State of Connecticut
Department of Developmental Services

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Appropriations Health & Hospitals Subcommittee Workgroup: March 11, 2011

Co-Chairs: Senator Toni Harp & Representative Juan Candelaria

We appreciate the opportunity to discuss Governor Malloy's recommended budget for Fiscal Years 2012 and 2013 as it relates to the Department of Developmental Services (DDS). We have included the following information in response to questions posed at the Appropriations Public Hearing on March 2, 2011:

1. ***Workers Compensation: what are the agency's plans to reduce injuries? (Rep. Dillon)***

RBA:
The Governor's recommended budget proposes that inflation for Workers Compensation program in DDS be cut by $802,638 in FY 12 and $2,164,243 in FY 13.

The Governor's recommended budget proposes level funding for FY 2012 and 2013. In FY 12, a onetime increase of $298,336 was added to address the 27th payroll costs on indemnity payments.

What measures do you use to know how well this program is being run and whether its customers are better off?

We monitor new claims and workers compensation expenses on a monthly basis. New workers' compensation claims filed by employees have consistently declined over the past ten years (see attached chart). Between FY 2007 and FY 2010, new claims decreased approximately 23.6%. New claims for FY 2011 are down 1.33% (thru 12/31/10) compared to the same period of FY 2010. Current FY 2011 to date expenditures are within our budget allocation.

Monthly average medical expenses increased approximately 12% from FYE 2006 to FYE 2007, 10.082% from FYE 2007 to FYE 2008, 9.37% from FYE 2008 to FYE 2009, 11.78% from FYE 2009 to FYE 2010 and have decreased approximately 5.85% from FYE 2010 to FYE 2011 (through 12/31/10). Year to date savings through February 2011 is $755,000.

Average monthly medical costs from FY 2006 - FY 2011 (through 12/31/10):

FYE	Monthly Average
2006	355,824.58
2007	398,594.19
2008	438,778.78
2009	479,902.13
2010	536,440.37
2011	505,071.13 (through 12/31/10)

Average monthly indemnity expenses from FY 2006 - FY 2011 (through 12/31/10):

FYE	Monthly Average
2006	681,135.29
2007	690,051.40
2008	688,816.36
2009	726,389.91
2010	728,850.57
2011	697,976.89 (through 12/31/10)

What steps could you take to reduce likelihood of injury and reduce costs? How do you engage your partners in playing a bigger role?

The Department works closely with the DAS Workers' Compensation Division managers, Gallagher Bassett's claims specialists and the Attorney General's office to ensure efficient claim processing, claim management and litigation management in an effort to reduce expenditures.

The Department has also partnered with DAS on several safety initiatives. Among them are a winter safety campaign, ergonomic evaluations, and several loss control funding projects. The loss control projects include the purchase of ceiling mounted lift equipment for several residential units, resident repositioning assistive devices and ergonomic office equipment.

In April 2009, the Department implemented an annual mandatory Body Mechanics training for staff on proper lifting and transfer techniques. The goal of this class is to help reduce injuries related to lifting and transferring the individuals we serve, as well as lifting in the office environment.

Safety Committees are maintained in each DDS region and at Southbury Training School. These committees assist in establishing and maintaining a safe workplace. The Committees meet on a quarterly basis to discuss current safety issues, workplace injuries and possible corrective or preventative measures to be taken. Reports are reviewed at each meeting showing the location where the injuries occurred and the type of injury sustained so that preventive measures can be targeted appropriately.

The Department periodically publishes articles in its Employee Newsletter to provide employees with important safety reminders.

The Department is committed to returning injured workers to work as soon as possible and is proactively accommodating light duty restrictions whenever possible and utilizes the DAS Selective Duty program for reimbursement of light duty wages for employees of 1199.

DDS is committed to continuing these efforts with the goal of reducing injuries and workers compensation expenses.

Do you have any data on whether this program is effective at preventing more costly services or treatment? Do you have data showing the rate of injury by facility or program within DDS? If so, do you know why some locations are more effective at avoiding injuries than other?

The data provided above concerning the reduction in new claims and control of expenses demonstrates that our program has been effective. Detail data is available for all claims. Data showing the locations where the injuries occurred and the type of injury sustained is reviewed quarterly at safety committee meetings so that preventive measures can be targeted appropriately. Rates of injuries at the various worksites are compared to look for patterns or anomalies that would warrant further review. We do know that some locations experience higher injury rates because of greater hazards that exist in the work site (e.g. intensive / aggressive client behavior, total care / lifting environments). We have implemented both engineering (e.g. use of ceiling mounted lift systems) and training (e.g. "Physical & Psychological Management Techniques" and "Body Mechanics") responses to risks that are common in DDS work sites.

2. ***What is the additional $20 million in Community Res. going to provide? (Rep. Walker)***

FY 2012:

- $1,171,322 – Leap Year day funding
- $7,339,393 – for 108 new residential age outs
- $4,462,795 – for the annualization of 2011 residential age outs
- $417,354 – for ten new 2012 'Money Follows the Person' placements
- $375,280 – funding for 'Over the Counter' pharmaceutical items no longer funded by Medicaid
- $500,000 – the reallocation of the funds from DSS for the Home Health program
- ($167,000) – the reallocation of funds to DSS for a client move into a private ICF/MR
- ($739, 626) – reduction of funding for Self Directed payments of 1%

FY 2013:

- ($1,171,322) – remove the Leap Year day funding
- $6,631,223 – for the annualization of the 2012 residential age outs
- $5,748,180 – for 83 new 2013 age outs
- $1,107,737 – for eight new 'Money Follows the Person' placements

3. ***What is the CLA census over time for public and private. Include number of homes and # of individuals served (Map of locations) (Rep. Walker)***

See attached map of CLAs as of March 9, 2011 and a chart with the requested CLA census/capacity data over time.

4. ***Explain the changes in the Birth to Three Insurance language? (Rep. Walker)***

The department projects that two changes to the Birth to Three insurance statutes would result in additional insurance revenue (**$1.6M in FY12 and $3.2M in FY13**), allowing the state to pay less money for services.

Change #1: Eliminate co-pays and deductibles for Birth to Three payments

Currently, even though insurance plans are billed $115.28 per hour for early intervention services, they pay less because co-pays are applied and because at the beginning of each calendar year, deductibles are applied. The state makes up the difference because state statute says that public funds may be used to cover co-pays and deductibles AND federal and state laws both say that we only charge parents based on a sliding fee scale. Therefore, we cannot ask parents for any additional out-of-pocket expenses. If the average co-pay is $20 per visit, then eliminating co-pays will result in 17% more insurance revenue. It is difficult to estimate the additional revenue from eliminating deductibles because policies vary so widely. The proposal will not affect deductibles used by Health Savings Accounts, as they would be exempt according to the Federal Income Tax Act.

Change #2: Raise the annual cap on insurance payments from $6400 per year to $50,000 per year specifically for children with autism spectrum disorders.

On average, children in Birth to Three are scheduled to receive 4.6 hours per month of service – about one visit per week. The average gross cost is $8,352 per year. Children with autism spectrum disorders, however, receive an average of ten hours per week or 40 hours per month – about 10 times more than other children. The average annual gross cost is $35,022 but can reach as much as $68,000 per year for some children. When the state autism insurance coverage legislation was passed, we thought that we would be able to recoup much of that extra cost from commercial health insurance. It has not worked as well as we had anticipated. The state paid $7,964,188 for autism services in FY10 and the autism programs received $692,834 in commercial insurance payments. Our estimate, based on the number of children, was that payments should have been approximately $2.4 million.

The reason there is such a discrepancy is that making the Birth to Three insurance coverage statutes and the autism insurance coverage statutes work together has been very difficult and very cumbersome. The result is that the payments have been much less than anticipated. Continuing to bill under just one statute (Birth to Three insurance) would be far easier, far more streamlined for our providers, and far more likely to succeed. As a tradeoff, the $50,000 annual limit is actually less than the health insurance plans are liable for now. That limit is actually $6400 (Birth to Three cap) PLUS $50,000 in behavioral therapy PLUS unlimited Occupational Therapy, Physical Therapy, and Speech Therapy visits as determined by an approved treatment plan.

5. ***What services are provided at CLAs (examples)? (Rep. Walker)***

Community Living Arrangements (CLA) are community based residential settings serving three to six individuals who have the need for continuous support and/or supervision. CLAs provide a normal home routine for individuals with intellectual disabilities in terms of personal care, activities of daily living, cooking, shopping, maintaining one's household and providing opportunities for recreation and inclusion in community activities and events. Individuals who live in CLAs differ in their abilities to undertake these activities semi-independently, with prompting or with supervision. These differing needs for support, guidance, training and supervision are addressed individually in a person's Individual Plan.

6. *Describe the oversight DDS provides for the private CLAs? (Rep. Walker)*

DDS oversees Community Living Arrangements (CLA) through the Quality Management, Case Management and Resource Management divisions.

<u>Quality Management</u>

Quality Management conducts announced licensing inspections prior to initial licensure, six months after initial licensure, one year after initial licensure and at least biennially thereafter. If, at the time of a licensing inspection, citation findings are poor, a home may be issued a one year licensing status. Unannounced licensing inspections may occur randomly as a means to follow up on provider plans of correction. Additionally, unannounced inspections may occur upon notice from the QM Director, Commissioner or Regional Director. Such visits may be the result of OPA findings, health or safety concerns or constituent concerns. All citation reports are shared with Providers and Regional Directors. Provider Plans of Correction for citations are managed by the Quality Review Specialist.

Quality Management conducts Quality Service Reviews (QSRs) at all CLAs during the alternate licensing year. The QSR includes a consumer interview, support person interview, observation, safety checklist and documentation review. The areas reviewed include: planning and personal achievement; relationships and community inclusion; choice and control; rights, respect and dignity; safety; health and wellness and satisfaction. The results of these visits are shared with the Provider, Resource Management and Case Management. Resource Management manages issues that require a provider corrective action plan.

<u>Case Management</u>

Case Management assists in the planning, support, service coordination, revenue enhancement, regulatory compliance and documentation in relationship to supporting individuals. Additionally, at least annually, the Case Manager conducts a Quality Service Review for each individual residing in a CLA.

<u>Resource Management</u>

Regional Resource Management meets with the Provider annually to review Provider Performance. The Provider develops a Continuous Improvement Plan (CIP) based upon a broad range of criteria including Provider self-assessment, consumer satisfaction surveys, site visit feedback, Abuse and Neglect Investigation recommendations, Licensing data, Quality Service Review data and QI data such as incident reports and Program Review Committee/Human Rights Committee performance. Updates to the previous CIP are presented at the annual Performance Meeting. After review of progress towards the previous plan, the new plan is presented. Regional Resource Administration may accept the new plan as presented, or may request that the Provider revise the plan based upon available data and issue identification.

Enhanced Monitoring is implemented in the event that a provider is not complying with statutes, regulations, policies, procedures, directives, provisions of the Purchase of Service Contract or the Provider Assurance Agreement and such non-compliance is negatively impacting supports to consumers. Enhanced Monitoring is an increased level of monitoring, beyond the regular monitoring, which is one component of the quality assurance and improvement system. Such increased monitoring may include, but is not limited to: frequency of site visits, provider meetings, and documentation requirements deemed necessary by the department to assess progress of the agency toward meeting identified goals and outcomes established in response to assessments of unsatisfactory performance.

Additional oversight mechanisms include incident reporting, the medication administration certification program and the abuse/neglect reporting and investigation system.

7. ***What are the per diem rates at the various settings and different levels of care? (Rep. Walker)***

The most current final rates that are approved from the Department of Social Services (DSS) for DDS services are based on FY 2009 service dates. Rates reflect direct, DDS indirect and external indirect costs. The current per diem billed rates for residential services are as follows:

Southbury Training School (STS): $886.89
DDS Community Living Arrangements (CLA): $774.18
Private CLA: $352.04
Private ICF/MR: $412.41

8. ***How is DDS maximizing federal funding for the clinical services line item? Can the insurance coverage to age 26 impact this line item if kids are not dropped from parents' coverage at age 18? (Sen. Harp)***

The Clinical Services Account funds goods and services related to the dental, nursing, pharmaceutical, medical, allied health and mental health service needs of DDS clients. All Clinical expenses are costs that are allocated to the Department's programs. The Department's Clinical Services Appropriation is allocated to programs that are benefitted by the expenses and the state receives 50% Federal Financial Participation (FFP) for those federally funded programs.

9. ***Provide details on the impact of OE inflation elimination.*** **(Sen. Harp)**

The Department believes that the Governor's FY 2012 and 2013 recommended funding levels for the Other Expenses (OE) account allows DDS to meet its financial obligations in this account. The Governor's Recommended Budget for FYs 2012 and 2013 funds the Department at substantially the same level as the Department's current FY 2011 B-1 OE Allotment. The only adjustment made in the Governor's Recommended Budget was the $112,299 reduction in both fiscal years for the OE applicable to the continued consolidation of DDS services. The Department believes it can manage its programs in Fiscal Years 2012 and 2013 with the funding provided within the Governor's Recommended Budget.

10. When was the last conversion of a group home from public to private? How many homes and the associated savings? (Rep. Tercyak)

The most recent conversion was implemented in Fiscal Year 2010 with the last homes transitioning in the summer of 2010 in response to employee reductions associated with a retirement incentive program. Seventeen Community Living Arrangements were converted under this process. The savings from the conversion was approximately 7.5 million dollars including an estimated savings by the comptroller of 6.5 million dollars based on a 57.66% fringe benefit.

Again, thank you for the opportunity to discuss the proposed budget for FYs 12 & 13 as it relates to the Department of Developmental Services. We would be happy to discuss these items or any additional questions that you might have.