REVIEW OF HOME AND COMMUNITY BASED SERVICES (HCBS) PAYMENT METHODOLOGIES AND RATES

PUBLIC COMMENTS AND RESPONSES

DEVELOPMENTAL DISABILITIES SERVICES DIVISION

DECEMBER 17, 2019

INTRODUCTION

The State of Vermont provides Medicaid-funded home and community-based services to persons with intellectual and developmental disabilities through the Developmental Disabilities Services Division (DDSD) within the Department of Disabilities, Aging and Independent Living (DAIL). Services are delivered through 15 contracted designated agencies and specialized services agencies.

Providers currently receive a unique bundled daily rate for each individual they serve based on the services included in each individual's approved service plan. Various concerns have been expressed related to this model, including a lack of consistency across individuals and providers, inadequate payment rates, approved and funded services that are not being delivered, and burdensome administrative requirements. As part of its commitment to economic, flexible, and sustainable provider rates, the State is in the process of a broad payment reform initiative for developmental disabilities services.

The payment reform initiative is multifaceted, including consideration of processes relating to assessing individual needs, service planning, the methodology by which providers are paid, monitoring and reporting service delivery, and DDSD's oversight role. A key component of this initiative is the establishment of a standardized fee schedule that reflects the reasonable costs of providing services consistent with the State's requirements. In order to develop this fee schedule, DDSD has undertaken a comprehensive rate study with the assistance of the national consulting firm Burns & Associates, Inc. (B&A). The rate study encompassed several tasks, including:

- A detailed review of service requirements
- Multiple meetings with service providers and other stakeholders
- Development and administration of a provider survey that was emailed to all providers to collect information regarding service designs and costs
- Identification and research of other available Vermont-specific data to inform the development of the rate models, including cross-industry wage and benefit standards

Based on this work, detailed rate models were developed. The models include the specific assumptions regarding the costs that providers face in the delivery of each service, such as direct support workers' wages, benefits, and billable time; staffing ratios; travel; and agency overhead.

The proposed rate models were released for public comment in June 2019. DDSD and B&A presented the proposals in separate meetings for providers and other stakeholders. Interested parties were given more than one month to submit written comments. Comments were received from Vermont Care Partners, which represent providers; the Vermont Developmental Disabilities Council; Green Mountain Self-Advocates, and several individual stakeholders.

In response to the public comments, DDSD has made a number of changes to the proposed rates:

- Updated wage data to account for inflation and the $14 minimum DSP wage set by the Legislature.
- Increased assumed health insurance costs in the benefits package for direct care staff
- Increased program support funding to 15 percent of the overall rates.
- Changed to an hourly unit of service for case management rather than a monthly unit.
- Added 1:2 and 1:3 rates for 'Individual' Community Supports (B01).
- Changed to a monthly units of service for 24-hour residential services rather than a daily unit.
- Added an hourly Shared Living service to be used to augment the daily Shared Living rates.
- Eliminated the rate model for Job Training (C03); the service will be reimbursed using the rate model established for Employment Assessment (C01) / Employer and Job Development (C02).

The remainder of this document provides DDSD's response to each rate-related comment submitted.

RATE STUDY PROCESS

1. Commenters expressed appreciation for the establishment of a formal and transparent rate-setting structure.

The Developmental Disabilities Services Division (DDSD) appreciates the support for the rate study. The development of transparent rate models is one element of the larger payment reform initiative. The rate models are intended to align payment rates with provider costs, to ensure a common understanding of these cost assumptions, to provide a foundation through which rates can be reviewed and updated over time, and to standardize rates across providers.

In addition to the establishment of a standardized fee schedule, payment reform for developmental disabilities services includes consideration of processes relating to assessing individual needs, service planning, the methodology by which providers are paid, monitoring and reporting service delivery, and DDSD's oversight role. DDSD continues to work with providers and other stakeholders on these components of payment reform.

2. Commenters questioned why the entire payment model has been changed if the root problem relates to service reporting and tracking. Commenters additionally questioned whether standardized rates were needed and if other strategies had been considered.

A 2014 report from the State Auditor found that "DAIL… cannot ensure that clients are receiving the planned services and that the payments being made reflect the services being performed."[1] Consequently, service reporting is a significant component of payment reform.

However, there are other important goals of payment reform. The State must demonstrate that it is compliant with federal Medicaid requirements that payment rates are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[2] It is not clear that current rates comply with this requirement. Presently, there is no uniform process for establishing rates as each provider develops its own rate for each service (other than Service Coordination, the rate for which is set by the State). It is generally agreed that the service-level rates developed by providers do not reflect service costs.

Other goals of payment reform include ensuring that Medicaid funds are being used for allowable services, aligning access to services and payment rates to individual needs, enhancing the portability of individualized budgets across providers, and supporting a fair and sustainable system. The establishment of standardized rate models supports these objectives.

DDSD considered several options prior to opting to move forward with a standardized rate schedule that will be incorporated into some type of bundled payment. DDSD decided against broadly implementing a fee-for-service payment model as this would reduce provider flexibility. DDSD also considered simply adopting the rates reported by providers, collecting encounter data, and reconciling payments to the service delivered. However, it was determined that this would have a negative financial impact on providers.

---

[1] Vermont State Auditor (October 14, 2014). Designated Agencies – State Oversight of Services Could be Improved, But Duplicate Payments not Widespread (Report Number 14-05). Retrieved from https://auditor.vermont.gov/sites/auditor/files/files/reports/performance-audits/Final-DA-report-II10.31.2014.pdf.

[2] 42 U.S.C. 1396a (a)(30)(A)

3. Commenters stated public awareness around the rate study has been minimal and that additional efforts should be made to ensure all interested stakeholders have an opportunity to participate. Commenters also stated there should be a process for incorporating adjustments recommended by public comments and for communicating these changes.

The rate study has been a multi-year process that has included a number of opportunities for the involvement of providers and other stakeholders. There were several meetings with providers to explain the process and goals of the rate study. In addition, the rate study was reviewed with the Statewide Advisory Committee for the Payment Reform project and the Payment Model workgroup. These groups include individuals receiving services, family members, advocates and providers.

Additionally, a provider survey was administered to collect information about the services being provided and the costs of those services. Based on the provider survey and other sources of data, draft rate models were developed outlining specific assumptions related to the cost of providing services.

These proposed rate models were published online and discussed in separate presentations for providers, individuals, families and other stakeholders. An invitation to participate in the presentations was distributed through provider and stakeholder networks. Comments were collected at each presentation. Stakeholders were also given more than a month to offer written comments in response to the draft rate models. This document has been written to summarize the comments that were received as well as DDSD's responses to each.

As DDSD moves forward with the larger payment reform initiative, it will continue to seek the input of individuals, families, advocates and providers. DDSD is seeking advice from stakeholder networks regarding how to engage a broader network of stakeholders.

IMPLEMENTATION

4. Commenters suggested analyses should be performed to determine the impact of the rates on individual providers. Commenters asked how rate models will be phased-in in order to minimize impacts on providers.

Providers currently receive an individual-specific daily payment for each individual who they serve. These payment amounts are calculated based on the services approved in an individual's service plan and service rates set by providers. The resulting value for each service in an individual's plan is added to establish an overall budget for that individual and is divided by 365 to create the daily rate. The figure below illustrates this process.

	Service 1 Cost	=	Est. Units of Service	x	Rate per Unit
+	Service 2 Cost	=	Est. Units of Service	x	Rate per Unit
+	Service 3 Cost	=	Est. Units of Service	x	Rate per Unit
=	Annual Budget				
÷	365 Days				
=	Individual's Daily Rate				

The provider bills this rate each day regardless of whether any specific service is delivered on the day as long as the individual is 'in service' (a provider cannot bill for days during which an individual is in a nursing home, for example).

It is widely understood that, overall, individuals do not receive all of the services included in their budgets and that the per-unit rates are not reflective of providers' costs. In the absence of accurate and complete encounter reporting, the extent of the underutilization of services is unknown. As it relates to the per-unit rates, the rate models have produced rates that exceed those reported by providers.

However, as discussed in the response to comment 1, the establishment of standardized rates is only one component of payment reform. The rate models will not be implemented in the absence of the other components, including encounter reporting. Once the overall structure of payment reform is determined, the impact on individuals and providers will be evaluated and an implementation plan, which could include a phased implementation, will be developed.

5. ***Commenters requested clarification about "the comment that fee-for-service billings related to the current waiver program may be expected." Commenters also requested clarification regarding service tracking as it relates to individual services being provided.***

   As discussed in the response to comment 1, payment reform incorporates several components. The rate models cover one component of payment reform: the establishment of a standardized fee schedule. At this time, the State does not intend to institute fee-for-service billing for the majority of services. Some services that are used by relatively few individuals, such as Therapies, may be reimbursed on a fee-for-service basis. The rates are intended to be used to 'price' the services within an individual budget. Decisions regarding the structure of provider payments – such as a daily or monthly payment, a single bundled payment or multiple payments covering a segment of services, how to establish payment amounts, etc. – have yet to be decided.

   Policies and procedures relating to service tracking and reporting are currently being finalized in the DDSD Encounter Data Submission Guidance. Providers will be expected to report all units of service delivered to individuals according to the guidance. During the initial phase of collection, encounter data will be used for the purpose of helping to design the payment model. Once the payment model is implemented, it is expected that the rates established through the rate study would be used to value encounters in order to reconcile payments to providers with services delivered. The process for reconciliation must also be developed.

   Tracking services delivered has been a long-standing expectation of the developmental disabilities program. The reporting process is being updated to enhance completeness and accuracy. Service tracking is used in other Medicaid programs with bundled payments, including the Department of Mental Health's case rate and the Program of All-Inclusive Care for the Elderly (PACE).

6. ***Commenters questioned the assertion that the cost of paying higher rates for services will be offset by underutilization, stating that most unused hours are due to staffing shortages rather than individuals voluntarily giving up service hours. Commenters expressed concern that services may be reduced to pay for the recommended rate increases in the absence of additional funding.***

   As discussed in the response to comment 4, it is understood that many individuals do not receive all the services included in their approved service plans. This is true in all home and community-based service programs as individuals may choose not to receive services on a given day for a variety of reasons. As posited by the commenters, it is also likely true that some underutilization is due to staffing challenges. Further, utilization rates vary by service. For example, residential services – which account for more than a third of the total value of individuals' budgets – will be almost fully utilized: if an individual is in the home, they have used that service. Other services, such as Community Supports, will be more subject to underutilization due to both individual choices and external factors. Without encounter reporting, the extent to which underutilization is due to 'normal' usage patterns or other factors is unknown.

   As noted in response to comments 1 and 4, the establishment of standardized rate models is only one component of payment reform and will not be implemented in the absence of the other components, including encounter reporting, which will provide greater insights into utilization patterns. The overall structure of payment reform has yet to be determined, but individuals' service plans must still be determined through a person-centered planning process that takes into account their assessed needs. Under all payment models, individuals retain the right to appeal any reduction in service.

Although it is possible that individuals' service plans may change as a result of the new assessment process and/or payment model, DDSD will not reduce the services that individuals use in order to fund higher rates for providers. Rates will be set to stay within the available funds allocated by the Legislature. Any increase in rates that is beyond current appropriations would be subject to the legislative budget process.

7. Commenters questioned how DDSD will ensure members receive the services they need in accordance with personalized planning regardless of rates or what the provider is paid.

Neither the development of standardized rate models nor the broader payment reform initiative changes person-centered planning requirements, which are included in both state and federal regulations and with which providers must still comply. Additionally, individuals have the right to file grievances and appeals when they believe they are not receiving the services they need.

One component of payment reform – comprehensive encounter reporting – will for the first time allow DDSD to monitor whether individuals are receiving the services that have been authorized and funded in their service plans. It is anticipated that DDSD will conduct additional audits on a sample of individuals to determine whether people are receiving services according to their individual service plans.

8. Commenters expressed concern that the rate models do not tie to performance indicators, such as ISA goals, consumer progress and satisfaction, or other measurable outcomes.

Although DDSD shares the goal of improving the quality of services, there is not currently sufficient consensus on what should be measured, how to conduct the measurement, and how to verify measurements: necessary elements for a structure that ties provider compensation to outcomes. For example, individual satisfaction is important, but it is affected by many factors unrelated to payment rates and is not necessarily correlated with service outcomes. These challenges have been observed in a number of reports issued by payers, provider trade associations, and other observers.[3]

DDSD currently has incentive payments based on the achievement of defined employment outcomes, which are easy to define and measure. Like most states, Vermont participates in National Core Indicators to measure overall system performance, but does not tie payment to this survey, which covers only a sample of individuals. DDSD remains interested in working with individuals, providers, and other

[3] See, for example:

The National Quality Forum (2016). Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement (Final Report). Retrieved May 11, 2018 from https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=83433.

Bennett, A., Curtis, P., and Harrod, S. The Milbank Memorial Fund. (July 2018). Bundling, Benchmarking, and Beyond: Paying for Value in Home-and Community-Based Services. Retrieved from https://www.milbank.org/wp-content/uploads/2018/07/MMF-HCBS-Report-FINAL.pdf.

Reaves, E., Musumeci, M. Medicaid and Long-Term Services and Supports: A Primer. Kaiser Family Foundation; 2015. Retrieved from https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/

UnitedHealth Care, Community & State. (May 2016). Quality Improvement for Individuals with Intellectual & Developmental Disabilities: A Proposed Framework. Retrieved from http://www.nasuad.org/sites/nasuad/files/CST11139_IP16_Whitepaper_NAB_ID_DD_050916.pdf.

American Network of Community Options and Resources. (January 2019). Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities. Retrieved from http://ancor.org/sites/default/files/advancing_value_quality_in_medicaid_service_delivery_for_individuals_with_idd.pdf.

stakeholders to explore opportunities to support high-quality services, including innovations in performance and quality measures. It is anticipated that this will be a future phase of payment reform. The first priority of payment reform, though, is to create a transparent and accountable system.

9. Commenters asked whether rates would be updated to account for future changes in the cost of living.

The rate models are structured in a manner that enables DDSD and policymakers to update specific cost assumptions in future years. In particular, the rate models are transparent, using data from a variety of published sources that are updated on annual basis, including Vermont-specific wage data from the Bureau of Labor Statistics (BLS), Vermont-specific health insurance data from the United States Department of Health and Human Services' Medical Expenditure Panel Survey, and the mileage rate from the Internal Revenue Service. As updated data is published, the rate models can be updated – although funding any increase in rates would be subject to the legislative budget process.

10. Commenters suggested there should be mechanisms in place to ensure training and supervision are occurring at approximately the levels assumed in the rate models, expressing concern that these expenses will be sacrificed to cover costs such as fringe benefits that are "underfunded".

As discussed in the response to comment 11, the rate models are intended to represent the reasonable costs of providing services consistent with State's requirements and individuals' service plans. The rate models include funding for infrastructure such as training for direct support professionals and program support (such as supervision), but these assumptions are not intended to be prescriptive. Existing regulations establish minimum training requirements for direct support workers, but at this time, DDSD does not intend to establish additional requirements based on the rate models.

Rather, providers are expected to structure their programs in the manner that best meets the needs of the communities and individuals they serve. It is therefore expected that, for any given provider, some costs will be lower than assumed and other costs will be higher. As it relates to fringe benefits specifically, it is noted in the response to comment 19, that the benefits assumed in the rate models are consistent with current benefits reported through the provider survey.

In addition, the current Quality Services Review process and the Agency Designation process both evaluate agencies' structures and performance related to training and supervision. These processes will continue.

RATE MODEL VARIATIONS

11. Commenter objected to 'one-size-fits-all' rates, stating that agencies are different sizes, operate in different labor markets, and have different internal cost structures.

The existing approach to establishing rates in which each provider develops its own rate for each service has resulted in substantial differences in rates for the same service. Further, it is generally agreed that these rates do not reflect the cost of providing services. The rate study assumes that DDSD should pay the same rate for the same service regardless of the provider delivering the service, an approach that is common across Medicaid in Vermont and in other states.

In order to address the fairness and adequacy of rates, the rate study produced standardized rate models. The assumptions in each rate model are intended to represent the total reasonable cost of providing services. However, these assumptions are not prescriptive and do not dictate providers' internal cost structures. It is expected that, for any given provider, some costs will be higher than assumed in the rate model and other costs will be lower than assumed. For example, a provider may pay a higher wage than assumed in the rate model, but spend less money on administration than assumed.

Even with standardized rates, providers have the flexibility to structure their services – consistent with State requirements and individuals' service plans – in the manner that best meets the needs of the individuals they serve, their communities, and their employees. It is true that once the overall payment model is established and implemented, agencies may need to make adjustments to bring costs in alignment with expected revenues.

12. Commenters stated wages and other living expenses in Chittenden County are higher than the rest of the State, but the rate study provides uniform rates regardless of where services are provided.

Although rates that vary based on the region of the State in which they are delivered were considered, the rate study did not find substantial differences in costs and recommends the establishment of consistent statewide rates.

Providers' single largest category of costs is the wages paid to direct care workers. As discussed in the response to comment 16, the rate models rely on Vermont-specific data from the Bureau of Labor Statistics (BLS) to estimate wage levels. The available BLS data does not support the presumption that wages in Chittenden County are consistently and significantly higher than wages elsewhere in the State.

In addition to state-specific wages, the BLS reports information for regions in each state, which are referred to as metropolitan statistical areas (MSA) and non-metropolitan statistical areas. Every county within a state is assigned to a single MSA or non-MSA. In Vermont, the BLS defines three regions: the Burlington-South Burlington MSA (which includes Chittenden, Franklin, and Grand Isle counties), the Northern Vermont non-MSA, and the Southern Vermont non-MSA. The table below compares the median wage both statewide and in the Burlington-South Burlington MSA for the BLS standard occupational classifications used in the rate models.

BLS Occupational Classification and Title		Statewide Median	Burlington MSA Median	Burlington MSA as % of Statewide
19-3031	Clinical/ couns./ school psychologist	$29.13	$24.15	83%
21-1015	Rehabilitation counselor	$18.62	$19.51	105%
21-1021	Child/ family/ school social worker	$23.90	$23.86	100%
21-1022	Healthcare social worker	$27.03	$26.10	97%
21-1023	Mental health/ sub. abuse social work	$18.44	$20.97	114%
29-1066	Psychiatrist[2]	$86.58	-	-
29-1122	Occupational therapist	$37.32	$39.56	106%
29-1123	Physical therapist	$36.01	$36.42	101%
29-1127	Speech-language pathologist	$34.34	$34.02	99%
29-1141	Registered nurse	$31.61	$31.15	99%
29-1171	Nurse practitioner	$48.87	$47.90	98%
31-1011	Home health aide	$13.41	$13.48	101%
31-1013	Psychiatric aide	$17.04	-	-
39-9021	Personal care aide	$13.24	$13.79	104%
39-9032	Recreation worker	$12.91	$12.39	96%

The rightmost column shows the Burlington-South Burlington MSA wage as a percentage of the statewide median. When the figure is greater than 100 percent, the MSA has a higher-than-average wage; when the figure is less than 100 percent, the MSA has a lower-than-average wage. As the table

demonstrates, some wages in the Burlington-South Burlington area are higher than the statewide figure, but others are lower. Further, when there are differences, they are usually modest, within plus-or-minus five percent. As a result, it was determined that wage assumptions that vary by region are unnecessary.

As discussed in the response to comment 11, the rate model assumptions are intended to represent the reasonable cost of providing services. It will be true that some agencies will pay higher wages than assumed while other agencies, for example, will incur greater travel expenses. Considering overall costs, the rate study concluded that standardized statewide rates are appropriate.

13. Commenters questioned how standardized assessments factor into the design of the rate models. Several commenters stated that services should have tiered rates.

DDSD intends to adopt a standardized assessment tool so that there is a consistent approach to determining individuals' needs, improving both transparency and equity. Decisions must still be made regarding the assessment tool, how it will be administered, and how assessments results – coupled with encounter data – will be used in a future payment model.

Given that these decisions have yet to be made, other states' experience may be instructive. Most states use assessments to establish groups of individuals with similar needs, recognizing that there will be variation of needs within any grouping. This grouping is then used to inform the amount of services that an individual receives (that is, individuals with greater needs receive more services) and/or the total payment to an agency.

As it relates to payment rates, the rate study recommends 'tiered' rates for certain services: Group Community Supports (B02) and Shared Living (H04 and H05). The rates for these services vary to account for the more intensive staffing needed by individuals with greater needs (for example, fewer individuals per direct care worker for Group Community Supports). It also assumed that the customizable rate models for Staffed Living (H02) and Group Living (H03) will take into account the needs of the individuals in these residences.

For services that are primarily delivered on a one-to-one basis, the rates are not tiered as providers' costs for an hour of support are not assumed to vary based upon individual need. For example, there are not different staff qualifications to work with individuals with greater needs. Rather, individuals with greater needs will receive more hours of service. Thus, the provider earns more for delivering more hours of support, but the rate per hour is the same. For several services, there is also a rate designed for situations in which an individual requires two staff to meet their needs.

14. Commenters stated rates for services provided at a ratio greater than one-to-one should not be higher so that there is no incentive to provide services in congregate settings. Conversely, commenters stated that there should be higher wage assumptions for staff working with multiple individuals.

The rate models are not intended to incentivize or disincentivize shared services. Rather, the rate models seek to fairly compensate providers for the cost of delivering services, whether one-to-one or shared services.

It is understood that most services are provided on a one-to-one basis, but there are instances when the sharing of staff support is appropriate based on factors such as individuals' relationships (for example, roommates or sibling may share staffing support) or interests. Some services are specifically intended to support groups of individuals, including Community Supports-Group Supports and Group Living, so the rate models reflect a sharing of supports. For services that are primarily provided on a one-to-one basis but that may occasionally be provided to groups of individuals, such as Supervised Living and Respite, the rate models include a modest premium (10 percent for two-person groups and 20 percent for three-person groups) to account for additional provider costs, such as more time spent on recordkeeping. The resultant rates are then divided by the number of individuals in the group so that the per-person rate is

much lower, but the provider earns somewhat more per staff hour compared to one-to-one services since they are billing for two or three individuals.

The rate models for group services include the same wage assumption as in one-to-one services as the rate study assumes that direct support professionals providing habilitative services should be compensated consistently regardless of setting (an individual's home, a provider home, a center-based program, or in the community) or staffing ratio.

15. Commenters stated that, in addition to appropriate wage and benefit levels, more should be done to attract and retain qualified workers into the field, including partnerships with colleges and vocational schools.

DDSD acknowledges the challenges faced by providers in recruiting and retaining staff. According to data reported by providers participating in the 2017 National Core Indicators' Staff Stability Survey, for example, the turnover rate for direct support professionals in Vermont was 34.6 percent.[4]

Recognizing the importance of compensation policies in attracting and retaining staff, the rate models sought to include competitive wages and benefits for DSPs. As discussed in subsequent sections of this document, a number of changes to increase the wage and benefit assumptions were made in response to public comments.

The causes of staffing challenges extend beyond compensation issues and so cannot be resolved through payment rates alone. DDSD looks forward to working with stakeholders to develop other strategies.

DIRECT SUPPORT STAFF WAGES

16. Commenters expressed appreciation for the general increase in wages. Conversely, other commenters stated the $14.75 wage assumption for direct support professionals is too low, suggesting that staff should be paid a 'living wage' and that wages should match those paid to mental health workers. Commenters stated the wage assumption is based on data from other states and is less than providers reported they pay their staff.

As further discussed in the response to comment 17, the wage assumptions included in the rate models are based on wage data published by the Bureau of Labor Statistics (BLS) for comparable positions *in Vermont.* Wage data for other states was not considered in the rate development process.

In response to these comments, however, the BLS wage data was adjusted. BLS data is published once per year – in March – representing the survey period ending in the previous May. Thus, the rate models rely on the BLS data published in March 2019, which reflects wages as of May 2018. To account for wage growth since that time, the wage data has been adjusted to inflate the wages to January 2020. In brief, the rate models now include an estimate of the effects of wage inflation and the legislative requirement that direct support professionals be paid at least $14.00 per hour.

Data from the federal Bureau of Economic Analysis was used to estimate wage inflation. According to the BEA, the compound annual growth rate for net earnings *in Vermont* between 2007 and 2017 was 2.4 percent.[5] Applying this growth rate to the 20 months between May 2018 and January 2020, yields a total inflationary adjustment of 4.03 percent.

[4] National Core Indicators. (January 2019). 2017 Staff Stability Report (Table 11). Retrieved from https://www.nationalcoreindicators.org/upload/core-indicators/2017_NCI_StaffStabilitySurvey_Report.pdf.

[5] Bureau of Economic Analysis. (2018). Bearfacts – Personal Income for Vermont. Retrieved from https://apps.bea.gov/regional/bearfacts/action.cfm.

The statewide minimum wage in May 2018 was $10.50 per hour; in the prior year, the minimum wage was $10.00. However, beginning in July 2017, providers were required to pay a least $14.00 per hour. The adjustment for this DSP minimum wage was designed to account for both spillover effects and wage compression. Spillover refers to the fact that the impacts of a minimum wage increase will extend to some wages that already exceed the new minimum wage. For example, an individual earning $14.25 per hour is likely to receive a raise as the minimum wage increases from $10.50 to $14.00 even though their employer is not obligated to provide a raise as they already earn more than the new minimum wage. Compression refers to the fact that the size of pay raises will diminish as the beginning wage increases. For example, the worker earning $14.25 per hour will likely receive a raise, but that raise will be less than the $3.50 per hour raise the worker earning $10.50 per hour will receive as the minimum wage increases to $14.00 (to assume otherwise requires the belief that every worker in the State – regardless of how much they already earn – will receive a pay raise when the minimum wage increases). Both phenomena are widely accepted in the economic literature[6], but a review of this research did not identify specific formulae for quantifying the effects. The rate models therefore include a methodology to estimate the effects. The table below illustrates this methodology.

Current Wage in $1.00 Increments	Percentage of Dollar Amount from Previous Step 'Captured' as Part of Wage Increase	Dollar Amount from Previous Step 'Captured' as Part of Wage Increase	Cumulative Wage Increase (in Relation to $10.00)	Revised Wage
$10.00	100.0%			$14.00
$10.01 - $10.99	90.0%	$0.89	$0.89	$14.01 - $14.89
$11.01 - $11.99	80.0%	$0.80	$1.69	$14.91 - $15.69
$12.00 - $12.99	70.0%	$0.70	$2.39	$15.70 - $16.39
$13.00 - $13.99	60.0%	$0.60	$2.99	$16.40 - $16.99
$14.00 - $14.99	50.0%	$0.50	$3.49	$17.00 - $17.49
$15.00 - $15.99	40.0%	$0.40	$3.89	$17.49 - $17.89
$16.00 - $16.99	30.0%	$0.30	$4.19	$17.89 - $18.19
$17.00 - $17.99	20.0%	$0.20	$4.39	$18.19 - $18.39
$18.00 - $18.43	10.0%	$0.10	$4.49	$18.39 - $18.43

[6] See, for example:

Miller, Stephen. (June 1, 2018). Address Pay Compression or Risk Employee Flight. Published by the Society for Human Resource Management. Retrieved from https://www.shrm.org/resourcesandtools/hr-topics/compensation/pages/address-pay-compression-or-risk-employee-flight.aspx.

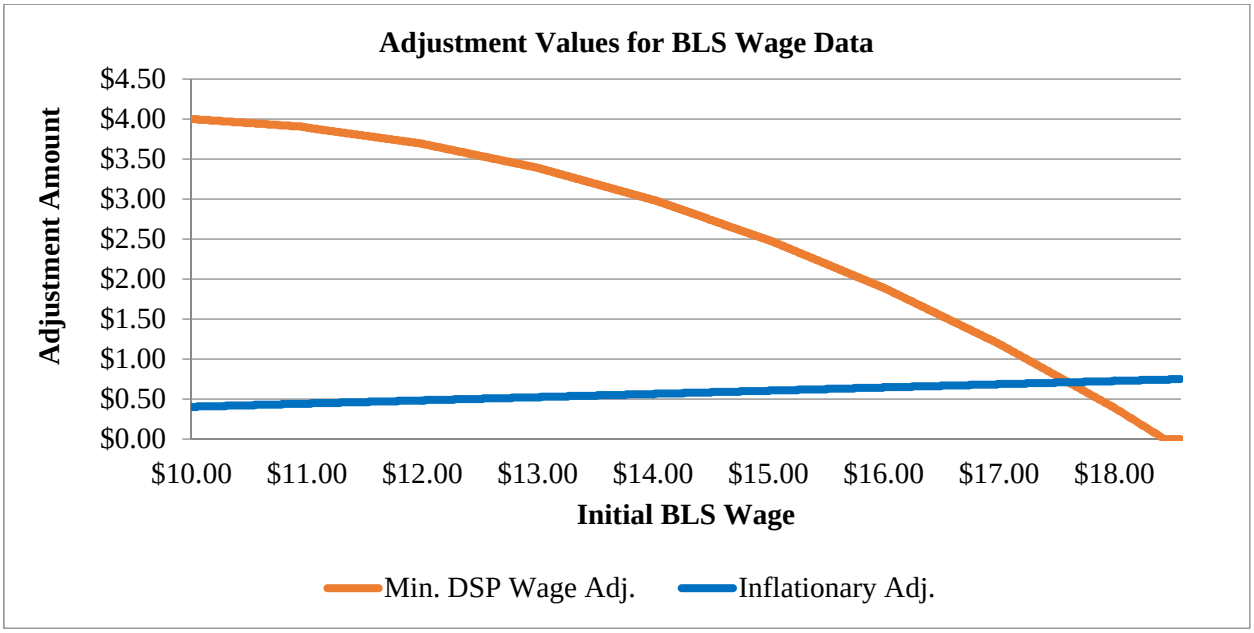
Phelan, Brian J. (December 19, 2013). Labor Supply Substitution and the Ripple Effect of Minimum Wages.Retrieved from https://www.aeaweb.org/conference/2014/retrieve.php?pdfid=306.

Rinz, K., and Voorheis, J. (March 2018). The Distributional Effects of Minimum Wages: Evidence from Linked Survey and Administrative Data. Published by the U.S. Census Bureau Center for Administrative Records Research and Applications. Retrieved from https://www.census.gov/content/dam/Census/library/working-papers/2018/adrm/carra-wp-2018-02.pdf.

In the first column, the table lists wage ranges in $1.00 increments. The next two columns provide an assumption of the amount of that $1.00 increment that will be 'captured' and added to the $14.00 DSP minimum wage. For example, for a worker earning $11.00, there is a single $1.00 increment above the current $10.00 minimum (technically, the bottom of the first wage range for those earning more than the minimum wage is $10.01 so this first 'dollar' is actually $0.99). According to the table, 90 percent of this first $0.99 is captured, translating to $0.89 ($0.99 multiplied by 90 percent). This total is added to the $14.00 DSP minimum wage such that this worker will be assumed to be earning $14.89 per hour after accounting for the DSP minimum wage. The fact that this worker will receive a raise beyond the $14.00 minimum illustrates the spillover effect, while the fact that they will now be earning $0.89 more than the DSP minimum compared to the $1.00 more than the existing minimum that they are currently earning illustrates the impact of compression.

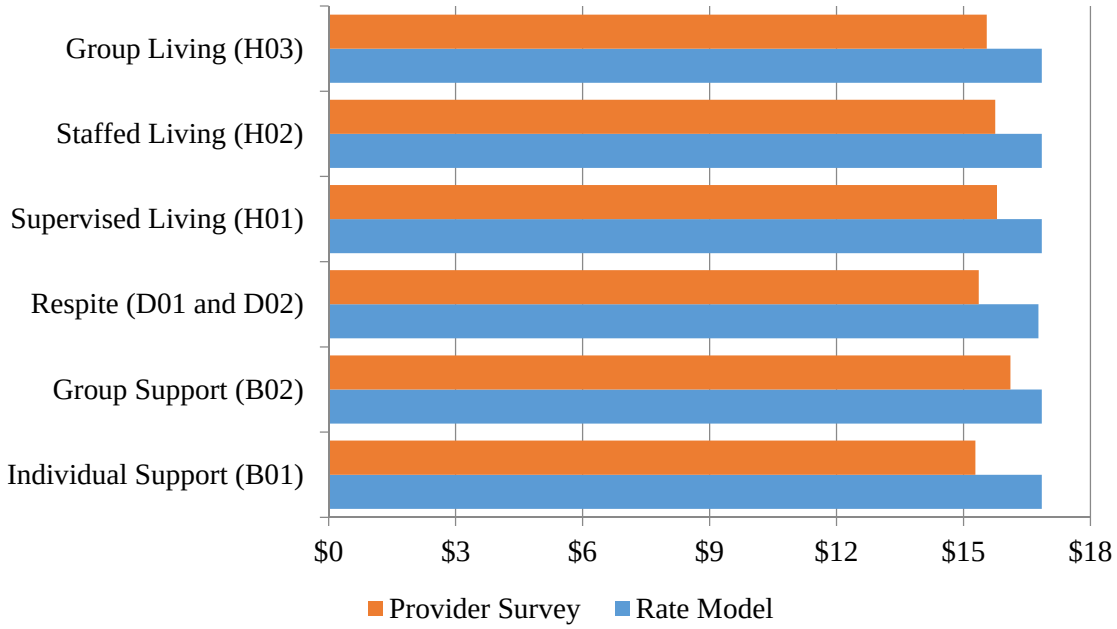
The fourth column is a running total of the aggregate captured dollar amounts in relation to the $14.00 DSP minimum wage. So, for a worker currently earning $12.00 per hour, they will capture 90 percent of the first $0.99 above the DSP minimum wage (as discussed in the previous example) and 80 percent of the second $1.00 above the minimum, for a total of $1.69 ($0.89 plus $0.80). Thus, their new wage will be $15.69 per hour. The final column lists the new wage ranges after the application of the values in the preceding columns.

The wage inflation and DSP minimum wage adjustments were separately calculated for every wage value, with the larger result applied. The table below illustrates the relationship between the initial BLS wage and the adjustment to account for the DSP minimum wage, as well as the value of the inflationary adjustment.



As shown in the chart, the calculated adjustments intersect at $17.60 per hours, meaning BLS wage values below this level received the minimum DSP wage adjustment and wages above this level received the inflationary adjustment.

Once the adjusted BLS wage values – which are reported in Appendix A of the rate model packet – are applied to the BLS occupations used to reflect the responsibilities of DSPs as described in the response to comment 17, the wage assumption for DSPs is $16.85 per hour; the wage assumption for Respite services is slightly lower ($16.77). As shown in the figure below, this exceeds the average wage reported through the provider survey for each of these services.



17. Commenters stated the BLS data does not consider the correct position classifications, mix of positions per service area, varying team structures (e.g., entry level, team lead, program supervisor, and program directors each providing the direct service), years of staff tenure, or shift differentials.

The Bureau of Labor Statistics (BLS) does not have a specific occupational classification for direct support professionals. That is not to say DSPs are not included in the BLS survey – they are – but they are grouped into a larger classification for personal care aides. However, the rate models make the assumption that considering only the personal care related responsibilities of direct support professionals undervalues their work. To account for the varied responsibilities of DSPs, the rate models therefore created a composite occupation drawing on multiple BLS classifications. The table to the right illustrates the mix of occupations used to establish the wage assumption for DSPs.

BLS Standard Occupational Classification	Weighting	Median Wage (Adjusted)
39-9021 Personal Care Aide	40%	$16.53
31-1011 Home Health Aide	20%	$16.64
31-1013 Psychiatric Aide	20%	$18.20
39-9032 Recreation Worker	20%	$16.33
Weighted Average		**$16.85**

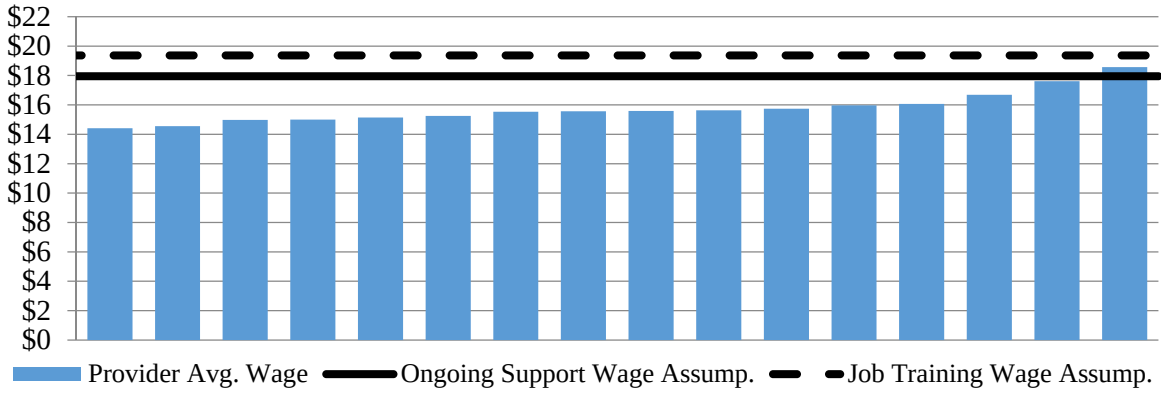
Once the mix of occupations was established, the median wages for these occupations were used to construct the wage assumptions. The median wage, also known as the 50th percentile, is the wage at which half the individuals in the occupation earn more and half earn less. Thus, the wage assumptions reflect a range of experience levels. As with all rate model assumptions, the assumed wage is intended to represent a reasonable average. Thus, it is expected that some staff would earn more than the assumed wage (for example, those with more experience) and others would earn less (for example, new hires).

As discussed in the response to comment 16, the wage assumptions in the rate models exceed the current average wages – accounting for differences in experience, shift differentials, and other factors – reported through the provider survey.

18. Commenters stated some agencies pay considerably more than the statewide average wage for employment services staff.

The provider survey found only modest variability in the wages paid to staff providing employment services. The chart below shows the average reported wage for staff providing Job Training (C03) and Ongoing Support (C04) services by provider.

Average Reported Wage for Employment Staff (C03-C04), by Provider



As shown in the chart, the average wage reported by provider ranged from $14.42 per hour to $18.57. After updating the wage assumptions as described in the response to comment 16, the rate model assumes an hourly wage of $17.95 for Ongoing Support and $19.37 for Job Training (which has been folded into the rate model for Employment Assessment (C01) / Employer and Job Development (C02)). As the chart demonstrates, these assumptions are almost uniformly higher than the current wages reported by providers.

DIRECT SUPPORT STAFF BENEFITS

19. Commenters stated that fringe benefits are highly variable across the system, though the rate models assume a standard benefits package. Additionally, commenters stated that the benefits rate factored into the rate models is too low, suggesting that the rate should be as high as 48 percent and should otherwise match the benefit rate of State employees.

The rate models include a standard benefits package for all direct support staff. As shown in the table below, the assumed benefits are in-line with current benefit levels reported through the provider survey (FICA and federal unemployment insurance are not included since these are standard amounts across the country; state unemployment insurance was funded at one percent: the rate charged to new employers).

Benefit	**Full-Time Staff**		**Part-Time Staff**		
	Rate Model	**Provider Survey**	**Rate Model**	**Provider Survey**	
Workers' Comp. (% of wages)	2.00%		2.00%		
Paid Time Off (days per year)	35	36	14	10	see comment 21
Health Insurance (cost per month)	$601	$532	$0	$70	see comment 20
Other Benefits (cost per month)	$200	$215	$50	$33	

The rate models translate this benefits package to a benefit rate expressed as a percentage of the wage assumption for the direct care worker in each rate model. The *benefits package* is the same in each rate model, but since the cost of some benefits is assumed to be fixed (health insurance, for example), the *benefit rate* varies according to the assumed wage. Specifically, there is an inverse relationship between wages and the benefit rate: as the wage increases, the benefit rate declines.

The assumptions in each rate model are intended to represent the total reasonable cost of providing services. However, these assumptions are not prescriptive and do not dictate providers' internal cost structures. It is expected that, for any given provider, some costs will be higher than assumed in the rate model and other costs will be lower than assumed. For example, a provider may pay a higher wage than assumed in the rate model, but spend less money on administration than assumed.

As with all rate model assumptions, the assumed benefits package is intended to represent a reasonable average and providers may tailor actual benefits to meet the needs of their workforce. For example, some staff may have more generous benefits (for example, those with more experience) and others may have less generous benefits (for example, new hires).

20. Commenters stated health insurance is offered to both full and part-time employees, and that the cost of insurance varies depending on the plan chosen (that is, employee-only plans or family plans).

The proposed rate models assumed that 80 percent of full-time direct care workers receive health insurance from their employer. For those participating staff, the rate models further assumed an employer share of cost of $500 per month per participating employee based on the cost of an employee-only plan. After accounting for the 20 percent of staff who do not participate in the health insurance plan, the result was an overall assumed cost of $400 per full-time employee.

In response to this comment, the assumptions were updated to assume that 45 percent of full-time staff participate in an employee-only plan (at the previously assumed cost of $500 per month), 15 percent participate in an employee-plus-one plan at an assumed employer cost of $875 per month, and 20 percent participate in a family plan at an assumed cost of $1,225. The assumptions of participation by plan type were derived from information from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey for private sector employees in Vermont. With these changes, the rate model now includes $601 per full-time employee per month, which exceeds the $532 cost reported by provider survey respondents.

The rate model does not include funding for health insurance for part-time staff as only three of 16 providers reported that they offer health insurance to part-time staff.

21. Commenter stated the assumed number of paid days off in the rate models are substantially less than what is actually offered by providers.

The rate models include funding for 35 days of paid leave (holidays, vacation, and sick time) for full-time staff and 14 days for part-time staff. These assumptions are consistent with benefit levels reported for full-time staff (36 days were reported) and exceed the levels reported for part-time staff (10 days).

As noted in the response to comment 19, the overall benefits package included in the rate models is consistent with current benefits reported through the provider survey.

PROGRAM OPERATIONS AND ADMINISTRATION

22. Commenters questioned how the rate models fund one-time purchases such as repairs for property destruction, crisis costs, wheelchairs, lift vans, etc. Commenters suggested that, in addition to the reimbursement rates for service provision, a payment mechanism should be in place to assist agencies with building an emergency pool of funds to acquire new equipment, to prevent crises, and to address unanticipated costs.

In general, the commenters are correct that the expenses they described are not yet part of the rate models, but several will be addressed as part of the broader payment reform effort. In terms of the specific items noted:

- Home maintenance and repairs – whether caused by an individual or not – are considered room and board expenses for which Medicaid funds cannot be used.
- Wheelchairs and other durable medical equipment should be accessed through Medicare or the Medicaid State Plan.
- Consistent with current practices, funding for accessible vehicles may be authorized, but the specific approach to incorporating these costs into provider payments and reporting the use of these dollars must still be developed.
- Crisis supports are covered services, but the specific approach to incorporating these costs into provider payments and reporting the use of these dollars must still be developed.

SERVICE PLANNING AND COORDINATION

23. Commenters noted that Service Planning and Coordination is currently funded based on an hourly rate, but the proposed rate model is based on a monthly rate. Commenters questioned the caseload assumptions in those rate models and stated that the use of a monthly rate would require development of policies related to reporting 15-minute encounters.

In order to maintain consistency with the current approach to approving and tracking Service Planning and Coordination services, the rate model based on a monthly unit of service has been withdrawn and a rate model based on a 15-minute unit has been established.

It is noted that, in many agencies, service coordinators act as program managers and are otherwise directly involved in the support of other programs. When acting in these capacities, the costs associated with the service coordinator are most appropriately attributed to the other services. That is, when a service coordinator is serving as a program manager – for example, hiring, training, and scheduling staff; designing curriculum; supervising a program; etc. – these are not service coordination expenses, but are program expenses associated with these other services. Thus, the Service Planning and Coordination rate model is not intended to account for these activities so, for example, the model does not include a productivity adjustment for service oversight. Instead, the program support funding included in the rate models for other agencies services was increased from 10 percent to 15 percent to account for the portion of time that service coordinators spend supporting these other programs.

Additional work will be needed to separate the tasks associated with case management and program management in anticipation of Vermont coming into compliance with federal rules related to conflict of interest in case management. Whether the federal Centers for Medicare and Medicaid Services approves a choice model in which a person has the option of receiving case management from their service provider or an independent case manager or requires the State to fully separate case management from direct service provision, separating case management from program management will be necessary. DDSD will work with stakeholders on this task.

RESIDENTIAL SERVICES

24. Commenters requested clarification regarding the Group Living and Staffed Living rate models. Commenters recommended that providers continue to be allowed to bill a single daily rate inclusive of all community supports the program delivers.

Due to significant differences in staffing levels across Group Living and Staffed Living homes, the rate study did not produce fixed rates. Rather, 'customizable' rate models were developed into which the provider would input the actual number of staff hours in the home, subject to approval. The rate model then prices these hours based on standardized cost assumptions for wages and benefits for direct support professionals and adds other expenses such as mileage, program support, and administration. Guidelines regarding the hours that should be funded through these customizable rates – such as whether to include only hours provided in the home environment and to separately report hours provided away from the home as Community Supports – must still be developed.

25. To accommodate occasional absences and vacancies, commenters recommended an abbreviated billing year (that is, dividing the annual cost of service by, for example, 350 days to produce a higher rate, but limiting billing to 350 days) and/or the inclusion of an occupancy factor in the rate models for residential services.

In response to comments, the unit of service for 24-hour residential services (Group Living, Shared Living, and Staffed Living) has been changed to a month. This eliminates the potential need for an abbreviated billing year or an occupancy factor since the full month of service will be deemed to have been provided as long as the individual was in the home for at least one day during the month.

For tracking purposes, providers will be required to submit encounters for the number of days that the individual was in the home. The number of days would not affect the reconciliation process, however. For example, if the monthly rate was $3,000 and the individual was in the home for only 15 days in a 30-day month, the provider would submit encounters for those 15 days, but these encounters would be 'priced' at $3,000 rather than prorated based on the number of days the individual was in the home. If an individual is absent from the home for an entire month, no encounters would be submitted for that month.

The current rules related to absences in the System of Care Plan would need to be amended. As the reconciliation process has not yet been established, this area is one that could be amended as encounter data is submitted and further work on the payment model is completed.

26. Commenters indicated that additional options should be made available to vary rates by acuity, including additional units of service for Shared Living.

As noted in the response to comment 13, there are 'tiered' rates for Shared Living services that vary the assumed payment to the home provider based upon the assessed needs of the individual.

In response to this comment, an additional hourly Shared Living service has been added to account for the costs of other residential staff. Policies will need to be developed to determine when service hours may be authorized, but it is expected that this service would be added for individuals with extraordinary needs through the exceptions process which is yet to be determined.

RESPITE

27. Commenters expressed appreciation for the overall increase in wages for Respite services, which have been chronically under-valued across the system.

DDSD appreciates the support for the proposed Respite rate models. There are separate rate models for Respite delivered by agency staff (which a few agencies indicated they do provide) and consumer-directed services. (The consumer-directed rate is also the rate for respite provided by workers hired by shared living providers.)

Respite is a critical support in helping families to support loved ones with disabilities in their own homes and DDSD hopes that the proposed rate model will help to ensure that the service is available to those who need it.

28. Commenters stated the Respite rate model should include a provision for mileage reimbursement.

It is understood that the delivery of Respite services differs from agency to agency and from person to person, but the rate models assume, generally, that Respite services are home-based and that workers usually work with only one individual during their workday. Based on the assumption that a worker provides Respite services to only one person during their workday, there is no mileage assumed for traveling between individuals. Further, traveling to that single visit is considered commuting time and none of the rate models include funding for employee commutes. Additionally, since it is assumed that services are home-based, the rate models do not include a mileage assumption associated with transporting individuals in the community.

Although the rate models do not include a specific assumption related to mileage, that does not prevent agencies from paying mileage reimbursement to staff or providing services in the community, recognizing that funding the associated costs would have to come from lower spending in other areas built into the rate models, such as program support or administration. For consumer-directed Respite, the individual receiving services has flexibility in setting their employee's wage and could consider paying a higher wage to cover mileage expenses.

29. Commenters stated the Respite rate model should include funding to pay for staff meals and activity participation expenses (a movie ticket, for example) when the staff person is accompanying the individual. Commenters stated that individuals currently use 'respite funding' for these expenses and stated that there should be clear rules related to how respite funding may be used.

For services delivered through an agency staff model, the rate model does not include specific assumptions related to these expenses, but expects such costs would be covered through the program support funding that is included in the rate models. As discussed in response to comment 23, the rate models for agency services have been revised to include 15 percent of the total rate for program support.

For services delivered through a consumer-directed staff model, the rate model does not include specific assumptions related to these expenses. Further, there is no mechanism for an individual who self-directs services to directly pay for such expenses; they may only direct funding to pay for hours of support. As noted in response to comment 33, however, individuals have flexibility in the wage that they set for their workers and could consider these expenses when establishing the wage. That is, they could set a higher wage with the expectation that staff will have to pay for their own expenses.

As noted in the response to comment 1, decisions regarding how the provider payment methodology will ultimately be structured have not yet been made, but it is anticipated that payments will be designed based on assumptions related to the utilization of covered services. Additionally, providers will be required to submit encounters for covered services and these encounters will be used for the purposes of reconciling provider payments to the service delivered. Paying for staff meals or activity fees is not a

covered service and, therefore, could not be submitted as an encounter. However, as described above, providers and individuals have flexibility in the use of dollars paid for covered hours of support (that is, when setting wage levels or determining how to use the funds in the rate models assumed to cover administrative and program support expenses).

BEHAVIORAL SERVICES

30. Commenter stated that behavior support and communication support services do not reflect the higher level of supervision and training necessary for these services, and that a behavior support worker should be supervised regularly by a behavior analyst.

The service requirements for Behavioral Support, Assessment, Planning and Consultation Services (E07) do not require that staff be a behavioral professional operating under the certification or licensure of a behavior analyst or similar position. Similarly, staff providing Communication Support (N01) services are not required to be staff who work under the certification or licensure of another professional. Thus, the rate model does not include the degree of supervision required in these practices.[7] Rather, the rate model assumes that these services are provided by staff who are equivalent to master's-level social workers who are able to practice independently.

CONSUMER-DIRECTED SERVICES

31. Commenters questioned whether there are additional ways to structure payments for self- and family-managed programs in a way that rewards the cost savings affiliated with self-managed programs since they are generally less costly.

As with other programs in Vermont that allow for consumer-direction of services, individuals hire, schedule, and manage the staff who provide services to them. The staff are paid for the hours they work through the contracted fiscal/ employer agent (FEA). Any changes to this payment structure should consider all programs with consumer-directed services. In addition, this workforce is subject to the collective bargaining agreement between the American Federation of State, County and Municipal Employees (AFSCME), the union representing these workers, and the State. As such, the rate study is not the appropriate forum for considering these changes.

32. Commenters stated there is a need to maintain the flexibility that exists today with regard to consumer-directed services without constricting how allotted funds are to be used.

The specific policies that the commenter wishes to maintain were not specified, but the rate study itself does not seek to make changes to consumer-directed policies. For example, the rates established in the rate models may potentially be used to establish budgets or funding levels as part of the larger payment reform effort, but individuals would still have the same degree of authority to set the wage levels for their staff. Although budgets or funding levels may be based on the rate models for consumer-directed services, it is anticipated that encounters will be priced based on the actual staffing costs paid through the fiscal/ employer agent (FEA).

[7] For example, the Behavior Analyst Certification Board requires that registered behavior technicians receive supervision equivalent to at least five percent of their time spent providing direct services. That said, much of this supervision occurs as the worker is providing services so this time is being paid for directly and a productivity adjustment is not needed.

33. Commenters stated self-directed service rate models should incorporate costs associated with acuity levels and the need for staff retention.

As discussed in the response to comment 13, the rate study does not include tiered, or acuity-based, rates for services primarily delivered on a one-to-one basis, such as most consumer-directed services, because staff qualifications do not vary according to the needs of the individual. The rate models for consumer-directed services include the same wage assumption as the rate model for the agency counterpart. However, individuals who choose to self-direct services – as with agency providers – have the authority to set wage levels that differ from those assumed in the rate model to attract staff, to account for individuals with significant needs, or to address other issues. As is currently true, those decisions will need to comply with existing policies and consider any applicable budgetary limit.

34. Commenter stated workers providing consumer-directed services should have benefits.

The rate models for consumer-directed services include assumptions relating to payroll taxes and mandatory benefits – including Social Security and Medicare payroll taxes, state and federal unemployment insurance, workers' compensation, and paid sick leave – but do not include funding for other benefits such as health insurance and holiday and vacation leave.

This is consistent with the longstanding policy that does not provide benefits to consumer-directed employees. Since benefits for these staff are subject to collective bargaining and adding benefits for consumer-directed staff would add significant costs in programs other than developmental services, the rate study is not the appropriate forum for considering potential changes to this policy.

35. Commenters stated consumer-directed rate models should include a productivity adjustment for training.

Consistent with current practices across programs, consumer-directed staff are only paid when they are providing services. There are not provisions that allow an individual to pay these staff when they are involved in other activities, such as training, so the rate models for consumer-directed services do not include any productivity adjustments. Since changes to policies related to consumer-directed services may be subject to the collective bargaining agreement and would impact other programs, the rate study is not the appropriate forum for considering these changes.

36. Commenters stated consumer-directed rate models should include funding for supervision since individuals and families who manage their own services provide considerable staff support. Commenters additionally stated that the five percent administrative rate is too low.

The rate models for consumer-directed services include five percent for providers' administrative expenses. Given that providers have less responsibility for consumer-directed services – for example, they have little or no responsibility for recruiting and hiring staff, scheduling, payroll, etc. – the administrative rate is one-half the rate built into the rate models for agency services.

It is understood that individuals and families must assume various responsibilities when they elect to self-direct services, but as is currently true, there is no mechanism to pay them for these efforts. Further, a change to this policy would impact other programs so the rate study is not the appropriate forum for considering such a change.