STATE OF FLORIDA
DEPARTMENT OF HEALTH
AGENCY FOR PERSONS WITH DISABILITIES
iBUDGET RULES DEVELOPMENT WORKSHOP

Office of the Agency for Persons with Disabilities
4030 Esplanade Way
Room 301
Tallahassee, Florida 32399

In Re: Public Workshop, Rules 65G, Florida Administrative Code
December 18, 2014

MEMBERS PRESENT:

Ms. Denise Arnold, APD Deputy Director of Programs
Mr. David Dobbs, APD, Budget Director

Xufeng Nu, Ph.D., APD Statistician

SPEAKERS:

Ms. Suzanne Sewell
Nancy Wright, Esq., representing The Arc of Florida
Mark Berry
Ms. Janice Phillips
Dr. Julie McNabb, Executive Director, The Arc of Florida

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(Whereupon, the public meeting was called to order by Ms. Arnold, after which the following occurred:)

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MS. ARNOLD: Good morning, everybody, and Happy Holidays to everyone. Thank you for being here. This is a public meeting to get your feedback on the algorithm that's used within the iBudget. It is the first of several meetings we will have, as Dr. Nu, our statistician from FSU, has done the work on the algorithm and we have re-engaged him to review what we did and to hear your feedback and to see if we can improve it in any way.

So I'm Denise Arnold with the Agency; David Dobbs with the Agency. I know we have lots of Agency staff back there, we won't introduce them but we're all very interested to hear, you know, your feedback. So we have two hours. We'll take whatever we need. We have a couple of people that have said they wanted to speak.

What I first thought is I would ask Dr. Nu to kind of tell us what his work will be over the next month or two, and then we'll start to get your feedback.

DR. NU: Yeah. Okay. Good morning. So I'm a statistician mainly as a designer for this algorithm. I'm a professor and Chair of advanced statistics at FSU, so I have been here 1991. First I came to Chicago in 1986 from Beijing. I went to Chicago for my Ph.D. and stayed there for five years. So that's - good morning.

MS. ARNOLD: So the task that you're going to do, you're going to look at the current algorithm and then you're going to get feedback from these folks.

DR. NU: Yes.

MS. ARNOLD: And then what are you going to do with that?

DR. NU: Okay. Let's see, I waited for everybody to sit down.

MS. ARNOLD: Yeah.

DR. NU: So you know the algorithm, that was developed in the year 2010, that's about four years old now, you see. So when I make the recommendation to the Agency, I said, you see, we need at least every two years, we need to update that algorithm. We keep getting new information then we update the algorithm. So that, anyway, that's the usual stage, everything where you started. You see a bump on the road, you

need some time to adjust, so that takes a little bit longer than we expected. That's - some people are still coming in.

MS. ARNOLD: Yeah.

DR. NU: So that's - maybe I - let's just wait until everybody has a seat.

MS. ARNOLD: Okay. There are seats up front, seats in the middle. Should we wait for these guys to set up?

A FEMALE VOICE: If you like, that would be great.

MS. ARNOLD: How long will it be?

A FEMALE VOICE: Let me hurry up then.

MS. ARNOLD: Okay. She's going to set up so let's wait a minute.

Talk amongst yourselves. We're very formal here.

And we are recording, I meant to tell you all, we are recording this meeting.

Did everybody get a handout just to remind you of the formula?

Okay. So we're going to continue on with our public meeting on the algorithm.

Dr. Nu, you want to continue?

DR. NU: Yes, let's continue. I mentioned that

the algorithm was designed in the year 2010; that's about four years old. That's time to update that algorithm and try to find an even better algorithm. So I mentioned that initially when I recommended the algorithm to the Agency I said we need to update the algorithm at least every two years. So we know that ever since you get it started, so ever since that's kind of a slow process, a slow process. So we went through some different issues and some lawsuits last year, July, we wanted to call for some, you see. But we successfully defended the algorithm, everybody believed that's a solid foundation. It's a good algorithm. So now you see this year we begin to talk about, to reevaluate the algorithm and try to update that algorithm.

So I looked at the data since the last month in November, so now we have – remember, when we have the algorithm we use the data that's 2007 through 2008. That's the year that the consumers (INAUDIBLE). That's 2007 to 2008. So that's about six years old. Now we have the data for the 2013-2014. That, I believe, partially followed the algorithm. Technically, I don't believe that completely followed the - using the algorithm to do the distribution. I believe it was partially,

partially. So we re-figured the model, used all the variables that we choose, used the 2013-2014 data. Actually, that's a surprise. I mean, we get a much better fit using the new data. That's because the – I believe we partially followed the algorithm, so that detail did – so we can discuss why that – I know because it's an adjustment, an adjustment. I believe that partially we followed the use of money for algorithm. So that's why we are, why you say, variation in terms some or most of you not so familiar. That's what we use how much of the model can explain the variation in the 2013-2014 expansion, use the model.

Suppose that there are two variations of what; what's the fraction your model can explain using that variation? So use the original algorithm in the 2007-2008 data, that's about 67%; that's .67, but using the new data now we have .73. Seventy-three percent. So that's a surprise. I'm very happy about; that's I imagine sometimes – I believe that's because that's, that this use of money partially follows that algorithm. So the detail, you see, we can discuss here.

So now we plan – what do we plan to do? We plan to update that QSI score to get all the new

information because the data, and I looked at it last month, let's just use the '07-'08 variables; we did not do our research. We did not do a search through that whole data (INAUDIBLE) response, did not go through that whole process.

The last stage, we would use all that new information to try to find the best model, best algorithm. I hope we can, you see, reach 75 percent or even better, you see, if we can reach close to 80 percent. That's when we quit because many out of state, they begin the algorithm. Everybody realize that you need some scientific way to manage your money, to get your payroll early to let the consumer know how much that he can spend. Everybody knows – many states, they did that a long time before us. So many states, they just started – we remember, they started with a much poorer model than we have. So they are using like 30 percent, 40 percent initially; but eventually you will get better and better. When this process continues, we can – people say because of money distribution – and the more closely we follow the algorithm because we still need a lot of adjustments because we have some special need that's not going to use the algorithm. We have a lot of issues that we needed to address, like

transportation, like (INAUDIBLE) expenses. All this kind of stuff, we need a special – sometimes we need a special kit. We can't use another algorithm completely, but our hope is probably in the first of two years, last year, probably we followed the algorithm, for example, 20 percent. Maybe eventually we can get 50 percent, we can get 80 percent eventually. We look at not a totally perfect system, but close to a very good, like 80 percent, or eventually after many years we can get 90 percent.

So everything, we need a process, we slowly started and it's getting better and better. Okay. Nothing started is perfect. We never reach perfect, but we will get better and better. Okay.

MS. ARNOLD: Thank you so much. That was very helpful.

Just to remind you all what the algorithm elements are, that's what's in your handout, and I think what Dr. Nu has said, you know, that top part we're trying to get it as close as we can. You know, maybe we'll get to 80 percent. So that whoever needs the extraordinary needs becomes lesser and lesser of a need to kind of capture that and to increase. Right now we do a fair amount of the extraordinary

need, but so the goal would be that the algorithm becomes closer and closer.

One of the things we wanted to hear from you about, we have a couple of people that indicated they wanted to speak, and so we'll start with them. But we want to hear your impressions and, you know, if Dr. Nu doesn't understand what you're saying, he may ask you what do you mean by something, but we really want to hear what your impressions are.

Before I do that, though, I wanted to tell you that we are collecting – he mentioned the QSI. We're collecting some QSI addendum questions, which you may be familiar with, that we used for the wait list to help prioritize the wait list.

But it's some questions about the health and the age of the caregiver and the ability of the caregiver to be able to work and if their caregiving responsibilities are preventing them from working. And so we have data that's been collected by our QSI assessors that Dr. Nu will get that is data he's never had before. And in addition, he will have all the new QSI data to look at which is volumes and volumes of data points – many, many data points. You know, I don't remember how many total questions there are in the QSI, but it's a lot and so he'll

have all of that, lots of good data for him to look at.

So that gives you kind of a feel for where we're going and I'll just ask Suzanne Sewell if she would like to come – and if she would, please come up here and we'll move this down. You can just sit down if you'd like and use that in front of you. Thank you so much.

MS. SEWELL: Thank you. We begin by saying that we are not experts on the algorithms, but we have seen some of the impact and results; and so part of what I will be addressing will be the results. You may have to figure out how to back in to the correction. Okay?

MS. ARNOLD: Okay. That's fine.

MS. SEWELL: We understand – yeah – we understand we have a complex mathematical formula. It's to be based on statistically validated relationships between client characteristics which are variables, and then clients' level of need should be incorporated in to determine the services that you want to get through the waiver. But it looks like based on past and current court rulings and then what we're hearing, too, that maybe the algorithm is not as effective as it needs to be, and there are some observations

that we've noticed.

The first one that we thinks needs more weighting is the age. Individuals, particularly those who are 55 or over, you can expect I think to start seeing some of the effects of aging coming into place. The population, I think, tends to age faster than others and I think you can assume for someone who's 55 and older, if they have a caregiver in place, it's probably – chances are they're going to be suffering from infirmities of aging, too, or some age-related effect. So we would want you to look at that.

DR. NU: Okay.

MS. SEWELL: Secondly, and again, this may be more outcome than the actual algorithm, but we do not think that the algorithm should be designed or in some way influenced by certain core services and the availability of those services. Your service needs are your service needs. We saw under implementation certain services just – such as transportation – being removed. Again, not sure how the algorithm is going to actually address that, but we need to be looking at need, individuals' needs and whatever that particular service may be.

Obviously, choice needs to be a major

consideration.

MS. ARNOLD: Yes.

MS. SEWELL: You mentioned the current assessment and evaluation methodology. We do think that needs to be looked at again so that the budgets that are generated are accurate predictors of cost, and then the funds should be distributed equitably based on the individual needs and obviously some consideration for available family or other support systems.

We did not identify specific mechanism for reserves that must be available for supplemental needs and how they're captured by the algorithm, and maybe this is the extraordinary needs pool. I'm not sure exactly how all that plays out, but we think that that does need to be addressed a little more. Our providers report difficulty once those extraordinary needs appear and never getting those approved or meeting those needs. So I think just how that process can work needs to be streamlined.

MS. ARNOLD: So you're saying it's difficult to get extraordinary needs approved? Is that what you're –

MS. SEWELL: Once you have your iBudget, it's hard to get the – yes, the amendments in the changes.

MS. ARNOLD: Okay. Okay. Thank you.

MS. SEWELL: Hopefully, other providers can speak to that, but that's what I'm hearing.

MS. ARNOLD: Okay.

MS. SEWELL: We do support the defined systematic process for establishing cost plans and services for individuals through the iBudget process, as long as the needs of individuals served are met and the program is adequately funded. And I think that was a major concern we saw. This was more of a cost containment exercise than it was an equitable distribution of funds that, that was how it was seen as it evolved.

There's a cost of care. I think the iBudget needs to recognize that. The funding has been increased. Hopefully, there are more funds to work with, but again, ultimately this needs to be addressing individual's overall service needs and not how do we ratchet back expenditures.

MS. ARNOLD: Okay.

MS. SEWELL: We would be interested in knowing more and understanding the type of data that APD has collected to date on the effectiveness of the current algorithm, what conclusions actually are understandable, what we know now other than how we

cut costs or save money. You know, are you confident and I assume there must be some question about competence, or we wouldn't be here trying to revisit this, but, you know, how close are we to actually meeting individuals' needs? At one point in time I thought we said, well, maybe about 60 percent. Now you're talking about mid-70s or whatever.

DR. NU: Yeah.

MS. SEWELL: So obviously we want to see a high degree of competence, yes, we are meeting folks' needs.

DR. NU: Yes.

MS. SEWELL: At one point in time there was some thought that, and I think this may even be indicated in the statute, that the iBudget algorithm could be useful for re-basing cost plans to live within the appropriations. Again, we would encourage you to back away from that. Let's look at meeting people's needs and what the cost of care is rather than trying to focus so much on cost savings.

Those are our comments. Thank you.

DR. NU: Thank you. Yeah, let me respond to Suzanne's comments and suggestion. Age, that's an important factor in the algorithm. So age in 2010 we needed to try a different way to handle age. For

example, currently we are just using age below 21 and age above 21, 21 and older. That's a two-level, you see, variable. So in 2010 we did try, like, I believe it was 55; I thought we tried it at 45, too. So basically when we began to search for the new algorithm, we want to see the age. That's an important one. We want to try different – we need to discuss – that's why I need everybody's input. Let's discuss which age, supposedly we have one more level, 45 or 55 or 60, when people are close to – you see, different from different sources. So, anyway, we need to discuss what's the best – you see, 21 that is one of them. Above 21, either 45 or 55 or 60, we can, you see – I can try different ways in my models to see which one fits better, but we also can discuss common sense which ones make sense. That's why we need everyone's help to improve the algorithm to get better because we want to serve that consumer better. We want good for all the people. So that's age.

The caretaker's age, we did not consider that one in the last algorithm. So I don't know, the caretaker generally they just have one main person or you have several people to provide the care.

MS. SEWELL: And that QSI addendum stuff we're

going to give you, we'll give you that data.

DR. NU: Okay.

MS. SEWELL: The age of the caregiver and their health and so you'll have more data than you had before about the caregiver.

DR. NU: Okay. Yeah, the caregiver, generally for one consumer or one who has three or four consumers, that's – also the consumer can't have multiple caregivers' help. Also, last time we also discussed about the family support. Right here you see family member also with or without, you see right here – you see where they come here regularly or this can – some factor we feel that's not so easy to, you see, specify how much support the consumer get from family, from relatives, from different sources. So that's about that part. But I believe it's the same as now, we have more complete data, so very hopefully we can get much better avenue. We will track all of the predictors or all the variables. Last time we have over 55. This time we may have 60. We may have 70. I want to use the computer until – go over, you see, all the searching and try to find the best I could. Definitely, that input from the, from you guys, from the meeting, that's essential. That's very important to our – for us to develop a beta model.

So let me see, Suzanne, age and the caregiver. Is that all you mentioned in your –

MS. ARNOLD: I think you hit most of the main ones, yep, so let's hear from someone else. We've got Nancy Wright.

Nancy, if you'll come up and sit here and we'll move the – thank you, Nancy.

MS. WRIGHT: Hi. This isn't microphoned –

MS. ARNOLD: No, it's just they need it for the camera.

MS. WRIGHT: All right. So I'll try and talk louder. I'm Nancy Wright, an attorney, and I'm here to represent the interests of the Arc of Florida.

So some of the things that you mentioned earlier were some of my main questions. In the 2010 legislative report, there was a lot of statements that certain data was unavailable to be able to analyze to determine whether or not it would be a good variable and you told the legislature – APD told the legislature that it would over time collect more data. And I know one of those was the age of the caregiver and you addressed that, that you're collecting that through the addenda. But, like

Suzanne, I think all of us would like to see what other data has been collected that you weren't able to use the last go around and, and we can kind of help you figure out whether or not we think that would be effective.

So that was number one. Now, in terms of the need for revision, I think it may be important to kind of point out you talked about – Dr. Nu, you talked about other states and they have started with an algorithm that had a pretty low R2 value which is not something I fully understand, even though I keep trying. But I will also point out that in other states this was not used as a cost containment measure, that an algorithm was intended as a baseline to try to equalize cost plans among people with very similar needs, and we all know that's a problem, that there may be people in the panhandle who have exactly the same sort of situation as people in South Florida, and even not taking into account cost of living, their cost plans are widely different.

So the algorithm I think that was its primary purpose and function, and of course the way it's been implemented in part because of lawsuits – I can't imagine how that happened – they – it, it just hasn't worked this way at all. So when you talk about 2013

and 2014 data and the number of people impacted by the algorithm, I've got to think it's very small because, because no one was increased so that's about 60 percent of the population. And then, and then no one was really – as of January of this year, no one was decreased. So the only people who got a decrease were the people who did not request hearings on the reduction. So that's all the algorithm affected for 2013 and 2014, which I don't think is a good sample data.

And the other thing to think about is those states that were using the algorithm as baseline to equalize, they had massive reserve funds. When you read the reports from these other states, they said don't think of iBudget as a cost cutter because you actually end up spending more because of this equalization process. What it does it helps contain the cost so that people can then use it as a budgetary system and move services throughout it. And that's, that's kind of not what happened here and the statute doesn't allow it to happen because the test for getting more services is pretty stiff. It's serious. I may misquote it but I believe it's serious immediate jeopardy to the health and safety of the client, the caregiver, or the public. It's nothing

about welfare.

If you, if, you know, if you took that literally to its extreme, that would mean if you kept somebody safe sitting in a room watching TV all day maybe you don't need more than that. Now, all of us know that if you're going to look at mental health and quality of life, you've got to look at more than that, and I think the Agency understands that but the criteria is pretty serious. And what leads me to is that if you're going to use the algorithm as a primary method to actually fund people then it's got to be better than any of the states out there because we're using it differently. And I don't know how to get there 'cause I have no understanding really of statistics, but I will tell you some of the places that I know have been problematic.

The first is in the family home. People in the family home – I had the great pleasure of going through 11,000 pages of documents in the Morland case, and it was clear from the very start in Agency meetings that the Agency's staff were very concerned about the impact that this was having when they started running the figures on people in the family home. And so that needs to be addressed, and maybe one of the ways to address it is through looking more closely

at the caregiver.

I have some other suggestions. One – I started looking at this trying to think who are the groups of people that I know are the most costly or require the highest level of services?

And this is true – I do special education; this is true for special education, it's true for my clients in any waiver whether it's a long term care waiver program or whether it's this waiver – and these are what I came up with. And the first one is behavioral problems, significant behavioral problems.

And those people in order to help them toward their own independence, the first obstacle you're trying to overcome is behavioral approaches to life that are making it difficult for their caregivers to do anything else but manage behaviors. So those people need an extra layer of support and services and their care is much more difficult and you generally have to pay people more to give, to give care; and the caregivers of people with serious behavior problems are, I'm pretty sure, the highest burnout rate of any that you'll find and the most likely to ultimately feel like they have to institutionalize their – the person they're caring for.

So – and, and one of the things that I see in the QSI that is problematic to me is that the way the QSI is scored many times doesn't actually reflect whether a person has those significant behaviors because it has embedded in to many of the questions when you look at how the responses are scored, somebody can get a very high response on a behavior issue if they're taking psychotropic medications. Now, I've got clients who take psychotropic medications and actually they've been very beneficial and they're really not a significant behavior problem. Sometimes – in fact, that's the point, it often doesn't work that way, but I think you need to take out of – I think you still need to ask the question about psychotropic meds but I think you need to take it out of its imbedded features in whether or not this person exhibits, actually exhibits these serious behavioral problems to get to the point where you're seeing what that person's needs really are.

MS. ARNOLD: I'm not really sure what you're saying there.

Can you state again?

MS. WRIGHT: So if you have a question on the – I don't have a QSI in front of me, but you'll have a question on the QSI that says that deals with

aggressive behaviors. You can get a score of three for – I don't know, you know, having those aggressive behaviors within more than a certain number of times in the past six months or something.

MS. ARNOLD: Mm-hmm, mm-hmm.

MS. WRIGHT: But you can also get a score three if you take one psychotropic med.

MS. ARNOLD: Oh, I see what you're saying. Okay. Separate the –

MS. WRIGHT: Right, separate –

MS. ARNOLD: – the use of the medication from what the –

MS. WRIGHT: From, from –

MS. ARNOLD: – behavior is?

MS. WRIGHT: – what the behavior is and how frequently it's occurring.

MS. ARNOLD: Okay. Okay. Thank you.

MS. WRIGHT: Okay. I think also that you need to give more weight to behavior, the total behavior score, that that will – that might actually help with skewing of a little bit more in favor of that.

The second area that I see that results in people needing a lot more services and a lot more consistent services are people who have very limited communication ability.

Those people require a much higher level of just hands-on, eyes-on. Their staff has to really understand them and see their moods and know how they typically are to discern whether or not they're having health issues, how to, how to discern between health and behavior issues.

MS. ARNOLD: Okay.

MS. WRIGHT: And there are, and there are – it's more difficult, I think, to help them become more independent as well. And I don't think that's anywhere in any of the, the scoring.

And then the third issue that I don't think is adequately addressed is the people with complex or chronic medical conditions. And I know that there was some co-variability – did I say that right – on, between the lifting and the trans-, the functional and the complex medical. But in real life I don't think I saw that that translated all that well. Maybe even looking at things as whether or not somebody requires any nursing care 'cause those are typically the people that have a much higher – I have a lot of clients that have a problem with transferring or lifting, but they don't need the high level medical care of other clients. That makes a big difference in their cost variability. So –

MS. ARNOLD: So you're thinking 'cause that was in the physical section of QSI that maybe we lost something by not –

MS. WRIGHT: I think you may have lost something by doing that, maybe focusing on the more chronic people that need nursing care.

MS. ARNOLD: Okay.

MS. WRIGHT: That's just a – I'm –

MS. ARNOLD: Okay.

MS. WRIGHT: I'm guessing here. I don't really know.

MS. ARNOLD: Okay.

MS. WRIGHT: So those are, those are – oh, and then the last thing was transportation.

Transportation is, as I understand it, it is so variable across the state that it would be almost impossible to come up with a factor that would handle it well. You'd either get too much for some areas, too little for others. It strikes me that it would be a much better approach if you – if you could do the algorithm and then add the transportation in based on what the actual transportation costs –

MS. ARNOLD: Oh, okay.

MS. WRIGHT: – for that area. Someone told me that in Orlando for instance it can be as much as

$30 or more a trip?

MS. ARNOLD: Mm-hmm.

MS. WRIGHT: And in, you know, my area it may be like six.

MS. ARNOLD: Tampa, too, they have very high –

MS. WRIGHT: Yeah, and then you're also going to run into issues – and maybe this is an extraordinary need issue; I'm not sure – but if you have people that have behavior problems and medical issues, their transportation costs are also going to be higher. So, thank you.

MS. ARNOLD: Thank you.

Did you want to address any of those?

DR. NU: Yes, yes, yes. Again, you gave some good points and good suggestions. Let's first talk about transportation. I think that's a good suggestion, probably last time we had several meetings, let's see, in 2010. So we discussed over and over again, we tried different ways – tried to figure out what's the best way we can handle the transportation. So I think basically these were good suggestions and probably we should treat it as a special need, like dental, dental. A lot of times we discussed – we decided, well, we have used this

algorithm to provide a base need. Then any other special need, like dental, like a special transportation, then we can add it based on different areas. I think that's a very good suggestion. That's a very good suggestion.

We can continue to discuss other people. You have some you see who have a good result. You think that's the way that's better to handle transportation because now currently we don't have a good variable to handle that transportation, that issue. So that I think if we treat it as a special need similar to a dental cost, that's probably a good way, probably that's a good way.

The QSI, let me – I believe most of you know that QSI, basically we have three parts. Okay. That's physical and functional and the behavioral. Okay. Behavioral. Okay. So we have three parts. Okay. So I do have the form you see here that's – I did not do the QSI. The QSI was, I believe that's by a different group; in South Florida they have a group that did that. Okay. So I just used the data, you see, or the collective – they approved the reliability. They did a lot of study, you see, that South Florida group. They did maybe two or three years. There was a way to collect the data and how

to, you see, evaluate it. That's (INAUDIBLE) and so they did about two or three years on that. So in the 2010 we just used the current QSI score, and you see after they had done all the study.

The QSI is essential. The QSI score, that's essential. Accuracy of a QSI, that's very, very important. Okay? The basic idea, we want people with similar conditions give that, give them a similar, you see, basis using money, okay. Basically, you see, that's the main idea. That's a way to distribute the money, distribute the funds.

So the QSI, you can see that the algorithm uses the QSI scores that you say is different variables. Besides, it even conditions – besides age, that's the main variable from QSI, from the QSI. So I saw some questions that you guy raised to it. Some people mentioned that the QSI score needed to go back to the consumer, verify it's obvious if somebody gave that score or go back to the consumer and verify, you say, its accuracy. Everybody agreed. I know that's a lot of time. Okay. I don't know that it's a category or some other people said they went through the updating, to be honest. I don't know what's the procedure that QSI score, that the Agency is currently

doing to try to update that QSI score.

But definitely that's the mostly important, we need accuracy as possible. Okay.

Also, you see she mentioned what some out of state agencies do, they just use the algorithm as you see it, like through a basic distribution, distribution of the money. So that's how to use that algorithm. Okay. My way, I have a category, you see, medium, tall; she's just newly joined doing this, having me doing this one. I always say "Possible". That's the word provided to the best group, you see, based on the data available. Okay.

The data, that's all you (INAUDIBLE) because, you know, they spend – they need a lot of money, need the peoples to work to – so that's, again, that's you can't look at it perfectly, you see, all kinds of data. You always try to improve that data quality. Okay. You try to get better and better. So I always say "TOSCA" (ph) that's a word to try to best guess the algorithm. Then how to use that one. So last time I know the Agency still have – does have an average pot. So it's just like the information, it seems that, you see, in the last year or 2013 and 2014 that the algorithm affects, it's very limited, very limited. So even though you have a case, we

still need approval from the 67% to 73%. Even with so limited, you see, effect. Okay. So that's – I think that's, you see, these improvements and have a good point. I hope that we continue our discussion. Like transportation, that's a good point, also. QSI score, we can discuss about how to, you see, what it does it look like in the new data? Anyway, we can continue to improve their quality.

MS. ARNOLD: Great. Thank you. Okay.

How about Mark Barry (ph)? I think you indicated you wanted to speak. Is that true?

MR. BARRY: I was on the line.

MS. ARNOLD: I figured you did. You were part of our original group. Yes.

MR. BERRY: My name is Mark Berry, and yes, I had the honor of being on the work group for the, for the iBudget and was proud to do so. Of course, later we went into hiding, those of us that were on the work group as we implemented the iBudget.

MS. ARNOLD: And now you're coming back out again?

MR. BERRY: Yeah, and that would be one thing that I would encourage you is that as you open this back up and look to refine and re-implement that you make it again, 'cause I believe the original intent

was a very good and worthy and noble and honest effort to, to equitably allocate funds to individuals in a fair way. But I think that you need to do it in a very open and disclosed way again. I think that's where – that's a big part of why and how we got off track. So I would encourage you to do that.

In the area of transportation, I think I was a noisy gong from the beginning on the, on the notion of transportation. And the algorithm is simply a way to fairly divide out the pie and I know that you have to pull out an amount for extraordinary needs which reduces the pie that gets allocated, and I do think that transportation has to be pulled out, also. But I don't think it should be part of extraordinary needs. Transportation is different than extraordinary needs. It's a fixed and predictable cost. If today's cost is $75 million, and I don't know if that's even close, but if the total cost today is $75 million, even once we put everybody through the algorithm and allocate their services out and they get probably pretty much close to what they're getting today, their cost next year is going to be about $75 million.

So it's a predictable amount that we can just pull out before we divide the pie and then reallocate

once they get their support plans and select their services, and it'll get more accurate and more predictable each year if you do that. So I would strongly encourage you because, as I said, dividing the pie if you have – I like to think of it, the best way for me to think of the iBudget and how the algorithm works is if you had twin brothers that had the exact same profile and one lived in Orlando and one lived in the panhandle and you didn't pull out that transportation, once they got their iBudgets, the one in Orlando would not be able to purchase as much day support as the one in the panhandle. So that's the simple reason for pulling that amount out and being able to give back what they need, what they had before the iBudget. So those are my comments. Thank you.

DR. NU: Good point. Good point.

MS. ARNOLD: Thank you, Mark.

DR. NU: Yeah, Mark, we worked together last time. Mark had very good suggestions last time, continues to help us this time.

MR. BERRY: My first son was just starting FSU and he graduated a year-and-a-half ago, so a long time coming.

MS. ARNOLD: Okay. Let's see who else. I'm

not sure. Let's see I have a question mark, Janice Phillips (ph); did you want to – thank you, Janice.

MS. PHILLIPS: I'm just going to add a couple of comments.

First of all, I support both Nancy, well, everybody who's spoken, Suzanne, their comments about what we need to look at. Just another comment with regard to the medically complex population. I think we need to look at maybe the number of medications people are on; that becomes very difficult for medication management. And it also impacts – is highly impacted by the level of our staff. You know, sometimes medication management is very difficult for us to handle ourselves, even for ourselves personally. And we're looking at people who maybe don't have a lot of experience with medications and we're asking them to manage sometimes multiple, multiple medications with multiple potential interactions.

So it's both a rate issue in my estimation and –

MS. ARNOLD: Okay.

MS. PHILLIPS: – and it also impacts how difficult somebody is to assist in their daily life

'cause that requires a lot of attention and a lot of time.

The transportation issue I agree with; I also agree it's not – it shouldn't be seen as, you know, as an exceptional need but it's – it is very variable from area to area, which could maybe be addressed in a different forum 'cause, you know, with transportation itself.

But that being said, the other is – two other short points. One point is that the dental, the DME issues, and the environmental modifications need to be a simplified process. Those cannot always be justified through the – I get confused with all y'all terms, even though I live it every day, but supplemental needs issues, it doesn't always flow to the top of that.

MS. ARNOLD: Okay.

MS. PHILLIPS: It still, even though the criteria's been adjusted on supplemental needs, it's still very difficult to reach the benchmark of getting additional funding. It's very time consuming. I'm a support coordinator for those of you who don't know. It is very, very time consuming on the part of us, on the part of the individual's family in most cases because that's where we're seeing the issue because

they are not impacted with the exceptional needs by and large.

MS. ARNOLD: Okay.

MS. PHILLIPS: So those, those –

MS. ARNOLD: But they're having trouble accessing the dental, DME, and environmental mods that they need; is that what you're saying?

MS. PHILLIPS: Right, right.

MS. ARNOLD: Okay.

MS. PHILLIPS: I mean, there's justification that they need those but they don't always float to the top of the criteria.

MS. ARNOLD: Okay.

MS. PHILLIPS: And then it also needs to be a somewhat more simple process.

MS. ARNOLD: Okay.

MS. PHILLIPS: And just from an APD standpoint, we're losing providers in all three of those areas because we don't have any business for them. So when we do have business for them, we can't get it done because of the lack of availability of providers.

MS. ARNOLD: Okay. Janice, do you have a thought about the age? Others have talked about 55. I've heard 40 from other people that have – do you have any sense on the, the older group?

MS. PHILLIPS: I think, I think we need to probably look at 50 at a minimum. We could drop it a little bit lower, but what we're seeing is the decrease in skills and abilities and cognitive function of people as they age around 50. We've almost become to look at the birthdays, you know, trying to predict and make sure that people are saying and looking at a person's needs and not just kind of letting it float to the top gently, but trying to get proactive about people's abilities at those ages.

More medical issues occur, more cognitive issues, so those things become, you know, more evident, you know, as a person gets at 50. I think 50 is a critical cutoff point. If you wanted to do something ahead of time, you'd need to drop it to 48 or 47, but I think by 50 you're either seeing some things that you're going to see or for some people you don't see it, but for a large number of people you do.

DR. NU: So, Janice, how do you think 50 versus 55?

MS. PHILLIPS: Because at 50 you see a lot of issues related particularly to people who have Down syndrome and their cognitive functions begin to be

impacted significantly at age 50. Not always at 50 but close to 50.

MS. ARNOLD: Go ahead, Debra.

DEBRA: We had retained Dr. CHINO who's a neurobiologist, who's doing training for us on the aging issue. And I think it's at 45 he suggested our Agency start videotaping because it's a very standard thing that they do projecting maybe dementia impact or whatever and starting with 45 in our population and you can see. Maybe that's something we kind of need to consider institionalizing because that's the most telling, that's what you've got to take to the medical personnel for some different diagnosis and tells us has it started.

MS. ARNOLD: Okay. So as you look at the data you'll kind of see, won't you, whether you start to –

DEBRA: Right, because they are in an accelerated aging pattern.

MS. ARNOLD: Yeah.

DR. NU: Let me ask the Agency about the modeling process, like age. Last time, you see, we did a trial like (INAUDIBLE) versus two – means below 21 and 21 and above. You see, like 50. At 50, people feel, well, likely people over 50 need more money. But

the practice for a lot of complicated issues. There's not a measured way – because sometimes, I give you an example, where I believe last time we tried the over 50 it gave you negative number. Then we don't want that because, you see, first we want to see – compare the model, so which model that's better. The end term is how much the fraction of your model explains the whole, that whole is a total variation. We call the variation consumer to consumer. We view the whole variation as one, then we see model, you model how much of that fraction you can explain by your model, the total variation. So that's so – I'll explain to you guys one more time, that's actually a lot of statistical terms, that's –

MS. ARNOLD: That's your thing.

DR. NU: That's harder for everybody to totally understand that. Wednesday, a good story, Wednesday, you see, I had a car accident. So a policeman came here. He saw me and he said, "Oh, Dr. Nu, I know you. You taught my class." So they began to worry, we can agree that he got it from a cop. But, anyway, many people are just – we as a society, statisticians, we – that's already helped our society a lot. But I know many people hate us

statisticians, students, so many students, for them, they are average students and are doing studies, so that's also a tough subject for them.

Okay. But, anyway, so that's – we will try different ways to see, given that visible way, and what's the best model. We definitely will try it like the age of 50 at this time.

MS. ARNOLD: And 45 maybe.

Was there anything else, Janice?

MS. PHILLIPS: That was, that was it. I was just going to respond to Debra. They probably have better data than me. Mine's all observation of people and interacting with people over time, but around 48 to 50 is where we're seeing it.

MS. ARNOLD: Okay.

MS. PHILLIPS: And maybe the QSI needs to have some questions because it's not just people with Down syndrome; it's people with cerebral palsy and people who are medically complex –

MS. ARNOLD: Yeah, yeah.

MS. PHILLIPS: – and that's difficult on a person's physical being, and you're seeing the impact, you know, in a lot of ways, not just their daily care but their cognitive abilities and other things. And I don't – and they're so subtle it's

hard. Currently, the QSI is not a subtle instrument. It's a very concrete and specific –

MS. ARNOLD: Right, it is.

MS. PHILLIPS: – instrument, but if there could be some things that are in there that make you look at it three years hence, you know, that you look at it again and see if there's any –

MS. ARNOLD: Well, I know there's some other assessments that y'all have shared with us about sort of that aging piece, and so maybe we need to look at, you know, adding that at some point in the process.

FEMALE VOICE: And then maybe do some age certain work, you kick into a further evaluation.

MS. ARNOLD: Right, exactly.

MR. BERRY: And I think –

MS. ARNOLD: Hold on, hold on. Let's see if Janice is finished.

MS. PHILLIPS: That's it.

MS. ARNOLD: Okay. Nancy had her hand up and then Mark.

MS. WRIGHT: So I did read in the 2010 legislative report where when you tried to look at to put, put 55 in or some of the other ages that you did result in actually having less cost plans, lower cost plans. But I wonder if maybe rather than an

age criteria if you had better data on dementia diagnoses because I suspect what's happening and what I see with a lot of my clients is exactly, you hit 50 and they start experiencing dementia and their skill sets; people who were not very high need now becomes much higher need. But the other thing I see is that as people with severe behavioral problems age, then a lot of times those behavior problems start becoming more manageable and go away so their cost plans can go down. So maybe the key is not the age so much as the diagnoses.

MS. ARNOLD: Okay. And Mark?

MR. BERRY: Just to kind of piggyback on that, the reason 21 was so significant was because the waiver doesn't allow you to purchase certain things under 21.

MS. ARNOLD: Right.

MR. BERRY: So it was, it was a concrete very determinable variable that worked and it gave better reliability. I think beyond that there's really no age break that works in terms of putting weight on it. What's important is the assessment that picks up the subtle differences and then how frequent we do the assessment. If we're only doing the QSI on people once every five years or three years, maybe

at a certain – maybe at the age of 45 or 50 you start to do it every two years or every year.

MS. ARNOLD: Right, yeah.

MR. BERRY: Or as the support coordinator as well as others feel it's needed, so that you're picking up those subtle difference because changes occur quickly as people get older.

MS. ARNOLD: Okay.

MR. BERRY: I, I still believe that 21 is really the only functional age break in the algorithm.

DR. NU: Since the model told us, that's our information. We tried the 55, there you see the fraction did not increase; sometimes you get some trouble. You get – you see a – not so much a (INAUDIBLE) – then you see, not the people, not like that way, you see.

MS. ARNOLD: We have in terms of people who said yes, I want to speak, I'm finished with that but we have plenty of time, so if you want to either ask a question or come up here, yes, please, come on up. And please give us your name even though I know you.

DR. McNABB: Hi, I'm Julie McNabb with Horizons Arc of the Emerald Coast.

MS. ARNOLD: Thank you, Julie.

DR. McNABB: And you really touched on some

important pieces, in my opinion, about the accuracy of the QSI data and that's really what I wanted to address. 'Cause the terms we're throwing around, statistics and predictability and equity and algorithms and validity and reliability, it all really comes down to people in the end. No matter how many terms and things you throw in there, it's not just the people we're taking care of; it's the people administering that QSI, the way it's being administered, the way questions are being asked, who they're asking those questions of, and we have situations where a family and the client would be asked questions about the day to day living skills of a client who didn't live at home. So the caretaker is not included, the provider is not necessarily included in the gathering of that data, and who better knows if you're – if they're living in your group home, you know whether they can toilet or cook or dress and the parent does not necessarily know that; and plus parents sometimes have no idea if someone has deteriorated or what's happened.

MS. ARNOLD: Okay.

DR. McNABB: So I do think it's really important to focus on how the – who that QSI is being administered by, who it's being administered to.

I think that – I don't know what training was done last time in terms of who was administering the QSI's, but when you're trying to do them across the state and you have that many people administering them, you have to find a way to reduce the variability, whether it's shorter. I don't know if they were Leichhardt Scales, I can't remember, but maybe you can't give so many choices; maybe it does need to be more questions, fewer choices than having so much opinion put in there.

The other piece is that when we're talking about the administration every three years is we had situations where the support – I don't remember if it was a support coordinator or a state support coordinator doing – administering them, but there were major changes like the death of a parent or a serious medical issue that they had no knowledge of and it wasn't in the QSI. I think three years is a really long time for an adult. I can't even tell you how many things have changed in my life in three years, so I do think that that needs to be administered more frequently. I think it's probably a conflict of interest if APD is the one administering the QSIs and also controlling the pocketbook.

And, finally, I think that when we talk about

the negotiations for extraordinary needs, it was one of the problems. We were in district 1, Area 1, had the worst implementation you could possibly imagine, and one of the pieces of that was that some support coordinators are better negotiators than others. Some support coordinators cared more, did a really good job of advocating for their clients, and some support coordinators didn't even take the time to decide or look to see whether it was accurate and if their client needed additional advocacy, and so I'm not sure.

I mean, I – this is supposed to be a scientific process. I'm all on board. I was totally on board with it from the beginning, but as soon as you put the people into it, the science kind of goes out the window if there's not some kind of control over the way that's done. And so I think the negotiations have to be looked at. There has to be some kind of structure to that versus who's good at talking people into things and who isn't. So those are my comments related to the QSI.

DR. NU: Very good comments, very good comments. So ideally, well, last time you see we discussed really I think the people – everybody feels we need, for example, every two years we update that QSI.

So definitely we cannot wait for too long. You see, everybody – the consumer condition keeps changing, keeps changing. We need to – so I hope that the Agency, yeah, can answer the question.

MS. ARNOLD: Yeah, and the other thing about the QSI and Leslie Petty's back there. She's from our State office. She is focused on the QSI and is improving a lot of the training and working with our QSI assessors, so yes, the QSI is always done by an APD employee. And one of the challenges, which is just what you're talking about, is the inner rater reliability (ph) which we do conduct and do every year with our folks. And so one of the big issues of why APD versus external folks was because the sheer number of support coordinators and trying to keep that inner rater reliability. We have, I don't know, maybe 60 or 70, Leslie, QSI assessors versus we have thousands of support coordinators. And so that was the reason for that. I hear what you're saying about maybe you feel like there's a conflict, but it is so important to us to keep that very consistent. And so as you've already said, there may be some challenges already with the 70 that we have, and we are continuing to update and improve that training because we definitely recognize that as critical.

So good comments. Thank you. Thank you very much.

Anybody else? Either questions? You don't have to come up here if you don't want to, but we would welcome it.

Yes, sir?

MR. VINSON: Yeah, my name is Dave Vinson (ph). Just a couple of comments.

In one of the lawsuits at trial, you know, there were discussions between I guess actually kind of dueling statisticians, you know, as far as what methods to apply, there was a box top method or something or something like that that they went through; and the statistician said no, that's not the right one. You know, and I would recommend that maybe, you know, you look to your stakeholders to see if maybe there would be like a volunteer statistician that would be on board just to knock ideas back and forth, back and forth, you know, as you're developing the algorithm.

The second thing that I think, you know, came into question during some of these proceedings was what – was in the QSI but was not applied, and I think that came from the physical section, and I see, you know, still now on the paper here you're pulling some pieces of it out, but I think there might be a question

that arises, why not just apply that whole section to the algorithm?

MS. ARNOLD: The whole physical section, David?

MR. VINSON: Right.

MS. ARNOLD: Yeah.

DR. NU: So that's – so, a functional section and the physical sections, there are some overlapped parts. So that's exactly the problem. Last time we tried to put the physical to the scoring, that came back with negative co-efficients, so that's because that, you see, the functional part, that's the co-efficient, that you have some overlapping, you have some interaction. So that's the physical part, so another thing significant, also give you a slightly negative number. So sometimes you see we just could not put it that way. But that seems to me to (INAUDIBLE) – when we get a more accurate QSI information, when we do researching about the base model, that may change, that may change. I hope it not changes too much because I used the tools from the 2013 and 2014 data and we have seen a significant improvement already, compared to 2007, 2008 data. That's already given us a big chunk of improvement, but we will see the new data, use the QSI new information, all the information possible to us, we

will do researching to see can we get these, which variable we're coming in, particularly we're coming in. What's the best aggregate for the new – based on the new information.

MS. ARNOLD: Mark, you had something?

MR. BERRY: Well, you know, I'm just thinking and asking questions out loud.

When we talk about reliability and predictability, what we were comparing was the – once we ran the iBudget we were comparing that to a base year of funding which was, I think, what was –

MS. ARNOLD: '07.

DR. NU: The '07-'08.

MR. BERRY: And so my question is, I mean, okay, that was now seven going on eight years ago and I imagine by the time you run the next one, it's going to be nine years. There's a lot of change in a lot of people's lives and I'm not sure, but I'm questioning are we now trying to realign to something that just shouldn't even mirror up anymore, shouldn't even –

DR. NU: I believe the new data to –

MR. BERRY: Have we lost our opportunity to have a baseline is what I'm asking?

DR. NU: Yeah.

MR. BERRY: 'Cause now, now our funding is all askew, you know, because of all the different things that we've done and how we've appropriated funds; and do we even have a reliable baseline that we can compare to without, say, getting a reliable assessment, doing an assessment on everybody that would give us a new baseline to, to predict it?

DR. NU: Good point, yeah. So that's – I imagine that whole, whole process that's gradually an improving process. I understand we missed one step. That's where we missed the valuable information in variable stages. That's the last time to – that's time already too long. I hope from now on, for example, every two years we can update it, the information in the algorithm. After we gradually – that's what we hoped from the beginning, we started from 67 percent; eventually we hope we can reach at least a 90 percent, obviously two year, two year, two year for sometime.

MR. BERRY: When you go to test your, when you go to test your reliability with different models that we develop from here on out, is '07 still going to be your baseline that you're comparing to, that you're trying to –

DR. NU: Well, currently, that's the only one

we have. So –

MR. BERRY: And that's a concern for me.

DR. NU: Yeah, now you see, after this we have the 2013, 2014. I hope here we get more regular, you see, process, you see, so eventually we can do a bigger part of the algorithm. Currently, I imagine also this, currently the algorithm that it effects is very limited.

MR. BERRY: But the reason we picked '07, just was because it was felt at least among all the stakeholders at the time that that was the last year that there was an honest effort to try to allocate the resources that people needed to meet their needs; and that we felt that of all the baseline we could come up with that that was best. After that we implemented the tiers and we started doing things to manipulate the allocations that mismatched allocations of resources to needs. So we felt that '07 was our best baseline.

DR. NU: Yeah.

MR. BERRY: But now nine years later, the people that were trying to predict back to '07, they've changed. So I think we really need to re-think what we're trying to, to create reliability back to.

MS. ARNOLD: So let me see if I understand what

you're saying. So we would look at all the data that you have and compare it to what? To the current allocation?

MR. BERRY: Well, I don't know. That's why I'm saying, I'm thinking of a line.

MS. ARNOLD: I don't know, either.

MR. BERRY: If there was – if we knew that there was a reliable assessment, then we could run that and somehow that would become our new baseline predictor?

MS. WRIGHT: Can I, can I ask?

MS. ARNOLD: Go ahead.

MS. WRIGHT: I think there are two things that we're talking about. One is, is assessing people and getting the scores on the assessment to try to figure out what their needs are that the QSI is?

MS. ARNOLD: Right.

MS. WRIGHT: And then the second is, how do you mess around with all the variables in that and figure out if you've come up with something that is remotely accurate to what their actual needs are? And that's where you have to, you have to look at something that you thought and at some point in the past was accurate, and that's where you looked at '07-'08 –

MS. ARNOLD: The '07-'08, yeah.

MS. WRIGHT: And from my personal experience with this program, you could not; you'd have to go back because you've had tiers and then you've had cost plan.

Does anybody remember cost plan re-basing? That had a lot of numbers in it, too.

MS. ARNOLD: That's why I dye my hair because of that.

MS. WRIGHT: And I didn't. And then we had a cost plan freeze and I don't know, that may still be kind of marginally in place but maybe not. I don't think it is. It's now – and now we're in this supplemental needs funding era, so I don't think there is another way to test it.

MR. BERRY: Well, but the problem is, Nancy, back to '07, now you've got say John Doe has now since then has had a stroke, is now gone from his family to living in a group home. He's maybe past the age of 21, so when you're trying to predict back you can't – it won't.

MS. WRIGHT: Oh, I see. So you're taking John Doe's QSI and –

MR. BERRY: You're trying to get reliability of the model –

MS. WRIGHT: – looking at John Doe's cost plan?

MS. ARNOLD: Cost –

MR. BERRY: So I'm thinking maybe like an assessment, if you could get a validated assessment that would maybe give, like a percentage score, then that –

MS. ARNOLD: But what do you mean by a validated assessment? What does that mean to you?

MR. BERRY: You know, we talked about a sensitive – you know, that the QSI maybe isn't the most sensitive or subtle – something –

MS. ARNOLD: Right.

MR. BERRY: – that's regarded nationwide as an accurate, reliable, valid assessment that would give us a scale of needs for people, that we would create a new baseline and then try to match the – then try to set the algorithm to that somehow so that it would be –

MS. ARNOLD: So you're talking about a whole new needs assessment? A different needs assessment?

MS. WRIGHT: Like the SIS?

MR. BERRY: I'm saying I don't think '07 is an accurate year; I don't think we have anything current. We've got to do something different.

MS. ARNOLD: No, but you're using the word "assessment" and I'm trying to figure out, are you

talking about the QSI assessment? Or when you're saying "assessment", I think you're –

MR. BERRY: Well, I think we mostly could all agree that the QSI is probably not the best –

DR. NU: Okay, okay, Mark. For Mark's information, for the new algorithm which year do you think we should use? I think this time we'll use 2013-2014.

MR. BERRY: But we know it's inaccurate. We know it's not a good year to predict to.

MS. PHILLIPS: Could you not take 2007, though, and adjust – I mean, we know at least on a regional level but we would have to – and I'm assuming the State office would know – whose plans have been readjusted based on need and have an adjusted 2007 now?

MS. ARNOLD: Oh. Based on –

MS. PHILLIPS: Based on – 'cause there's some people who haven't had – who have had changes because of Morland or the, you know, the algorithm issues –

MS. ARNOLD: Yeah, or because of just their life situation.

MS. PHILLIPS: But if, if they've had an adjustment to their budget based on a change of need

going from – actually, there's two variables there. One's 21 and one's 22. If that variable or a variable in needs, we've had – we've got some people who have aged and we've done supplemental funding. My concern is I don't want their – their budget can't go back to 2007.

MS. ARNOLD: Right, right.

MS. PHILLIPS: So could you do an amended amount from the 2007 and adjust it to compensate for those who've already –

MS. ARNOLD: Okay. Well, we'll look at that.

MR. BERRY: I don't know how you do that in a standardized way, though.

MS. ARNOLD: We'll look at that. Okay. We've got lots of hands. We haven't heard from this lady in the back there.

FEMALE VOICE: Getting back to the assessment, I really –

MS. ARNOLD: And your name, please?

MS. JACKSON: Kathy Jackson (ph).

MS. ARNOLD: Thank you.

MS. JACKSON: I really think that we brought up some issues about the QSI that could be amended. I would – I don't want to start all over again looking at new tools that we have to pay money for. I think

if we make some modifications to the QSI as people have talked about, I think that would be, to me, fine.

MS. ARNOLD: Okay. Thank you. And Suzanne?

MS. SEWELL: I think the similar variable that you have or the thing that you compared to '07-'08; as I recall the expenditures were about $958 million. Now, that was not the appropriation; we were running about $150 million on a deficit. What we have now is about $970 something million, so the only real comparable thing is the pot of money that you –

MS. ARNOLD: We have $938 right now.

MS. SEWELL: $938? And then –

MR. BERRY: Yeah, but it's a percentage that each person gets of that.

MS. SEWELL: So you were at about $950 in '07-'08. Okay.

DR. NU: So, Mark, let me ask you one question. You mentioned that actually we have plenty of useful tools in 2013 and 2014, but you said that it's not accurate.

MR. BERRY: If we – we all agree that the appropriation that the individual cost plans in aggregate are dysfunctional to a high degree. Why would we want to predict to something that's

dysfunctional? So that's why we had '07-'08; we were saying, well, that was as close to maybe, you know, accurate as we could get. And since then things have gotten all skewed because of the different allocation methods that we've had. And so –

MS. WRIGHT: I can't imagine using 2013-2014 –

MR. BERRY: Right.

MS. WRIGHT: – as being, as being accurate. That's a combination of the problems.

MR. BERRY: I mean, we could come up with – we could come up with an accurate model maybe but why do we want to make it accurate to something that's dysfunctional?

So we want to rely – we want, we want a good –

MS. ARNOLD: But tell me why it's dysfunctional.

DR. NU: Yeah, that's my question, too.

MS. ARNOLD: Tell us why it's dysfunctional.

MS. WRIGHT: Well, I can. So 2013-2014, you didn't, you didn't adjust upward for those people who were impacted by the, by the tiers and that was 60% of the population. And then about another – I don't know, another 10 – how many people asked for hearings?

MS. ARNOLD: About 9,000.

MS. WRIGHT: About – no, several thousand. Several thousand asked for hearings.

MS. ARNOLD: Oh, that's right. The hearings were about 3,000, yeah. I was thinking of the whole Morland population.

MS. WRIGHT: They got a notice of reduction that was based on an algorithm plus this combined summing of the services. So that was – and that was kind of trashed by the first DCA. And so you had those people who asked for a hearing and they got – they just have continued with their old tier cost plans. And then you had this real – this other percentage that went ahead and accepted the reduction, and I think the federal court said that those people were not given accurate information to understand whether they should ask for a hearing or not.

MS. ARNOLD: But all of those have been restored.

MS. WRIGHT: They've all been restored but restored to what? They're tier level cost plans. So which, which everyone recognizes were very problematic. The cutoffs in the tiers ended up with all kinds of issues for people. I can't see how you can use anything that's tier –

MR. BERRY: I mean, even when we were doing the iBudget, we didn't want to use the '09-'10 because we thought that would be inaccurate.

DR. NU: That's because that's the tier system, right?

MR. BERRY: Right.

MS. WRIGHT: Well, that's what this is.

MR. BERRY: So now we're several years past the tier system with more tiers and I think re-basing and –

MS. ARNOLD: But I mean, if you looked at, but the, you know, the people that were below their algorithm have now been restored. The people that were going to be reduced from their tier have now been restored. So the current approved cost plans, I guess I'm trying to think that through; is that not a good –

MS. WRIGHT: Those are tier cost plans, though.

MS. ARNOLD: No, they're not all the tier cost plans.

DR. NU: Well, we really need data that is more closely to the real need.

MR. BERRY: Right, which would be an assessment.

DR. NU: You needed, as you say, that's, that's closer to that consumer's real need, which year we

think of the best – the current data that we have; which year that's more close to consumer's real need? That's what we talking about.

MR. BERRY: I would say if we could do an assessment that could convert into monetary cost plans, even though it's done academically, and then use that to try to predict to.

MS. ARNOLD: Okay.

MR. BERRY: I agree we –

MS. ARNOLD: So something similar to –

MR. BERRY: It's got to be based on real assessment.

MS. ARNOLD: – to Kathy that said adjust your 2007 to something more – okay. And Julie?

DR. McNABB: To summarize it the best I understand, the reason you can't go back, the reason is because since 2007 which is the last year they were based on need, you've had tiers, nothing to do with need; you've had cost plan re-basing, nothing to do with need; you've had cost plan freezes, nothing to do with need; and then you had the whole thing last year with the QSI, the hearings, and all that that we just talked about in those reductions. So since 2007 there's been nothing based on need, so no matter what you do between looking backwards, none

of those years have anything valid. They're client-based –

MS. ARNOLD: So what do you think of the suggestion Kathy had about looking at '07-'08 and adjusting, adding to it based on –

DR. McNABB: I just can't see how you would do that objectively and fairly across what population are you talking about? What percentage do you need out of the 30 thousand – how many are we serving? Thirty-some-thousand? And what percentage would you need to make sure you adjusted accurately for parent deaths and medical – all the things that happen –

MS. ARNOLD: Well, you'd look at everyone. You wouldn't select them, you'd look at everyone and look at their current cost plan.

DR. McNABB: Yeah, but how are you going to do that?

MR. BERRY: Denise, obviously we're not going to solve it today.

MS. ARNOLD: Yeah.

MR. BERRY: I don't know what the real answer is or how big of a problem it is, but again, when I talk about being an open and disclosed process, I think this is why and I think it's good –

MS. ARNOLD: Yeah, and I'm trying to get as much

as we can in our two hours because he has a lot of work to do.

Yes, Kathy?

MS. JACKSON: I'd like to go back to the other suggestion that was made by Dave which is that I think for us to be feeling good and moving forward that we're all trying to do something that's right and is open and people are being, you know, communicated with or whatever, is that I think Dr. Nu is a, you know, obviously very intelligent man, he teaches at Florida State; but then there was a battle in the court situation where another statistician looked at things a little bit differently. I go back to what Dave suggested and say maybe we should look at more than one statistician to take a look at are there volunteers from other universities or other –

MS. ARNOLD: We have a second statistician.

MS. JACKSON: – where we –

MS. ARNOLD: We do have Dr. Tao here who will also be helping Dr. Nu.

MS. JACKSON: Okay. And Dr. Tao works for who?

MS. ARNOLD: FSU.

MS. JACKSON: Okay. Well, maybe we should look at the University of Florida as well. I don't know, but I just think that –

MS. ARNOLD: Oh, we don't do that. Just kidding, joke, it's just a joke.

MS. JACKSON: But just to say that there is representation from more than one statistician to get at and then have another meeting just like this for them to jointly say, now, this is what we've gotten together with and we heard from all of you in this meeting; we heard your concerns and now we're going to go back to the drawing board and come up with something to re-present again.

MS. ARNOLD: Okay.

Other people? Suzanne?

MS. SEWELL: I just wanted to make the point again about the funding levels. '07-'08 was described as the gold standard because that's the highest expenditures were, so I think the only real marriage to '07-'08 is you had a high expenditure level so that should have been the best. So a lot has happened since then. It has to be factored, but there are bigger pots of money now.

MS. ARNOLD: Okay. Linda?

LINDA: You know, I really think, and based on what I hear from providers in our group, there are a number of people whose needs are being met. They're not, you know, they're not adversely affected by their

current cost plan. They have adequate funding. I think you have the groups of outliers that maybe get caught up in the tier thing because that wasn't adequate to meet needs that are, that are now being impacted by the iBudget. But I don't think it's fair to say that people's needs are not being met. I think we have probably a fairly large percentage of people who are comfortable with where they are and somehow then we need to figure out how to accommodate those outliers whose needs are not being met at this point.

MS. ARNOLD: Yeah, thanks, Linda.

MS. PHILLIPS: I don't know how that's done.

MS. ARNOLD: Thank you for that.

Janice?

MS. PHILLIPS: That is exactly why I said we need to look at the people that have adjusted cost plans.

MS. ARNOLD: Yes, yes.

MS. PHILLIPS: If we go back and look at people who've had additional needs and those have been vetted through the process, that is very intense; if anybody wants to talk to me in detail about how much time that takes, I'll be glad to talk to you. But it's a lot of information that we have to gather and provide

and bounce back and forth between APD staff and negotiate.

With that being said, let's don't lose sight of the fact that one of the prime reasons I thought that we started this process years ago was to develop something that would be an equitable division of the resources and those were not equitably divided in 2007.

MS. ARNOLD: Yeah.

MS. PHILLIPS: So that was the reason we had a problem.

MS. ARNOLD: Yeah, that was another layer of problem, yes.

MS. PHILLIPS: So you can't – to me, even back then, I mean, the whole process then was – would have been some people went up, some people went down.

MR. BERRY: Right.

MS. PHILLIPS: And then you, you know, you provided information that the people who went down couldn't deal with the down part because of their needs at that point in time. So, you know, we're kind of back at that same point in time, to be honest with you, because everything's been reinstated. So for good, bad, or ugly, if it was due to the tiers, there was a reduction; or if, you know, cost plan

re-basing and all of that, we're now back at a point that everybody has a budget.

Is that budget reflective of what they need and the only comparison tool they have is their algorithm budget at this point? So to me, we're sort of at the same point we were back in 2007.

MS. ARNOLD: Gotcha. Other thoughts? What about you? What, what things do you need to know from them so that you can do what you need to do?

DR. NU: So that – okay. Now that's a, that's very important question. Which year to use as a baseline? So do we do that from 2007-2008, then do further adjustment to currently? Do that kind of adjustment that we get always based on 2013-2014, we do some adjustments? We need – I tell you, a statistician could not decide which year, what kind of adjustment. So that's – at that point, though, we're just as good as you guys. You guys are even better than the statistician. I tell you that the methodology you have to search for the best algorithm. Then you say, what do we do? Okay. (INAUDIBLE) you have people, they also agree. You see, the methodology we use to – that's not a big problem. That's just the transformation – I show him actually the transformation we use, that's the best

transformation. That's the only point. Okay.

But the main point that really makes a difference, that would be the real data. The real data, for example, the depend variable. What should we do? There are – we use 2007-2008 again to do some further adjustment? That's the best way? Or do we use 2013-2014? We do some adjustment back. So we need to discuss that, you see, and I really would like to hear any more suggestions, any, you see, you guys' thoughts on this.

MS. ARNOLD: Is there any third option?

DR. NU: Okay.

MS. ARNOLD: Dr. Nu, is there any other option?

DR. NU: I don't think we have other option.

MS. ARNOLD: Okay. So our options are '07-'08 or '13-'14.

MR. BERRY: Which are not –

MS. WRIGHT: And either way there's got to be adjustments.

DR. NU: Let's do some adjustments.

MS. ARNOLD: Yeah, both of those with adjustments.

Suzanne and then Julie?

MS. SEWELL: I think, and we've said this all along, once you implement these things how do you

put Humpty Dumpty back together again? I mean, he falls. You know. We have the fallout here; here we are. So to go back to '07-'08, I just don't see how you re-create that. I mean, people's lives have changed, their services have changed. People are no longer getting services.

MS. ARNOLD: But they're suggesting we adjust for that. And we know who's gone up from that, who's aged out.

MS. SEWELL: I don't know how in the world you ever go back and adjust for all of that. I mean, I've got –

MS. PHILLIPS: It makes the whole pot of money go up, for one thing.

MS. WRIGHT: But I don't think the pot of money matters in terms of – because what you're doing is you're looking at the ratio that's effective, aren't you?

MR. BERRY: Right, yeah.

MS. WRIGHT: So you're not – you don't really look at the – if it's like a billion dollars –

MS. ARNOLD: Well, no, the pot of money does matter, doesn't it?

MS. WRIGHT: – (Inaudible) – ratio that one person gets over another.

MR. BERRY: Right.

MS. WRIGHT: Of that fund, funding, for accuracy.

MS. PHILLIPS: That's what drives the money that's allocated.

MS. WRIGHT: Just because we don't think '13 and '14 – what you're trying to do is see what, what – whether or not it's accurate in terms of actual needs being met.

DR. NU: Yeah.

MS. WRIGHT: And we think too many things have happened since 2008 that are not needs based. I think that's –

MS. ARNOLD: But we have some additional data we're going to use that we didn't have before.

MS. SEWELL: But ultimately you're given this pot of money and distributing the pot of money.

MS. ARNOLD: Right.

MS. SEWELL: So it's a similar pot of money to '07-'08, which I've said about four times now, so you've got a similar pot of money you're looking at, you're trying to figure out where people are now and if it's adequate.

MS. ARNOLD: Yeah, and you're trying to see how that distribution works and if it's more reflective

of their needs. So let's say he runs a new algorithm against '13-'14 and someone in the family home that looks very similar to the other in the family home and they were like this before in terms of difference, and now we've brought them so they're a little bit more even, isn't that what we're looking for? So in one sense maybe it doesn't matter which pot you use because you're trying to see, are we getting better at the algorithm's prediction?

Yes, Julie?

DR. McNABB: I have three quick points.

Can we use a subset of your numbers of people that are identified by the Agency that haven't had very many changes since '07 and '08, if we agree by some miracle that that was the right year? I mean, could - is it possible to use a subset and not use the entire population, is one question.

The second one is: When you're talking about whether or not people's needs are being met, I think it's really hard to just say yes, there's lots of people because people get used to eating less food, you know. They just get used to fewer services, used to having to make do with things when really it might be very difficult, it might be oppressive to them to have to do that. So I'm not sure that it's fair

to just say, oh, they seem okay, let's go ahead and use it.

And my third point is the pot of money I think is only looked at after the entire process is done. It really doesn't have anything to do with the algorithm. The algorithm is run completely independently of the pot of money, and then the pot of money is looked at and the algorithm is applied and say these guys can dispense your money. So it's really hard to – and I just don't think it's even part of the equation.

DR. NU: So first that it's not that it's based on just partial, sub-population, because our tactic we plan to use the algorithm for that whole population. Okay. So you suggest a partial population, people will argue, well, you can use the model you're using to develop just based on partial population; you cannot use it for that whole population. Like the current model, we run about 30,000 for 2013 and 2014 because we did, you see, reevaluation, try to use the 2013 and 2014 data to check the model, you see. You see the model, you see, what's the performance from the model? Use the new data. Actually, whatever reason I believe that it's because the partial allocation that's based on

that model. We got a better fraction, we got a better fraction from 67 percent to 73 percent.

So, first, we cannot use a partial sub-population to develop model. We need every use.

So, we do – for example, adjustment, we need to discuss detail about the – should we use the 2007-2008 data, through that adjustment up to the current situation? Or should we use 2013 and 2014 adjustment back to some other adjustment. The data we really wanted to reflect, the real unique, that's the data we want. Okay. So, for example, transportation now I feel you see we have a comment and comments and solution for transportation. The 2007-2008, I don't believe we removed that transportation.

MR. BERRY: Right.

DR. NU: Now we need do a further adjustment remove that transportation, put that pot aside. Then we do an algorithm for those for all people, you see, not consider transportation. Now you see we add the transportation back for when you implement it that algorithm. For example, we need to use that kind of adjustment. So now I think that's very important, that's essential. We need to discuss the common agreement to decide what should we do for the

dependent variable. For the independent – for the QSI, it seems, you see, the Agency have been updating information. We just need to make sure that's accurate. Again, nothing is 100 percent accurate but we want as accurate as possible, that we needed to – that's – we call that the independent variable. But for dependent variable, that's so essential which year was the way we do that. That's you see it. Then we need to do a lot of adjustment, that's just from 2007-2008, it seems it's about seven years away.

When we developed a model in year 2009-2010, it seems that's the natural we use that year. It's very natural we used that year. Now, you see, we face an even more complicated problem, you see. We should work on it – do we think 2013-2014 seems – many of you feel that's not needed. We need a base. So that's, you see, we need consider how to do that adjustment.

MS. ARNOLD: Yeah. It doesn't sound like we have consensus from you all on what you're thinking.

MR. VINSON: I think the '13-'14 pull the transportation out for the dependent variable, you know. I don't know. I mean, what's going to happen is you might just – because we're in a funds are

allocated now dysfunctionally, it's just that we're probably going to see bigger swings once we do the algorithm, some people are going to lose more or have more added to them.

MS. ARNOLD: Yeah, yeah.

MR. VINSON: We need to standardize them.

MS. ARNOLD: And on the independent variables, the QSI, right? I'm learning, I'm learning.

DR. NU: Yes.

MS. ARNOLD: We have additional data points which is the QSI addendum that we never had before, and that's the ones again about the caregiver age, health condition –

DR. NU: Yeah, caregiver age.

MS. ARNOLD: And the family's ability to work and also do caregiving. So I think that will be some very interesting data, too.

DR. NU: Yes, very interesting, yeah.

MS. ARNOLD: Okay. Go ahead, Nancy.

MS. WRIGHT: Let me ask, so we've got 30,000 people now in iBudget and presumably they have their cost plans. Now, once we start running a new algorithm are those people's cost plans all going to be changed up or down, or are we only talking about –

MS. ARNOLD: You mean, when we're all finished and ready to implement?

MS. WRIGHT: Yeah.

MS. ARNOLD: I don't think we know that yet. I don't think we know the answer to that.

MR. BERRY: It puts the factor where we first – you know, we were originally going to do like a five year transition because the swing was –

DR. NU: That's a word you'll still get – some people will get it down, and some people will get up.

MS. ARNOLD: We need to have that discussion when we know a little better.

DR. NU: So you have a new algorithm that's, you see, that you'll work at, a different amount. Just based on the current QSI –

MS. WRIGHT: I can see how you (INAUDIBLE) for the 30,000 for 2013-2014, 'cause I think when you ran it for the original group on the rollout you discovered almost immediately that there were discrepancies with family homes. I mean, it seems like if you ran it but you didn't intend to, to immediately apply it. People would start to realize what's happening here. Is this going to really have a devastating effect on a certain population that

there was no intent that that happened for. But to do that and apply it seems given the fact that we don't have a very reliable database, it seems like a very poor idea.

MS. ARNOLD: Well, I think we want –

MS. WRIGHT: My suggestion here.

MS. ARNOLD: We want to see what the new algorithm shows us and continue to kind of figure that out on the difference between the current and the new, and at some point make a decision to implement. But we want to see what that impact is for sure to see have we done a better job in the family home or do we think some of these behavior issues are – or because we pulled transportation out and ran it, did that seem – so there will be a lot more discussion once he runs and shows you the impact. But it sounds like maybe we're all okay with '13-'14?

MS. WRIGHT: No, not all of us.

MS. ARNOLD: No? Not all? Okay.

MS. SEWELL: I think we would say it's the best you have to work with at this point.

MS. WRIGHT: I don't know that we're ready to say that.

MS. ARNOLD: You don't know that you're ready

to say that. Okay. Other questions you have? Dr. Nu?

DR. NU: So that's, yeah, I believe you say that 2013-2014, that is one of the years we have to consider. We do different adjustments, so what kind of adjustment besides the transportation we decided we move that part out? So by the other transportation, what kind of adjustment that we can make of the data, to make the data as close as to the consumer's real need?

FEMALE VOICE: Wasn't the transportation companion – (INAUDIBLE).

DR. NU: Then probably we need to move that out, too.

MS. ARNOLD: There's a difference between what he pulled out of the algorithm and how we implemented, so don't get confused with how we implemented. I think what you did in the original was you did pull out transportation or no? I can't remember.

DR. NU: No.

MS. ARNOLD: Okay. We did not, that's right.

MR. BERRY: No, never did.

MS. ARNOLD: We pulled out dental, DME, and the environmental, and support coordination.

MR. BERRY: Yeah, because you were looking at

different levels of support coordination.

DR. NU: Yeah, you see, this time we need to do those adjustments.

MS. ARNOLD: So what he's asking is, do you agree with those being pulled out?

MR. BERRY: Yes, if they're going to be –

MS. ARNOLD: And add transportation?

MR. BERRY: – if they're not going to be in the pie that gets divided –

MS. ARNOLD: So add transportation to the ones you already did. Okay. And that's the other question; is there anything else you're thinking of? So it sounds like if we add the transportation as a pullout, that would be a good step. Okay.

FEMALE VOICE: The only thing I can think of a pullout, I don't think we can do without family consultation – legal representation. Is this a one time thing?

MS. ARNOLD: Oh, no. We never implemented it.

No, that won't work. Okay. So that gives you a feel for that.

Anything else?

DR. NU: Any other suggestions, comments?

MS. ARNOLD: Nursing. What about it?

FEMALE VOICE: Well, it's such a small

percentage of people.

MS. ARNOLD: Should nursing be pulled out? We could look at that.

MS. WRIGHT: Maybe we could go back and see.

MS. ARNOLD: Yeah, and I want to make that point. We do have a – you know, we noticed in here that there is a website or, excuse me, an address you can send your comments to. We encourage you to do that because we'll be reading those and working with Dr. Nu over the holidays, and we plan on having another public meeting sometime in January, middle to latter part of January, where he will have had time to do some of his work and we can kind of see some results and kind of talk all of that through. So there will be more time so keep your thoughts coming.

Our intention is to post some feedback that we've received from different public meetings we've had and different input we just received, so we will be doing a summary of that posting that on our website.

What else? I think that's it. So you guys have given us some great suggestions.

DR. NU: Yeah, thank you. That's very valuable. That's –

MS. ARNOLD: And we really do want this to be

an open dialogue so thank you, Mark, for your comments and we've all been through a lot of tough years here implementing iBudget, and we're all here still, so let's take a moment to appreciate that and we will make it better. Thank you so much for coming and hope you have happy and safe holidays.

* * * * *

(Whereupon, the public meeting was concluded.)

C E R T I F I C A T E

THE STATE OF FLORIDA,)

COUNTY OF WAKULLA,)

I, Suzette A. Bragg, Court Reporter and Notary Public, State of Florida at Large,

DO HEREBY CERTIFY that the above-entitled and numbered cause was heard as herein above set out; that I was authorized to and did transcribe the proceedings of said matter, and that the foregoing and annexed pages, numbered 1 through 85, inclusive, comprise a true and correct transcription of the proceedings in said cause.

I FURTHER CERTIFY that I am not related to or employed by any of the parties or their counsel, nor have I any financial interest in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my seal, this 5th day of January, 2015.

SUZETTE A. BRAGG, Notary Public
State of Florida at Large
My Commission Expires: 2/21/2017