Developmental Disabilities Services
Caseload and Utilization Methodology Review

September 11, 2013
Report to Joint Fiscal Committee
Per Sec. E. 333 (a)(2) of Act 50 of 2013

INTRODUCTION

This fiscal forecasting methodology review is required by the FY14 appropriations bill. The review recognizes that the Developmental Disabilities Service (DDS) system has evolved overtime under the policy frame work set out in statute and the current System of Care Plan (SOCP) which, in turn, sets the funding priorities for the DDS system. This framework is drawn from a clear sense of values and principles shared across the stakeholders in the system. Our review considers the current practice of implementing this framework within the funding levels that have been provided through annual legislative appropriations.

The review of caseload and utilization methodology is based on this policy framework and does not include consideration of potential system demands that are currently outside that framework.

The team sought to understand the fiscal and business structures and processes as well as the primary cost drivers within the system under the current policy framework. The team reviewed recent actual fiscal information and tested various projecting and trending methods for accuracy against actual recent expenditures.

Charge

The charge for this methodology review is set out in Sec. E. 333 of Act 50 of 2013 the Fiscal Year 2014 Appropriations Act specifically in subdivision (a) (2):

Sec. E.333 Disabilities, aging, and independent living - developmental services

(a) The Department of Disabilities, Aging, and Independent Living, the Agency of Human Services, the Department of Finance and Management, and the Joint Fiscal Office shall:

(1) After review of preliminary fiscal year 2013 close out of the developmental services appropriation unit, present an estimate to the Joint Fiscal Committee at its July 2013 meeting regarding the amount, if any, of the fiscal year 2014 Developmental Services program budget that needs to be addressed through administrative or operational changes in order to manage the service needs within the appropriated funds;

(2) Review the methodology for forecasting both the caseload and utilization for developmental disabilities programs and shall report any recommendations for changing this methodology to the Joint Fiscal Committee at its September 2013 meeting;

(3) Recommend a consensus estimate for the fiscal year 2015 developmental services caseload, utilization, and budget to the Emergency Board at its January 2014 meeting.

Participants

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Meetings

The team met seven times in both Williston and Montpelier through a combination of in person and conference calls between June and present day. Meetings were scheduled on two occasions with client and provider representatives who requested a meeting to ask questions, provide information and present their thoughts on the system and the current methods of fiscal forecasting for the program. The written questions and thoughts submitted are in Attachment A and Attachment B.

Overview

Each of the stakeholders - consumers, advocates, providers and the State have interests in the system. Like most, if not all public programs, whether the current policy framework balances shareholder interests is a source of continued discussion and debate. Again like most public programs, annual funding recommendations are one of the primary areas where such debates are focused.

Beginning in FY12 the DDS system faced unanticipated increases both in caseload and utilization. This required a $3 million FY13 midyear budget adjustment and an FY14 budget increase above recent trend rates at $7.4 million. As a result, the FY14 budget includes a $2.5 million system savings target. The manner in which this savings target is addressed is a topic of the DDS Legislative Policy Workgroup. This recent fiscal experience also raised questions as to whether the existing budget projecting methods were adequate, resulting in the mandate for this fiscal review.

Dynamics of the System

The fiscal review team sought to understand fiscal and business structures and processes as well as the primary cost drivers within the system as it is currently operated under the existing policy

framework set out in statute and operationalized by the current SOCP and the funding priorities established therein. These are summarized as follows:

Each DDS consumer is unique; a budget is developed for each consumer based upon his or her own individual strengths and needs.

It is expected that this program will continue to grow due to several factors. There are the relatively predictable "June Graduates" moving from the education system. There is also a steady demand driven by increased individual need as consumers and care givers age. Demand from the public safety caseload continues and is more challenging to predict. Growth has and could continue to come from as yet unforeseen new areas, such as the recent need for DDS services by refugees.

The State sets and executes the policy framework and determines the annual appropriation funding level.

Direct services are provided by regional non-profit Designated Agencies (DAs) and Specialized Service Agencies (SSAs) with assistance from a supportive Integrated Service Organization (ISO).

A small number of consumers or families self-manage their budgets.

Eligibility for DDS waiver services is based on both the determination of defined clinical disability and meeting a funding priority of the SOCP. The process begins at the local DA through eligibility and needs assessment. Once this is determined a funding recommendation is made to the state Equity or Public Safety funding committee. Approval of the committee results in the new or amended specific budget for the consumer. The DDS Legislative Policy Workgroup report provides a detailed description of this process. This report also provides statistics regarding FY13 requests for new or increased services. A total of 713 applications resulted in 478 referrals to the state funding committees.

Individual budgets are reviewed annually by the DAs/SSAs with the consumer and his or her support team. There is no state level annual review.[1]

Each DA/SSA begins the fiscal year with an allocation that reflects the sum of the approved budgets for the consumers they serve. Throughout the course of the year budgeted funds for consumers who change or terminate services[2] are removed from a DA allocation and become available to offset new caseload and new service needs as they arise and are approved by the state funding committees.

[1] DDAIL has made a proposal for inclusion in the updated SOCP (July 1, 2014-June 30,2017) that the state Equity and Public Safety funding committees consider an individual's entire budget concurrent with the consideration of the best way to meet a person's needs in reviewing a request for increased services. DDAIL expects to issue a decision about this soon.

[2] This may be due to reasons such as death, move out of state, move to a new region, move to a nursing home, incarceration, switch to self/family managed, or switch providers.

Modest adjustments to individual budgets are made internally by DAs within their existing allocations.

Reimbursement for the DAs/SSAs is essentially a cost reimbursement system with the service rates being set by the agencies. There is not a formal rate setting process, they are required to provide the state with annual financial audits.

The Public Safety caseload appears to be experiencing increased cost per case growth. In order to be considered a risk to public safety, the SOCP requires an individual meet at least one of the following:

- Committed to the custody of the DAIL Commissioner under Act 248 because of being dangerous to others. Services are legally mandated.
- Convicted of a sexual or violent crime has completed his or her maximum sentence and there is evidence that the individual poses a substantial risk of committing a sexual or violent re-offense.
- Substantiated by DAIL or Department of Children and Families (DCF) for sexual or violent abuse, neglect, or exploitation of a vulnerable person and there is evidence that the individual poses a substantial risk of committing a sexual or violent re-offense.
- In the custody of DCF for committing a sexual or violent act that would have been a crime if committed by an adult, is now aging out of DCF custody, and there is evidence that the individual poses a substantial risk of committing a sexual or violent re-offense.
- Not charged with or convicted of a crime, but the individual's risk assessment contains evidence that the individual poses a substantial risk of committing a sexual or violent re-offense.
- Convicted of a crime and under supervision of Department of Corrections (probation, parole, pre-approved furlough, conditional re-entry) and DOC is actively taking responsibility for supervision of the individual for public safety. Public Safety Funding only pays for supports needed because of the individual's developmental disability. Offense-related specialized support needs, such as sex offender therapy, cannot be funded for an individual who is under the supervision of DOC.

The Severely Functionally Impaired/Complex Community Case (SFI/CCC) caseload is similar to the DDS waiver caseload but is not part of the DDS waiver. The funding for this initiative was added in the FY13 budget adjustment and FY14 base as a new policy initiative. The funds for this initiative are not related to the DDS waiver base budget or budget adjustment. If this initiative was not funded, how these funds would alternately be allocated would be an executive/legislative determination and would not automatically result in an increase in the DDS waiver funding level.

DDS waiver services are not an entitlement. There is a feedback loop between the level of funding authorized by the legislature annually and the SOCP funding priorities. SOCP funding priorities have been tightened in response to fiscal realities (FY09 rescissions, Challenges for Change etc.). It has not been the practice of this program to freeze or establish a waiting list for DDS waiver services, any such practice would need to take into consideration the State's

requirement with respect to the Olmstead decision3. Vermont statute governing the SOCP identifies the public process for DDAIL to prioritize people and services allowing them to manage to the funds available. In a given fiscal year, when the funding level is projected to be below the allocated budgets the SOCP allows a rescission process to approved service budgets. The Legislative Policy Work Group report summarizes methods that are or have been used to manage the program budget.

The DAs/SSAs have increased the use of contractors over time for the provision of services.

Act 48 of 2013 (S.59) An Act Related to Independent Support Providers) permits direct support providers[4] to collectively bargain with the State of Vermont on issues that could have a fiscal impact, such as compensation, benefits, professional development and training, and procedures for resolving grievances. Unions have actively been seeking to represent Vermont direct care workers. It is not yet clear when any contract would be executed but it is possible that fiscal impacts of a negotiated contract could partially impact FY15 and are very likely to impact FY16. The effects of a negotiated contract and the subsequent impact on the cost of DDS services provided by direct care workers will need to be estimated.

Fiscal Picture

Table 1 provides an overall fiscal summary of the DDS system for FY09 through FY14 for the waiver program and other DDS budget lines. FY09 through FY13 reflects actual year end expenses and FY14 reflects the current budgeted amount. The waiver program accounts for 96% of total expenditures. There are two distinct caseload groups within the waiver; Regular and Public Safety DDS consumers. Table 1 shows the following:

Regular DDS consumer caseload growth has averaged 3.58% between FY09 and budgeted FY14, while the average growth rate for this consumer group has averaged 3.82%. The actual unit cost (expenditure per consumer) for this consumer group dropped by 2.4% between FY09 and FY13, but is budgeted to increase by 3.7% in FY14.

The Public Safety consumer group has seen caseload growth averaging 3.9% and total cost growing 9.8% on average in this five year picture. The cost per case has steadily risen as a result; the five year unit cost growth rate is 31.7% (averaging 5.79%) from FY09 to budgeted FY14.

[3] *Olmstead v. L.C.*, 527 U.S. 581 (1999), is a United States Supreme Court case requiring states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. .

[4] Direct support provider is defined as "any individual who provides home- and community-based services to a service recipient and is employed by the service recipient, shared living provider, or surrogate [of the service recipient]."

In total, average cost growth of the DDS waiver is 4.4%, with caseload growth at 3.6%. It is interesting to note that the total DDS waiver caseload appears to be increasing as a percent of the total Aged, Blind and Disabled Medicaid eligibility group growing from at or just below 17% to just over 18% projected in FY18.

Table 2 provides expenditure detail by provider and by type of service for the DDS waiver program for three years, FY10 through FY12. The detail for FY13 is not yet available but will be added to this data set when it becomes available. This summary shows the expenditures for the Regular and Public Safety caseloads combined.

The provider detail shows a range of cost per case from $47k to $75k with a steady average of $53k. A handful of designated agencies and specialized service agencies have significant caseload and expenditure increases with modest changes in most of the other agencies. Only one agency, Washington County MH, experienced caseload increase and total expenditure decrease in this time period, although several agencies saw cost per case decreases within this time frame.

The cost detail by type of service shows Housing services are the largest service category at 38% with the next largest categories being Community Supports at 18% and Respite at 11%. These categories have also seen the largest increases. This summary shows that approximately 6% less was spent on employment and transportation services from FY10 to FY12. The administration allocation for the DAs/SSAs went down by 1.5% while case management increased 2.8%.

Details of the housing expenditure show a wide cost range across the various types of housing services and the cost changes over this time period.

Table 3 provides the total, fully annualized, actual new and increased service budgets approved by the state funding committees for FY07 through FY13 for the Regular and Public Safety caseloads. For the same time period, it also shows actual returned equity revenue that was available in each fiscal year. Each of the data categories are represented in a line graph. The year over year rate of change for each of these data series are also graphed. These graphs are useful in depicting the relative volatility of each data series.

DDS Programs

TABLE 1

DDS Waiver	Actual FY09	Actual FY10	Actual FY11	Actual FY12	~Actual FY13	Budgeted FY14	CAGR '09-'14
Regular Caseload $	110,146,930	113,106,785	117,108,815	119,659,364	123,853,075	132,832,629.00	3.82%
		2.69%	*3.54%*	*2.18%*	*3.50%*	*7.25%*	
Regular Caseload #	2,172	2,253	2,330	2,427	2,503	2,590	3.58%
		3.73%	*3.42%*	*4.16%*	*3.13%*	*3.48%*	
Regular $/Consumer	$50,712	$50,203	$50,261	$49,303	$49,482	$51,287	0.23%
Public Safety $	18,299,242	19,831,615	20,799,109	21,957,764	26,434,163	29,167,371	9.77%
		8.37%	*4.88%*	*5.57%*	*20.39%*	*10.34%*	
Public Safety Caseload #	200	207	209	220	230	242	3.89%
		3.50%	*0.97%*	*5.26%*	*4.55%*	*5.22%*	
Public Safety $/Consumer	$91,496	$95,805	$99,517	$99,808	$114,931	$120,526	5.67%
Waiver Savings Target						**($2,500,000)**	
DS Waiver total	$128,446,172	$132,938,400	$137,907,924	$141,617,128	$150,287,238	$159,500,000	4.43%
	5.18%	*3.50%*	*3.74%*	*2.69%*	*6.12%*	*6.13%*	
DS Total # of Consumers	2,372	2,460	2,539	2,647	2,733	2,832	3.61%
	4.49%	*3.71%*	*3.21%*	*4.25%*	*3.25%*	*3.62%*	
DS Total $/Consumer	$54,151	$54,040	$54,316	$53,501	$54,990	$56,321	0.79%
DDS Other							
Flexible Family Funding	1,364,898	1,114,898	1,103,749	1,103,749	1,043,888	1,043,888	
SSBG	321,309	313,512	313,512	313,512	308,262	298,784	
Misc GF Grants	116,528	60,362	131,244	96,393	108,214	155,125	
Targeted Case Mgt	442,958	433,899	409,959	402,710	422,173	590,553	
Rehab Services (PASARR)	108,585	81,266	103,410	186,179	100,442	277,454	
Bridges Program (children)	27,327	626,684	672,397	666,505	755,001	1,126,421	
Westview ICF/MR	1,274,070	1,274,070	1,261,329	1,266,288	1,339,734	1,266,775	
Misc One Time Grants	671,957	439,810	982,674	1,502,293	2,632,365		
Subtotal	4,327,632	4,344,502	4,978,274	5,537,630	6,710,080	4,759,000	
Rate Increase (COLA)						2,936,999	
SFI/CCC Base					1,270,247	1,875,000	
SFI/CCC Caseload #					16		
SFI/CCC $/Consumer					*$79,390*		
Total Other DS	4,327,632	4,344,502	4,978,274	5,537,630	7,980,327	9,570,999	
TOTAL DS Waiver and Other	132,773,804	137,282,902	142,886,198	147,154,758	158,267,565	169,070,999	

DDS-Billed Services

TABLE 2

DDS Waiver - by provider	FY10 Persons	FY10 $	FY10 $ %	FY10 $/Per	FY11 Persons	FY11 $	FY11 $ %	FY11 $/Per	FY12 Persons	FY12 $	FY12 $ %	FY12 $/Per	Two Year Change FY10-FY12 Persons	%	$	%
Counseling Service of Addison County	118	6,357,726	4.8%	53,879	118	6,302,845	4.6%	53,414	128	6,508,858	4.6%	50,850	10	8.5%	151,132	2.4%
Champlain Community Services	54	2,626,554	2.0%	48,640	53	2,603,984	1.9%	49,132	55	2,661,879	1.9%	48,398	1	1.9%	35,325	1.3%
Howard Center	445	21,992,916	16.5%	49,422	484	24,193,523	17.5%	49,987	526	25,700,434	18.1%	48,860	81	18.2%	3,707,518	16.9%
Health Care & Rehab Service (SW VT)	234	11,679,030	8.8%	49,910	245	12,402,444	9.0%	50,622	249	13,002,549	9.2%	52,219	15	6.4%	1,323,519	11.3%
Lamoille Community Connections	83	4,546,613	3.4%	54,778	85	4,421,966	3.2%	52,023	81	4,498,930	3.2%	55,542	-2	-2.4%	(47,683)	-1.0%
Lincoln Street Inc.	55	3,066,416	2.3%	55,753	52	3,019,477	2.2%	58,067	55	3,134,361	2.2%	56,988	0	0.0%	67,945	2.2%
Northeast Kingdom Human Services	276	14,275,313	10.7%	51,722	273	14,385,084	10.4%	52,693	269	14,371,649	10.1%	53,426	-7	-2.5%	96,336	0.7%
Northwest Counseling & Support Services	225	10,731,071	8.1%	47,694	234	11,553,933	8.4%	49,376	246	12,258,618	8.7%	49,832	21	9.3%	1,527,547	14.2%
Rutland Mental Health Services	243	12,621,632	9.5%	51,941	251	13,051,774	9.5%	51,999	257	12,742,426	9.0%	49,581	14	5.8%	120,794	1.0%
Sterling Area Services	73	5,075,204	3.8%	69,523	76	5,278,117	3.8%	69,449	77	5,370,178	3.8%	69,743	4	5.5%	294,974	5.8%
Specialized Community Care	41	3,082,741	2.3%	75,189	42	3,032,082	2.2%	72,192	44	3,327,564	2.3%	75,626	3	7.3%	244,823	7.9%
Transition II (self managed)	71	3,261,832	2.5%	45,941	68	3,315,272	2.4%	48,754	76	3,663,092	2.6%	48,199	5	7.0%	401,260	12.3%
United Counseling Services	131	6,201,571	4.7%	47,340	127	6,124,112	4.4%	48,221	129	6,125,009	4.3%	47,481	-2	-1.5%	(76,562)	-1.2%
Upper Valley Services	184	12,994,695	9.8%	70,623	191	13,268,419	9.6%	69,468	193	13,068,470	9.2%	67,712	9	4.9%	73,775	0.6%
Families First	36	1,571,857	1.2%	43,663	41	2,199,051	1.6%	53,635	48	2,518,326	1.8%	52,465	12	33.3%	946,469	60.2%
Washington County Mental Health	229	12,852,364	9.7%	56,124	224	12,755,841	9.2%	56,946	236	12,664,785	8.9%	53,664	7	3.1%	(187,579)	-1.5%
Total	2,498	132,937,535	100.0%	53,218	2,564	137,907,924	100.0%	53,786	2,669	141,617,128	100.0%	53,060	171	6.8%	8,679,593	6.5%

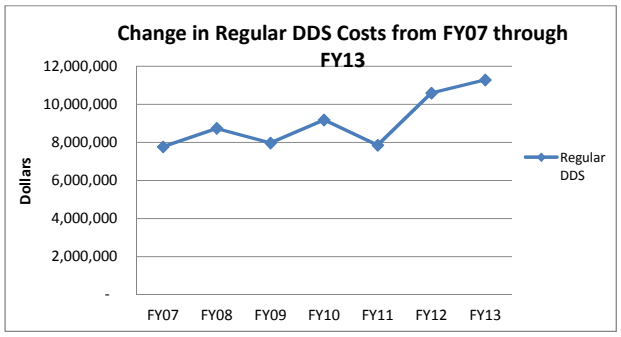
DDS Waiver - by type of service	FY10	$	$ %	$/Per	FY11	$	$ %	$/Per	FY12	$	$ %	$/Per	Persons	%	$	%
Service Planning & Coordination	2,498	14,201,690	10.7%	5,685	2,564	14,536,115	10.5%	5,669	2,669	14,595,966	10.3%	5,469	n/a	n/a	394,276	2.8%
Employment Services	796	9,447,679	7.1%	11,869	786	9,227,776	6.7%	11,740	773	8,893,009	6.3%	11,505	-23	-2.9%	(554,670)	-5.9%
Community Supports	1,606	23,714,830	17.8%	14,766	1,789	25,190,202	18.3%	14,081	1,690	26,039,014	18.4%	15,408	84	5.2%	2,324,184	9.8%
Respite (Family/Home Provider Supports)	1,787	13,950,898	10.5%	7,807	1,836	14,832,684	10.8%	8,079	1,855	16,191,449	11.4%	8,729	68	3.8%	2,240,551	16.1%
Clinical	1,684	4,103,699	3.1%	2,437	1,718	4,394,833	3.2%	2,558	1,710	4,535,789	3.2%	2,653	26	1.5%	432,090	10.5%
Crisis Supports (Indiv,State,Local)	316	2,625,142	2.0%	8,307	327	2,693,048	2.0%	8,236	299	2,645,433	1.9%	8,848	-17	-5.4%	20,291	0.8%
Housing	1,749	49,754,897	37.4%	28,448	1,786	52,083,243	37.8%	29,162	1,798	53,849,958	38.0%	29,950	49	2.8%	4,095,061	8.2%
ISO	2,204	451,493	0.3%	205	2,317	452,994	0.3%	196	2,355	551,296	0.4%	234	151	6.9%	99,803	22.1%
Transportation	1,132	3,165,481	2.4%	2,796	1,071	3,011,437	2.2%	2,812	1,072	2,969,410	2.1%	2,770	-60	-5.3%	(196,071)	-6.2%
DA/SSA Agency Admin	2,498	11,521,726	8.7%	4,612	2,564	11,485,592	8.3%	4,480	2,669	11,345,804	8.0%	4,251	n/a	n/a	(175,922)	-1.5%
Total	2,498	132,937,535	100.0%	53,218	2,564	137,907,924	100.0%	53,786	2,669	141,617,128	100.0%	53,060	171	6.8%	8,679,593	6.5%

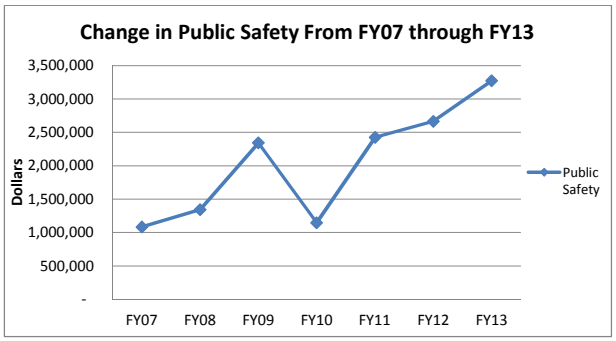
Housing Detail	Persons	$	$/Per	Persons	$	$/Per	Persons	$	$/Per	Persons	%	$	%
Supported/Assisted	259	3,267,359	12,615	289	4,192,008	14,505	309	4,509,604	14,594	50	19.3%	1,242,245	38.0%
Staffed Living	41	3,426,583	83,575	41	3,629,471	88,524	45	3,872,810	86,062	4	9.8%	446,227	13.0%
Group Living	97	7,671,097	79,083	99	7,553,766	76,301	96	7,278,231	75,815	-1	-1.0%	(392,866)	-5.1%
Home Providers	1,325	35,368,686	26,693	1,345	36,691,845	27,280	1,338	38,170,117	28,528	13	1.0%	2,801,431	7.9%
Goods	27	21,172	784	12	16,153	1,346	10	19,196	1,920	-17	-63.0%	(1,976)	-9.3%
Total	1,749	49,754,897	28,448	1,786	52,083,243	29,162	1,798	53,849,958	29,950	49	2.8%	4,095,061	8.2%
	70.0%			69.7%			67.4%						

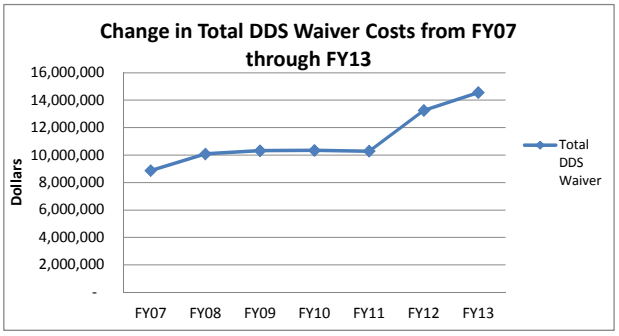
TABLE 3

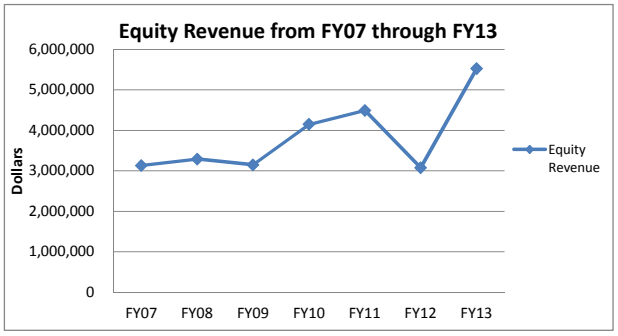
DAIL DDS Forecasting - Actual Data

	FY07	FY08	FY09	FY10	FY11	FY12	FY13
Regular DDS	7,779,862	8,744,004	7,984,657	9,193,599	7,860,246	10,597,742	11,288,502
Public Safety	1,088,199	1,346,958	2,344,670	1,150,115	2,429,694	2,668,329	3,275,045
Total DDS Waiver	8,868,061	10,090,962	10,329,327	10,343,714	10,289,940	13,266,071	14,563,547
Equity Revenue	3,138,112	3,297,548	3,153,894	4,152,415	4,496,601	3,081,631	5,529,545



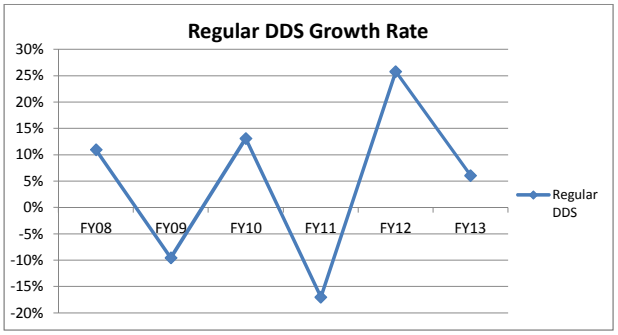


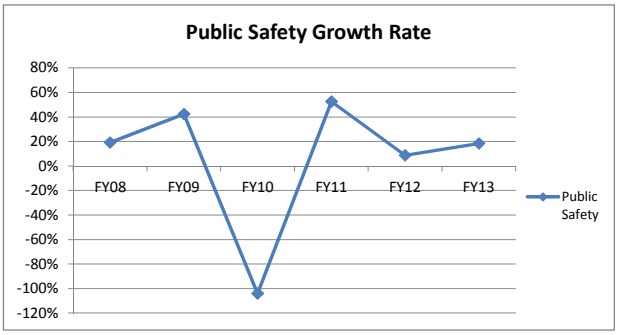


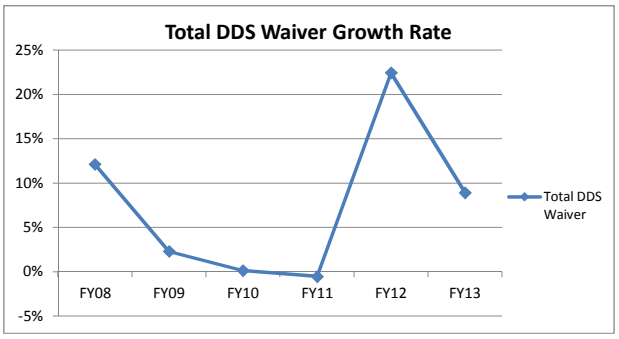


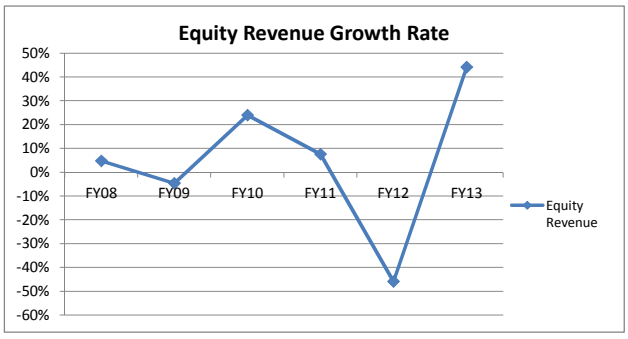
Growth Rate

	FY08	FY09	FY10	FY11	FY12	FY13
Regular DDS	11%	-10%	13%	-17%	26%	6%
Public Safety	19%	43%	-104%	53%	9%	19%
Total DDS Waiver	12%	2%	0%	-1%	22%	9%
Equity Revenue	5%	-5%	24%	8%	-46%	44%









Analysis

Current Budget Projection Method

Like any other program funded by the State, each DDS appropriations request is initially developed eighteen months in advance of the start of a fiscal year. That means data from the most recent fiscal year is not included in initial budget development. However, the fiscal experience in the initial months of a fiscal year is generally considered.

The current budget methodology consists of a three year average of the actual annualized new caseload and utilization approved by the state Equity and Public Safety Funding Committees, less the three year average of the actual returned equity revenue amounts for the past three years. This increment is added to the current year budget to establish the budget request for the coming fiscal year.

The 3-year average actual experience of FY10, FY11 and FY12 for approved new funding, less 3-year average equity revenue was added to the FY13 budget (plus budget adjustment) forming the basis for the FY14 budget proposal. A policy decision was included in the FY14 budget requiring the DDS program to achieve a $2.5 million savings target. The actual results of FY13 indicate a revision of target to $2.23 million as described in the memo the Joint Fiscal Committee in July 2013 in Attachment C.

Under this method, FY15 will incorporate the same 3-year averages of FY11, FY12 and FY13 would be added to the current FY14 base budget to arrive a 'steady state' budget recommendation.

As a methodology this works reasonably well when the trends are fairly consistent. It will not be very accurate or timely when trends are less consistent or changing at an accelerating rate up or down. The methodology appears to work well capturing the steady program cost drivers like June Graduates and increased individual budget need over time. It does not appear to work as well at capturing the more volatile Public Safety trend or other unforeseen cost drivers.

Historical Forecasting Accuracy:

To assess the accuracy of the traditional three year average forecasting methodology, the group compared a series of hypothetical forecasts to the three year average. The goal of this exercise was to determine if there was a forecasting method that would have more accurately and consistently predicted the increase in DS waiver needs in FY13, FY12 and FY11. The group ran hypothetical forecasts for regular caseload, public safety caseload, the total waiver, and the equity revenue. Using historical data, the following forecasting methods were tested for comparison with the three year average:

Methodology	Description
3 year median	Median value between the three complete previous FYs of data

2 year average	Average of the two complete previous FYs of data
Most Recent Completed FY	The actual dollars spent in the last closed FY.
3 Year Maximum	The maximum value over the last three previous complete FYs
3 Year Minimum	The minimum value over the last three previous complete FYs
Weighted Average (0.5, 0.25, 0.25)	The most recent completed FY was given a weight of 50% and the two following FYs were each given a weight of 25%
Weighted Average (0.75, 0.25)	The most recent completed FY was given a weight of 75% and the following FY was each given a weight of 25%
3 year average	Average of three complete previous FYs of data

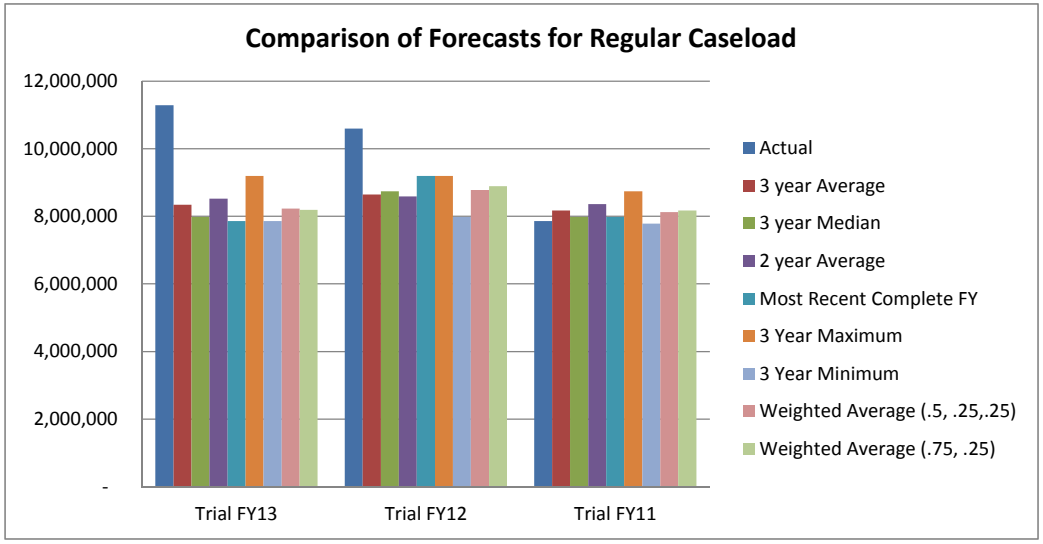
The results of these forecasts can be found on the following pages. The tables contain the trial forecast for each fiscal year and method, the variance between the forecast and the actual spend in the fiscal year, and the percent error. Several statistics are also provided to demonstrate the forecasts accuracy and consistency over time. The Mean Error (ME) is the average variance over the three fiscal periods and the Mean Percent Error (MPE) is the average percentage error over the three fiscal periods. These two statistics show the bias of the forecast; meaning the forecast generally over or under estimates the result. If the ME or MPE is positive it illustrates that the forecast is generally an underestimate, if either are negative it means that the forecast generally overestimates. The Mean Absolute Error (MAE) and Mean Absolute Percent Error (MAPE) use the absolute value of forecast variance and percent error to eliminate the negation of over and under estimates over time. These statistics can be used to assess the precision of a forecast; they demonstrate, on average, how much a method will vary from the actual value.

The results of this analysis indicate the in FY11 the 3-year average worked well for the Regular caseload and reasonably well for the DS waiver overall. It does not show much accuracy for the Public Safety caseload or the equity revenue. The accuracy of this method continues to fall in FY12 and FY13, however, none of the alternate methods using the same baseline data resulted in a better FY13 result for the DS waiver overall, including the most recent maximum or the most recent closed fiscal year. These alternates would have resulted in a similar budget adjustment need for FY13.

Regular Caseload Forecasts

	FY13			FY12			FY11		
Actual	$ 11,288,502			$ 10,597,742			$ 7,860,246		
	FY13			**FY12**			**FY11**		
Models	**Trial FY13**	**Variance from Actual**	**Percent Error**	**Trial FY12**	**Variance from Actual**	**Percent Error**	**Trial FY11**	**Variance from Actual**	**Percent Error**
3 year Average	8,346,167	2,942,335	26%	8,640,753	1,956,989	18%	8,169,508	(309,262)	-4%
3 year Median	7,984,657	3,303,845	29%	8,744,004	1,853,738	17%	7,984,657	(124,411)	-2%
2 year Average	8,526,923	2,761,580	24%	8,589,128	2,008,614	19%	8,364,331	(504,085)	-6%
Most Recent Complete FY	7,860,246	3,428,256	30%	9,193,599	1,404,143	13%	7,984,657	(124,411)	-2%
3 Year Maximum	9,193,599	2,094,903	19%	9,193,599	1,404,143	13%	8,744,004	(883,758)	-11%
3 Year Minimum	7,860,246	3,428,256	30%	7,984,657	2,613,085	25%	7,779,862	80,384	1%
Weighted Average (.5, .25,.25)	8,224,687	3,063,815	27%	8,778,965	1,818,777	17%	8,123,295	(263,049)	-3%
Weighted Average (.75, .25)	8,193,584	3,094,918	27%	8,891,364	1,706,379	16%	8,174,494	(314,248)	-4%

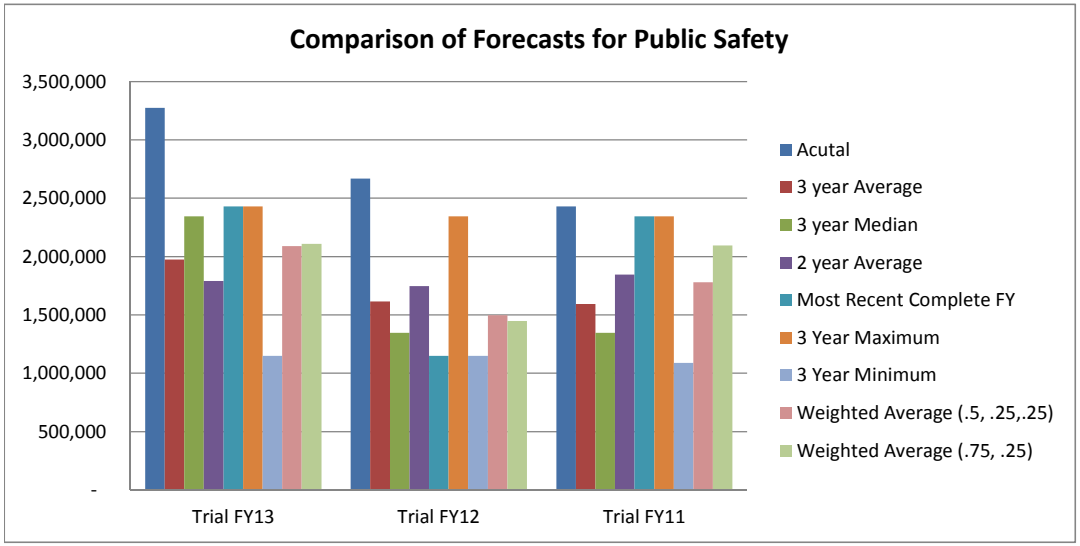
	Mean Error	**Mean Percent Error**	**Mean Absolute Error**	**Mean Absolute Percent Error**
3 year Average	1,530,021	14%	1,736,195	16%
3 year Median	1,677,724	15%	1,760,665	16%
2 year Average	1,422,036	12%	1,758,093	17%
Most Recent Complete FY	1,569,329	14%	1,652,270	15%
3 Year Maximum	871,763	7%	1,460,935	14%
3 Year Minimum	2,040,575	19%	2,040,575	19%
Weighted Average (.5, .25,.25)	1,539,848	14%	1,715,214	16%
Weighted Average (.75, .25)	1,495,683	13%	1,705,181	16%



Public Safety Caseload Forecasts

	FY13			FY12			FY11		
Actual	$ 3,275,045			$ 2,668,329			$ 2,429,694		
	FY13			FY12			FY11		
Models	Trial FY13	Variance from Actual	Percent Error	Trial FY12	Variance from Actual	Percent Error	Trial FY11	Variance from Actual	Percent Error
3 year Average	1,974,826	1,300,219	40%	1,613,914	1,054,415	40%	1,593,276	836,418	34%
3 year Median	2,344,670	930,375	28%	1,346,958	1,321,371	50%	1,346,958	1,082,736	45%
2 year Average	1,789,905	1,485,141	45%	1,747,393	920,937	35%	1,845,814	583,880	24%
Most Recent Complete FY	2,429,694	845,351	26%	1,150,115	1,518,214	57%	2,344,670	85,024	3%
3 Year Maximum	2,429,694	845,351	26%	2,344,670	323,659	12%	2,344,670	85,024	3%
3 Year Minimum	1,150,115	2,124,930	65%	1,150,115	1,518,214	57%	1,088,199	1,341,495	55%
Weighted Average (.5, .25,.25)	2,088,543	1,186,502	36%	1,497,965	1,170,365	44%	1,781,124	648,570	27%
Weighted Average (.75, .25)	2,109,799	1,165,246	36%	1,448,754	1,219,575	46%	2,095,242	334,452	14%

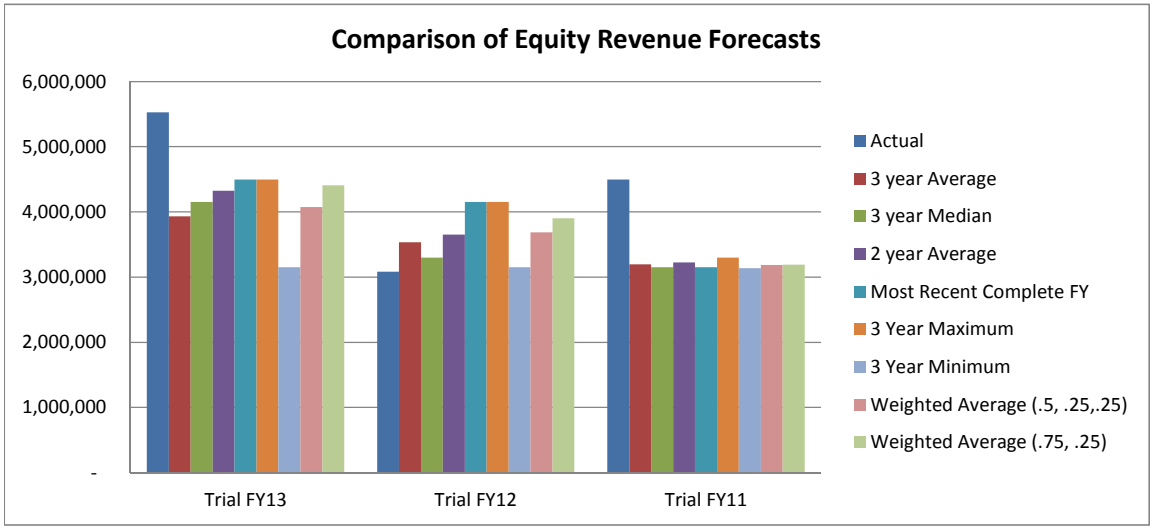
	Mean Error	Mean Percent Error	Mean Absolute Error	Mean Absolute Percent Error
3 year Average	1,063,684	38%	1,063,684	38%
3 year Median	1,111,494	41%	1,111,494	41%
2 year Average	996,652	35%	996,652	35%
Most Recent Complete FY	816,196	29%	816,196	29%
3 Year Maximum	418,011	14%	418,011	14%
3 Year Minimum	1,661,546	59%	1,661,546	59%
Weighted Average (.5, .25,.25)	1,001,812	36%	1,001,812	36%
Weighted Average (.75, .25)	906,424	32%	906,424	32%



Returned Equity Forecasts

	FY13			FY12			FY11		
Actual	$ 5,529,545			$ 3,081,631			$ 4,496,601		
	FY13			**FY12**			**FY11**		
Models	**Trial FY13**	**Variance from Actual**	**Percent Error**	**Trial FY12**	**Variance from Actual**	**Percent Error**	**Trial FY11**	**Variance from Actual**	**Percent Error**
3 year Average	3,934,303	1,595,242	29%	3,534,619	(452,988)	-15%	3,196,518	1,300,083	29%
3 year Median	4,152,415	1,377,130	25%	3,297,548	(215,917)	-7%	3,153,894	1,342,707	30%
2 year Average	4,324,508	1,205,037	22%	3,653,155	(571,524)	-19%	3,225,721	1,270,880	28%
Most Recent Complete FY	4,496,601	1,032,944	19%	4,152,415	(1,070,784)	-35%	3,153,894	1,342,707	30%
3 Year Maximum	4,496,601	1,032,944	19%	4,152,415	(1,070,784)	-35%	3,297,548	1,199,053	27%
3 Year Minimum	3,153,894	2,375,651	43%	3,153,894	(72,263)	-2%	3,138,112	1,358,489	30%
Weighted Average (.5, .25,.25)	4,074,878	1,454,667	26%	3,689,068	(607,437)	-20%	3,185,862	1,310,739	29%
Weighted Average (.75, .25)	4,410,555	1,118,991	20%	3,902,785	(821,154)	-27%	3,189,808	1,306,794	29%

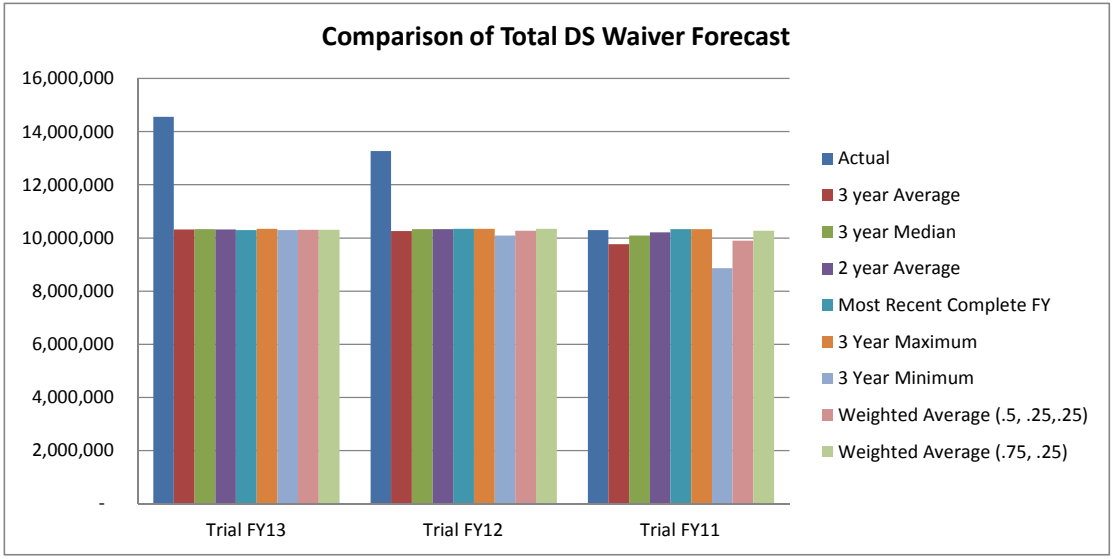
	Mean Error	**Mean Percent Error**	**Mean Absolute Error**	**Mean Absolute Percent Error**
3 year Average	814,112	14%	1,116,104	24%
3 year Median	834,640	16%	978,585	21%
2 year Average	634,798	11%	1,015,814	23%
Most Recent Complete FY	434,956	5%	1,148,812	28%
3 Year Maximum	387,071	4%	1,100,927	27%
3 Year Minimum	1,220,626	24%	1,268,801	25%
Weighted Average (.5, .25,.25)	719,323	12%	1,124,281	25%
Weighted Average (.75, .25)	534,877	8%	1,082,313	25%



Total DS Caseload Forecasts

	FY13			FY12			FY11		
Actual	$ 14,563,547			$ 13,266,071			$ 10,289,940		
	FY13			FY12			FY11		
Models	Trial FY13	Variance from Actual	Percent Error	Trial FY12	Variance from Actual	Percent Error	Trial FY11	Variance from Actual	Percent Error
3 year Average	10,320,994	4,242,553	29%	10,254,668	3,011,403	23%	9,762,783	527,157	5%
3 year Median	10,329,327	4,234,220	29%	10,329,327	2,936,744	22%	10,090,962	198,978	2%
2 year Average	10,316,827	4,246,720	29%	10,336,521	2,929,551	22%	10,210,145	79,796	1%
Most Recent Complete FY	10,289,940	4,273,607	29%	10,343,714	2,922,357	22%	10,329,327	(39,387)	0%
3 Year Maximum	10,343,714	4,219,833	29%	10,343,714	2,922,357	22%	10,329,327	(39,387)	0%
3 Year Minimum	10,289,940	4,273,607	29%	10,090,962	3,175,109	24%	8,868,061	1,421,879	14%
Weighted Average (.5, .25,.25)	10,313,230	4,250,317	29%	10,276,929	2,989,142	23%	9,904,419	385,521	4%
Weighted Average (.75, .25)	10,303,384	4,260,164	29%	10,340,117	2,925,954	22%	10,269,736	20,204	0%

	Mean Error	Mean Percent Error	Mean Absolute Error	Mean Absolute Percent Error
3 year Average	2,593,704	19%	2,593,704	19%
3 year Median	2,456,647	18%	2,456,647	18%
2 year Average	2,418,689	17%	2,418,689	17%
Most Recent Complete FY	2,385,526	17%	2,411,784	17%
3 Year Maximum	2,367,601	17%	2,393,859	17%
3 Year Minimum	2,956,865	22%	2,956,865	22%
Weighted Average (.5, .25,.25)	2,541,660	18%	2,541,660	18%
Weighted Average (.75, .25)	2,402,107	17%	2,402,107	17%



Recommendations

Risk and uncertainty are inherent in any forecasting and it is a good practice to indicate the degree of uncertainty associated with any forecast. Up-to-date data and applied judgment grounded in experience and knowledge are necessary to make the forecast as accurate as possible. This can be seen in the FY13 budget experience, while the initial budget for DDS required a $3 million budget adjustment based on the annualized experience of FY12 and early FY13. The year ended very close to, i.e. just under the newer revised amount.

The charge in Sec.E.333 (a) (3) requires this fiscal group to come to a consensus on a FY15 steady state estimate for the DDS budget by January 2014. Our recommendation is that a two pronged approach be used:

First, utilize the current methodology; include an update for approved new funding through the first quarter of the FY14, to project an FY14 budget estimate and develop a FY15 estimate.

Second, project DDS waiver costs by category of service once FY13 detail is available. Each category type would be discussed independently and a consensus reached on the time series and projection method (simple regression or average) for each. All the results would be summed to provide both an updated FY14 estimate and FY15 estimate.

This two pronged approach will result in a range and, from within that range a final overall consensus estimate can be reached. There will still be a degree of uncertainty associated with each of the estimates reached. An annual consensus process could continue similar to the Medicaid process and over time, one methodology might be indicated as a better model. An accumulation of these data sets is anticipated to be very useful in scoring significant policy changes, including the Act 48 (S.59) direct care collective bargaining impact anticipated in the near term.

Attachment A

Some Thoughts about the Continuing Upward Case Load Pressure in the DS System
January 2013; August 2013
William Ashe, Ed.D.

Working in the system for as long as I have, I do have some impressions on why the case load pressures in Vermont's DS system are continuing to rise. This in my view is a very complicated issue for which no definitive research exists (to my knowledge anyway) to clearly answer such a complex question at this time. Nevertheless, I do think it is valuable to consider the range of realistic variables that are likely contributors to the overall trend. As I have thought about this, I have come across very few variables which arguably function to reduce the case load pressure through natural means. The following list is not prioritized in any particular fashion.

1. Refugee Population - This is clearly a recently new and distinct group that can be pointed to as a driver behind some of the pressure. Currently the pressures are located in Burlington as this is where the current population is resettling. For the Fiscal Year just completed this group accounted for nearly a million dollars in case load expenditure. It appears that this pressure level will continue through this fiscal year as well.
2. Autism Spectrum Disorder incidence rate - Without looking at the data I think the incident rates for ASD have increased in recent years from 1:165 to 1:100 approx. This has I think been over the past decade or less. This has increased the numbers of people meeting funding priorities. Recently (2012) the CDC reports an increase in the Prevalence of Intellectual and other disabilities in the United States. This is led by the increase associated by ASD but includes other disability categories as sell.
3. Some years back (2001), the State altered its eligibility standards to include PDD. This has increased the number of people I think, and is also driven by number 2 above.
4. I think there has been a phenomenon where evaluators, knowing what it takes for people to get support, will make sure that their write ups more clearly speak to the specific language of the eligibility standards than what might have been previously the case. I know for a while the State did not want to accept reports from certain evaluators believing that reports would be stretched in order to make people eligible. There was a time not too long ago that an expectation was that DAIL approves an evaluator (for anyone on the spectrum) in advance. There were also several evaluators we were told by DAIL not to use.
5. Over the past 20 years or so I believe the population in Vermont has increased by 60,000+ people (I think since 1990). While I am not certain about the year to year changes the population trend in Vermont has been upward. As estimates of people with DD are based upon a % of the total population, this upward trend clearly translates to more people meeting eligibility as a function of population change. I do not know the magnitude of this.
6. As a function of the above, the "baby boomer" effect should be as real with respect to people determined eligible for DS services as with anything else.
7. The DS system in Vermont over the past 10-15 years has been nationally recognized and highly touted here in Vermont and elsewhere. Things that are seen as viable and desirable attract attention, and I don't think Vermont's DD system has been any different in this regard. The values and principles of the Vermont system have in large measure been delivered upon. Individual choice, empowerment, freedoms, employment, typical lifestyles, etc. are things that all of us want for ourselves and want for our children and other family members. Families

have sought out the DS system as a vehicle for their disabled family members to achieve a fairly high standard of life quality. This has translated into a continued increase in referrals.

8. Other state agencies have seen the DS system as being able to serve challenging people in relatively cost effective fashions. This includes DCF, DMH, DOE, and DOC. Referrals from these Departments has provided a continued referral stream. Often these individuals have been very challenging and very expensive. In the case of education, where people used to graduate at age 22, it is now much more common for graduation to occur at age 19. This has increased the people coming into the DS system at an earlier age.

9. The DS funding priorities and the State System of Care Plan has created "sort of" an entitlement for anyone who meets the funding priorities. For education graduates, the standard really is for people to have a job when they graduate. June grads continue to represent a significant number of new referrals each year.

10. Over the years the DS funding priorities have become I think very visible to many sectors of Vermont - agency and non-agency alike. While the typical person on the street may not have any idea what a funding priority is, that is increasingly not the case for persons with disabled family members and agencies involved in the service and support side of the equation. I think the DS system is much more readily identified and consequently referrals have increased.

11. The primary way people leave the DS system is by death. The death rate of people in the system is far lower than is the demand for new services. Consequently the service trend remains upward.

12. Contributing to the increase in system referrals is the reality of life expectancy. Due to life style as well as significant medical advances, life expectancy is increasing I believe for all segments of the population. I suspect life expectancy for people with disabilities may be more dramatic than for the non-disabled population. For example, in just the span of my career I believe the life expectancy for people with Down Syndrome has risen from about 35 years to now approaching 60 years. Another example can be found in every agency where people with complex medical needs are being supported in the community system where 20 years ago this would not have been possible. These are very expensive supports typically. Unlike many other "systems" the DS system serves people across their life span.

13. As people age, their needs increase (just like the rest of the population). Dementia is but one example. Increasing needs due to aging is one of the chief reasons for why the cost of care for individuals continues to rise.

14. I think (but am not completely sure) that the referral rate to ACT 248 continues to rise. Often these are very challenging people to serve. In addition to referrals, people on ACT 248 tend to remain there for long periods of time. The result is an ever increasing number of people being supported in this program.

15. The ways we have available to us to get people off of services, or into less costly services, is very limited when looked at from a systems viewpoint. The supervision needs that people have do not lessen quickly. The people that we serve, by in large, do not adapt well to demands of changing environments and expectations. The world that they live in (as do we) is continually changing in many ways. With some exceptions of course, the level of supervision and support that someone requires will not change a whole lot over time. This is particularly true as environments (in all of its dimensions) change - i.e. the full range of people, places, and things. People do learn a whole lot in the DS system... but the vast number of things that one needs to learn and be competent with in order to live independent lives (and ones that are significantly less costly) is beyond the abilities of many ... both the learners and the teachers. As I said there are some exceptions here certainly.

16. Over the years, to manage the budget the state has eliminated all of the proactive funding priorities. This policy has resulted in the current reactive system. Who knows how many less people we might now need to serve if the proactive and low cost priorities had been preserved? Currently about 50% of the people referred for services who are eligible are not approved for funding because their circumstances do not rise to the crisis levels defined by the State's Funding Priorities. How many of these persons ultimately are approved as their circumstances deteriorate is an unknown.

17. The economic realities in our society make it more challenging for families to support their family member than what was the case years ago. The availability of in home natural supports appears to be diminishing. We are encountering many more single parent homes than what use to be the case. Further, we are also seeing very few "intact" families where both parents are not employed. Increasingly there is no one home to care for (including basic supervision for safety) the person with the disability.

Interwoven into the above are many of the reasons for funding increases for existing people, as well as funding needed for new people served in the DS system. Changes in the needs of existing people, however, are not well understood at times by people not involved in the day to day aspects of service delivery. For this reason, it may be useful to look at the reasons for changes in the funding needs for existing people more specifically.

First, it is important to note that the basic premise behind the development of the funding plan for an individual is the concept of "no more and no less". This essentially means that the assessment of an individual's needs is intended to define on a person specific basis the minimal level of support that the individual will require in order to live successfully within a community setting. As everyone differs in terms of the needs and the supports that may be naturally available, funding levels will differ from one person to the next, even when their clinical and supervision needs are very similar. This means also that when a person's needs lessen (because of new skills, or perhaps positive changes in available natural supports), the amount of resources are changed to reflect these new needs. This is accommodated through an internal adjustment process where dollars are moved between people to accommodate for fluctuations in needs between and among existing consumers. When the needs of existing people change in significant ways proposals for additional case load funding are developed. The basic premise remains the concept of "no more and no less" when funding proposals are developed. Funding priorities need to be met in order for a funding request to be supported. Among the specific variables that contribute to new needs for existing people are the following.

1. As people age their needs often increase. Examples of such changes are medical conditions such as dementia, cardiac compromise, incontinence, loss of physical ability, (essentially the development of the same types of medical conditions that affect the general population). When these changes progress to the extent that existing supports are no longer sufficient to support the person successfully (as defined by the funding priorities), funding requests are developed to request additional financial support. Examples include greatly increased personal care needs, added supervision for people who no longer sleep through the night, wandering, and increased behavioral issues.
2. Nursing homes are full of people who could no longer be managed at home. In the DS System, people tend to be maintained within their home (often a developmental home) throughout the end of life process. This often necessitates increasing supports within the home to manage this added care successfully.

3. Many “existing consumers” live at home with aging parents. As these care givers age, and in some cases pass on, more supports become necessary. Natural supports are part of the supervisory package for many people. Such unpaid supports are not often replaceable except by some array of paid supports. This situation results in funding requests based upon this change in need.

These reasons are not exhaustive of every reason for the increasing case load pressure within Developmental Services. This listing is intended to illuminate some of the more observable reasons for case load pressure, and to accentuate the reality that these reasons are very much intertwined.

Attachment B

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June 30, 2013
Stephanie Barrett
Associate Fiscal Officer: Senate Appropriations
Vermont Legislative Joint Fiscal Office

Dear Stephanie Barrett,

My name is Nicole LeBlanc and I was appointed by the Vermont Developmental Disabilities Council and confirmed by Secretary Doug Racine to be on the Developmental Disability Services Legislative Work Group. I spoke to someone in your office and she said that you were the staff person looking at how DAIL estimates how much money is needed each year for Developmental Disability Services.

Our next meeting is July 19th. I look forward to reading your ideas about different ways to do budget projections for Developmental Disability Services. As a member of Workgroup I have a few questions that may be helpful to consider when evaluating different ways to do budget projections.

When I wrote to you last week I was asking to stop by and talk to you in person about my questions. But I am leaving to go on vacation on Monday and so I decided to send you my questions. Thanks for taking the time to read my questions.

- **Estimating the number of new referrals coming from refugee community:** A few numbers I heard were that for one agency, Howard Center, served 24 people from the refugee community from 2009 through 2011. But then during the first 9 months of 2012 there were 22 additional refugees who were funded for services. Is there a way to connect with refugee sponsoring organizations to anticipate future needs?

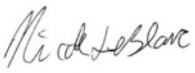
- **Aging individuals:** I have been reading about how the overall population of Vermont is getting older. I am a member of the Equity Committee that reviews proposal for new services. In general, people seem to be either in their late teens and 20's or late 50's and older. So if the number of older people in Vermont is growing I am wondering how that will impact the request for services. For example, in the past 6 months or so I have reviewed several proposals from people who grew up in Brandon Training School, got out and lived for the most part on their own but who now need help as they approach the later years of their life.
- **Aging Parents**: Another issue is people with developmental disabilities living with aging parents. DAIL reported in 2012 that around 54% of people receiving either waiver services or Flexible Family Funding were living with their parents. I review a lot of proposals from people who are in need of residential supports because their parents are getting older or are sick. Is there a way to track the age of family caregivers and somehow roughly estimate future needs?
- **The Reduction of Children's Personal Care Services:** There have been big changes in the Children's Personal Care Program resulting in a reduction of services for people under 21. Losing children's services has been a big blow to some families' ability to keep their sons and daughters at home. Does the formula being developed estimate future needs taking into account the number of children who are no longer getting children's personal care services?
- **Youth Aging Out of DCF Services**: Another ongoing source of referrals is youth who are aging out of DCF services. I heard that in the past DCF provided more of what is called "Over-18" agreements where they continue to fund services for youth who are at-risk beyond age 18. Can the state look into that? How many "Over-18" agreements did DCF provide in the 80's and 90's and how many are they funding now? As a member of the Equity Committee I do see a lot of proposals for youth leaving DCF.
- **Autism Definition Changes**: You may have heard that DSM-5 has made changes both eliminating and expanding some types of developmental disabilities. For example autism has been redefined. Since reportedly there has been an overall increase in the number of people diagnosed with autism I am wondering how this might influence our ability to predict who will be eligible for services in the future.
- **Employment Rate for Youth**: One of the funding priorities is to maintain employment of youth graduating from high school. How are the school's doing at finding jobs for graduates who qualify for developmental disabilities services? If the schools get better at

finding people jobs (and I hope they do) this could result in an increase in requests for employment services.

- **How Accurate has Our Way of Projecting Needs Worked over the Past 20 Years?** DAIL has been using a specific formula to estimate what funding will be needed for the next fiscal year. I've heard that for at least the past 5 years or more there have been rescissions or the need to go to budget adjustment to fund unmet needs. I am curious to know how successful this formula has been at predicting future needs over the past 20 years. I wonder how many times and for how long this problem of running out of money has happened?
- **People Who Are Eligible For Services But Do Not Meet A Funding Priority:** Each agency keeps a list of people who apply for services, are determined eligible but do not met a funding priority. This list may be useful in assessing current needs and projecting future needs. In addition to the numbers, does DAIL keep a record of what types of services these people need? (For example there are some people eligible for services who just need job support but the funding priority for support to keep a job is limited to youth graduating from high school.)
- **Costs per Person Over-Time Compared to Other Service Programs:** Sometimes DAIL factors in the cost of living increases when calculating the cost of services per person and sometimes they do not. But either way, DAIL reports that the costs per person have remained roughly the same over the past 20 years (and possibly have gone done if you factor in the cost of living increases). It seems that level of efficiency on the part of providers cannot last forever. Have the costs per person in other similar human service programs remained the same? Should we look at other programs to see how their rates or costs per person are estimated to change in the future?
- **The Need for More Funding for Some People Already Getting Services:** Each year about half of new caseload dollars go to people already in the system who have new needs. Is DAIL able to provide a profile of these individuals and the needs addressed to be able to figure out where the funding pressures are?
- **The Impact of Changing Funding Priorities:** Over the years real needs have been projected, but then funding priorities were changed so that some needs would not be met by the State. That seems to hide what is really needed. Is there a way for us to come up with a more stable baseline to use when making projections? How can the lost funding priorities be factored in?

I want to thank you for all of your hard work to refine the way we assess what people need. Your efforts will help us get back on track and figure out a way to be more proactive instead of reactive.

Sincerely,



Nicole LeBlanc
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Attachment C

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STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee - Pursuant to Sec. E. 333(a) (1) of Act 50 of 2013

Date: July 23, 2013

Subject: Developmental Services - FY14 Budget Savings Target

Sec. E.333(a) (1) of the budget bill requires JFO, F&M, AHS, and DDAIL to review the FY13 fiscal close of Developmental Services and present an update of the estimate regarding the FY14 budget savings target.

The FY14 budget as passed includes a savings target of $2.5 million. This is approximately 1.5% on the overall DS budget. Total DS appropriations have been:

FY09 Final	FY10 Final	FY11 Final	FY12 Final	FY13 Final	FY14 Passed
$134.85 m	$144.91 m	$148.62 m	$151.54 m	$160.98 m	$169.88 m

FY13 came in $272,626 below expectation, this experience in the absence of any other changes or updates results in an adjusted FY14 savings target of $2.23 million. Actual experience in the initial months of FY14 will inform whether there is a need for further adjustment.

In its simplest form, the DS budget is comprised of the individual service budgets for eligible Vermonters less available equity funds. Equity funds are the base funds that get reallocated when an individual leaves the system (moves out of state, death, etc.). Services are provided by the Designated (10) and Specialized Service (5) Agencies. These agencies conduct the intake and assessment and determine financial and clinical eligibility based on the System of Care Plan which identifies and prioritizes the range of fundable services. A local agency funding committee makes recommendation for new or enhanced client services to the state Equity or Public Safety Committees. While each request is specific to the approved service needs of the individual, each DA is ultimately paid based on their actual cost structure including administration. The overall DS budget is limited by the funds appropriated by the legislature. Reductions are made through a

rescission process in the System of Care when resources are lower than the projected amount for approved individual budgets.

In addition to the $6.1 million caseload increase initially budgeted, the FY13 BAA increased appropriations by another $3.0 million for caseload. These increases were the net of projected caseload and projected equity. The Department tracks the annualized, approved incremental changes to individual budgets as well as available equity resources on a monthly basis. This tracking is the source of the $272,626 adjustment to the FY14 target.

The as passed FY14 appropriation is based on several components:
1. The FY12 base
2. Plus the $11.39 m 3-yr average increase for caseload for FY10, FY11 and FY12[1]
3. Less $3.91 million of projected equity funds base on a three year average
4. Plus the same $3 million that was added in the budget adjustment
5. Less the $2.5 million savings target
6. Plus $1.875 million added for the SFI/CCC population (this is non-DS caseload)
7. Plus $2.94 million for a provider rate increase beginning in November 2013
8. Then a small number of minor adjustments – mostly net neutral

The adjustment to the savings target is based solely on the FY13 close out position. Actual experience in the first four or five months of FY14 will inform if further adjustments are needed. For example, in FY13 the actual equity amount available was $5.6m, the FY14 level of equity will need to keep pace to avoid additional pressure in the program. The overall budget timeframe, means there is a one year lag in the actual data available for the three year average. If a 2-yr and 3-yr average is updated with FY13 experience, a range of potential additional trend pressure could be between $900k and $2.2 million potentially impacting FY14 and likely impacting FY15 in some measure.

Attachments
1 – Language from Budget Bill
2 – FY13 and FY14 DS Budget Build Summary
3 – FY13 DS Caseload Monitoring – Final

Sept. 2013 - Caseload and Utilization Review Required by Sec. E.333(a) (2)

For the required caseload and utilization review, the fiscal group has begun reviewing and mapping in more detail the overall DS business/budget process, within that context we will be looking at both the caseload and utilization components. The purpose of the mapping is both to inform our analysis and identify the points in the process where recommended policy changes could impact the caseload estimating model.

[1] This includes both the regular DS caseload as well as the public safety caseload