all bundled services, not just the ones we can bill for. Thanks.

Response to Comment 8: Caseload projections that are a key component of the rates proposed for July 2020 implementation are based on information reported by providers, including Washington County providers. The goal in updating and standardizing the rates across regions is to create equity and recognize the number of children and families being served. Total contract funding is projected to be essentially level for Washington County from July through December of 2020, with an expectation that the region will continue to serve the same population they have reported serving in six months of data submission, averaging 153 clients per month. The State will have additional utilization data in time for the January 1, 2021 contracts, and the intent is to use that information to adjust the regional allocations.