Department of Disabilities, Aging & Independent Living

Developmental Disabilities Services Division

Legislative Report – Related to the Progress Implementing the DS Payment Reform Model

In accordance with:

Act 27 (2025) E.333: Report on or before February 15, 2026 to the House Committee on Appropriations and the Senate Committee on Appropriations on the progress implementing the Developmental Services payment reform model.

Submitted to:	The House Committee on Appropriations The Senate Committee on Appropriations
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Introduction

The Department of Disabilities, Aging and Independent Living/Developmental Disabilities Services Division (DAIL/DDSD) has worked diligently with key partners, including individuals with lived experience, families and guardians, advocates, and providers such as Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Case Management Organizations (CMOs) to create a deeply collaborative, interdependent system designed to ensure conflict-free processes. A fundamental component of Vermont's conflict mitigation strategy has been implementation of a new payment model. The core pillars of this model are:

- Transparency,
- Accountability,
- System standardization,
- Choice,
- Access to high quality services.

Conflict of Interest Mitigation

Implementing an updated funding process and a new payment model are an integral part of the State's conflict of interest mitigation strategy in response to the 2014 Centers for Medicare and Medicaid (CMS) mandate. Through the Agency of Human Services (AHS), Vermont submitted a Corrective Action Plan (CAP) in 2021 to address compliance issues related to the State's Home- and Community-Based Services (HCBS). This CAP was accepted in 2023.

Generally referred to as "conflict-free case management", in the Developmental Services Home- and Community-Based Services (DS HCBS), conflict-mitigation required addressing more than the service delivery of case management services. Because of the inherent system design, "one-stop shopping", DAs—and to a lesser extent SSAs—controlled all aspects of the DS HCBS process: starting with eligibility determination and ending with the development of funding proposals and setting regionally based rates.

To correct for the conflict within this approach, the DDSD implemented an independently administered, validated assessment tool. This tool, the Supports Intensity Scale for Adults (or SIS-A) provides a standardized method to determine needs for individuals receiving DS HCBS.

- Introducing an independent party to administer this assessment removes potential conflict and increases consistency across the State. This new approach addresses the long-standing concern that some areas of Vermont were able to access increased services for people based on DA/SSA staff's ability to communicate information.

The DDSD also needed to unwind the components of the previous system where DA/SSAs prepared funding proposals on behalf of individuals. Under the old model, an individual would work with their service delivery provider (DA/SSA or Direct Service Organization—DSO) to determine the set of services to best meet their needs and the DSO would assign the costs correlated with these services to present to the State Funding Committee. The inherently conflicted points in this process were:

- By the service provider directing the conversation with an individual related to the services to meet a person's needs. Based on availability of services, a DSO might influence plan development, and

- By allowing agency set rates, versus State set rates, there was a lack of transparency, standardization, and consistency in the costs of services within the DS HCBS system.

Implementation Steps

To correct the issues identified in both the Vermont State Auditor's report and the CMS mandate, the DDSD undertook a number of steps:

- Adoption of a standardized needs assessment tool,
- Implementation of zero-paid encounter claims associated with Per Member Per Month (PMPM) billing,
- Provider Network informed rate study to establish State-set rates for DS HCBS supports, and
- Development of a unique and nuanced payment model, designed with significant input and assistance from key partners.

Standardized Assessment Tool

Beginning with a pilot in July 2021, the DDSD implemented an independently administered, standardized assessment tool: the Supports Intensity Scale-Adult (SIS-A) version. This is a well-researched, standardized tool used in multiple states and countries to measure the amount of support people with developmental disabilities need in their everyday lives. The SIS-A focuses on an individual's strengths versus their challenges and is consistent with the system's core values including self-direction, individual choice/control, and person-centered services.

Additionally, Vermont has contracted with a third-party to conduct the needs assessment to ensure consistency, quality of training and maximum independence from the rest of the system. Undertaking this approach ensures the previous conflict within the DS HCBS design is mitigated.

From July 2022 through February 2026, more than 4,420 needs assessments have been completed through the SIS-A. This includes individuals in the DS HCBS population who have received their initial SIS-A needs assessment, as well as those participants who have reached their needs assessment renewal date. See Appendix A for breakdown of needs assessment requests by service provider. This tool operates on a three-year (3-year) cycle for full reassessment, although an Annual Needs Protocol occurs with the individual's case manager to screen for significant changes in a person's needs which might justify a full needs assessment off-schedule. Additionally, individuals (or their guardian) can request an assessment at any time.

By employing a standardized needs assessment and Vermont's tiered funding approach, this model enables the DDSD to analyze data that previously was unavailable. Preliminarily, the Division is able to review housing, authorization and access to services based on an individual's assessed level of need. Prior to the implementation of this approach, the DDSD did not have access to this information and could not view these indicators. Understanding information, at this level, regionally and statewide, will inform policy and quality improvement.

Encounter Data Reporting

To increase the clarity of the payment model, the DDSD instituted zero-paid encounter claims (also known as "Encounter Data reporting") as a component of the Per Member Per Month (PMPM) aspect of payment. This addition allows for greater data reporting and analysis based on the information submitted by providers related to the specific services provided.

To increase provider capacity to meet the Encounter Data reporting requirements, the DDSD invested $750,000 in SFY2020 to the administrative base of the network DSOs with the intention to hire additional staff to perform additional billing activities related to this requirement. In that same year, the Legislature appropriated $1,500,000 to support DA/SSA electronic health record development. Encounter Data reporting was formally adopted in SFY2022 but not included as part of the payment structure until SFY2026.

The intervening years were considered an opportunity for DA/SSAs to develop their infrastructure and staff resources; during this phase-in period, provider agencies were held harmless from the impact of the quality and quantity of their reporting.

Rate Study and Development of Standardized State Set Service Rates

To create a set of standardized rates for the services offered through DS HCBS, the DDSD undertook a rate study, with the assistance of a consultant—Burns and Associates—to understand the associated costs. Vermont embarked in the initial study in 2019, with a proposed rate study produced in July 2019. As work continued to implement the payment model, COVID-19 struck and resources were redirected due to the impact of global pandemic on the developmental disabilities services system.

As the service system readjusted to life post-pandemic, efforts to implement the DS Payment Reform restarted. Following the emergency-driven hiatus, it was determined that based on passage of time and change in underlying factors, another rate study, using the same consultancy

group, was warranted. This new study was conducted in 2023-2024 with a proposed fee schedule and payment model unveiled in May 2024. In addition to use of information from across the provider network, this rate study is anchored using data from the Bureau of Labor Statistics. This ensures that the resulting rates within the model are comprehensive, current, representative of the entire labor market and State-specific.

Throughout calendar year 2024 and into calendar year 2025, the DDSD, provider network and other key partners met regularly to discuss the proposed fee schedule and payment model. The result was necessary adjustments to both the standardized rates and payment approach to ensure stability within the system. Notable changes include:

- Increases to the administrative factors within the services rates to 15% of program and administrative costs, for a total 30% administrative factor built into each service delivery rate, with the exception of the Shared Living Stipend. The Shared Living Stipend has an administrative factor of approximately 38% to account for the services support that direct service organizations provide.
- Adjustments to rates based on fringe costs inclusive of various factors provided by DA/SSAs, including health insurance costs and paid time off.

Based on this collaborative work, the State's final DS HCBS set rates were established in August 2024.

Hybrid Payment Approach: PMPM and FFS Billing

The DS Payment Model implemented on October 1, 2025, has 6 steps:

1) Assessment: Individual level of need is identified as described in the ***Standardized Needs Assessment*** section (see Appendix B).
2) Budget Assignment: Individual receives a budget range based on their residential placement, assessed level of need, and any additional supplied context; budget ranges based on a model service mix priced using the fee schedule (see Appendix C).
3) Service Planning: Person-centered planning process, facilitated by the Case Manager, determines the specific services to approve, up to the limit of the budget range. Each participant is provided with an individualized service plan and corresponding budget. Service planning is expected to address the individual's specific unmet needs, not to maximize the possible budget.
4) Provider Payment Establishment: Individual's service plan is priced based on the fee schedule and a utilization, or service delivery, factor to establish a bundled monthly per member payment rate. This factor is based on each agency's historic demonstration of services provided, as recorded through Encounter Data reporting. Residential supports and fee-for-service billing are paid at 100% of the service rate.
   Additionally, a specified set of DS HCBS supports are paid outside of the monthly payment, through fee-for-service billing.
5) Service Delivery: Providers deliver services according to the person-centered plan and bills
6) Reconciliation: The services actually delivered will be priced based on the fee schedule; if

providers do not deliver the services for which they are paid, they must repay the state.

Supports included in the monthly per member per month payment include residential supports, community supports, employment supports, and self/surrogate directed supports, including but not limited to respite (i.e., ARIS-paid services). Services which were moved out of the monthly PMPM payment and to fee-for-service billing include Clinical Assessment, Therapy, Behavioral Support, Assessment, Planning, and Consultation, Medication and Medical Support and Consultation, and Other Supportive Services.

In addition to the service mix established by an individual's person-centered planning and resulting Individual Support Agreement, the model includes a "flexibility factor" and "risk corridor", both intended to support the need to nimbly serve individuals with intellectual and developmental disabilities in their homes and communities. The "flexibility factor", currently set at 5% of the agency's per member per month billing. These dollars are essentially funding to support any approved Medicaid program need or support. This would include group-based community programs, Medicaid allowable crisis response, or short-term service delivery. This aspect of the model is not tied to delivered service.

The one-sided "risk corridor", set at 3% for SFY2026, provides additional financial protections for agencies during the reconciliation process. If service delivery is less than 3% of the agency's established utilization factor, the difference in utilization is not subject to reconciliation. Or, simply put: if Agency A has a utilization factor of 75% and delivers 72% of services, Agency A is held harmless from reconciliation.

Next Steps: Process Analysis and Improvement and Reconciliation

The DDSD considers the current period following "go-live" on October 1, 2025, as "Early Implementation and Stabilization" of conflict-of-interest mitigation and the new payment model. Between May and October 2025, individuals (and guardians, as applicable) chose a Case Management Organization and met with their case manager. By the end of October, 98% of individuals engaged in DS HCBS had a chance to become acquainted with their new case manager. As the Fall progressed, relationships have deepened and the teams have had continued opportunities to grow.

As part of implementation, the Division acknowledged that populations of individuals would have existing service mixes that fall outside of their assessed level of need funding maximum. A validation study, undertaken in partnership with DA/SSA staff, in calendar year 2023, indicated that approximately 15% of individuals engaged in DS HCBS would meet this definition. This is not to suggest that this population is receiving a higher level of support than is necessary to meet their needs. There are specific needs that are not captured through the standardized needs assessment.

To address this, the Vermont Payment Reform Advisory Committee developed a "context document" containing specific topic areas, and detailed questions, that provide additional

information to support a mix of services that would exceed a person's needs assessment funding maximum.

- Examples of needs that might cause this include 2-to-1 (2:1) staffing or criminal justice and public safety related support needs. These aspects of a person's support profile are not specifically addressed through the SIS-A. The DDSD developed the Exceptions Request process as a mechanism to manage these funding needs.

Exceptions Requests

Based on service authorization information data collected from the Direct Service Organizations, provided for State Fiscal Year 2026 (SFY2026), and needs assessment information from the SIS-A assessment performed for individuals enrolled in the DS HCBS, the DDSD calculated that roughly 460 participants have service mixes that exceed the Standardized Funding Maximum. This represents less than 15% of the total participants enrolled in DS HCBS (3,394 individuals in SFY2024); See Appendix D. This data parallels that of the validation study undertaken prior to implementation, in calendar year 2023, further corroborating the methodology.

The Exceptions Process is a team-based funding request, prepared and submitted by the Case Manager. In conjunction with the individual (and their guardian, as applicable), the Case Manager creates a request that describes the necessary supports to meet the individual's needs and details the associated costs. This request is submitted to the State Funding Committee for review. As detailed in the Vermont State System of Care Plan for Developmental Disabilities Services, the State Funding Committee consists of DDSD staff including but not limited to the DDSD Specialist Team, DDSD Quality Management Unit representatives, the DDSD Nurse Specialist, and policy team members. Recommendations from this Committee are forwarded to the DDSD Director, or designee, for final review and determination.

To provide adequate time for individuals (and their guardian, as applicable) to review information specific to their services, during early implementation, the DDSD extended transitional funding through January 31, 2026. This allowed:

- Additional time for individuals to establish relationships with their newly assigned Case Manager,
- Meet as a team to discuss current needs and available funding, and
- Determine if an Exceptions Request was appropriate.

Appendix E contains data related to the number and status of Exceptions Requests submitted to the DDSD.

To monitor the success of implementation, the DDSD continually connects with key partners to gather information. The information gathering, both informal and structured, comprises the backbone of the assessment and analysis the DDSD is engaged in. Working collaboratively with

Case Management Organizations and the provider network, the DDSD has been prioritizing updating existing policies and guidelines to address the DDS system new processes and design, the implementation of the new payment model and provide role and responsibility clarity. The policy and standard revisions have also provided an opportunity to revisit best practices within the Developmental Disabilities Services system. To receive feedback, the DDSD meets with Case Management Organizations to provide technical assistance weekly. This provides a forum for questions to be posed and issues to be raised. Additionally, there is a weekly "drop-in" session to provide a similar opportunity to all providers within the network.

To connect directly with individuals with lived experience, the DDSD has monthly conversations through the DAIL Advisory Board, the Developmental Services State Program Standing Committee and a "Coffee Talk" session with members of the Green Mountain Self-Advocates (GMSA). The DDSD has established meetings with the Vermont Developmental Disabilities Council to expand connections with individuals, families, guardians, and advocates.

Additionally, outreach from key partners to the DDSD is made directly as concerns arise. As the payment model went live, initial concerns related to the timelines for processing the Per Member Per Month (PMPM) component were raised. Without an acceptable contingency plan, for when reviewing and approving authorizations by the Case Managers and the DDSD requires additional time, the Direct Service Organizations expressed apprehension related to their financial health. As a solution for this issue, the DDSD employed a safeguard, allowing agencies to bill the previous month's PMPM rate. As the variations in the agency's aggregate PMPM are generally modest, this approach has been effective in addressing the challenge. During reconciliation, discrepancies will be accounted for, and authorized services will be paid.

Throughout the month of January 2026, the DDSD has engaged the DA/SSAs in a review of services delivery/utilization factor review. The current factor is based on SFY2024 Encounter Data reporting; this data had been analyzed and cleansed to be useable. A review of SFY2025 authorized services data provided by the Department of Vermont Health Access was generally aligned with the previous year's study. Additionally, consideration of systemic changes, to improve the efficiency of these processes for the future have been identified and are under consideration internally.

Next Steps

As the DDSD continues through the Early Implementation and Stabilization Phase of the new payment model, open and multidirectional communication is imperative. Only through this continued collaboration will it be possible to maintain the tradition of responsive, person-centered supports that have been the hallmark of the Developmental Disabilities Service systems.

Building off the lessons learned through the January 2025 service delivery/utilization factor review sessions, the DDSD will assess areas in the model to adjust to create greater efficiency, especially as it relates to reconciliation, an agency's financial position, and potential liability.

Questions that have been identified have been:

- Encounter Data reporting related to agency-managed subcontracts,
- ARIS-directed supports and the reconciliation process, and
- ARIS-directed supports and the Direct Support Organizations' potential risks and liabilities in their limited ability to provide monitoring as the Medicaid provider of record.

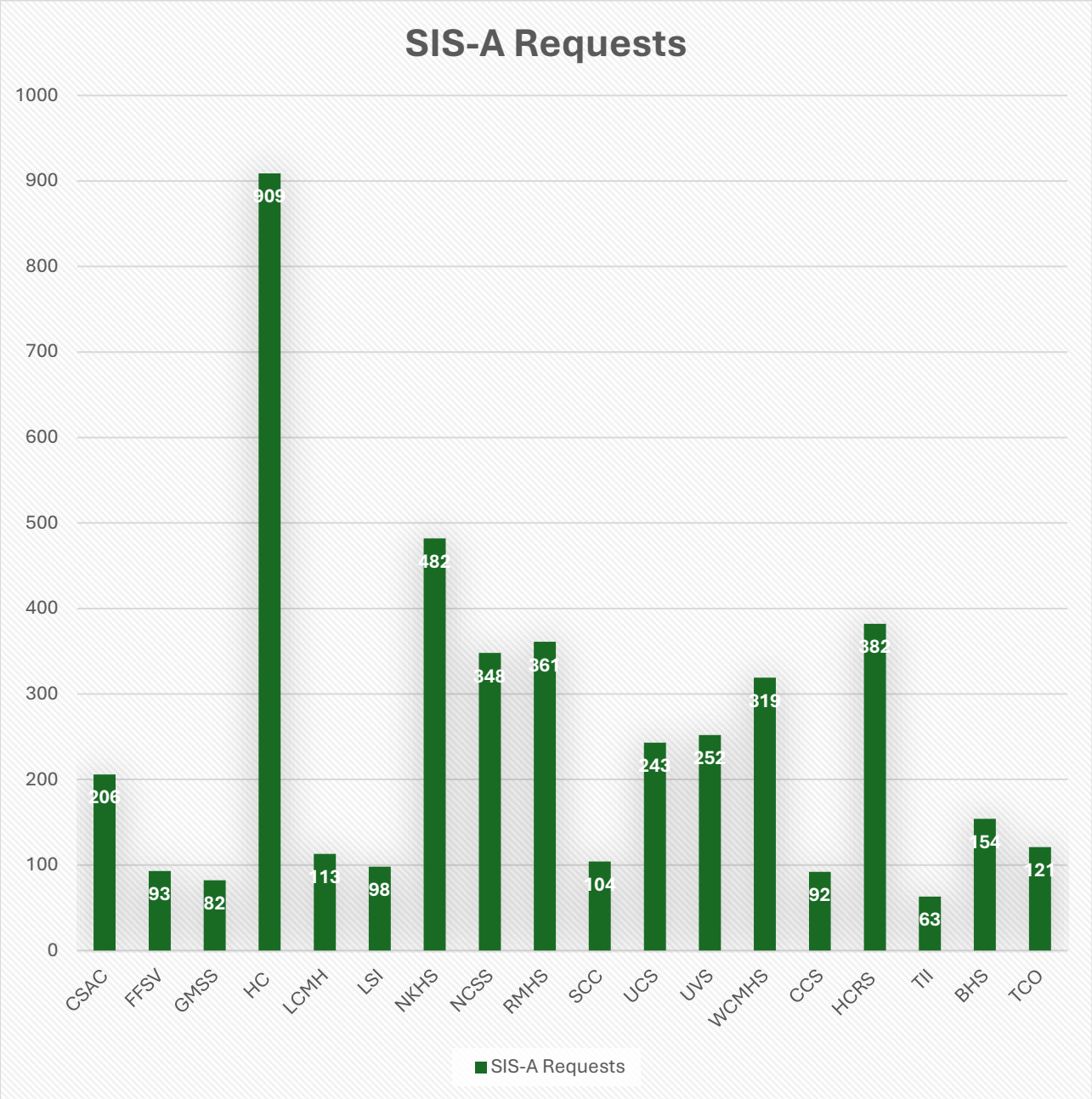
Additionally, concerns were raised during this Early Implementation phase, around ramifications from the required changes in the management of the Individual Support Agreements (ISAs), and the potential liability it creates for Direct Support Organizations. The Department responded and addressed these concerns in alignment with CMS rules.

Within the functioning components of Conflict-Free Case Management and the new Payment Model, the DDSD will continue to work through other challenges identified, such as the natural changes in timing and processes created through the deconflicting of services. The DDSD will continue to identify allowable solutions, in partnership with Case Management and Direct Services Organizations, to alleviate impacts on individuals engaged in services. These solutions will be documented in policy and standard to ensure necessary direction and clarity for all those interested. All DDSD policies and standards are assigned a timeline for which they will be reviewed, generally annually, but updates can be made as necessary.

With the addition of the DDSD data analyst positions, Encounter Data claims, information from the standardized needs assessment, and the detailed information from the authorizations, the DDSD will evaluate the new payment model as well as trends within service delivery and provide valuable insights for quality assurance and improvement activities. These expanded resources will allow the DDSD to provide transparent reporting internally and externally. The advent of a fully functional database, building off of the nascent phase of the Division's document repository (DDSD Client Record Management System or CRMS) will enhance this goal.

Appendices

Appendix A: Breakdown of SIS-A Requests by DDS Service Provider



Appendix Vermont's Supports Intensity Scale Levels of Need

Level	Description	Support Needs Index	Med. Support (Sec. 1A)	Bx. Support (Sec. 1B)
1	Low general support need, no extraordinary medical or behavioral needs	71 or less	6 or less	10 or less
2	Moderate general support need, no extraordinary medical or behavioral needs	72 - 88	6 or less	10 or less
3	High general support need, no extraordinary medical or behavioral needs	89 - 106	6 or less	10 or less
4	Very high general support need, no extraordinary medical or behavioral needs	107 or More	6 or less	10 or less
M	Extraordinary medical support need	Any	7 or more OR Verified Need	10 or less
B	Extraordinary behavioral support need	Any	Any	11 or more OR Verified Need

Appendix C: Level of Need Standardized Funding Maximums

Residential Setting	Living Independently	
Level		Standardized Annual Funding Maximum
1	Low general support need	$59,660
2	Moderate general support need	$93,152
3	High general support need	$106,208
4	Very high general support need	State review for this level
M	Extraordinary medical support need	State review for this level
B	Extraordinary behavioral support need	State review for this level

Residential Setting	Living with Natural (Unpaid) Supports	
Level	Description	Standardized Annual Funding Maximum
1	Low general support need	$56,940
2	Moderate general support need	$100,192
3	High general support need	$126,368
4	Very high general support need	$145,888
M	Extraordinary medical support need	$165,408
B	Extraordinary behavioral support need	$165,920

Residential Setting	Shared Living	
Level	Description	Standardized Annual Funding Maximum
1	Low general support need	$112,146
2	Moderate general support need	$154,026
3	High general support need	$175,471
4	Very high general support need	$256,179
M	Extraordinary medical support need	$262,899
B	Extraordinary behavioral support need	$283,179

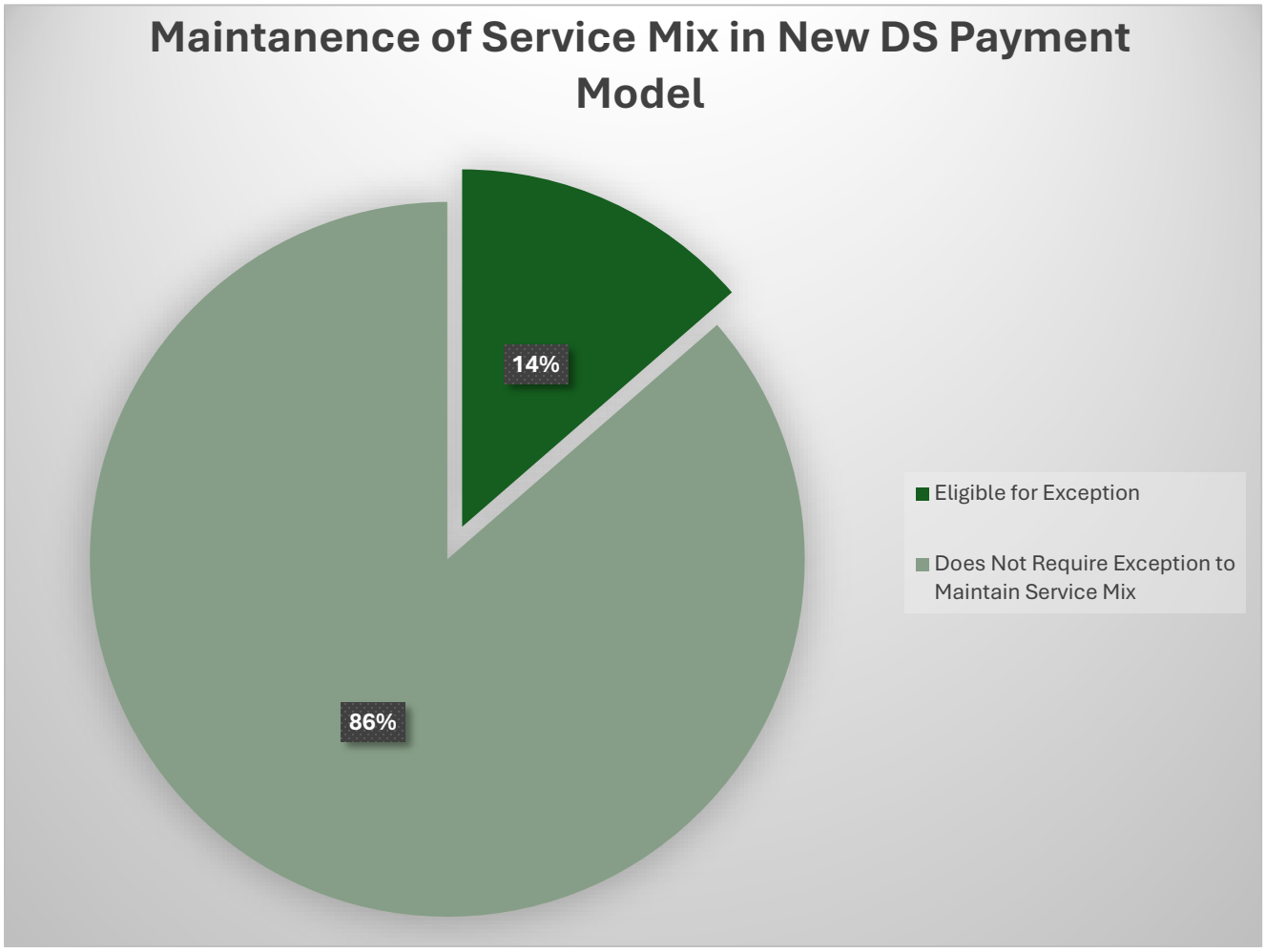
Residential Setting	Group Living (3-4 Bed Home)	
Level	Description	Standardized Annual Funding Maximum

1	Low general support need	$209,556
2	Moderate general support need	$254,901
3	High general support need	$300,280
4	Very high general support need	$327,936
M	Extraordinary medical support need	$327,936
B	Extraordinary behavioral support need	$362,528

Residential Setting	Group Living (5-6 Bed Home)	
Level	Description	Standardized Annual Funding Maximum
1	Low general support need	$195,726
2	Moderate general support need	$239,411
3	High general support need	$254,918
4	Very high general support need	$277,044
M	Extraordinary medical support need	$277,044
B	Extraordinary behavioral support need	$310,636

Residential Setting	Staffed Living	
Level	Description	Standardized Annual Funding Maximum
1	Low general support need	$471,088
2	Moderate general support need	$476.052
3	High general support need	$477,176
4	Very high general support need	$477,176
M	Extraordinary medical support need	$477,176
B	Extraordinary behavioral support need	$484,108

Appendix D: Percentage of People Who Are Able to Maintain Current Service Mix Based on Outcome of SIS-A Assessment


Maintanence of Service Mix in New DS Payment Model
14%
86%
Eligible for Exception
Does Not Require Exception to Maintain Service Mix

Appendix E: Exceptions Request Data, as of February 11, 2026

Exception Data	
Status Description	**Number of Proposals**
Pending Review Continued benefits preserved	286
Returned for Additional Information More Information Necessary to Support Determination	105
Reviewed Request Approved	55
Reviewed Request Denied	4
Total Requests Submitted	**450**