STATE OF VERMONT
AGENCY OF HUMAN SERVICES

Vermont's Designated Agency System for Mental Health, Substance Abuse & Developmental Services

System Evaluation and Five-Year Projection of Service Demand and Cost Analysis

THE PACIFIC HEALTH POLICY GROUP

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Notes to the Reader:

The Pacific Health Policy Group (PHPG) would like to thank those who contributed to this study, including state staff, Designated Agency staff, Specialized Service Agency staff, advocacy groups, interested individuals, clients, and their family members.

The Pacific Health Policy Group relied on utilization and expenditure data provided by the Agency of Human Services, departments within other states, and published studies. PHPG consultants did not independently validate all of the data provided.

PHPG references "The Department of Developmental and Mental Health Services" (DDMHS) throughout the report. That department was replaced during the recent re-organization of the Agency of Human Services. Mental Health and Substance Abuse Services are now within the Department of Health, while Developmental Services is within the Department of Aging and Independent Living.

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Executive Summary

The Pacific Health Policy Group was retained to conduct a study of Vermont's Designated Agency System for developmental, mental health and substance abuse services. The study includes a comprehensive evaluation of the services provided and the populations served. Service gaps and consumer perspectives also are identified. The financial viability of the system is examined and a series of options for managing system costs are presented in this report. This Executive Summary presents a number of key findings, which are more fully described throughout the full report.

Shift to Community-Based Services

Over the past 20 years Vermont has accomplished a virtually complete de-institutionalization of its programs for individuals with mental illness and developmental needs. With the closure of the Brandon Training School and the downsizing of the State Hospital to just over 50 beds, the vision for the Designated Agency system of care was realized through the development and implementation of a host of home- and community-based services and supports. Today, the Designated Agencies (DAs) and Specialized Service Agencies (SSAs) provide mental health, substance abuse and developmental services to more than 30,000 people, with combined revenues for all programs of $215.7 million in fiscal year 2004.

While the cost of providing services and treatment in the community is much less expensive on a per capita basis than institutional care, total costs for developmental, and mental health and substance abuse services provided through the DA system has continued to increase. Between FY1998 and 2004 costs increased at an average annual rate of 9.3 percent. Key factors contributing to that growth in costs include:

- ✓ General inflationary effects
- ✓ Rapidly rising health and other insurance costs
- ✓ Caseload growth
- ✓ Improvements in treatment modalities resulting in increased demand for new services

Some program areas have grown faster than others, with developmental services expenses increasing at 7.6 percent from FY1998-2004 and children's services expenses growing at 17.8 percent over the same period. In the case of developmental services, consumers find community-based supports more desirable than the former institutional model and therefore more people seek out those services. The other factor affecting demand for developmental services is the aging population of developmentally disabled persons and their caregivers. Nearly one-quarter of the developmentally disabled population in Vermont lives with an unpaid caregiver over the age of 60 years. Some caregivers are in their 80s.

With respect to children's services, there has been a tremendous expansion in services and programs for families, including "Success Beyond Six." Federal Medicaid funding for these services has also increased significantly. Matching funds to obtain the federal revenues for the Success Beyond Six program have been provided by the schools and the

Department of Education. Total agency revenues, primarily from the local education agencies through the Success Beyond Six program, grew from $3.3 million in FY1998 to $20.5 million in FY2004.

At the same time, the demand for substance abuse treatment is rising. The provision of these services, however, has the potential to reduce costs in the Correctional system over time. Services for individuals with serious mental illnesses (CRT program) are provided under the auspices of a federal demonstration waiver which permits Vermont to use Medicaid funds to finance these services. Growth in agency expenses for that program (7.1 percent between FY1998 – FY2004[1]) has tracked closely with the level of health care inflation in the state.

Since fiscal year 2001, the State has taken steps to slow the rate of growth in expenditures for the DA system. Between FY2001 and 2004 the average annual increase dropped to 8.2 percent, a level much closer to the overall increase in health care expenditures in the state (7.6 %), but still well in excess of the growth in state general fund revenues. During that three-year period, caseload increased a total of 8.1 percent, demonstrating a continued increase in demand. Additionally, the reduction in the state's federal matching rate for Medicaid in recent years means that the actual state share of cost is rising more rapidly.

The community-based system continues to evolve with the introduction of new and creative initiatives such as School-based Services for children and families, and shared management of services with clients. The Designated Agencies have, by and large, been successful in operating efficient, community-based systems for a wide range of behavioral and developmental services.

Focus on Community Needs – the Unique Advantage of the DA System

The non-competitive nature of the DA system and the bottom-line regional responsibilities delegated to the Designated Agencies has fostered the development of a system of care that is highly effective in meeting the unique needs of Vermont communities. The agencies work with local organizations and providers to identify needs and develop responsive programs.

As the demands on the system have grown, the Designated Agencies have responded with innovative approaches to providing the highest level of service possible to the most people in need from a funding base that is largely comprised (86.5%) of public funds. This includes funding from the various departments of the Agency of Human Services, including Medicaid, Social and Rehabilitation Services (SRS), and Alcohol and Drug Abuse Programs (ADAP), as well as the Department of Education (through the school districts). However, the DAs and SSAs are struggling to meet the growing needs of their communities.

[1] A portion of the growth in the CRT program is accounted for by a shift in funds for emergency services for the seriously mentally ill to the CRT program budget.

In general, consumers and family members are satisfied with the services and care they receive through the Designated Agency system. Many spoke of the critical role those services play in their lives and in their ability to maintain their independence and function as contributing members of their communities. However, some consumers expressed dismay about the lack of funding to meet more of their communities' needs. Many are concerned about the future and the commitment of state policymakers to continue the existing model of service delivery. They fear that budgetary constraints will result in a retrenchment in both the volume and type of services, returning them to a world of less independence, productivity and community participation.

Comparing Vermont to Other States

Vermont compares favorably to other states in the New England region and the nation as a whole on measures of utilization and outcomes. In many areas, Vermont stands among the leaders in implementing nationally recognized "best practices" within its service delivery system for persons with mental illness, emotional disturbance, substance abuse treatment needs or developmental disabilities. Following are several highlights of the comparative analysis presented in this report:

- ✓ Vermont leads the nation in terms of the percentage of the population of developmentally disabled persons being served in individual or very small group (less than six persons) living arrangements, with 97 percent of all persons served in such settings.

- ✓ Vermont's caseload of developmentally disabled persons is 190 per 100,000 population versus 160 nationally, 284 in Maine, 155 in New Hampshire, and 193 in Rhode Island.

- ✓ Vermont's expenditures for developmental services per dollar of personal income placed it tenth in the nation, behind Maine and Rhode Island (first and third respectively), but ahead of New Hampshire.

- ✓ Vermont ranked number one in terms of the percentage of developmental services and state mental health expenditures matched with federal funds through the Medicaid program.

- ✓ The proportion of Vermont's per capita mental health expenditures spent on inpatient psychiatric care for publicly funded clients was less than half the national average (16.7% versus 38.2% of total expenditures).

- ✓ In a study of the correlation between community mental health utilization rates and incarceration rates in 14 states, Vermont had the highest utilization of services and the lowest level of incarceration.

- ✓ Vermont ranked seventh in the nation in terms of per capita expenditures for substance abuse treatment, which is another factor influencing incarceration rates.

Options for Managing System Costs

The report presents a series of options for the state's consideration in developing a strategy and plan for the management of system costs over the next five years. Some of these options are administrative in nature, while others involve modifications in how services are delivered. They have varying degrees of implications on how the system functions, the services it can provide and its capacity to meet the demands placed on it.

One of the options involves tying the level of expenditure growth to some relatively stable and predictable economic indicator, such as growth in personal income, health care expenditures, or gross state product. This would bring improved predictability to the annual budgeting process. However, the long term ability of the system to meet the needs of the community is inextricably tied to the level of funding that is committed to it. If the rate of growth slows to the level of the increase in the State General Fund (currently approximately 3.2%), there is little doubt that there will be significant unmet needs. Over time, that level of funding increase will probably not support the current caseload and volume of services as inflationary effects mount. This is particularly true in light of the human resource challenges faced by the agencies. High rates (in excess of 30%) of turnover due to non-competitive wages, soaring health benefit and workers' compensation costs and an ever-increasing case mix of clients has already negatively impacted the agencies' cost structures and administrative efficiency. Chapter 6 of this report presents three models of the financial future of the system under three distinct scenarios with respect to system funding.

In summary, the Designated Agency system appears to have accomplished the goals set for it by the State of Vermont. It provides a cost-effective system of services, based on the needs and desires of Vermonters. It is more expensive than the systems in place in the majority of states, but it has also accomplished more than many of the others. It is a "values-based" system designed to draw forward those in need and provide them with the tools to achieve their best possible quality of life. It is not a system in need of drastic change, but one that does need a better process of long range fiscal and operational planning.

With pressure mounting on all state-funded programs that are growing at rates in excess of growth in the State's revenues, Vermont's Agency of Human Services (AHS) must take steps to optimize its funding of the DA system. To do so, AHS needs more consistent data on service costs and outcomes across the designated agencies. This will enable AHS, in collaboration with providers and stakeholders, to identify cost effective and efficient program models that produce the best outcomes and highest levels of client satisfaction. It also will help AHS justify requests for increased funding.

The system is at a crossroads. Decisions need to be made with respect to the state's commitment to the community-based system of care for people with mental health and developmental needs. Policymakers and stakeholders need to work collaboratively to develop a five-year funding plan that is consistent with both fiscal realities and the state's commitment to its citizens. The financial plan should address both inflationary effects in the system (cost of living increases for personnel, rising energy and insurance costs, facility maintenance, etc.), and funding for caseload growth, at least for essential

services. The people whose lives are deeply affected by these decisions are counting on responsible and compassionate stewardship.

Substance Abuse Treatment Services – The demand for substance abuse treatment has grown significantly in Vermont in recent years. However, funding increases have not allowed the DAs to keep pace with demand. In fact, the DAs are not required to provide this service at all. In those service areas where the DAs do provide some treatment and services, there is variable access. For FY2004, the state is providing approximately $3.85 million (state and federal) in funding for substance abuse treatment. Total agency expenses per client average $1,566, with average direct and operating costs per client of $1,418. Revenues per client average $1,503, creating a gap between revenues per client and total agency expenses (including administrative overhead.) (See Appendix 6 for more information on substance abuse treatment services.)

Developmental Services – The number of persons with developmental disabilities who accessed funds newly appropriated for caseload growth averaged 254 per year during the four year period FY2000-FY2004. Owing to financial constraints in the DDMHS budget, a moratorium on funding to provide comprehensive services to newly identified persons was implemented on December 1, 2001. The moratorium created a backlog of cases that DDMHS estimates would cost the state $2 million per year if these individuals were being served, $847,000 of which would be from the general fund. Each DA maintains a waiting list of people who have needs that meet the funding priorities, but for whom there are insufficient funds to serve. (See Appendix 4 for more information on developmental services.)

Additionally, only about three-quarters of Special Education graduates eligible for developmental services and supports meet the State's funding priorities and therefore actually receive home and community-based services funding. Caseload growth has also been affected by the number of people with a diagnosis of Autism requesting services. See Chapter 2 for a further discussion of gaps in services.

Growth in Revenues and Caseload

Exhibit 1.1 includes information on the growth in revenues and caseload by program type during the period from FY1998 to FY2004. The growth in revenues was partially consumed by caseload growth (in all areas except Adult Mental Health) and partially by inflationary effects and increasing client needs. It should also be noted that the decline in revenues for emergency services was partially offset by the fact that in FY2000 funds were transferred from the emergency/crisis services budget to the CRT program, which provides emergency services for CRT enrollees.

Exhibit 1.1 – Average Annual Growth Rates by Category of Service (FY1998 – FY2004)

Category of Service	Average Annual Growth Rates	
	State-Funded Revenues[8]	*Caseload*[9]
Children's Mental Health	17.8%	5.9%
Adult Mental Health (OP)	10.4%	-1.6%
Adult Mental Health (CRT)	6.4%	0.3%
Substance Abuse Treatment	4.6%	2.5%
Emergency/Crisis Services	-10.5%	21.8%
Developmental Services	7.6%	4.5%
Total for all Designated Agencies	***9.6%***	***3.0%***

However, the information provided in Exhibit 1.1 above does not reflect more recent changes in revenue and caseload growth. The average annual increase in state funded revenues to the DA system between FY2001 and FY2004 fell to 7.3 percent per year, with caseload increasing by a total of 10.1 percent (3.3 percent annually). For developmental services, the average annual increase in revenue in that time period was 5.6 percent, with caseload increasing a total of 10.3 percent. Accordingly, it is apparent that the state has already taken some steps to slow the rate of growth in expenditures for the DA system.

In a state where the overall population is growing at a relatively low rate (1.7% from CY2000 and CY2003), legitimate questions are raised as to why caseload continues to grow at levels above that rate. The answers to those questions are multifaceted. There are a number of issues impacting the demand for services beyond absolute increases in the number of persons needing services. These include:

- ✓ Lessening of the stigma associated with seeking treatment for mental illness – individuals with mental illness are more likely to present for services than in the past as the public's awareness of the causes and available treatments grow.
- ✓ Greater availability of community-based services – many individuals consider community-based services and treatment programs more desirable than services provided in institutional settings. Accordingly, as more community-based programs become available, persons who did not previously seek services come forward.
- ✓ Longer lifespan for certain developmentally disabled persons – as the treatment and medical care for persons with developmental disabilities has improved, these individuals are living longer and more productive lives. As a result, their need for services continues over a longer period of time and the parental model of care is often exhausted.

[8] Includes state funds and grants, federal grants, federal matching funds from Medicaid and school funds.
[9] Defined as the number of clients served.

- ✓ Increased incidence of identifying children and adolescents with mental and emotional problems – diagnostic techniques have improved substantially over the past decade, resulting in more children and adolescents being identified as having various types of mental health problems that require treatment to resolve or ameliorate the symptoms. As a result, more state agencies are purchasing children's services from the DAs.

Going forward, there are serious concerns about the State's ability to sustain the current level of expenditure increases in this area with state general fund revenues expected to increase only 3.2 percent in FY2005. Those concerns led to the request for this study by the State legislature.

Interagency Comparisons

The Designated Agency system includes eleven DAs and six SSAs. There is substantial variability within the system in terms of the numbers of clients served, the array of services available, and the demographics of their client population. Their expenses per client also vary, with a number of outliers in each program category. See Tables 1.2, 2.2, 3.2, 4.2, and 6.2 in Appendices 1 – 6 for the Designated Agency expenses per client for Adult Mental Health, CRT, Children's Mental Health Services, Developmental Services, and Substance Abuse Treatment services, respectively.

The sometimes substantial variation in costs per client across the DAs may be partially explained by the demographics of the population served. For example, Washington County Mental Health Services and Howard Center Human Services (Chittenden County) have the highest cost per client for children's mental health services. These two DAs also serve the highest proportion of children with Schizophrenia and other Psychoses. However, not all of the differences are explained by case mix.

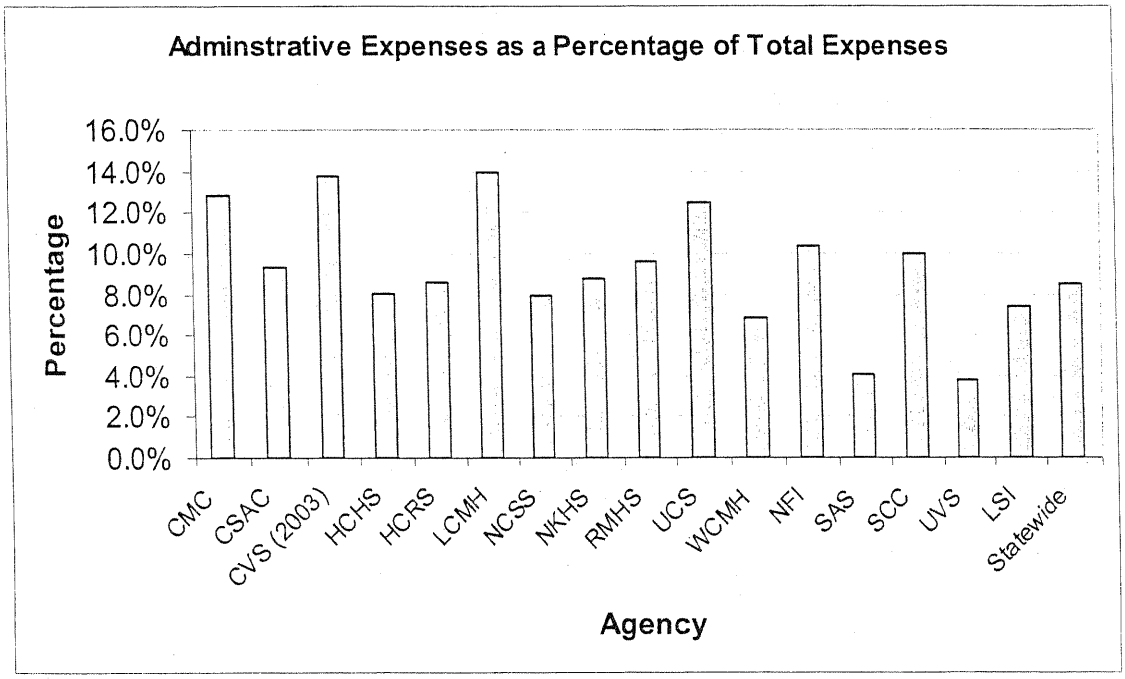
Some of the variation in the overall cost per client can be explained by differences in personnel and administrative costs. However, it is obvious that other factors, such as the intake process and treatment philosophies and patterns, contribute to the differences. There are also varying levels of service being provided across the DA regions – some of which is probably driven by the actual resources available in the community. Here again the level of services provided will also be influenced by the practice patterns of providers in the system and the agency's approach to "rationing" services when there are fiscal shortages.

Differences in the rate of growth in utilization and costs across the DAs/SSAs can also be observed. The agencies have taken different approaches in different regions in part in response to community priorities and demand. For example, some DAs are providing significantly more substance abuse treatment services than others. Some of this is related to their sources and uses of funds, but presumably some of the differences are explained by the demand in the community for increased availability of treatment for substance abuse.

As a part of this comparison, the agencies' administrative costs were evaluated in terms of the relative size of the organization, measured in this case by the number of clients

served. Among the nine DAs that are designated for all population groups (Adult and Children's Mental Health, Developmental Services and CRT), there appears to be some correlation between administrative expenses and volume of clients served. Lamoille County Mental Health Services has the highest administrative costs at 14 percent and the lowest number of clients served (1,117 in FY2004). The Howard Center for Human Services, with the largest number of clients served (5,657 in FY2004), has administrative costs among the lowest (8%). However, Washington County Mental Health, which served 2,278 clients in FY2004 (somewhat above the middle of the range), has the lowest administrative costs at about 7 percent. However, there are many reasons why administrative costs may justifiably vary across the DAs. These include differences in case and service mix, capital cost differences, building costs (i.e. rents), allocation methodologies for staff time, etc.

Figure 1.3



Given the uniqueness of the DA system in Vermont, it is not surprising that there are differences in utilization and costs. The very nature of the system emphasizes community needs – programs and services that are tailored to some extent to the individual regions in the state. While there is a base of services that each DA must and does provide, there is enough flexibility in the system that the presence of differing levels of utilization and costs by program should be expected.

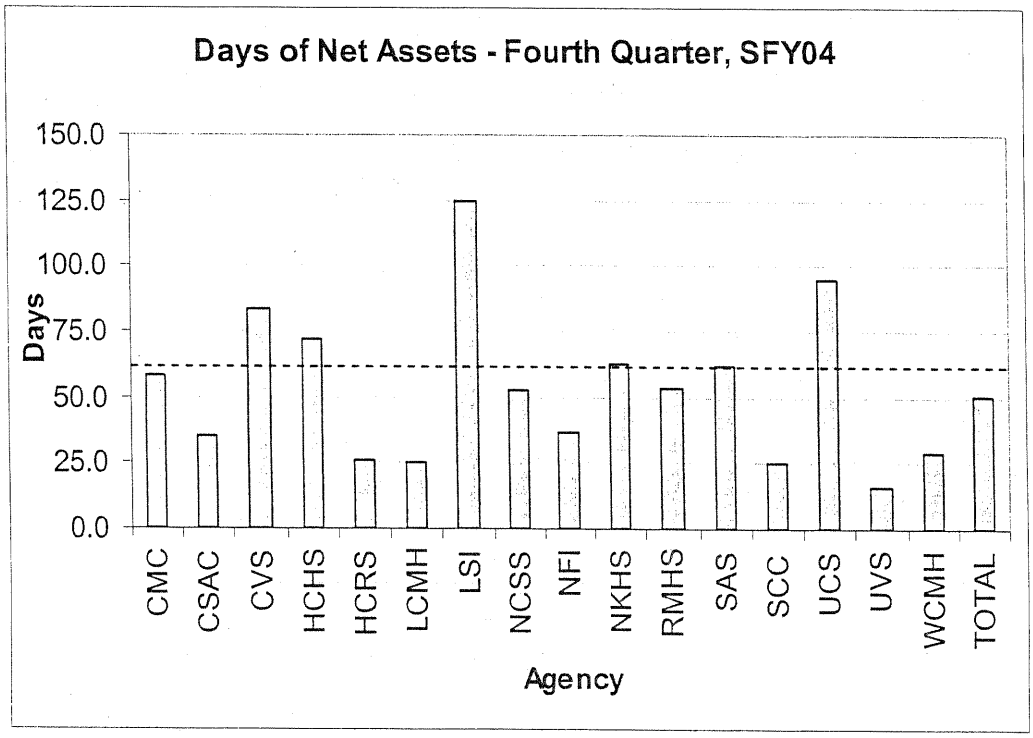
Fiscal Stability of the Agencies

DDMHS collects and monitors data to assess the fiscal performance of each agency. DDMHS established a series of fiscal benchmarks that it monitors, including current ratio, days of cash reserves, and days of net assets.

DDMHS monitors the financial performance of each agency by reviewing expenses and revenues, by program area on a monthly basis. Currently, all agencies comply with the Department's current ratio benchmark. Based on SFY2004 financial information, six agencies reported days of cash reserves below the Department benchmark of 30 days.

Each agency's days of net assets, one of the key performance indicators, is closely monitored by the department. DDMHS established a benchmark for this indicator of 60 days; eleven of the 17 agencies fall below this benchmark. Figure 1.4 provides each agency's position, based on financial data through the Fourth Quarter of State Fiscal Year 2004.

Figure 1.4



Summary of the Study Approach and Content

PHPG began conducting the study of the DA system in August of this year and accelerated its efforts and those of the Designated Agencies, the various committees involved in the process, and state staff to meet the timelines imposed by the legislation (report due November 1, 2004). The report includes projections of the demand for services and the projected costs of the system over the next five years. The report also presents findings in several areas examined during the course of the study:

- ✓ existing gaps in services by area and consumer perspectives and concerns (Chapter 2)
- ✓ the "best practices" employed within the DA system (Chapter 3)
- ✓ human resource issues and the need for infrastructure investment in the Designated Agencies (Chapter 4)
- ✓ regional and national comparisons with Vermont's DA system (Chapter 5)

As a part of its analysis of the future demand and cost of the existing system, PHPG evaluated the system's relative productivity, looking at both intrastate and regional and national data for comparisons. The comparative analysis also attempted to identify reasons why costs differ across service areas from those in other parts of the state or in other states in the region or nation. This assessment included analyzing data available on:

- ✓ staffing ratios
- ✓ utilization levels
- ✓ outcomes
- ✓ benchmark costs
- ✓ outlier cases

The cost analysis separately examines the implications of multiple factors affecting cost growth within the system, including:

- ✓ inflation
- ✓ growth in demand
- ✓ human resource costs
- ✓ overall funding needs

Three models projecting utilization and costs within the DA system over the next five years are presented in Chapter 6. These include:

1. *General Fund Growth Model* – This model assumes that Designated Agency budgets will be restricted to an average annual rate of growth equal to what is anticipated for the General Fund over the next five years, or 3.2 percent.

2. *Health Care Inflation Model* – This model sets the growth rate equal to the projected average annual health care inflation rate, as published by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), or 7.6 percent. (BISHCA bases its projections on data from the National Healthcare Expenditure Survey.)

3. *Demand Model* – This model targets program components within the Designated Agencies that were reported by the various stakeholders, including the agencies, to be underfunded, and contributing to a reduction in access to services. Most significantly, it includes a three percent annual increase for DA providers in 2006, 2007 and 2008 to address wage issues as well as other pressures on operating budgets. The three-year adjustment would enable agencies to increase staff salaries by ten percent or more, depending on other budget priorities.

Following the completion of the integrated fiscal and policy analysis, PHPG consultants identified a series of options for managing system costs over the next five years. Chapter 7 presents those options and their relative implications for the program overall. Chapter 8, the final chapter, discusses the need for a collaborative business planning and budgeting process, involving policymakers and stakeholders alike.