

Request for Information (RFI) Response Summary Feedback

Case Management for Individuals with Developmental Disabilities and Individuals

Vermont Agency Human Services (AHS; Department of Disabilities, Aging and Independent Living (DAIL); Development Disabilities Services Division (DDSD) and Adult Services Division (ASD)

RFI RESPONSE 1. THIS RESPONSE IS REQUIRED.

Introduction. Introduce yourself and/or the organization or the group you are representing. Describe your or your organizations' involvement with health care, behavioral health, case management, developmental disabilities services, brain injury services, or services for other at-risk populations, including number of years and type of experience in the fields. Identify whether you are responding with a specific population in mind.

There were seven respondents to this RFI. Of these respondents, four were from potential bidders to the RFP; three were from advocacy organizations.

RFI RESPONSE 2. **Redesigned System Overview.** State proposes a system that includes one or more statewide case management entities to provide Developmental Services (DS) and Brain Injury Program (BIP) case management services. Depending on the responses, State may choose to award all BIP case management to a single qualified organization due to the small size of the BIP population (approximately 100 participants).

- A. Describe the minimum population size and composition of an enrollee group that a single statewide case management entity may need to serve to meet State requirements and to develop/maintain a viable business.

RESPONSES SUMMARY:

A range of minimum population sizes to maintain business viability were from 105-165 enrollees to 600-900 enrollees.

A mix of enrollees from each tier category (DS Basic, DS Standard, DS Intensive and BIP) would be necessary for business viability.

Recommendation to consider one global rate for all service provision (vs. tiered rates) would simplify the billing process and spread the financial risk between the State and CME.

Responses were mixed whether BIP enrollees should be served by one organization. Some felt that BIP enrollees should be served by all awarded case management entities referencing the need for choice. In addition, utilizing multiple CMEs to serve BIP enrollees will offer flexibility if a

CME fails. Others indicated one BIP CME would provide the expertise and focus needed to serve this specialized population.

More CMEs available may make it challenging to maintain equitable caseloads – especially in rural areas. If multiple CMEs, recommend organizing and awarding them regionally to meet the geographic requirements for proximity to enrollees.

Request for a map of CM enrollee population depicted geographically by tier to assess best way to serve enrollees was requested.

Recommendation to align BIP services under one DAIL division.

RFI RESPONSE 3. Case Management Definition and Activities. Section D.2.a defines case management and the activities that must be carried out by the CME and individual case managers.

A. Describe any gaps or challenges CMEs may face in implementing the case management definition and activities outlined to meet the vision and goals as established for the State’s home and community-based service system as outlined in Section B Purpose of Request of RFI. What recommendations do you have to solve those gaps and challenges?

RESPONSES SUMMARY:

Challenge to meet rural service and support needs including lack of public transportation to support state’s largely rural population.

May have difficulty finding qualified personnel, recommending expansion of telehealth flexibility and developing “telehealth checklist”. Checklist would outline scope and frequency of services provided via telehealth with safeguards ensuring meeting client needs that need more in-person support.

Case management rates for brain injury have been historically lower than for other populations and recommend parity in rates.

Several respondents raised concerns with the 60 mile/60 minute access requirement indicating that recruiting high-quality staff in some areas of the state may be difficult. Also stating that when staff are on leave, may be difficult to maintain this standard. Respondents requested the state consider greater flexibility such as increasing the standard to 90 miles/90 minutes or allow CMEs to utilize technology as needed if the CM is providing high quality, person-centered services.

CMEs may face challenges balancing the proposed caseload sizes, staffing ratios and contract requirements by levels.

A centralized assessment process may complicate the completion of assessments, (i.e. SIS-A). Assessment provider may experience staffing issues as well. Recommend establishing clear and universally applied guidelines to coordinate assessments with entity. Allow service level agreement (SLA) flexibility for CME.

Assessment process requires communication between vendors. With no statewide system or multiple systems could lead to data exchange/information challenges. Recommend ensuring communication and information sharing is secure. Provide data sharing and record retention system to aid coordination.

Recommend creating transparency and space to allow individuals/organizations to feel heard and included in new system. CMEs need understanding of change management and how to successfully engage stakeholders in meaningful communication. Stakeholder meetings established to explain changes and how will be operationalized. Recommend establishing a list of CMs looking to join new CME and track which CME they join to support continuity for enrollees who would like to stay with that CM. New CMEs should be encouraged to hire existing CMs in system.

Recommend more than two CMEs. Recommend 4 organizations.

CMs service expectation should include providing information in an accessible manner; facilitating connections to self-advocacy groups and peer advocates; introduce, explain and facilitate supportive decision-making and alternatives to guardianship; support individuals through complaint, grievance and appeal process; access to interpretation and translated material; and support individuals who are hurt, afraid and experiencing mental health challenges.

CMs should be required to meet enrollee in-person once per month.

Direct Service Providers will be expected to fill most if not all CME-specific gaps and challenges especially during initial transition period as well as gaps with intake & eligibility tasks performed by DDSD. Recommend 2-year transition plan with compensated guidance provided by current providers.

Direct Service Providers will be responsible for all relevant attachments and coordination listed tasks in D.2.a. Providers should remain a primary member of the individual's team with equal authority and decision-making capacity to CME.

Recommend providing more information on how state will balance commitment to choice with "minimum census for financial viability". If CME is underperforming and drops below minimum census, how would this be remedied?

Recommend CMEs be expected to research and identify community resources outside of the current designated and specialized service agency system. Including representative payee services, economic benefits, securing spots on public housing waiting lists.

RFI RESPONSE 4. **Case Management Business/Operations Process.** Section D.2.c provides an overview of case management business and operations processes proposed by State.

A. Describe any gaps or challenges CMEs may face in implementing the Case Management Business/Operations processes to meet the vision and goals as established for the State's home and community-based service system as outlined in Section B. Purpose of Request of RFI. What recommendations do you have to solve those gaps and challenges?

RESPONSES SUMMARY:

Staffing and proposed rate structure are primary challenges with business operations model. Low numbers of qualified CM personnel, especially in defined catchment areas (60 miles/60 minutes access requirement).

With tiered rate structure, CMEs are unable to ensure financial sustainability if not guarantee mix of cases. Enrollee assignment to CME could be challenge with balancing need for choice with minimum CME caseloads and geographic distribution to meet access standard. Also, on-going distribution may also have similar challenges with a balanced distribution.

Recommend initial assignment where enrollees have option of active or passive enrollment. Limiting re-assignment to once or twice per year, notwithstanding exceptions. Periodic review of CME assignment for early identification and mitigation of unbalanced caseload issues. Ongoing assignments will need to account for demographics such as acuity and geographic location to ensure CMEs have similar populations initially.

Recommend individuals should be presented with all CME options regardless of census to ensure complete choice.

Recommend required timeframes at each stage of Business Operations process to avoid individuals getting "stuck" and ensuring moving through system efficiently.

Lack of uniform electronic documentation system could slow down or delay exchange of information – especially initial intake and annual redetermination. Recommend uniform documentation system. DDSD needs adequate staffing and transparent communication across Providers and service recipients when conducting eligibility, intake processes.

CMEs should be included in providing feedback about providers during state reviews and re-designation process.

Concerns related to State's understanding of self-direction as described in business process section of RFI. Self-direction is not equivalent to contracted services. Self-directed services are just one component of a broader spectrum of service such as respite and shared living, which are overseen and managed by providers. Some contracted services can be self-managed, family-managed and/or provider managed.

Providers are not prioritized as fundamental contributor to person-centered planning and service access. Recommend providers are mandatory participants in service planning, including approval on service provision.

CME must confirm funding amounts to providers which is not clear in RFI. Must be clear scope of authority over individual's budget that includes flexibility for providers to adjust as person's life changes. Changes occur daily and could lead to interruption of service if no funding flexibility.

Important to understand support brokering role with crisis services.

Recommend engagement with Green Mountain Self Advocates and peer mentors to help people served participate fully in choice decisions.

RFI RESPONSE 5. **CME and Staff Requirements.** Section D.2.d provides an overview of CME and staff requirements.

- A. Describe any gaps or challenges CMEs may face in implementing the CME and Staff Requirements to meet the vision and goals as established for the State's home and community-based service system as described in Section B. Purpose of Request in RFI. What recommendations do you have to solve those gaps and challenges?

RESPONSES SUMMARY:

With Vermont's low unemployment rate, may encounter difficulties with finding qualified staff.

May not be able to find person that meets QDDP and CM supervisor qualifications.

National shortage of RNs and LPs to meet clinical supervisor position requirements. Individuals who need support with nursing and/or behavior consultation generally receive this service through the waiver or state plan services – direct providers. Requiring behavior intervention plans or health plans to be reviewed by two sets of professionals (direct providers and CME) could lead to conflict within the team. Recommend eliminating this requirement. If not possible, allow LCSW, MSW or BCBA to fill this role. If including clinical supervisor position, recommend state set rates at high end of the range at each level.

Recommend statewide fast track QDDP process for experienced CMs. Alternate QDDP endorsement process, where otherwise qualified individuals can receive QDDP endorsement based on years of experience and training without two years of direct supervision from a QDDP.

Suggest agencies build relationships within community to help fill need for RN and LP clinical support. CMEs should employ RNs and LPs for intensive consultation and support needs.

Some respondents felt variability of referral patterns and client locations may pose logistical challenges in maintaining the 60 mile/60 minute access standard. Providing flexibility in how the measure is met/documented is important to ensure monitoring of this requirement isn't administratively burdensome. Others felt 60/60 access standard is fair and reasonable.

Recommend removing requirement of a small caseload for CM supervisors. CM supervisors often do carry small caseloads to cover leave/PTO or "overflow" in the event of an open CM position. Small caseload can reduce effectiveness of CM supervisor. Could change requirement from up to 10 CMs per supervisor to 15 or 20 CMs per supervisor with no supervisor caseload.

Allow use of employee and contracted CMs for flexibility in CM caseload increases/decreases and to cover gaps with long-term absences or staffing shortages.

Recommend expanding DS Standard CM of 1:30-35 individuals to 1:35-50 to allow for mix of acuity and needs. Enrollees in this broad group (80% of enrollees) may have a wide range of needs. There is fluctuation in service needs for individuals between "levels" so need to ensure CME is able to meet needs at caseload ratios.

Recommend equitable authority, status and pay between CM and Provider program management positions. Need to protect from "poaching" by other entities and prevent further system destabilization.

Respondents wanted more clarity on how the PMPM rate was determined including cost analysis, assumed direct/indirect costs, other state case management rate analysis.

Respondents wanted clarity on how caseloads were determined including whether based on other state's experience and whether the client satisfaction in these other states were considered when determining caseload sizes.

RFI RESPONSE 6. Organizational Structure. Please describe the CME organizational structure needed to successfully launch statewide case management services in Vermont. The CME organizational structure proposed should be able to meet requirements in Section D. Anticipated Requirements. In your response, please include at a minimum the position types, number of FTEs, and geographic locations of staff. The response should also include how clinical support, quality and compliance responsibilities will be managed.

RESPONSES SUMMARY:

A variety of staffing compositions and geographic locations were proposed including:

To cover 105 -165 enrollees, 4 FTE geographically dispersed with one CM supervisor and contracted RN or LP. Dedicated finance and billing staff – at least two FTEs.

Staff composition would include District Manager; Case Manager Supervisor; Client Success Manager; Case Manager; Training Specialist; Compliance Manager; and Billing Specialist.

State Director – supervise CM/clinical supervisors and HR/Administrative coordinator.

Compliance officer assigned from national office to work with State Director.

State office located in Burlington or Montpelier or another easily accessible location.

Divide state into regions or areas of service based on geographic location – each CM supervisor assigned an area. CMs would work remotely in their town of residence.

Staff would be strategically located in 14 regions as well as major cities and neighboring states to ensure meeting access standard (60mile/60 minute).

Recommend one program and one clinical leader. Number of FTE CMs will be based on number of CMEs awarded, number of regions awarded to each CME and location of enrollees in each region.

Quality Lead to monitor compliance with DAIL contract deliverables; monitor and report on all quality measures and activities; track and trend performance improvement activities and participate in any quality improvement committees established by State.

Staffing composition includes Program Leader; Clinical Leader (licensed); Regional Managers: Case Managers; Quality Support Team; Crisis Support Team; Staff Support Team; Data Scientist.

RFI RESPONSE 7. **Case Management Information and Records Management** Section D.2.h provides an overview of the State’s proposed options for case management information and records management.

A. Based on the options provided, describe which option would be the best interim solution and why.

B. Please describe other possible interim solutions that could be implemented within the proposed implementation timeline of mid-2025; ensuring collaboration and communication across case management, direct service providers, and state staff; and is able to share and manage program elements including participant files, records, and person-centered plans.

C. Please describe any gaps and challenges within case management information and records management in the current system that you would like to see improved with the redesigned system.

RESPONSES SUMMARY:

Respondents selected Option A and B with one respondent providing a third option of a specific system currently used by that respondent. Other recommendations/suggestions included:

Need to devise and maintain easily understandable file-naming convention across system.

Allowing different systems would work because most systems would allow for state officials and community provider access. State could choose to implement an electronic documentation system for the CMEs only allowing access to the information by all needed entities and give the State time to explore system that would work for all providers.

Interim and permanent information and records management solutions need to be compatible with current direct service provider systems: Netsmart, Credible and Carelogic.

Recommend reviewing current challenges in Colorado related to roll out of new IT management system by AssureCare.

Current DDSD website is difficult to navigate. Website should be updated to support informed choices.

RFI RESPONSE 8. Start-Up Grants and Expenses (*Potential Respondents Only*) State anticipates providing funding to support start up and transition costs.

- A. Please describe a new CME's anticipated start up and transition needs based on your knowledge and experience. State anticipates start up and transition funds would be available before and after the implementation date. Please use the information provided in Section D. Statement of Work as a basis for your assumptions when describing your start up and transition needs, where applicable. State understands that Section D. Statement of Work, may not provide all of the information needed. In this circumstance, please use (and state) other assumptions based on your knowledge and experience in starting up new case management services.

RESPONSES SUMMARY:

One respondent indicated that they identified no need for start-up funding.

Respondents provided the following examples of start-up costs:

Recruiting and onboarding; orientation and ongoing training; equipment and technology (computers, phones, office equipment, etc.); Electronic medical records system; funds to cover the gap between when employees are hired and trained but before CME has a caseload and the ability to bill for services; Consulting fees for collaboration with GM self-advocates and peer mentors.

Hiring and training new CM, Clinical supervisors and other staff can require several weeks of non-reimbursed expenses. CMs may not have enough individuals on their caseloads to cover the fixed costs for the employer during transition phase.

New electronic documentation for CME with licensing fees. Each CM needs laptop, cell phone, hotspot, and printer