

Chapter 7: Options for Managing System Costs

The Vermont State Legislature and the Agency of Human Services should consider a number of options for improving the management of costs within the Designated Agency system in the near and longer term. Some of these options have the potential to negatively impact the program and/or its beneficiaries and therefore should be carefully considered in light of the degree of budget shortfall experienced in the state. Others have the potential for cost containment without adversely impacting the current system; however, the level of anticipated savings may not be as significant. The implications of each option are presented along with the potential impact.

Many of the options presented herein will require additional evaluation and analysis to determine if they are actually viable and appropriate. The timeframe and budget provided for this study was not adequate to conduct a thorough analysis of all of the options outlined herein.

While the Designated Agencies receive revenue from sources other than DDMHS, the majority of their funding (86%) comes from public funds, including federal Medicaid and SCHIP funds. Essentially, each Designated Agency's budget governs the extent of services provided. If budgets do not grow as fast as the demand for services, some people are simply not served. The DAs take varying approaches to the utilization of new funds; however, a slight majority (53%) of the DDMHS funding increases in recent years has gone to caseload growth and the addition of new services. The average annual growth rate of DDMHS funded revenues per client served was 6.6 percent while total public funding increased by 9.6 percent between FY1998 and FY2004. During that time period the average annual growth rate in expenditures for services provided in the DA system was 9.3 percent.

Data comparability issues limit in-depth state-by-state comparisons of Vermont's level of public expenditures for developmental and mental health and substance abuse treatment services. However, some helpful comparisons, using data and information from nationally recognized research institutes, are provided in Chapter 5 of this report. That analysis shows that Vermont generally ranks among the top tier of states in terms of spending for behavioral and developmental services, although it does not rank first. Vermont ranked tenth in terms of "fiscal effort" for developmental services and fifth in terms of per capita state mental health agency expenditures.

Vermont has done an excellent job of utilizing federal Medicaid funds to support services for the developmentally disabled and those with mental health and substance abuse problems. In Vermont only 33 percent of the state's developmental services budget is paid from the state general fund. This is in contrast to 59 percent in Massachusetts and 62 percent in Connecticut. The national average is 44 percent. In 2001, 88 percent of DDMHS' budget was Medicaid funded (state and federal dollars), making it number one in the nation.

However, in recent years the State's federal matching funds rate has been declining. This is due to a change in the formula used by the Centers for Medicare and Medicaid

Services, (CMS) to determine match rates. The reduction in the rate has had a negative impact on State's budget since the loss was made up with monies from the State General Fund. Going forward, any further reduction in the rate must be calculated into the funding levels for the DA system.

Options for Consideration

A series of options are outlined below. These options are divided into three categories:

- ✓ Expenditure limits and caps
- ✓ Service modifications
- ✓ Administrative modifications.

Expenditure Limits and Caps (including changes in reimbursement methodologies)

- *Limit expenditure growth in the level of per capita state general funding allocated to the DA system to the annual increase in a select measure of economic growth in the state (e.g., state general fund revenues, personal income, gross state product or healthcare inflation)*

Under this option the annual increase in the appropriation for DAIL/DOH and the DA system would be limited to the projected annual growth in a pre-selected measure of economic growth in the state. Any increase in federal Medicaid funds would be in addition to the state general fund increase. For example, if the expenditures for the DA system were capped at the growth in state general fund revenues for the current fiscal year, the budget for the DA system would increase approximately 3.2 percent in FY2005. If this methodology had been in place in SFY2003 and SFY2004, actual state funded revenues for the DA system would have been \$4.0 million and \$11.5 million lower than actual funding, respectively. The number of individuals served and the level of service provision would presumably also have been reduced proportionately. See Chapter 6 for the five-year projection of expenditures and services under the "Revenue" Model.

As an alternative, the legislature could opt to cap expenditure growth for the DA system at the level of the overall growth in health care expenditures, using a pre-selected source for the measure (e.g., CMS Office of the Actuary, Bureau of Labor Statistics, BISHCA). This approach acknowledges that these expenditures are being made primarily for health care services, which have historically grown at a higher rate than the overall consumer price index.

Linking the growth in expenditures for the DA system to a pre-selected measure of economic growth significantly enhances the predictability of the budget from year to year, so long as the measure chosen is relatively stable and predictable. It also reduces the back-and-forth negotiations that play out when budget requests vary widely from year to year, or are unexpectedly high from the legislature's perspective. By laying out a five-year plan for growth in funding to the DA system, expectations of the system can also be better managed. Communities, consumers and family members, the provider system, and the state departments that monitor the program will all know what to expect. The entire

system will be better able to make strategic decisions about investments in programs and plan more effectively for growth in caseload and utilization.

- *Implement a ratesetting methodology for CRT services that moves toward a statewide average cost, with special provisions for outliers*

The transition to a statewide rate (adjusted for case mix and other variables as necessary and appropriate) could be implemented over a multi-year period to prevent a funding crisis in any given area. A multi-year transition would allow the delivery system in each region time to make the adjustments necessary to provide community-based services for an amount equal to or less than the statewide average per capita cost under the institutional model. While moving to a statewide average rate for CRT services will not likely engender any measurable degree of savings, it may help ensure that resources are allocated more equitably across the state.

- *Implement an individualized budgeting process for CRT clients similar to that used for the developmentally disabled*

Under this approach, the Designated Agencies would develop individual service plans and budgets for CRT clients with service profiles that exceed some expenditure threshold. Those plans and budgets would be subject to DDMHS approval. While there would be no “upper limit” on any individual budget, this process would provide more oversight and monitoring of very high cost cases. Again, this option should not be expected to produce anything other than marginal moderation in costs for the highest needs group over time.

- *Continue to allocate increases in funding for the DA system (beyond the proportion of the increase allocated to human resource-related costs) to caseload growth and new services*

The Agency of Human Services would designate the proportion of any increase in funding to the DA system that is to be used to improve wages or benefits for personnel. The remainder of the increase would have to be used to either serve more clients or add services consistent with the funding priorities established in the System of Care Plan for each category of service. Funding increases could not be used to maintain existing services; the DAs would be expected to manage their own costs in a manner that will ensure that new monies (other than those allocated to human resource costs) can be used to expand the program. However, caseload growth could include funding for consumers whose needs increase over time.

- *Require all persons presenting for children's or adult mental health services and substance abuse treatment services to complete the application and eligibility determination process for Medicaid/VHAP within 90 days of the commencement of services by the DA/SSA*

Persons found eligible for Medicaid/VHAP would have a partially federally-subsidized payment source. Adults would also be required to apply for Supplemental Security Income (SSI) if their condition is deemed disabling and their income is very low. Based

on the number of uninsured persons in the state with income at or below the eligibility standard for VHAP (approximately 40%), this process could result in a number of clients being found eligible for federal Medicaid under the VHAP waiver. The state could also amend the VHAP eligibility standards to waive the requirement that applicants be uninsured for at least one year before they can be enrolled, if they can demonstrate that they lost their coverage involuntarily or dropped coverage because their share of the premium was more than five to ten percent of their income.

Service Modifications

- *Improve access to respite services for aged parents serving as the primary caregiver (unpaid) for developmentally disabled adults*

DAIL should consider increasing its financial commitment to respite services, with priority services targeted to single-parent households where the caregiver is 60 years old or older or two-parent households where the caregivers are aged 70 years or older. The goal of increased respite services is to maintain the parental living model as long as appropriate and possible for those who desire it. The maintenance of the parental model should reduce the costs associated with alternative placements in the near and medium term. Of the 655 developmentally disabled adults living with elderly unpaid caregivers, many are at risk of caregiver exhaustion, resulting in the need for an alternative living arrangement. If the provision of respite services delays an out-of-home placement on average for one additional year, the savings is estimated at \$25,000 per person per year.

However, over the longer term (next seven to ten years) DAIL must plan for the inevitable loss of a significant number of these parents as caregivers.

- *Add wraparound case management services as a State Plan benefit under Medicaid and SCHIP for especially high need children receiving personal care services*

This would make the benefit more commensurate with need, with federal funding covering 61 percent or 73 percent respectively of the cost. While the addition of wraparound case management services would not reduce expenditures, it would fill a gap in the current system of care for children and families with exceptional needs.

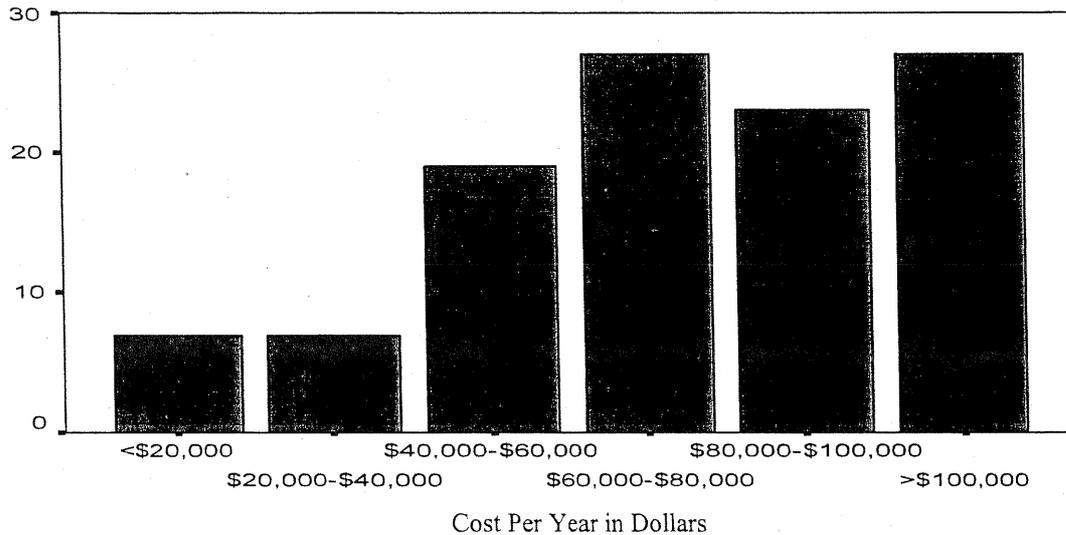
- *Evaluate alternative residential models for developmentally disabled offenders requiring 24-hour supervision, if such models are determined to be an appropriate setting for treatment and to provide for the safety and security of the individual and others in the community on a more cost-effective basis than the current system*

The Division of Developmental Services and the Designated Agency System has absorbed the burden of providing services to many developmentally disabled individuals who have committed offences in the state. Whether these individuals come to the system because they have been formally found incompetent to stand trial and therefore are mandated to the civil custody of DDMHS (now DAIL) under Act 248, or they have served their maximum sentence in the Vermont Correctional System and can no longer be retained in DOC's custody, the Department is required to ensure that they are supervised in the community and provided necessary treatment. DAIL has also become

the entity responsible for offenders aging out of the State's child welfare, protective services, foster care and juvenile justice systems.

Currently, there are 110 offenders being served through the DA system. Total expenditures on services for this group are \$8.8 million, with an average cost of \$79,000 per person. About 40 percent of these expenditures are made on behalf of 27 offenders with annual costs greater than \$100,000.

Number of Offenders



At present Vermont relies heavily on developmental homes, with some persons cared for in staffed homes or supervised apartments. A few others return to the homes of their families where family members provide residential and supervision. Since a portion of the services received by this population of developmentally disabled persons is funded by Medicaid, the state must factor in the potential loss of federal matching funds if an alternative "institutional" model is considered. The cost-effectiveness of such a model should also be evaluated considering development (start-up) costs, as well as the ongoing cost of capital investment (e.g., interest on bonds), facility maintenance, staffing, and oversight. It may be the case that the model currently in place in Vermont is the most effective and cost efficient, given the relatively small number of individuals involved and the lack of good, existing alternatives. A much more thorough analysis of this issue, beyond that included in the scope of work for this study, is needed.

- *Provide counseling and therapy services for children and adults under a group and/or family therapy model*

The DAs would provide individual therapy services only if the group or family model proves ineffective or is not appropriate for clinical or other reasons. The difference in cost for group versus individual therapy is significant and therefore the most cost effective group model should be used to the greatest extent possible.

- *Centralize mobile crisis and emergency services in some regions of the State*

DOH should evaluate opportunities to consolidate contracts and grant funding for specific functions within emergency services. Those DAs that could provide the best regional coverage and deliver and coordinate services in a more efficient and cost effective manner would be contracted to provide these services for a larger service area.

- *Telemedicine for both Child/Adolescent and Adult Psychiatry Services*

The shortage of child and adolescent psychiatrists available to treat children and teenagers served through the DA system is serious. Psychiatry services for adults are also limited. DDMHS should consider the development of a psychiatric telemedicine program to support the DA system through contractual arrangements with psychiatrists in the urban areas of the state through the University of Vermont and/or Dartmouth Medical Schools. If implemented, these telemedicine services should be added to the State Plan for Medical Assistance under Title XIX. Managed care programs in other parts of the country have used the telemedicine option successfully when addressing shortages of psychiatrists.

Administrative Modifications

- *Tie administrative allocations for wage increases to the increases (cost of living and step increases) provided for state employees on an annual basis*

Under this option AHS would provide an adjustment to Designated Agency budgets for wage increases in an amount that could, over time, permit the equalization of wages within the DA system to those of other public employees. At a minimum, such an adjustment should allow the agencies to move their wage levels to something that more closely mirrors the public sector wage levels in Vermont. With the Designated Agencies functioning as a type of quasi-governmental system, wage equity is an important issue for maintaining a stable and experienced workforce within these programs.

- *Streamline the agency designation and quality review processes*

DAIL/DOH should consider moving to a biannual rather than annual agency quality review process when a DA/SSA has a multiyear history of passing their quality service reviews (no priority areas for improvement) and the agency is also fully accredited for all major services (not provisionally accredited) by a national accrediting organization such as CARF.²⁴ Agencies that are not accredited or that have priority areas for improvement would continue to be reviewed annually (accreditation would not be required). A biannual process for at least a portion of the agencies will reduce both state and agency administrative costs and should not negatively affect the quality of the program when providers have a long history of providing high quality services and treatment. At a minimum, the reviews of the various programs, including adult and children's mental health, developmental services, substance abuse treatment and emergency/crisis services should be coordinated by DAIL/DOH to reduce the administrative burden for the agencies (i.e., time spent during site visits, preparation of data and reports, etc).

²⁴ DDMHS should require that any unimplemented plans submitted to the accrediting entity to secure accreditation be subject to continued state oversight.

DAIL/DOH should also consider eliminating the every-four-year process of re-designating agencies if the quality service reviews yield positive outcomes and the agency remains accredited by a nationally recognized accreditation body. Even if a reduction in the level of administrative activities does not translate into a short term reduction in costs, it could reallocate some staff time to client service.

- *Evaluate options for reducing the documentation and reporting requirements imposed on the agencies*

DAIL/DOH should conduct a detailed review of its documentation and reporting requirements to determine if any requirements could be eliminated or modified to reduce the administrative burden on the agencies without compromising the operational and fiscal integrity of the program. As with any streamlining of the agency designation process, a reduction or consolidation of documentation and reporting activities should permit the DAs to shift staff time more in favor of client service. The DAs should similarly review their own internal documentation requirements and procedures to determine if there are opportunities for reducing the amount of paperwork required.

- *Streamline requirements and reporting across mental health and substance abuse treatment programs*

DAIL/DOH should also evaluate opportunities for reducing the administrative burden in these two programs given the significant overlap of clients using both mental health and substance abuse treatment services.

- *Offer the Designated Agencies the option of “buying into” the VHAP program for employed direct services providers*

If the VHAP fully-loaded premium equivalent option is more cost effective than the group health insurance alternatives available to the agency, AHS should consider allowing the DAs to “purchase” VHAP coverage for these individuals and their covered dependents. The “premium” would be set at the actuarially equivalent cost of providing the VHAP benefit package to current program enrollees. While the expansion of VHAP coverage to a new group of previously privately insured individuals will likely be controversial, it may be a more affordable alternative for direct service providers with modest incomes who are otherwise facing an increasing share of cost for health coverage. This could assist the DAs in reducing their overall health insurance costs, while providing a more affordable (less out-of-pocket cost) option for lower income workers.

Similarly, the state could allow the agencies to buy into the state employees’ health benefit plan; however, the savings may be minimal (if any) given the relatively high cost of that program (mid-range monthly cost of \$367 for single coverage, and \$1,009 for family coverage).

- *Establish a centralized recruiting and information center for employment opportunities within the DA system*

The center would serve as a clearinghouse and disseminate information about jobs available statewide through the Designated Agency system. Such a center, for which the state may be able to obtain some form of grant funding, could help lower recruitment costs for the DAs and SSAs.

- *Explore the development of a Demonstration Waiver program for Developmental Services similar to the one recently proposed for the Nursing Facility/HCBS population*

A waiver could provide the state more flexibility in providing some minimum level of services to persons currently eligible, but who are screened out by the funding priorities. This could potentially address the “all or nothing” nature of the current system. At the same time, a waiver could potentially capture additional federal matching funds for that portion of Flexible Family Funding (FFF) which is used for Medicaid-covered services, most notably respite services. Currently, approximately 17 percent of the funds (\$141,314) provided to families through the FFF program are used for respite. By leveraging the federal financial participation for that service, approximately \$282,000 in federal matching funds could be drawn.

- *Develop/update a series of benchmarks for the following indicators:*
 - Staff turnover (direct services and all other staff, separately)
 - Key financial indicators (days of assets, liquidity and solvency ratios, etc.)
 - Productivity of direct service providers by type (e.g., hours of client service, number of encounters, etc.)

DAIL and DOH should work jointly with representatives from the DAs to establish a series of benchmarks for key system performance indicators, as well as a simple method for the collection and tracking of this data. The departments would use this information (along with the expenditure and utilization data currently provided) to help it evaluate the overall performance of the system and the impact over time of the state’s investments in it.