DAIL HCBS Conflict-of-Interest and Payment Reform Overview

House Human Services Committee
February 11, 2025

What are the components of Conflict of Interest (COI)

Independent Intake, Eligibility, and Referral

- Move to a centralized approval

Independent Needs Assessment

- Use of a standardized, norm referenced tool (SIS-A) for individuals aged 16 and older
- Use of a standardized assessment for Brain Injury Program participants

Separate Case Management activities from Service Coordination

- Notable person-centered planning and ISA development

Alignment with State’s philosophy and core values

- Especially person-centered, respect, and leadership

Compliance with federal requirements

What are the components of Conflict of Interest (COI) – Choices for Care

Independent Intake, Eligibility, and Referral

- Intake and Eligibility determination completed by Adult Service Division Registered Nursing staff (Long Term Care Clinical Coordinators - LTCCCs)
- Options Counseling provided by State LTCCC
- Referral to Local Area Agency on Aging for Case Management, Enhanced Residential Care, or Nursing Home
- Annual utilization review and continued eligibility determination completed by State LTCCC

Independent Needs Assessment

- Case management agency use of a State approved assessment tool (ILA) to develop a person-centered care plan and individualized service plan for all Choices for Care and Brain Injury Program participants.

Separate Case Management activities from AFC Service Coordination and FC Advisor Services

- Notable person-centered planning and development
- Independent Options Counseling

Changes to Developmental Services Intake/Eligibility/Referral

Separate these roles from the Designated Agency

Working to develop an independent, centralized contract for intake, eligibility and referral to case management entities

Eliminate perceived or implicit bias related to intake and eligibility

Will ensure standardized and impartial referral information for referring individuals to case management options

Changes to CFC Eligibility/Referral

Separate annual assessment and person-centered care development from the role of Adult Family Care and Flexible Choices Agency

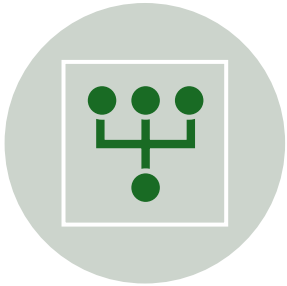
Case manager coordinates the annual assessment with the participant's team and provides choice counseling for all CFC HCBS service/settings options

Eliminate perceived or implicit bias related to continued eligibility and choice counseling

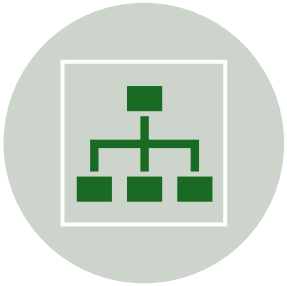
Will ensure standardized and impartial referral information for referring individuals to Choices for Care options

New Developmental Services Independent Needs Assessment Process

Adopted the Supports Intensity Scale—Adult (SIS-A)



Established an independent Needs Assessment process in 2022 by contracting with an outside organization (PCG)



Ensures that the entity providing the services is not the entity assessing the needs of the individual

Independence of the assessor removes the potential for partiality

Case Manager Roles and Responsibilities

Assessing and Planning

Person Centered Planning process/ISA, planning around supports to be provided, etc.

Identifying and Linking to Supports

Choosing Support provider agencies, types/amounts of support

Coordination

ISA/PCP implementation, support collaboration, facilitate or support individual to facilitate team meetings, problem solving, changes in services

Monitoring

ISA implementation, satisfaction, health & wellbeing, service utilization

Advocacy

Expectations of Brian Injury and Developmental Disabilities Case Manager/Case Management Entities

- Frequency of visits based on need
- Required to have ***at least*** one in-home visit annually
  - Number of in-home visits increase with acuity and/or residence.
- Case Management Entities are statewide organizations and must have an in-state presence
- Case Managers must be located within 60 minutes or 60 miles of the individuals that they support
- Caseload sizes will vary based on the needs of the individuals supported
  - Estimate that caseloads will be around 32
  - Significantly smaller than caseload sizes nationwide

Expectations of Case Manager/Case Management Entities – Choices for Care

5 Area Agencies on Aging provide case management to all CFC participants in designated geographic area.

Frequency of visits based on need.

Minimum of monthly Contact

Face-to-face visits not less than once every 60 days.

Required to have ***at least*** one in-home visit annually

Number of in-home visits based on acuity and participant preference

Face to Face Visits required at least every 60 days

Caseload sizes vary based on the needs of the individuals supported

Estimated caseloads not to exceed 50

Caseload impacted by client acuity – High/Highest/MNG

Future role of Service Program Managers

- Moving to Program Management
- Flexibility to meet each agencies' specific needs
- Focused on the supports provided within the agency
- Hiring/Training/Supervising staff
- Monitoring shared living homes/SLP contracts
- Ensuring Direct Support Staff are collecting information related to outcomes in ISA

Major Goal: Achieve Federal Compliance

Vermont has been working on a plan for Conflict-of-Interest compliance for about 10 years

One of the last states in the country to meet the requirements

Under a Corrective Action Plan with Centers for Medicare and Medicaid (CMS) to meet the requirement

Must come into compliance by May 2026

Brain Injury and Developmental Disabilities Conflict-of-Interest: Current Timeline

February 2025

- Announce number of Case Management Entities (CME)
- Begin contracting process

April 2025

- Execute contracts
- Announce CMEs
- *Tentative*: Begin Referral component of I/E/R contract

May 2025

- Open house opportunities to meet CMEs
- Begin enrollment process

June 2025

- Enrollment deadline
- Auto-enrollment

July 2025

- Transition meetings begin
- Initial SIS-A assessments complete
- Funding assigned based on SIS score

September 30, 2025

- Transition period ends
- Last day for Service Coordination to be encountered

October 1, 2025

- Case Management begins as billable service
- Service Coordination converts to “program management”

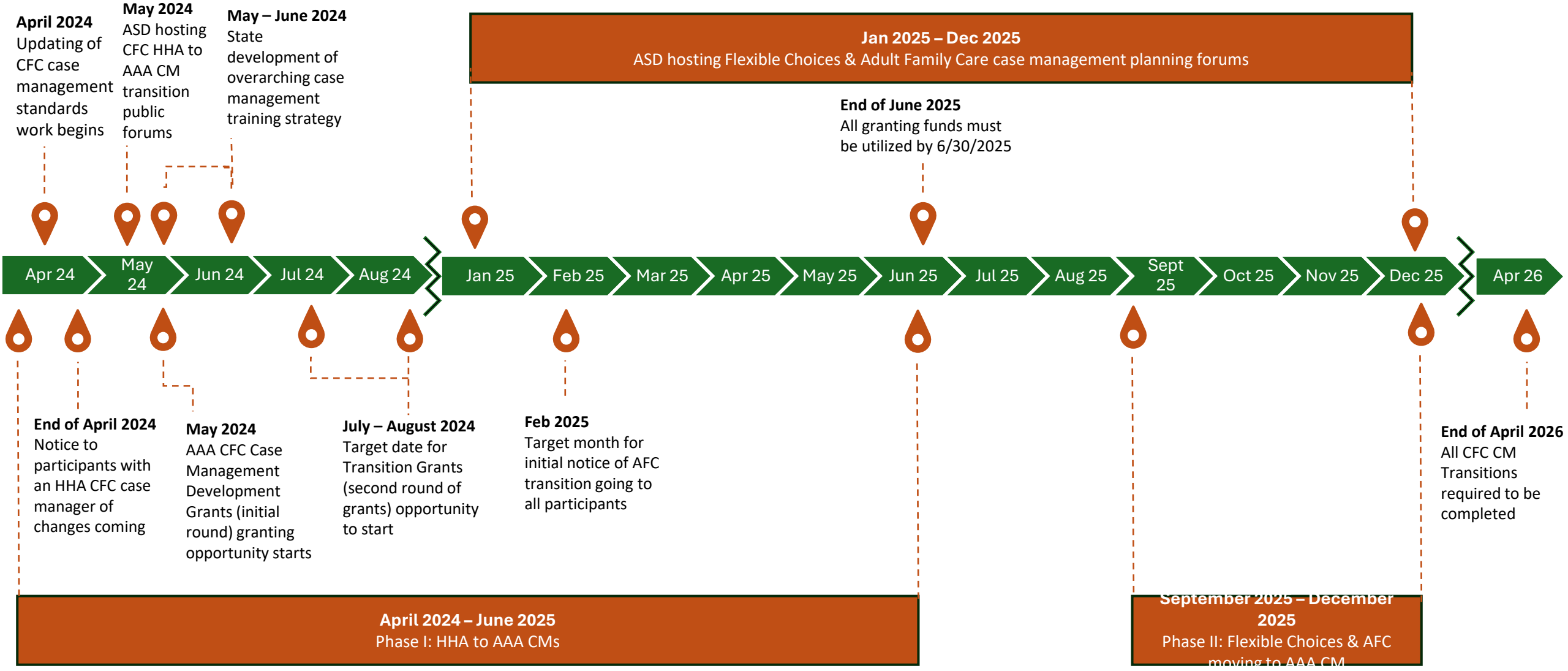
December 2025

- Transition process ends
- Transition grant funding must be expended

April 2026

- Vermont must reach full compliance with COI

CFC Transition Planning Timeline



Conflict-Free Case Management

Conflict Free Case Management meets federal Corrective Action Plan

Separate entiies to provide intake, needs assessment, case management and direct service

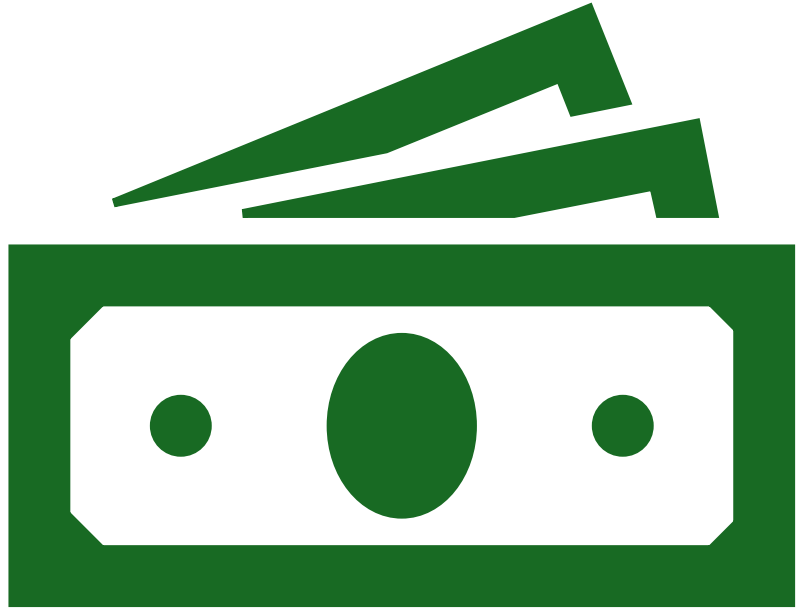
Conflict Free Case Management Considerations and Focus of Transition

Transition grants for both incoming Case Management Entities and existing Direct Service Organizations

Continue the ongoing meetings with providers

Expand the communications with individuals and family

Payment Reform Overview



Why is Payment Reform Happening?

The DS Payment Reform project began in January 2018 in response to State audit findings.

The current DS payment system does not have standardized rates or needs assessments and lacks the ability to account for all services provided and associated spending Lack of adequate direct care workers is affecting service delivery, while the current payment and monitoring system is not able to validate individual budgets and services or track outcomes.

The new model is designed to incentivize service utilization and identify gaps to improve quality and service delivery.

Goals of Payment Reform

Transparent

Easily described and understood

Effective

Create a payment model that supports people getting appropriate services to meet their needs

Equitable

Resources are available in a similar way across the state

Accountable

State can identify what services were delivered to people

Sustainable

Pay providers reasonable rates for delivering services

High Level Overview of the Future Process

Complete the SIS-A and identify level of support, 6 different levels.

Individual receives a budget range based on their residential setting, SIS-A level of support, and ‘context’; budget ranges are based on a model service mix priced using the fee schedule.

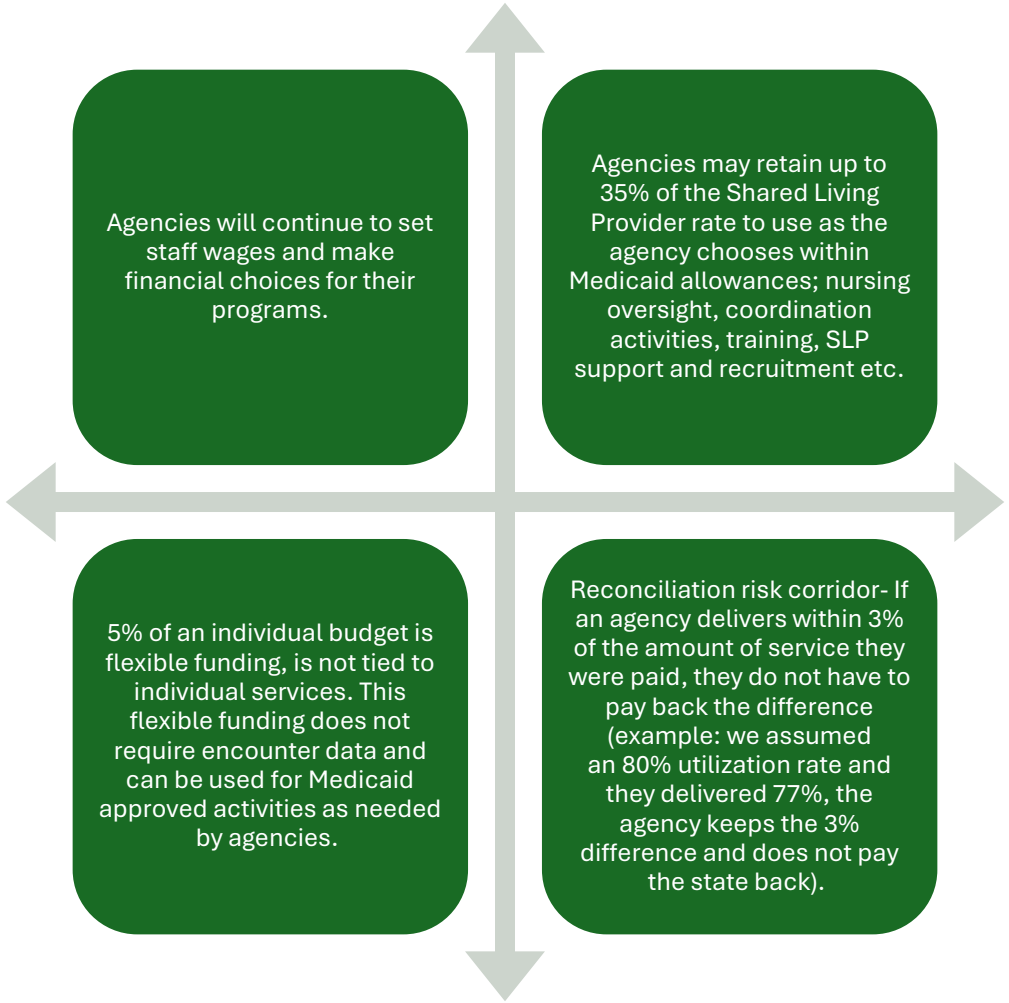
Person-centered planning process to determine the specific services to approve, up to the limit of the budget range. If the budget range does not meet the needs, the case manager can request an exception.

Agency’s monthly payment is calculated based on individual service budgets and a utilization factor (how much service the agency can deliver) to establish a bundled monthly payment amount (some services will be paid outside of the monthly payment).

Monthly data reports continue to be sent to agencies, and quarterly meetings are held to monitor service utilization. This will allow for more accurate payments to agencies, reducing risk of large over or under payments.

Reconciliation process—If providers do not deliver the services for which they are paid, they must repay the state. If they deliver more service than they were paid for, the state will pay the agency if the services were approved in individual budgets.

Flexibility Within Agency Budgets



Levels of Support- SIS-A Scores

Level	Description
1	Low general support need, no extraordinary medical or behavioral needs
2	Moderate general support need, no extraordinary medical or behavioral needs
3	High general support need, no extraordinary medical or behavioral needs
4	Very high general support need, no extraordinary medical or behavioral needs
M	Extraordinary medical support need
B	Extraordinary behavioral support need

Transition

- Throughout the process, there has been a regular flow of information, including concerns, that we continue to address. We appreciate that transitions can be challenging. Our goal is to mitigate the anxiety and appreciate the complexity of this transition.
- Have worked, and continue to work with the provider network closely to address areas brought to our attention by key partners in order to provide the greatest amount of stability.
- Agency and system wide financial estimates rely on data submitted by agencies.
  - Some agencies are more skilled at reporting timely and accurate data than others.
  - Currently working on analyzing FY '24 data which is more complete FY '23 data due to technical assistance.
- It is a lot of information for people to take in and understand. Working with advisory groups to help DAIL understand how to share information in an accessible way and prepare for public comment this spring.

Payment Reform

Rates will be standardized and based on the rate study

Payments to providers will be transparent

Services delivered to individuals will be transparent

Providers will be paid for services delivered

DDSD will be in compliance with state and federal rules to account for all services and associated spending

Reliable monthly payments to providers

Opportunity for improved data collection and quality improvement

For More Information

DAIL HCBS Conflict of Interest:
https://vermonthcbs.org/

DAIL/Developmental Disabilities Services Payment Reform:

DDS Payment Reform | Developmental Disabilities Services Division