Chapter 1: Introduction and Background

During the Calendar Year 2004 Legislative Session, the Vermont State Legislature passed language authorizing a study of the State's Designated Agency Provider System for developmental, mental health and substance abuse services. Specifically, the Legislature directed the Secretary of the Agency of Human Services, in collaboration with a newly-formed Committee on the Department of Developmental and Mental Health Services' (DDMHS) Designated Agency Provider System, to contract with a consulting firm to review and present options for managing costs and ensuring the financial sustainability of this provider system. Through a competitive procurement, the Pacific Health Policy Group (PHPG) was chosen to conduct the study. This report contains PHPG's findings and recommendations with respect to the Designated Agency System in Vermont.

This study is being conducted concurrent with similar analyses of issues related to the Vermont State Hospital and the Department of Corrections' provision of mental health and substance abuse services to inmates. The outcomes and recommendations of both of those studies have an impact on the Designated Agency system. The potential implications for the DA system are discussed in this report. The Agency of Human Services will ultimately need to coordinate the implementation of the various options and recommendations from all three of these studies.

Background – the Designated Agency System in Vermont

State law specifies that Vermont's publicly-funded community services system for individuals of all ages with developmental disabilities and mental health disorders be provided through contracts between the Department of Developmental and Mental Health Services (DDMHS) and private, nonprofit community provider agencies. Currently, DDMHS contracts with 17 such provider agencies, 11 of which are known as Designated Agencies (DAs), and six of which are Specialized Service Agencies (SSAs).[2] With one exception, there is only one Designated Agency per geographic region.[3] The Designated Agencies have, by statute, bottom line responsibility for assuring that a comprehensive range of services are available for the following priority populations within their defined service area:

- ✓ adults with mental illness
- ✓ children and adolescents with severe emotional disturbances (SED)
- ✓ people of all ages with developmental disabilities

The SSAs have contracts with DDMHS to provide unique types of services to one of these priority populations. However, while they are an integral part of the network of care in their areas, the SSAs do not have full responsibility for the geographic area in which they provide services since that is the responsibility of the Designated Agency in that geographic region.

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[2] Vermont Supported Living, a Specialized Service Agency, will cease operations at the end of SFY04.

[3] The Clara Martin Center and Upper Valley Services both serve the same region, but with unique services. Each is "designated" based on the population they serve.

In addition to the services for the DDMHS priority populations, the DAs also provide outpatient and outreach services for adults and children with less severe behavioral disorders. Services provided to these individuals are not mandated, but they are funded with state dollars to a great extent. Many of the individuals needing outpatient mental health services or substance abuse treatment are being discharged from the Vermont State Hospital or a facility within the Department of Corrections. These people often have extensive needs and present with a complex set of problems. The DAs also serve persons with Post-Traumatic Stress Disorder (PTSD).

The DAs also are responsible for providing emergency mental health services in their geographic areas, on a 24-hour/7 days per week basis, for both individuals in crisis and in response to community-wide crises (e.g., violent community events). A number of the DAs also are the primary providers of substance abuse treatment services in their communities and have contracts with both DDMHS and the Division of Alcohol and Drug Abuse. Many also have contracts with the Department of Corrections, the Division of Child Welfare and Youth Justice Services (within the Department of Children and Families), the Department of Aging and Independent Living, and the school districts.

Finally, the Designated Agencies provide secure residential support and supervision (up to 24 hours per day) respite and therapy for individuals with developmental disabilities who have committed crimes. This system for serving offenders has evolved since 1988 when Act 248 was adopted by the Vermont State Legislature. The Act established a statutory framework for the civil commitment of people with mental retardation who have been determined "dangerous." The Act provides for non-institutional supervision of offenders found incompetent to stand trial. While Act 248 applies only to persons with mental retardation and not other developmental disabilities, the system for non-institutional supervision of offenders has expanded to include two other groups:

- ✓ Persons with developmental disabilities who have completed their sentence in the Correctional system in Vermont and can no longer be held in that setting, but who still require supervision and treatment to ensure public safety.
- ✓ Individuals "aging out" of the former system of Social and Rehabilitative Services, now known as the Child Welfare and Youth Justice Services division of the Department for Children and Families. These include developmentally disabled individuals whose offenses were committed when they were minors and are no longer eligible to be served through the juvenile and foster care system when they become adults.

Based on information provided by the Division of Developmental Services within DDMHS, only about 20 percent of the offenders being served through the DA system have been determined incompetent to stand trial owing to mental retardation. Another ten percent of the group served is comprised of persons "maxing out" their prison sentences. The remaining 70 percent are persons "aging out" of the child welfare system. A full report on Offenders with Developmental Disabilities was prepared for the Legislature in January 2001 by DDMHS.

Because of the unique status of the Designated Agencies and Specialized Service Agencies as sole providers of DDMHS contracted services, these entities are subject to DDMHS oversight and expectations with respect to the level and quality of services provided. Further, the agencies are expected to serve all clients within the priority populations within the funding availability and guidelines of DDMHS. Priority populations are defined as adults with mental illness, children and adolescents with severe emotional disturbances, and people of all ages with developmental disabilities. The provision of services to the developmentally disabled is based on a series of funding priorities established within the State's System of Care Plan for Developmental Services.

The agencies each receive funding through a system of annual budgets for each DA/SSA. Reimbursement is based on the actual services provided, with some services paid for using case rates. A system of care plan is developed on a rolling, three-year basis which lays out the goals for each of the mandated service types (Developmental Services, Adult Mental Health, and Children's Services). A series of statewide funding priorities also are in place for developmental services. The priorities guide the agencies in determining who, among those eligible for services based on their conditions', will actually be served. Given the funding constraints within the overall DDMHS budget, only a portion of those who need, and are eligible for, services can actually be funded.

The DAs are not required to provide substance abuse treatment services, but many do. The DAs who provide substance abuse treatment services are, in the aggregate, experiencing a shortfall between revenues and expenses.

The staff at the DAs/SSAs and the consumers and family members characterize the state's current system as "values-based." They describe the system as one in which providers and families strive to ensure that persons with developmental or behavioral impairments have an opportunity to be active participants in the community. The system that exists in Vermont today is built around community-based services, with extremely minimal use of institutional alternatives. The current system has given many such individuals greater independence and allowed them to become productive members of society.

As attitudes have evolved with respect to the capacity of individuals with mental illnesses and developmental needs to achieve an independent and productive life, the model of care has changed. Instead of large institutions for mental diseases and training schools for the developmentally disabled that once housed thousands of people in Vermont and elsewhere, a system of care has emerged designed to keep people in the community and to maximize their ability to function at the highest possible level.

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 often increase when community options become available. This is because more individuals will seek community supports than institutional alternatives. Simply put, when a service or new technology that people need to improve the quality of their lives becomes available, they will seek it out. This has been the case in Vermont, as well as elsewhere in the nation.

The unique design of the Designated and Specialized Services Agency system in Vermont has fostered strong ties between the agencies and the communities they serve. The agencies take seriously their responsibility to the community as the primary providers of publicly-funded developmental and mental health and substance abuse services. The agencies work with local organizations to identify needs and develop responsive programs. They undertake fund raising activities to fill some of the shortfall between the cost of providing services and their revenues from the state and other payors. If this delivery system were altered significantly or replaced with an open, competitive model, those historical relationships could be disrupted, and the new or modified system may not be as effective in meeting the needs of the community.

Vermont has achieved many of its goals with respect to system reform, particularly in regard to the principles emerging from the Developmental Disabilities Act of 1996. 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, or developmental disabilities.

Statement of the Problem

As stated earlier, the Legislature directed that a study be conducted on the financial sustainability of the Designated Agency Provider System. Their ultimate intent was identified as "ensuring that consumers have access to a comprehensive and adequate continuum of care." In assessing the issues impacting the DA system's financial viability, the state's ability to adequately fund these programs is paramount.

Rising expenditures from State General Funds

Vermont relies on the Designated Agency system (comprised of the DAs and SSAs) to provide services to some of its most vulnerable citizens, including a small number of individuals who pose significant public safety concerns. The demand for services has steadily increased in recent years, with the total average annual expenditures for community-based services increasing at an average rate of 9.3 percent between SFY1998 and SFY2004. Total public-funded revenues have grown from $107.4 million in FY1998 to $186.6 million for FY2004. A portion of this growth has been due to an expansion in caseload. The total number of clients served through the DA system grew from 25,267 to 30,368 during this period.

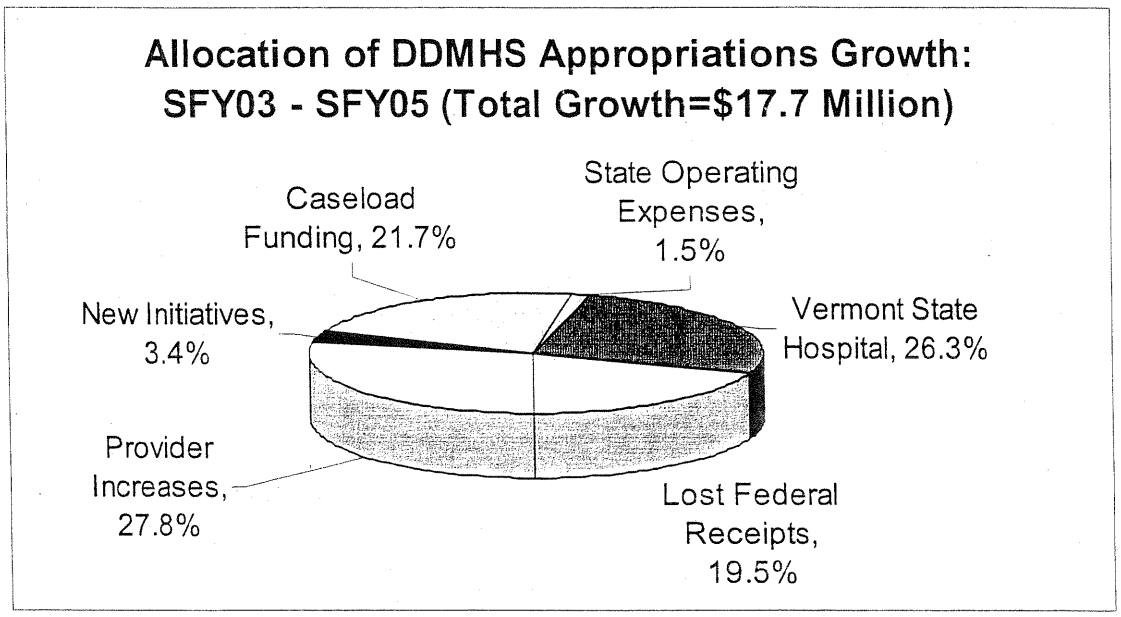
The DA system accounted for 53 percent of the total DDMHS general fund appropriations growth between SFY2003 and SFY2005 (Figure 1.1). Additional funding for the DA system was allocated among provider increases, new initiatives and caseload growth. (Caseload funding includes expenditures for the provision of additional services to existing clients.) Nearly 47 percent of the increase was due to three factors:

- ✓ State operating expenses (1.5%);
- ✓ Vermont State Hospital[4] (26%); and

[4] Vermont State Hospital increases include higher operating cost and replacement of federal funding due to the facility's decertification.

✓ lost Federal receipts[5] (19.5%)

Figure 1.1



In recent years the state general fund's revenues grew at rates in the 2.5 to 3 percent range. While a portion of the total expenditures for the DA system are financed with federal Medicaid matching funds, the state general fund is picking up a larger share in recent years. In FY2001, several developmental services funding priorities for waiver clients were suspended due to budget constraints. These funding priorities were mostly for children whose services were lower cost on average. This resulted in a substantial increase in the demand for personal care services financed by Medicaid, thereby shifting funds from the developmental services budget to Medicaid.

The state has made extensive use of federal Medicaid waivers to help fund many of the services provided by the DAs/SSAs.[6] These community-based services are, in many instances, provided in lieu of more costly institutional care. However, in recent years Vermont's federal matching funds percentage has been declining due to a change in the formula used by the government to calculate each state's rate. The loss of those federal funds means the state must pick up a larger share of the total cost of Medicaid services. In FY2004, the total state general fund dollars flowing to the DA system was $53.4 million (DDMHS general fund). Other state and local funds equaled $14.3 million. Federal Medicaid matching funds equaled $98.2 million.

The gap between expenditure growth for these developmental and mental health and substance abuse services and the rise in general fund revenue is not entirely surprising. The services provided by the Designated Agencies are a type of health care service and their growth rates can be expected to more closely mirror the rate of growth in the health

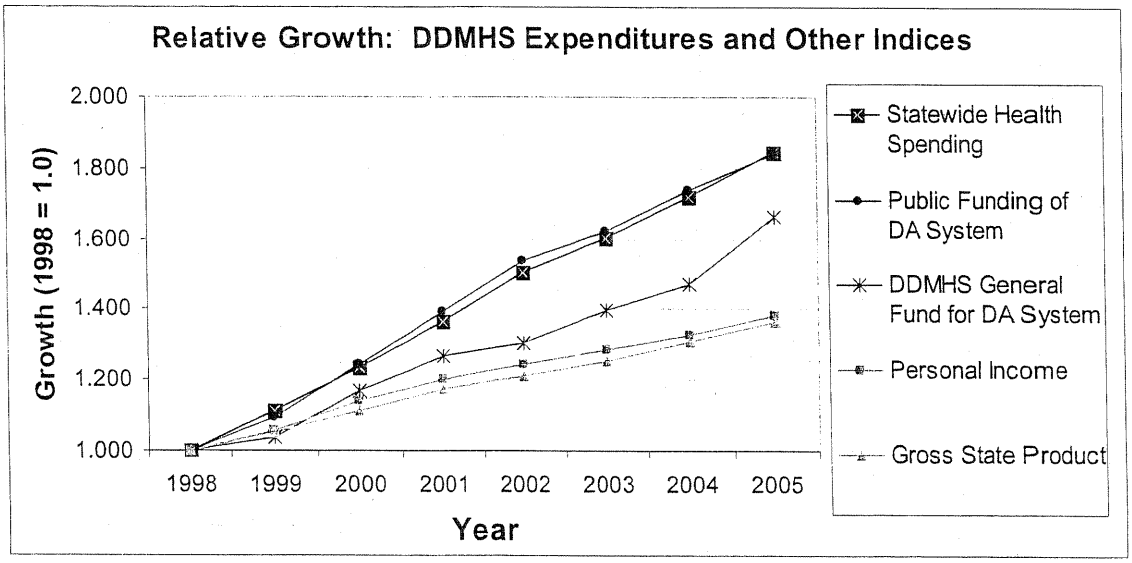
[5] Lost Federal receipts include reduction in the federal match rate and replacement of funds due to termination of a federal grant program.

[6] Vermont has waivers for its CRT program, Developmental Services program and for children with Serious Emotional Disturbance.

care sector overall. Therefore, it may be meaningful to compare the rate of growth in spending in Vermont for the developmental and mental health and substance abuse treatment system with the increase in overall health care spending.

Nationally, health care inflation has hovered in the seven to eight percent range in recent years and the medical component of the Consumer Price Index has consistently exceeded the overall CPI in the past decade. The gap between the rise in health care spending and the growth in Gross Domestic Product (GDP) continues, with health care now consuming 15 percent of GDP.[7] Additionally, increases in expenditures should be evaluated relative to increases in other economic measures such as personal income and Gross State Product (GSP) in Vermont. Figure 1.2 provides this comparison, along with the trend in overall health care spending in the state.

Figure 1.2



Issues impacting expenditures and caseload

The mandated services and programs within the DA system each have some unique aspects which have impacted expenditure and utilization patterns. Following is a summary of the key issues in each major program.

Community Rehabilitation and Treatment (CRT) Services – The CRT program underwent a transformation as a result of the development of an 1115 Demonstration Waiver program in 2000. The program serves individuals with serious mental illness, many of whom have also been treated in the Vermont State Hospital at some point in their lives. The CRT program provides a comprehensive range of clinical services, as

[7] Source: CMS, OACT, National Health Statistics Group and US Department of Commerce, Bureau of Economic Analysis.

well as supports (including employment and housing supports.) Between FY2000 and FY2001 the Designated Agency expenditures per client actually declined slightly from $9,104 to $8,865 as funds shifted with the implementation of the waiver program. However, since that time expenditures have slowly risen to the FY2004 level of $9,700, owing to inflationary effects within the Designated Agencies. Funding for emergency services was moved to the CRT program area in SFY2000, contributing to CRT program growth. Caseload growth has been very small (0.3%), reflecting a relatively stable proportion of the population needing this type of intensive community rehabilitation and treatment. Expenditures per client vary across the Designated Agencies (see Appendix 2, Table 2.2). However, the agencies must essentially manage their programs to a global budget and therefore are motivated to manage high cost cases as efficiently as possible. DDMHS also monitors certain global outcomes measures (e.g., hospitalization and employment rates) as an indicator of the effectiveness of the program (see Appendix 2 for more information on CRT services).

Children's Mental Health Services – Vermont maximizes its use of federal Medicaid matching funds to the greatest extent possible for the purpose of financing children's services. A significant proportion of children and adolescents served through the DAs are Medicaid eligible. By FY2004 children's public expenditures through the DA system, including the Success beyond Six program, had risen to nearly $60 million, up from roughly $22 million in FY1998. The Success beyond Six initiative alone accounted for about $20 million of the expenditures in FY2004. And while DA budgets were reduced below their initial appropriation during the course of the year in FY2002 (in response to a downturn in the economy and a corresponding budget shortfall in Vermont), in absolute terms expenditures continued to grow throughout the period. The agencies report increased demands on the system as more children and adolescents are diagnosed earlier as having emotional or substance abuse problems. The DAs have supported increased availability of services through the schools and more and more parents are presenting in need of services for their children. Additional funding also has been provided through the Intensive Family-Based Services (IFBS) program. The addition of school-based services and case management as billable services under the Medicaid state plan in FY2001 – FY2002 resulted in a spike in expenditures, with slightly over 60 percent of the cost being financed with federal matching funds. (See Appendix 3 for more information on children's mental health services.)

Adult Outpatient Mental Health – Total state funds allocated to the Designated Agency system is currently approximately $3.2 million (state and federal funds), or about one-half of the DAs total revenues for adult outpatient mental health services. The remainder is raised from other revenue sources (e.g., private health insurance). The current level of funding is not adequate to provide outpatient mental health treatment to all who need it. Since 1998 the total number of clients served has steadily declined from 7,847 to 7,120 in FY2004. Overall expenses per client have remained above revenues and cumulative losses exceed $5 million for the period FY1998 – FY2004. Accordingly, the agencies must prioritize those in need and/or provide minimal intervention and refer the individual on to other community resources. (See Appendix 1 for more information on adult mental health services.)