

## **Additional Proposals to Enhance Agency Outcomes and Reduce Costs**

In addition to the proposals submitted in March for the consideration of the Commission, here are some additional possibilities.

Before suggesting those possibilities, however, it should first be observed that the Appropriations Committee budget includes a number of very positive recommendations for enhancing agency outcomes and reducing costs, following the protocols and procedures suggested by David Osborne and Peter Hutchinson in The Price of Government, including

- Building on Governor Rell's proposal to expand re-entry furloughs to 45 days, directing the Commissioner of Corrections to evaluate a number of recommendations "to reduce the pressure on the prison system and enable significant savings in the incarceration of non-violent offenders." "Such recommendations shall include the redistribution of savings into appropriate community resources and reentry programs as needed in order to facilitate a reduction in the incarcerated population, a reduction in recidivism and the safeguarding of public safety." The combination of these David Osborne-type proposals, reflecting the Pew Center's recommendations included in One in 31, is anticipated to save \$20.656 million in FY 2010 and \$35.656 million in FY 2011. (See pp. 336-37 of Appropriations Committee budget.)
- Recommending that the Department of Social Services restructure the "Medicaid Continuum of Care," by undertaking an "Integrated Care Initiative" and restructuring the "Nursing Home Finance Advisory Board." The Integrated Care Initiative would contract with Medicare Special Needs Plans to "integrate Medicaid funding and benefits with the Medicare SNPs," saving "money through the provision of care in the least restrictive, most appropriate setting," and managing "both the Medicare and Medicaid payments made on behalf of nursing home residents." The restructuring of the Nursing Home Finance Advisory Board would give it "the authority to close nursing homes that fall into receivership and to distribute the residents to other area homes." This combined initiative is anticipated to save \$25 million in FY 2010 and \$75 million in FY 2011. (See write-up on pp. 229-231 of the Appropriations Committee budget.)
- Recommending that DSS implement a Medicaid waiver to provide family planning services. At a cost of \$2 million, 90% reimbursed by the federal government, a gross savings of \$6 million is anticipated to be realized in FY 2011. (See p. 233 of the Appropriations Committee budget.)
- Following the lead of Governor Rell, recommending that DSS develop a state-of-the-art online screening system to identify individuals with

mental illness and mental retardation who could be better served in community rather than institutional settings. The anticipated savings of \$3.8 million in FY 2010 and \$8.3 million in FY 2011 assumes the closure of 100 nursing home beds in FY 2011, with additional closures in the future. (See p. 239 of Appropriations Committee budget.)

- Exploring the transition of certain ConnPACE eligible clients to the Medicare Part D Low Income Subsidy program, to reduce anticipated state outlays by about \$25 million in FY 2010 and \$30 million in FY 2011 (although also reducing state Medicaid revenues.) (See write-up on pp. 248-249 of the Appropriations Committee budget.)
- Following the lead of Governor Rell, recommending the development of an online eligibility information verification system to coordinate ALL applications for public assistance in the Medicaid, SAGA, TFA and State Supplement programs, as well as the Food Stamp program (retitled SNAP). This would not only provide better service, but save money, anticipated to be \$1.5 million in FY 2010 and \$3 million in FY 2011. (See write-up on p. 232 of the Appropriation Committee budget.)
- Hiring a consultant, at \$500 thousand per year, to help “achieve reinvention savings” of \$3 million per year in personal services in the Department of Public Health. (See p. 184 of the Appropriations Committee budget.)
- Leveraging nearly \$2 million in private contributions from the William Caspar Graustein Memorial Fund and the Annie E. Casey Foundation by providing \$600,000 in state dollars to the State Department of Education in both FY 2010 and FY 2011 to improve Early Childhood Learning. (Appropriations Committee budget, p. 293.)
- Providing \$200 thousand per year to Legislative Management for “Enhancing Agency Outcomes,” “to assist state agencies in promoting efficiencies and achieving accountability to reduce state costs.” The Appropriations Committee budget anticipates saving \$6 million in FY 2010 and \$50 million in FY 2011 through this initiative, in addition to the above bulleted savings in individual agencies. (See p. 5 of the Appropriations Committee budget, and OFA’s summary of the budget.)

### **What additional areas should be reviewed by the Commission to Enhance Agency Outcomes?**

1. **Pursue a Section 1115 Medicaid waiver for the SAGA program**, as recommended by the Connecticut Hospital Association (CHA), to save the state about \$27.5 million per year, while at the same time increasing payments to SAGA service providers (with the waiver, paid under Medicaid rates) by about \$45 million annually. The following material is taken from a CHA proposal dated March 2, 2009:

While the federal government pays for half the expenses of the state's Medicaid program, the state pays the majority of the cost of SAGA (State Administered General Assistance). With the goal of maximizing available federal funds, the General Assembly has twice recognized the importance of seeking an 1115 waiver for the SAGA program. Section 17b-192(g) of the Connecticut General Statutes – passed in 2003 and reaffirmed in 2007 – requires that the Commissioner of the Department of Social Services submit an application to the federal government for such a waiver by March 1, 2004 and January 1, 2008, respectively.

Converting SAGA to Medicaid requires removing the cap on SAGA funding and increasing SAGA payments to providers to the Medicaid rate. Despite an estimated 30 percent increase in hospital payments and a 5 percent increase in non-hospital payments that would be required by the state under the waiver, the increase in federal funding would more than offset the increase in cost; the state would save approximately \$28 million per year over current expenditures, while hospitals and other providers would get the benefit of \$45 million in increased SAGA funding.

The following table from CHA provides details:

**Considering the impact of a SAGA waiver irrespective of a federal enhanced match (currently being included as part of the federal stimulus package).** *The state saves \$27.5 million and providers get an additional \$45 million. In addition, Connecticut benefits from the “ripple effect” of funds invested in Medicaid: the Connecticut general economy would be boosted by \$95 million, 766 jobs would be added, and more than \$34 million would be generated in Connecticut salaries and wages.*

SAGA	Current	Amount to make SAGA equal to Medicaid	New
Matched	\$110,000,000	\$35,000,000	\$255,000,000
Not matched	\$100,000,000	\$10,000,000	
Total spent	\$210,000,000	\$45,000,000	\$255,000,000
Federal share	\$55,000,000		\$127,500,000
State share	\$155,000,000		\$127,500,000
<i>Net savings to state per year</i>			\$27,500,000
<i>Benefit to providers (hospitals and others)</i>			\$45,000,000
<i>Increase in general economy</i>			<b>\$94,950,000</b>
<b>Increase in CT jobs</b>			<b>766</b>
<i>Increase in CT salaries and wages</i>			<b>\$34,200,000</b>

2. **Seek to maximize Federal Medicaid revenue in DMAS**, following the recommendations of the CT Legal Rights Project, Inc., and the National Alliance on Mental Illness, CT, February 2009, which is copied below:

Since the Governor's Blue Ribbon Commission (BRC) Report was issued in July, 2000, Connecticut has pursued initiatives to replace an institutionally-biased, crisis-oriented and fragmented approach to mental health care with a more cost-effective, community-based, person and family focused system. While some progress has been made, the state's current fiscal dilemma challenges us to review recommendations and consider measures that could be implemented both immediately and longer term to improve the state's efficiency and outcomes while preserving vital housing and services. The goals are to:

- Maximize federal revenue while strengthening the community system of housing and supports,
- Reduce reliance on expensive long-term, institutional settings, including out of state placements, and
- Promote community integration in accordance with state policy and federal law.

**Maximize Federal Medicaid Revenue**

Both DCF and DMHAS have already collaborated with DSS to increase federal reimbursements under Medicaid by expanding the services covered under the state plan for the low income individuals they serve. This is particularly significant given the expected increase in the federal Medicaid reimbursement rate under the stimulus package. However, there may be more services for children that could be covered under HUSKY or the Behavioral Health Partnership, and there are many DMHAS services currently state grant funded that could be covered as optional<sup>1</sup> rehabilitation services under Medicaid<sup>2</sup>.

Expanding Medicaid Adult Rehabilitation Services

An actuarial study conducted by the Mercer Consulting Group for the Department of Social Services (DSS) identified in their February 2004 published study the following ***new federal revenue for these existing DMHAS services as Medicaid rehabilitation services:***

Assertive Community Treatment Teams (ACT)	\$10,554,692
Supervised Housing (services only)	11,141,684
Supported Housing (services only)	7,074,768

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<sup>1</sup> The state can also expand Medicaid under the 1915(i) state plan option, which enables states to provide a prescribed set of home and community based services to individuals that earn less than 150% of the Federal Poverty Level and require less than institutional levels of care.

<sup>2</sup> The federal Medicaid program has both mandatory and optional services.

Mobile Crisis		<u>6,167,272</u>
	Total estimated	\$34,938,416 <sup>3</sup>
	Targeted Case Mgt. current revenues	<u>7,000,000</u>
	<b>NET NEW FEDERAL FUNDS</b>	<b>\$27,938,416<sup>4</sup></b>

Due to concerns about expanding an entitlement and disrupting the community providers, OPM and DMHAS have moved cautiously on Medicaid coverage for adult mental health services, only covering rehabilitation services at group homes thus far. However, since that study was issued, the state has allocated funds to build the capacity of community providers to comply with Medicaid requirements for a wider range of services, if implemented. It is also important to note that Connecticut is the only state that does not use the Adult Rehabilitation Option under Medicaid in any significant way as a funding vehicle for mental health services.

In addition, the state has received federal approval to operate a home and community based services waiver for persons with mental illness who can be diverted or discharged from nursing homes which began April 1<sup>st</sup>. In the course of developing this waiver, DSS and DMHAS have developed service definitions and a rate-setting methodology for services to be covered under the waiver. Two of these, assertive community treatment and community support services (included as ACT in the Mercer study), could be covered by the Medicaid state plan expanding the population served and increasing federal revenue, possibly during SFY 2010. The capacity building required to bill for services in supervised and supported housing requires further investigation.

In order for the Medicaid maximization of community mental health services to work long-term, DMHAS must retain grant funds for the transition costs into Medicaid fee-for service, non-medical services (social support), and non-Medicaid eligible clients. In addition, the rate-setting structure must cover the cost of providing services, and funds must be targeted to expand housing options and services for individuals with complex needs. The impact of these measures must be monitored to report the outcomes on inappropriate institutional and emergency room care.

#### Expanding Medicaid Waiver Slots

The state can also maximize federal revenue by increasing the number of persons with mental illness to be served under its Medicaid home and community based services waiver for persons who can be diverted or discharged from nursing homes . Currently the waiver allows Connecticut to serve 72 persons in each year of the waiver, for a total of 216 persons. However, in 2006, DMHAS estimated that 420 individuals with mental illness in nursing homes had “high discharge potential.” In addition, the State has lost an estimated \$7.5 million in Medicaid reimbursement because the

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<sup>3</sup> Group homes are excluded since DMHAS and DCF are already proceeding with coverage of their services under the Rehab Option.

<sup>4</sup> Mercer Government Consulting Group, *Estimate of the Budget Neutrality of the Connecticut Behavioral Health Partnership, Technical Appendix*, Feb. 2004, Appendix J.5.

number of persons with mental illness in some nursing homes has exceeded the federal limit. During the past two years DMHAS and DSS have developed their infrastructure to pursue nursing home discharges, and this should support an expanded waiver population.

#### Maximizing Medicaid Billings for Outpatient Services

Federal revenue can also be maximized by assuring that outpatient services provided by state operated and contracted providers are billed to Medicaid to the fullest extent allowed. Services provided by state operated programs and facilities are billed through the Department of Administrative Services not DMHAS. DMHAS and other state agencies do no direct billing, nor are their budgets dependent upon any income generated. The state should determine if standards regarding productivity, timely and accurate billing, and targets related to income recovery have been established to maximize what the state does collect for its billable services.

#### Increasing Medicaid Funded Intermediate Care at Private Hospitals

DMHAS presently operates 830 inpatient psychiatric beds, with no federal reimbursements for any patients between the ages of 21 to 65, with the exception of a small number of persons with Medicare coverage. This means that the state pays 100% of the cost of care. The per capita cost of the 572 licensed beds at CVH, originally built in 1867, is \$1177 (based on SFY 06-07), an increase of roughly 37% in five years, and the per capita cost of the 128 licensed beds at Cedarcrest Hospital, built in 1910, is \$1284, an increase of more than 39% in five years.

Except for services provided in the Whiting Forensic Division, and some specialized inpatient long-term treatment, the intermediate inpatient mental health treatment and the alcohol and drug inpatient treatment provided at state facilities could be provided at many general hospitals if they were adequately compensated for the cost of providing that care and a system for assuring discharges to stable and appropriate settings, not shelters, were in place. This would require that DSS establish a new Medicaid intermediate inpatient service rate with specific provider standards for treatment, rehabilitation, and discharges that would be closely monitored for compliance and outcomes.

3. Explore additional opportunities to **Invest in Cost-Effective Housing and Community Services in DMHAS** as alternatives to inpatient care services or incarceration, again as recommended by a paper produced by the CT Legal Rights Project, Inc., and the National Alliance on Mental Illness, CT, February 2009, which is an extension of the material in #2 above, and is continued below:

#### Transferring some intermediate inpatient care services to private hospitals

Such transfers could both alleviate the gridlock in the state's mental health system and create an opportunity to transfer resources from inpatient settings

to the community. It is well documented that the lack of adequate funds for housing and community services and supports for persons with psychiatric disabilities contributes to the utilization of nursing homes, prisons, shelters, emergency rooms and hospitals at a significant cost to the taxpayer and the individuals. Conversely, community options, particularly supportive housing, reduce hospitalizations, increase employment and education, and contribute to increasing neighborhood property values. **Any state workers displaced could be transferred to provide the community treatment and support as was done when state hospitals were closed.** The state's long term gain is in reducing institutional costs, gaining Medicaid payment for inpatient care, expanding resources for community integration without jeopardizing jobs, and concomitantly, reducing emergency room costs.

#### Reducing Institutional Costs for Children

Riverview state psychiatric hospital is the only state operated psychiatric hospital for children in New England. Its average daily census is under 70 patients, many of whom are referrals from the Juvenile Court for evaluations. At the same time, Connecticut continues to send children out-of-state, presumably because there are no state alternatives. The cost-effectiveness and efficacy of this facility and those out of state placements must be closely examined. Any actions regarding the intermediate inpatient psychiatric care for children and youth must be tied to strict treatment standards and a discharge planning process, to developing cost and care effective solutions, and allowing creative solutions with the state workforce at Riverview to address community alternatives or specialized in-state residential care for children placed out-of-state.

#### Expanding Alternatives to Incarceration

Currently, almost 20% of persons incarcerated in CT prisons and jails have been diagnosed with a mental illness. Since 2000, the number of inmates with moderate to serious mental illnesses rose from 2,200 to over 3,700 today. Along with homelessness and nursing home admissions, this is a stark example of the deterioration of our basic mental health system. Department of Corrections officials confirm that an estimated 1,428 persons with moderate to serious mental illnesses are incarcerated for low-level, non-violent offenses.<sup>5</sup> This represents a substantial number of non-violent offenders with mental illnesses who could safely live in the community, if they had housing and services. Instead of providing services and housing, the state spends approximately \$40,000 to \$60,000 per person to incarcerate people. Although it may not be possible to do a "one on one" closure of prison beds for every person we can take out of prison or divert from prison, over time we will reduce the number of prison beds. State staff who are no longer

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<sup>5</sup>As of October 2007, the Department of Corrections (DOC) reported that of the 3,897 inmates with mental health issues classified as level 3, 4 and 5, 1,741 were not convicted of, or on bond for, a violent or serious offense (46%). The DOC reports the Mental Health level 3 numbers to be inflated by approximately 20% because they include inmates with problems that are probably not directly attributable to serious psychiatric illness. This still leaves 1,428 inmates with moderate to serious mental illnesses who are in prison for low level offenses.

deployed to state institutions could form the core of new community supervised placements for diverting and discharging people from prisons who do not need to be there.

#### Planning and Oversight

Many of these measures require planning and oversight. The state has an existing strategic planning body that could oversee this process and present a report to the Governor and the Legislature by June 1, 2009—the Community Mental Health Strategy Board. Chaired by the Commissioner of DMHAS, the DCF Commissioner and a representative of OPM also sit as voting members of the Board, and other relevant state agencies have non-voting seats. Hospitals and advocacy groups also are members. There are currently vacancies on the Board to which union, consumer and family, and community provider representatives could be appointed.

4. **Leverage private investment** in Connecticut's economic competitiveness **by continuing to invest, and even expanding state investments in, such effective public-private partnerships as CERC** (the Connecticut Economic Resource Center). (See the letter of CERC to the Commission, April 14, 2009)

CERC, specifically, was created during the recession of 1989-1992 to maintain state economic development functions at a time when the state government did not have the resources to fund them directly. Funded primarily by Connecticut's utilities, telecommunications companies, and other private sector partners, CERC's contribution to state economic development since 1993 has exceeded \$40 million. At present, CERC provides \$1.5 million annually to leverage and support the economic development activities of state agencies and quasi-public agencies, dollars that are critical to economic development efforts, and dollars that would have to be spent by the state if CERC did not provide support. The state's share of CERC's work, provided through two contracts, is only \$400,000.

Among the services CERC provides are:

- Connecticut's Business Response Center, to inform businesses what services are available from the state and other providers (128,000 contacts since 1993)
- Smart Start, Connecticut Licensing and Information Center (50,000 customers since 1997)
- Connecticut SiteFinder, the state's most comprehensive online database of available commercial properties (591 sites, with 20 million square feet of space leased, purchased, or constructed)
- Representation at conferences and trade shows, which state employees cannot attend because of a ban on out-of-state travel



- Objective research, marketing and strategic planning services, including annual benchmark reports on Connecticut's technology growth and strengths
- Sponsoring David Osborne's initial visits to Connecticut to elaborate on The Price of Government strategy

Connecticut has a long history of using non-profit providers to provide many state services to our residents. Rather than try to re-invent the wheel, we should use the existing providers like CERC to provide efficient and effective services, leveraging private contributions to economic competitiveness.

5. Instead of trying to smush agencies together – as the national government tried to do by creating the Department of Homeland Security, an effort that David Osborne points out contributed to three years of non-productivity by the 22 affected agencies – **expand the role and scope of existing state agencies like the Office of Workforce Competitiveness that already provide what Osborne calls the “steering” function.**

According to Osborne and Hutchinson, “Homeland Security is a classic example of the knee-jerk impulse to consolidate. This impulse promises greater efficiency through elimination of duplication and overlap, but too often it delivers huge bureaucracies with so many layers that authority is fragmented, communication is difficult, and decisions take forever. . . . [C]onsolidations demand vast amounts of energy, most of which is directed at the bureaucratic structure and the people inside. They divert energy from the work to the workplace.” (Price of Government, pp. 115-116).

Instead, Osborne and Hutchinson say, the best option for government leaders who want to achieve the best results, using the most effective strategies, is to develop an organizational structure which “consolidate[s] funding streams and steering authority, but not the organizations that do the actual rowing. . . . [S]teering – setting policy and direction – focuses on doing the right things. Rowing – service delivery and compliance operations – focuses on doing things right. Housed in separate organizations, each can concentrate on its mission.” (Price of Government, p. 117).

In Connecticut, the Office of Workforce Competitiveness was created several years ago to get various agencies providing educational and training services to work together to build the workforce of the future. It is a classic “steering” organization, bringing together different agencies’ program funding to leverage private dollars to focus on enhancing workforce preparation in very specific areas.

For example, in FY 2009 alone, OWC leveraged \$450,000 in state funding with \$361,000 in funding from private organizations to support the Hartford Construction Jobs Initiative (the “Hartford Jobs Funnel”). It directed a total of \$1,768,000 to Career Ladders Projects, using \$500,000 of OWC funds, and a combination of CREC, Community Colleges, DSS, a U.S. Department of Labor grant, and Robert Wood Johnson Foundation dollars for the predominant portion of the funding. It leveraged \$105,000 of OWC funds for the Jobs Funnel in New Haven with \$1,225,000 of other funding from such diverse sources as Yale University, the Housing Authority of New Haven, and the City of New Haven.

OWC has been the “convening” agency for bringing together efforts to provide education and training for nanotechnology in the state. And it has developed an overall strategy for “Building a Pipeline of 21<sup>st</sup> Century Talent in Connecticut,” to bring together lifelong learning opportunities for the entire workforce.

Such “steering” efforts to build the foundations for future economic competitiveness should be supported by directing expanded funding to OWC, rather than hamstringing its efforts by cutting funding for its staff and programs.

## **In Conclusion**

“With the goal of reducing costs to the state and enhancing the quality and accessibility of state services,” (PA 09-02, Section 9) the Commission on Enhancing Agency Outcomes has a very broad mandate. The above suggestions, together with other proposals previously submitted, provide a useful starting point for deliberations to accomplish its goal.