

APPENDICES

Appendix A

Commission on Enhancing Agency Outcomes

Initial Report to
the Governor, President Pro Tempore of the Senate,
and the Speaker of the House
State of Connecticut

Pursuant to Public Act 09-7
September Special Session

February 1, 2010



Commission on Enhancing Agency Outcomes

Members

By Virtue of Office

Senator Gayle Slossberg, Co-Chair
Government Administration and Elections
Committee Chair

Representative James Spallone, Co-Chair
Government Administration and Elections
Committee Chair

Senator Michael McLachlan
Government Administration and Elections Committee Ranking Member

Representative John Hetherington
Government Administration and Elections Ranking Member

Senator Toni Harp
Appropriations Committee Chair (or designee)

Representative John Geragosian
Appropriations Committee Chair (or designee)

Senator Dan Debicella
Appropriations Committee Ranking Member (or designee)

Representative Craig Miner
Appropriations Committee Ranking Member (or designee)

Senator John Kissel
Program Review and Investigations Committee Chair (or designee)

Representative Mary Mushinsky
Program Review and Investigations Committee Chair (or designee)

Secretary Robert Genuario
Secretary of the Office of Policy and Management (or secretary's designee)

By Virtue of Appointment

Representative Robert Megna
Speaker of the House Appointee

Representative Russell Morin
Speaker of the House Appointee

Senator Bob Duff
Senate President Pro Tem Appointee

Senator Gary LeBeau
Senate President Pro Tem Appointee

Chancellor Emeritus William Cibes
House Majority Leader Appointee

Shelley Geballe
Senate Majority Leader Appointee

Representative Vince Candelora
House Minority Leader Appointee

William Aniskovich
Senate Minority Leader Appointee

SECTION I

Introduction

The Commission on Enhancing Agency Outcomes was first established in February 2009 via legislation enacted to mitigate the FY 09 state budget deficit (P.A. 09-2). Its legislative goal from the beginning has been to reduce state costs and enhance the quality and accessibility of state services. Its membership and certain responsibilities, however, have changed through subsequent legislation. It is currently composed of a 19-member panel of legislators, legislative appointees, and the secretary of the Office of Policy and Management (or designee).

This initial report, required by public act, identifies subjects for further study; it may be viewed as the commission's work plan for the year. Although the members of the commission believe all of the recommendations are worthy of consideration, probably no member endorses every concept. The commission is required to submit a full report on its findings and recommendations no later than December 31, 2010.

Background

After its original enactment in February 2009, the commission's authority and responsibilities have been amended twice – in the FYs 2010-2011 biennial budget bill passed on August 31, 2009, and effective September 9, 2009, and in one subsequent budget implementer, passed on October 2, 2009.

Original enactment: February 2009 P.A. 09-2 (Sec. 9)¹

As first enacted, the commission was, and still is, directed to:

- identify functional overlaps and other redundancies among state agencies; and
- promote efficiency and accountability in state government by:
 - identifying ways to eliminate such overlaps and redundancies, and
 - making such other recommendations as the commission deems appropriate.

These activities are to be done with the goal of reducing costs to the state and enhancing the quality and accessibility of state services.

Originally, the commission also was directed to consider the merger of state agencies to further the goals of the commission. Two specific mergers were suggested for consideration in the legislation: 1) the Departments of Mental Health and Addiction Services and Social Services; and 2) the Connecticut Commission on Tourism and Culture, portions of the Office of Workforce Competitiveness, and the Department of Economic and Community Development.

¹ P.A. 09-2 An Act Concerning Deficit Mitigation Measures for the Fiscal Year Ending June 30, 2009

The commission's original 17 members included: the chairs and ranking members of the Government Administration and Elections Committee (GAE), the chairs and ranking members of the Appropriations Committee, the secretary of the Office of Policy and Management (OPM), and eight legislative appointees. The GAE chairs are the chairs of the commission.

GAE administrative staff and nonpartisan legislative staff were to serve as administrative staff to the commission. The commission was to report on its findings and recommendations no later than July 1, 2009, to the governor, the house speaker, and the senate president, and terminate on July 1, 2009, or upon receiving the report, whichever was later.

***First amendment: August 2009
P.A. 09-3 June Special Session (Sec. 56)²***

Two actions in the biennial budget bill passed in August 2009 affected the commission. First, the reporting requirements and the termination date of the commission were changed. The commission was to submit an *initial* report, still no later than July 1, 2009, on its findings and recommendations, but also periodically submit additional reports. The commission's termination date was set at June 30, 2010.

Second, under the August 2009 biennial budget act, general fund lapses in both FY10 and FY11 were attributed to "Enhancing Agency Outcomes"-- \$3 million in FY10 and \$50 million in FY11.³ The apparent intent is that the commission is expected to achieve at least those amounts in savings as a result of its work.

***Second amendment: October 2009
P.A. 09-7 September Special Session (Sec. 49)⁴***

In a bill implementing the biennial budget passed in October 2009, the commission's responsibilities, membership, reporting requirements, and duration were further amended.

In terms of the directives to the commission related to agency mergers, the references to specific agencies for possible merger were deleted. The commission is still required to consider the merging of state agencies generally, as well as streamlining state operations to further the goals of the commission.

The act also added the co-chairs of the Legislative Program Review and Investigations (PRI) Committee to the commission, increasing its total membership to 19. The PRI Committee is required to assist the commission, within existing budgetary resources, as determined by the PRI Committee. This provision refers to the PRI Committee making available some of its full-time permanent, nonpartisan professional staff resources to assist in carrying out the commission duties.

² P.A. 09-3 June Sp. Sess. An Act Concerning Expenditures and Revenue for the Biennium Ending June 30, 2011

³ The total lapse amount for FY10 was \$473,293,794, and for FY11, \$530,363,090.

⁴ PA 09-7 Sept. Sp. Sess. An Act Implementing the Provisions of the Budget Concerning General Government and Making Changes to Various Programs

The commission's required reports now include this initial one, due by February 1, 2010, to identify subjects for further study; and a full report on the commission's findings and recommendations due no later than December 31, 2010. The commission's termination date was extended to December 31, 2011.

Activities to Date

During its initial work phase, from March through May 2009, the commission sought and collected ideas for reducing state costs and streamlining government from many quarters. The commission's first meeting was held on March 18, 2009.

An IBM representative and a consultant connected with IBM presented information to the commission on April 24, 2009, about electronic approaches to state government infrastructure, cost savings, and efficiency improvements, as well as to enhancing human services efficiency and effectiveness. On May 27, 2009, the Office of Child Advocate made a presentation entitled *Lessons From Across the Country: Improving Human Services Delivery*, which included a case study of the Allegheny County (PA) Department of Human Services. The commission held two evening public hearings in April, one in New Haven and one in Danbury. The commission requested by letter certain information from state agencies including whether they conducted administrative hearings; how contracts were negotiated; and if they issued permits or licenses. Related data was also requested. Inquiries about state printing facilities, interagency or outsourced printing, and agency mailing activities also were made. Responses were received from a number of agencies.

After the long biennial budget process for FYs 2010 and 2011 finally concluded, on November 30, 2009, the newly constituted commission met. Commission members received a document called Proposed Areas of Focus, which was a preliminary list of all the ideas gathered by the commission to date, requiring further review. On December 14, 2009, the commission held a public hearing in Hartford to seek both feedback on its preliminary list and additional ideas for savings and service improvements.

The commission met on January 22, 2010, to review the preliminary Proposed Areas of Focus list, re-organized by topic area to facilitate the review. That list combined with ideas from the December 14 hearing is the basis for this initial report identifying subjects for further study. The approach the commission took to evaluate the list is explained below.

Approach Used to Identify Subjects for Further Study

At the commission's January 22, 2010, meeting, each Proposed Area of Focus was assessed as to how soon a proposed idea (or part of it) might be implemented, using the following timeframes:

- Immediately (during the 2010 legislative session)
- Short-term (by 18 months)
- Long-term (three to five years)

No areas of focus were eliminated from the list.

Section II contains the results of this review process, organized by these topic areas:

- Personnel/Agency or Function Consolidations or Mergers
- Regulatory and Procedural
- Contracting and Purchasing
- Administrative
- Revenue Maximization: Federal and State
- Information Technology/Automation
- Medicaid and Other Large Budget Areas

In addition to the estimated implementation timeframe for each item under the topic area, information about support and opposition voiced during the December 14 public hearing is provided. Appendix A contains a full listing of all persons and organizations that testified or submitted written testimony to the commission at all three of its public hearings.

The tasks the commission anticipates would have to be completed and/or the additional information necessary to move forward on implementing the proposals also are presented for each topic area. Cost savings are noted for some of the proposed areas of focus, but the basis for most of these cost-savings is unclear. Therefore, except in the few cases where the cost information source is identified, no specific savings are attached yet to any proposals. It is anticipated that potential savings will be determined as proposals are further explored and refined. It is expected that the nonpartisan staff offices—Program Review and Investigations (PRI), Office of Legislative Research (OLR), and Office of Fiscal Analysis (OFA)—would develop more accurate savings estimates collaboratively.

The commission expressed interest at the January 22 meeting in following up with the agencies that did not testify at or submit testimony to the December 14, 2009, public hearing, which might further refine proposals.

Next Steps

The commission understands this initial report encompasses many ideas to achieve its overall goal of reducing state costs and enhancing the quality and accessibility of state services. At its January 27, 2010, meeting, the commission acknowledged that this effort needs to go beyond generating ideas and issuing proposals, to actual implementation. Without an overall strategy to achieve implementation, the commission is concerned that the report will just “gather dust”.

Thus, in order to accomplish its savings goal and meet its final report deadline, the commission after submitting this report on February 1, 2010, will take the following next steps.

- The commission co-chairs shall review the tasks outlined in each area and assign those tasks in accordance within its authority.

- The commission co-chairs shall meet with the General Assembly majority and minority leaders, and representatives of the executive branch, to determine which immediate and short-term ideas will be included as legislation in the 2010 General Assembly session. The co-chairs shall report back to the full commission on or before February 17, 2010, with which ideas will be submitted to the relevant committees as legislation.
- The commission co-chairs shall lay out a work plan for fully exploring each short-term and long-term idea no later than February 26, 2010. The co-chairs shall review these work plans with the commission and update the commission on the status of the short-term legislation no later than March 5, 2010.
- The commission shall create a specific plan to save \$3 million in FY 2010 and \$50 million in FY 2011 as specified by the adopted biennium budget. The commission shall approve a specific plan for FY 2010 savings no later than February 26, 2010, and for FY 2011 savings, no later than April 16, 2010.

In addition, it was also suggested that the legislative members of the commission work with their leaders to support and assist the commission's efforts.

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SECTION II

This section outlines an ambitious work plan for the Commission on Enhancing Agency Outcomes to be carried out over the next several months. As described in the previous section, the work plan is organized into seven broad categories with all the proposals under consideration by the commission contained under the relevant category. The work plan also contains the anticipated time frame for the proposal to be implemented, and a brief explanation regarding the time frame designation. The work plan also highlights support or opposition for the proposal based on testimony (oral or written) submitted at the commission's December 14, 2009, public hearing. Finally the work plan summarizes the tasks that will be necessary to research and structure the proposal for implementation, if that is what the commission determines. The work plan also recognizes that more definitive cost-savings estimates will be developed at the stage when proposals are more formalized.

The seven categories contained in the work plan are: I) Personnel/Agency or Function Consolidations or Mergers; II) Regulatory and Procedural; III) Administrative; IV) Contracting and Purchasing; V) Information Technology and Automation; VI) Revenue Maximization: Federal and State; and VII) Medicaid and Other Large Budget Areas.

I. PERSONNEL/AGENCY OR FUNCTION CONSOLIDATIONS OR MERGERS

IMMEDIATE TO SHORT-TERM

Proposal #1:

Streamline economic development ***agencies, processes and functions*** for simpler access, greater focus and reportable outcomes, and explore other opportunities for consolidations such as the merger of Cedarcrest and Connecticut Valley Hospital, and the consolidation of 23 agencies into six state agencies (See Appendix B for Senator Debicella's and Senator McLachlan's proposals).

Proposal #2:

Move additional state agencies to DAS SMART Unit for administrative functions

Explanation. Proposal #1 could be done this legislative session; the governor's budget called for a merger during the 2009 session. The 2009 program review study on economic competitiveness recommends a merger of the Connecticut Development Authority and the Connecticut Innovations Inc., and a transfer of some business development functions from the Department of Economic and Community Development to the merged authority. Savings potential short-term from rents and other expenses about \$1 million; longer-term from not refilling positions. Most of these savings are not from state budget, since these are quasi-public but savings could translate to more funding to businesses, and less to agency operations.

Proposal #2 could also be done on an immediate to short-term basis, as the Department of Administrative Services is open to the idea (per its December 14, 2009 testimony).

SHORT-TERM

Proposal #3:

Review delivery of state human services focusing on being more consumer-driven, efficient, accountable and transparent.

- a) ***Consolidate administrative functions*** including fiscal operations, human resources, payroll, central office legal, information technology, communications, public relations, quality management, rate setting and rate enhancement and may include other areas.
- b) ***Programmatic changes*** (see Long-term below)
- c) ***Enhance internal operations***
 - consolidate training – maximize federal funding
 - online applications systems (see broader recommendations in Category V)
 - consolidate contracting

Proposal #4: ***Consolidate and execute the “steering” function***⁵ – across existing state agency lines – for: (A) health care; (B) services to persons with disabilities; (C) education and job training; (D) integrating institutionalized persons back into the community; (E) supporting innovation and entrepreneurs and other economic development; (F) housing; (G) sustainable resource management; (H) transportation and infrastructure; and (I) public safety, corrections, and homeland security. A “steering function” in each area could use funding streams to provide services from the most effective and efficient providers. It could also facilitate the consolidation of “back-office” administrative functions such as personnel/human resources, payroll, affirmative action, fiscal/budget/accounting, and contract management from the relevant agencies.

Alternative ways for consolidating and executing a “steering” function include, but are not limited to:

- ***Add a “Deputy Chief of Staff” for each function*** in the Governor’s Office, or a “Secretary” of each function, above the Commissioner level, or a divisional head at OPM in charge of each function. Such positions would be supported by a Cabinet composed of Commissioners of relevant agencies.
- ***Review the role and function of the Office of Policy and Management (OPM)***, addressing this responsibility for coordinating policy, planning and

⁵ The idea is from Osborne and Hutchinson, The Price of Government, Chapter 5, “Consolidation.” In their view, “steering” – setting policy and direction – focuses on doing the right thing. “Rowing” – service delivery and compliance operations – focuses on doing things right. The best option, according to Osborne and Hutchinson, is to consolidate funding streams and steering authority, but not the organizations that do the actual rowing. Using consolidated funding streams, steering organizations can purchase results from any rowing organization (provider) they consider best equipped to provide them. The benefits: more effective steering and more competitive service delivery.

implementation throughout state government, perhaps realigning state employee positions to better equip OPM to perform these functions.

- **Require the creation of Interagency Steering Committees** (similar to one created by Executive Order 15 in 2007) made up of Commissioners of relevant areas (sub-groups of A through I above) to meet at least quarterly to report to the governor and/or the secretary of OPM on how these “steering functions” are being implemented. Commissioners would be required to attend.
- **Meetings of the Interagency Steering Committees would be public** and, as much as possible, televised on Connecticut Network (CT-N). (Washington State does this as a way of making government more transparent, elevating the planning/coordination function to a high level, and adding a substantial degree of accountability). If obstacles exist, like funding streams, commissioners should have authority to come to resolution.

Explanation. The commission discussed how the steering function might be implemented at its January 27, 2010, meeting, and concern was expressed that introducing cabinet level or secretary positions may be perceived as adding another layer of bureaucracy and that other ways of achieving the coordination by functional area should be explored. Alternative approaches are listed above and are considered short-term as much could be accomplished through executive directives to consolidate such functions. In fact, the interagency steering council for responsible growth areas has already been created by executive order but needs to be reactivated; a similar approach is recommended for education and workforce development in the state economic strategic plan (issued September 2009).

Savings from a back-office consolidation among agencies serving persons with disabilities were estimated by the Program Review and Investigations staff in 2003 at \$8 million annually, based on analysis of savings of 10 percent of the administrative costs then. Current analysis would be applied to current administrative costs in agencies to estimate savings now, but analysis should include an assessment of reductions that may have occurred in these areas since 2003. Also, any reorganization that calls for reductions in staff will have to consider both the current “no layoff” agreement in place, and restrictions in the current SEBAC agreement with state employees.

LONG-TERM

Proposal #5: *Programmatic changes* required under agency consolidations of human services agencies (or others)

Proposal #6: Explore *modifying state employee pension plans* and other state employee post-employment benefits (OPEB), like *retiree health care costs*.⁶

⁶ See, especially, the analysis by the Pew Center on the States, *Promises with a Price: Public Sector Retirement Benefits*, 2007, at <http://www.pewcenteronthestates.org/uploadedFiles/Promises%20with%20a%20Price.pdf>

Proposal #7: *Apply cost-benefit analysis to the delivery of state services by state agencies and private providers and utilize the principles of results-based accountability (RBA) for both state agencies and state-contracted service providers and vendors.* (RBA means the method of planning, budgeting, and performance measurement for state programs that focuses on the quality of life results the state desires for its citizens and that identifies program performance measures and indicators of the progress the state makes in achieving such quality of life results in addition to the programs and partners that make a significant contribution to such quality of life results.)

Public Hearing Testimony on Agency or Function Mergers and Consolidations

Support for Proposal #3 from Connecticut Business and Industry Association. Connecticut Non Profit Human Services Cabinet support for aspects of Proposals #3 and #4 consolidating administrative functions like contracting and data collection, and using clear and consistent guidelines, but skeptical of creating a behemoth agency. “Keep The Promise Coalition” (Amdur) suggests making human services more “population focused”, but cautions against a mega-agency. The Connecticut Community Providers Association supports Proposal #4 but suggests community providers be involved.

Community Health Resources (Gates) suggests separating administrative and support functions from regulatory functions before consolidating or reorganizing.

Senator Debicella (Sen. District 21) testified that additional consolidations and mergers are possible—suggests 23 agencies can be merged into 6 new agencies, and Cedarcrest and Connecticut Valley Hospital can be merged, and suggests no more than three layers (in agency organizations) exist between Commissioners and line staff.

The Department of Public Health opposes Proposal #3 consolidation of (back office) administrative functions, especially accounting and contracting, but thinks there may be value in cross-training. Department of Administrative Services is open to Proposal #2 – additional agencies under SMART program.

Tasks To Develop and Refine Proposals

- Need to **determine refill rates**, types of positions approved/not approved – should there be approval only of line or direct service and not on administrative or managerial?
- Need to determine number of **retire/rehires**
- Related longer term – examine need to build in an incentive for managers to **keep** personnel (and other **costs**) **down** – no incentive for that now
- Need to determine the number and percent of state employees in **hazardous duty positions** – additional benefits—how do percent and benefits—compare with other states?
- **Examine state employee pension plans, health care benefits, and unfunded liability.** How do benefits compare with other public pension and health care plans? What actions have other states taken to address?

- **Consider other potential proposals:** other *consolidation opportunities* – and consolidation of administrative functions (not just for human services agencies) and other similar functions.
- **Review SEBAC agreement** and other collective bargaining agreements to better determine restrictions, as well as determine barriers that exist because of information technology and databases.
- **Determine cost-savings estimates** for refined proposals.

II. REGULATORY AND PROCEDURAL

IMMEDIATE TO SHORT-TERM

Proposal #8: Implement lean processes in all executive branch agencies

Explanation. This was considered immediate, at least for some state agencies, since this has already been implemented at the Department of Labor and some areas of the Department of Environmental Protection. It could be done without legislative action, and there are state employees already trained in the concept and application of the processes.

SHORT-TERM TO LONG-TERM

Proposal #9: Streamline licensing and permitting processes

- a. business to state government including but not limited to DOT, DRS and DEP (e.g., water permits, human service providers)
- b. general commercial activity
- c. consumers

Proposal #10: Overhaul DMV functions focusing on consumer needs (esp. reducing lines at DMV) that would improve efficiency, accountability, and transparency

Proposal #11: Expand online applications statewide (also recommended in Information Technology/Automation section) and **expand satellite locations** where residents and businesses may obtain licenses, permits, and apply for assistance. **Provide clear instructions on agency websites** as to what information and documentation will be needed no matter how the application is made.

Explanation. Proposal #10 and aspects of Proposal #9 were identified as short-term as the most problematic processes and functions would first need to be identified; then ways to streamline and expedite the processes would need to be implemented, including determining alternative locations for processing state transactions. The commission members also discussed that one of the problems that could be addressed immediately is more predictability about state processes, which can be provided by clearly informing people about what the requirements are and what documentation and information they will need to produce online and/or in person to successfully complete the transaction.

However, commission members discussed that any approaches to application or issuance of state licenses, permits, or assistance must consider the confidentiality and protection of information and records. Further, any regulatory streamlining must be done without imposing additional risk on public health or safety or the environment (i.e., the underlying need and criteria for license or permit), which may be more long-term.

Public Hearing Testimony on Regulatory and Procedural Issues

DEP indicates streamlining licensing and permitting (Proposal #9) is important, and DPH has had success with on-line licensing and is working on one behavioral health license. The Connecticut Community Providers Association supports establishing one overarching licensing protocol for community providers. The Connecticut Business and Industry Association supports any streamlining that will help promote business development and thereby enhance state revenues.

CBIA supports LEAN processes (Proposal #8), as does DEP. TTT Transformations LLC, a private consulting firm, also testified in support of LEAN and other quality improvement processes.

Tasks To Develop and Refine Proposals

- Require each agency to identify its one most problematic regulatory process.
- Identify one or two main processes at DMV that impact the most state residents to target for improvements and/or cost savings, including exploring opportunities to expand services to outside agencies.
- Work with business groups to identify most problematic regulatory processes impacting economic development in the state.
- Analyze processes to determine where bottlenecks or duplication are occurring, and develop structured proposals for streamlining, including better local/state coordination.
- Work with Blue Ribbon Commission on Municipal Opportunities and Regional Efficiencies (MORE) to assess what proposals it is implementing that will streamline regulatory processes and improve efficiencies.
- Determine time and cost savings to customers (e.g., businesses, providers, individuals).

III. ADMINISTRATIVE

IMMEDIATE TO SHORT-TERM

Proposal #12: *Require “direct deposit” of all state payroll checks*, unemployment compensation checks, and workers’ compensation checks, to eliminate printing and mailing costs. Confirming information can be available online through CORE-CT.

Proposal #13: *Require a centralized, uniform electronic process for recording and transmitting state employee time records* throughout state agencies

SHORT-TERM

Proposal #14: *Consolidate administrative hearings* and/or use judge trial referees to provide administrative hearings for all agencies, as is recommended for CHRO. A **pilot program** might be established where certain administrative areas would be consolidated with hearing officers assigned with expertise in that area, addressing the concern that such hearing officers have knowledge in that area.

Proposal #15: *Printing* within state agencies

- a. *consolidate printing centers*
- b. *introduce and expand paperless processes*

Explanation. These proposals were identified as short-term, with the commission suggesting that an immediate pilot program to consolidate hearings might be undertaken. While requiring “direct deposit” appears more immediate, it would require notice to both employees and the public of the change. Also, there may be issues because some banks charge a fee for electronic deposit, while some individuals may not have accounts where direct deposits can be made.

Public Hearing Testimony on Administrative Issues

The Commission on Human Rights and Opportunities supports Recommendation 14, while the Departments of Public Health and Environmental Protection oppose it, stating that hearing officers need expertise in the specific area. CBIA supports Recommendation #12, and suggests immediate implementation, while State Comptroller Wyman opposes it, indicating it might cost more money than it saves.

Pitney Bowes testified that using better software and implementing better document management for both printing and mailing would be beneficial.

Tasks To Develop and Refine Proposals

- Determine the agencies and personnel involved in conducting administrative hearings now.
- Determine the subject matter areas of the administrative hearings and decisions, and current workloads.
- Determine the vacancies in these areas, and the number of refilled (or rehired retirees) positions.
- Determine where and how a pilot program to consolidate administrative hearing might be most feasible and effective, as well as the feasibility for longer-term implementation.
- Identify all various processes for recording of time and attendance and obstacles to making uniform, consistent, electronic process, and costs/savings estimates (personnel and other) from one process.
- Determine the costs (printing and personnel) throughout state government of paper checks, and statements.

- Determine the costs and obstacles to direct electronic deposit, and confirm that there would be savings (printing, personnel, etc.)
- Determine the printing needs, including reporting, of state agencies, and where and how that is done, and explore areas where that can be reduced or done electronically. Estimate cost savings from refined administrative proposals.

IV. CONTRACTING AND PURCHASING

IMMEDIATE

Proposal #16: *Enforce use of p-cards* (review audit findings)

Proposal #17: *Expand the use of reverse auctions for purchasing*, and also use for services.

Explanation. These were determined to be immediate as they could be implemented administratively within the executive branch agencies without legislation or other mandates, except that **legislation would be required to extend reverse auction use to services.** The reverse auction proposal (#17) was not among the list of preliminary proposals but was discussed at the January 22 and 27, 2010, commission meetings, and proposed its expanded use among agencies, towns, as well as for services and products. The practice is already used in some state agencies, including at the Office of Policy and Management for the purchase of energy used by the state.

SHORT-TERM

Proposal #18: *Mandate “managed competition”* – among both internal state government and external providers – for most services (excluding functions involving state-sanctioned violence (e.g., prisons and police), those which protect due process rights, those which handle sensitive security and privacy issues, and those that require absolutely fair and equal treatment (courts)).⁷

Proposal #19: *Cooperative Purchasing Opportunities – create and/or join* cooperative purchasing venture to allow certain eligible entities to purchase goods, certain services and utilities from state/multistate contracts. Greater volume allows for better price. (see Minnesota)

- Requires legislation to define joint powers/governmental entities that may join program. Includes municipalities, school districts as well as other entities – certain tax exempt, non profits and charitable organizations
- And/or join multistate cooperative purchasing organization – see for example **www.USCommunities.org**; other cooperatives allow participating government entities to avoid the time-consuming competitive bid process that involves

⁷ See David Osborne and Peter Hutchinson, The Price of Government, Chapter 7, “Buying Services Competitively.”

formulating and issuing requests for proposal, evaluating vendors, and negotiating contracts. Each participating government entity adds an addendum to the original contract, slightly altering the contract's terms and conditions to meet its own purchasing requirements. Since all purchasers are working off one contract, instead of the contractor having to maintain thousands of contracts across the country, they only have to maintain one. By us streamlining our side, [vendors] can provide the products and prices at a much lower cost than they could otherwise.

- Enforce bulk purchasing rules for higher education (see audit)

Proposal #20: *Join Multistate Contracting Alliance for Pharmacy* purchases – (see Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP), created in 1985, a voluntary cooperative purchasing group that combines the purchasing power of its members to receive the best prices available for pharmaceuticals, hospital supplies, and related products. MMCAP contracts with over 160 pharmaceutical manufacturers, and also has contracts for distributors (to support the pharmaceutical contracts), hospital supplies, returned goods processing, flu vaccine, and vials and containers. MMCAP's niche is to provide, through volume contracting and careful contract management, the best value in pharmaceuticals and related products to its members - eligible governmental health care facilities. Currently, MMCAP has membership agreements with 45 states and the Cities of Chicago and Los Angeles - 43 Participating Entities and over 5,000 eligible facilities.

Proposal #21: *Effectively utilize Eastern States Contracting Alliance* modeled on Western state alliance (WSCA) created in 1998 by the State of New Mexico. The WSCA are four contracts with PC manufacturers to provide, through volume contracting and careful contract management, the best value in PCs to the participating entities in 41 states that currently use these contracts. In January 2004, administration and management of these contracts was transferred to the Materials Management Division. Sixteen contracts, based on solicitations issued by Minnesota since February 2004, have become effective at various times since September 2004.

Proposal #22: *Share services/purchasing with neighboring states* (see Minnesota and Wisconsin-savings identified \$10m each state); see for example backing up each other's databases, investing together in communications systems for law enforcement and purchasing products from each other.

Explanation. Proposals #18 through 22 were all determined to be short-term, although the commission determined some aspects of Proposal #18 have the potential for being more long-term. The commission determined that all could be implemented by executive branch agencies and would not require statutory changes. In the case of the purchasing agreements, the Department of Administrative Services indicates (December 14, 2009, public hearing) that it already engages in several purchasing alliances for the state (and some municipalities).

The Department of Administrative Services indicates it already belongs to the Eastern States Contracting Alliance, which is part of the larger National Association of State

Procurement Officials (NASPO), but DAS states it need a legislative change granting it authority to purchase off an already existing contract, as DAS needs to be part of the group that develops the specifics for each procurement contract.

LONG-TERM

Proposal #23: Master contracting

- business to state government
- internal within state government
- intergovernmental
- consumers to state government
- municipalities

Explanation. The master contracting and all the subcategories listed in Proposal #23 were determined to be a long-term initiative. This would entail clarifying the definition of what a master contract actually means, what agencies and areas might be subject to it, and what the obstacles would be. Further, some aspects of Proposal #18 in mandating managed competition for some services could be longer-term if they have implications on personnel issues with SEBAC or other collective bargaining contracts.

Public Hearing Testimony on Contracting and Purchasing

The Department of Administrative Services indicated it would need further clarification on “master contracting”; in some cases DAS indicates it already does this. TTT Transformations LLC, supports a standard contracting process, and the Commission on Children supports master contracting, if it is implemented by “issue”. AFSCME Council 4 suggested implementing a contract services budget, and convening of the Contracting Standards Board.

CBIA supports Proposals #19-22, on group and cooperative purchasing and the Comptroller indicated that in some cases these cooperative arrangements work and in other cases they are not as successful. UCONN and the State University system indicated they are already doing cooperative purchasing, but UCONN indicated it should retain its purchasing authority because of unique higher education needs.

DAS stated it would need further clarification on the use of the **p-cards (Proposal #16)**, and the Comptroller supported their use, with scrutiny.

Tasks To Develop and Refine Proposals

Re: Contract Types and Aggregate Expenditures

- Identify all major types of state contracts and categorize:
 - Purchase of service agreements
 - Personal service agreements
 - Procurement Contracts
 - Other
- Identify which agencies oversee contracts

- Determine total dollar amounts
- Status of budget provision calling for reduction in contracts

Re: Individual Contractors and Contracts

- Identify individual contractors and non-profits
- Determine contracted amounts and services provided
- Determine continued need for contract
- Identify administrative expenses of contractors/non-profits
- Determine status and impact of budget provision calling for reduction of \$95 million in state contracts in each of FYs 10 and 11
- Determine the status of the State Contracting Standards Board
 - Determine potential obstacles to “managed competition”, including collective bargaining provisions
- Determine what other states have done to address contracting in current fiscal environment, and current best practices

Re: Purchasing

- Determine aspects noted above for all state purchasing activity, including the status of *Buy Smart-Buy Together*, a joint purchasing effort undertaken by the state a few years ago
- Inquire of Auditors the use of p-cards in state agencies, and review any audit findings.
- Determine states’ best practices for purchasing, and potential cost-savings if best practices are implemented
- Determine current status (extent and areas) of Connecticut’s involvement in multi-state alliance contracts, and potential for wider use and savings potential.
- Review plan for prescription drug purchasing by state agencies required by P.A. 09-206.

Re: Regionalization

- Determine what opportunities exist for regionalizing contracting, purchasing, and other services in the state, and what obstacles exist, and what is needed to eliminate obstacles.
- Identify ways of using state financial incentives or reductions to encourage implementation of regional contracting and purchasing.

V. INFORMATION TECHNOLOGY/AUTOMATION

IMMEDIATE TO SHORT-TERM

Proposal #24: *On-line applications system statewide* (example, Department of Motor Vehicles drivers’ licenses, and is also listed in Regulatory/Procedural Section)). Other agencies should include Departments of Higher Education, Social Services and Transportation. *Clients should be able to file an application for any social service with any social service agency.*

Proposal #25: *Use the Internet* to allow residents to determine the time and place of receiving services from state agencies (*self-service*) *including applications for licenses and permits* –and using the generated data to make services data to make services more responsive.⁸

Proposal #26: *Use the Internet to make processes more predictable* by informing residents and businesses of information, documentation needed to complete transaction or process.

Proposal #27: *Leverage the existing statewide state fiber network* to provide training to state agency personnel (such as DCF, DMHAS, DSS, DDS, affirmative action, etc.) by interactive video, rather than by travel to multiple locations with multiple presentations.

Proposal #28: *Make regulations for all state agencies accessible online* and other relevant information such as rules, policy guidelines.

Explanation. These proposals were determined to be achieved in the short term since Internet capabilities would allow for these to be accomplished without creation of new systems, and some online applications, webinars etc. are already available and should be able to be expanded relatively quickly.

SHORT-TERM TO LONG-TERM

Proposal #29: *Consolidate data centers*

Proposal #30: *Use managed competition* for certain information technology services, such as email, file sharing, and database applications, and forms automation and processing, and explore use of open source software and enhancing interoperability.

Explanation. These proposals were determined to need further exploration before clear designation of a time frame for implementation, as it is not clear where all data centers reside, and what computer systems and data are compatible. It is possible that certain aspects might be accomplished in the short-term, but longer-term implementation is more realistic.

LONG-TERM

Proposal #31: *Designate a lead state agency to modernize statewide communication platform*

Proposal #32: *Facilitate the creation and use of statewide, interoperable electronics systems for state records, including an electronic health records system* (EHR) to reduce health care costs and improve quality of service.

Explanation. Proposals #29, 30 and 31, and aspects of #32 above will require significant research on what the current state systems provide, and what the obstacles are to modernizing

⁸ See Osborne and Hutchinson, *The Price of Government*, chapter 9, “Smarter Customer Service: Putting Customers in the Driver’s Seat.”

platforms and making systems interoperable. Creating and accessing electronic health records statewide should be more short-term. Although such an EHR is available free of charge from the federal Veterans Health Administration,⁹ potential state users of an EHR state that the VA system does not meet their needs. However, the Connecticut Health and Educational Facilities Authority (CHEFA) is writing a federal grant proposal that will be submitted through the Department of Public Health to access \$200 million in federal stimulus funds under Section 3014 of the American Recovery and Reinvestment Act (ARRA) to be combined with \$50 million in tax-exempt bonds to be issued pursuant to Section 10a-186a of the Connecticut General Statutes, for the purpose of creating interoperable EHR systems for Connecticut providers. Moreover, a collaboration is under way to secure up to \$43 million in federal Medicaid funding (100 percent of state Medicaid expenditures for this purpose), under Section 4201 of the ARRA, to support the adoption, implementation or upgrade of certified EHR technology by eligible hospitals in Connecticut. Both of these efforts should be supported by the General Assembly. Potential out-year savings in Medicaid costs: considerable.

Public Hearing Testimony on Information Technology and Automation

The Commission on Children supports online application (#24) for benefits with common applications. The Department of Information Technology supports data center consolidation, expanding statewide application processes, including licensing, but does not support the managed competition approach to information technology.

There was support for developing electronic health records (EHR) (#32) systems from various parties, including the Connecticut Community Providers Association, UCONN (which indicates it is already implementing), and the Department of Public Health, which supports the concept but not the VA system, indicating it does not encompass needs of all providers. The Connecticut Hospital Association supports the EHR proposal, but indicates the state would need to put up some state dollars in order to get a federal match.

CBIA supports modernizing systems, consolidating data centers, and managed competition in the information technology area. The Comptroller supports consolidation as well as virtualization of servers per CORE-CT, the state's automated business system for personnel, payments etc. DPH is concerned about confidentiality of client data if data centers are consolidated.

Tasks To Develop and Refine Proposals

- Require the Department of Information Technology (DOIT) to provide description of current information technology systems, what is provided by DOIT, and what state agencies perform.
- Determine what resources (staff, equipment, and other) are currently expended on information technology and automation currently.

⁹ See David Osborne, "Memo to the New President: Reinventing Health Care," January 15, 2009, on page 12 of the printed version, available at the website of the Public Strategies Group, specifically at: <http://www.ppionline.org/print.cfm?contentid=254877>

- Determine best practices (e.g., Digital Government) for state information technology and other processes, and what implementation would cost or save.
- To the extent possible, (and within available resources) work with outside consultant services (with no product or service to sell) to assess current systems and alternatives.

VI. REVENUE MAXIMIZATION: FEDERAL AND STATE

FEDERAL IMMEDIATE TO SHORT-TERM

Proposal #33: *Pursue a Section 1115 Medicaid waiver* for the SAGA program, while increasing reimbursements to providers. This action is already required by Section 17b-192(g) of the Connecticut General Statutes, but has not yet been implemented.

Proposal #34: *Seek new federal revenue* for existing Department of Mental Health and Addiction Services (DMHAS) (ACT, Supervised Housing services, Supported Housing services, Mobile Crisis) as Medicaid rehabilitation services.

Proposal #35: *Maximize federal revenue by billing Medicaid*, to the fullest extent allowed, for outpatient services by DMHAS state operated and contracted providers

Proposal #36: Take advantage of *federal assistance to veterans*, by requiring all state agencies to ask clients seeking assistance “Have you served in the military?” and forwarding name and addresses of veterans to the Dept of Veterans’ Affairs, which can then seek out all forms of assistance to veterans.

Proposal #37: *Maximize emergency TANF (temporary assistance) and Supplemental Nutrition Assistance Program-Employment and Training Reimbursement Program funding* (SNAP E&T, formerly FSET (Food Stamp Employment and Training))

Proposal #38: *Designate a person in each state agency* for maximizing federal funds and grants.

STATE IMMEDIATE TO SHORT-TERM

Proposal #39: Confer with the *Department of Revenue Services (DRS)* about what the agency needs to *promote full tax collections*, and consider whether adding auditor positions would increase tax collection.

Proposal #40: Impose a *\$75 fee for filing discrimination complaints* at the Commission of Human Rights and Opportunities (CHRO) to discourage the filing of frivolous complaints, and allow for a waiver if indigency is shown.

Explanation. The Commission on Enhancing Agency Outcomes concluded at its January 22, 2010, meeting that certain aspects of federal revenue maximization could be achieved immediately if a more aggressive approach was taken by executive branch agencies to seek out, research eligibility criteria, and apply for federal (and other) funding. The commission also believed that inquiring about veteran status could be implemented immediately if required of all executive branch agencies, although DMHAS testified that the information cannot be shared unless permission is granted. Other aspects of the proposals would be short-term but not immediate, as waiver applications or expansions would have to be explored, and some might require additional state money before Medicaid funds would reimburse.

The commission also determined that state collections could also be maximized, and in particular thought that DRS processes/resources could be reviewed for increasing collection of taxes owed. Using an idea brought forward at the December 14, 2009, public hearing, the commission thinks establishing a fee for CHRO complaint filings, as long as there is a indigency waiver, would be beneficial.

Public Hearing Testimony on Federal and State Revenue Maximization

The Connecticut Nonprofit Human Services Cabinet supports greater efforts at Medicaid reimbursement (#33) (and other funds); CBIA supports waiver for the SAGA program, as does the Connecticut Hospital Association, and the Connecticut Community Providers Association, but with “carve outs” for some services.

The proposals for seeking Medicaid funding for additional Department of Mental Health and Addiction Services (DMHAS) (#34) and other outpatient services (#35) were supported by various testifiers including the Connecticut Community Providers Association, the National Alliance on Mental Illness (NAMI-CT), and the Department of Mental Health and Addiction Services (although DMHAS noted that many services are not federally reimbursable). The “Keep the Promise” Coalition also supported #35.

Other revenue maximization proposals suggested at the public hearing were:

- adding auditor positions at Department of Revenue Services to garner taxes owed
- eliminate some tax expenditures (tax credits) that do not provide a public benefit
- impose a filing fee at CHRO, with a waiver for the indigent
- TANF and FSET funding (commission January 22, 2010 meeting)

Tasks To Develop and Refine Proposals

- Determine total federal dollars received in Connecticut, and how (and in what agencies) the state applies for federal dollars and/or federal Medicaid waivers.
- Identify human services that are currently 100 percent state-funded, and analyze whether there is potential for Medicaid (or other) federal funding.
- Determine how other states are organized for obtaining federal revenues (and what incentives are provide to agencies for seeking and obtaining), and whether consolidation or contracting out of this function makes sense.

- Discuss with National Conference of State Legislatures, Council of State Governments, and National Governors Association.
- Determine maintenance of effort issues around Medicaid, waivers, and state funding.
- Research whether state agencies should be allowed discretion to negotiate with persons to settle outstanding accounts for money owed to the state at lesser amounts than owed.
- Research number of DRS auditors/tax collection return amounts; find out if any other point in DRS process could be enhanced to increase collection of taxes owed.

VII. MEDICAID & OTHER LARGE BUDGET AREAS

MEDICAID IMMEDIATE to SHORT-TERM

Proposal #41: Fully *implement drug recycling* programs

LONG-TERM

Proposal #42: *Control long-term health care costs*

Proposal #43: State needs to *invest in appropriate planning capacity* to address issue of *long-term health care costs*.

Explanation. The commission determined there are many aspects to this broad proposal (Proposal #42), and therefore not much could be done immediately to control long-term health care costs. Many suggestions were proposed at the December 14, 2009 public hearing – from rebalancing the care system to provide more community-based care and expanding newer community initiatives like “Money Follows the Person”, to expanding waivers for current home care services and community-based services for the young mentally ill, and transferring more clients from state-run programs to community providers. However, one commission member cautioned at the January 22, 2010, meeting that the state, in its efforts to control costs, must be careful not to create two parallel, expensive entitlement programs.

Public Hearing Testimony on Controlling Long-term Health Care Costs

The Commission on Aging suggests rebalancing the system more towards home care, streamlining the home and community-based waiver systems and supports the “Money Follows the Person” initiative. CBIA also supports more care in the community and by community providers rather than state agencies and suggests a cost analysis of Southbury Training School. Senator Debicella also supports greater services by community providers rather than state agencies.

Other suggestions for controlling long-term health care costs were more administrative and may well lend themselves to the review of contracting and administrative segments of the work plan, for example, to develop a single application process for most social services, standardize data and reporting systems, and increase collaboration among nonprofits to offer and

coordinate more back office services. Some efforts at controlling costs might be able to begin immediately, like full implementation of drug recycling programs (#41), and fall prevention programs for the elderly.

Tasks To Develop and Refine Proposals

- Explore whether federal restrictions exist on state reducing optional Medicaid services.
- Determine capacity and occupancy rates of nursing homes, administrative costs of nursing homes, and potential ways of reducing the number of beds and/or homes.
- Explore obstacles to transferring additional services to community providers from state agencies (e.g., SEBAC and other collective bargaining agreements).

CORRECTIONS SHORT-TERM

Proposal #44: *Provide community services* to approximately 1,400 persons in prison with moderate to serious mental illness who are incarcerated ***ONLY for low-level, non-violent offenses***. If community services cost \$20,000 per person, vs. \$32,000 per incarcerated person, savings would be \$17 million annually. Medicaid reimbursement for community services could provide additional federal revenue of \$10 million or more.

Proposal #45: The state should carefully review the potential for saving money and improving public safety by ***enhancing*** its programs for ***community corrections*** as alternatives to incarceration for lower-risk-level, non-violent offenders, including in the weeks and months prior to release from prison – using proven risk-assessment methods and evidence-based supervision programs. Such programs have proved effective in states like Texas and Arizona, they cost far less than incarceration, and they improve outcomes (including protecting public safety, improving offenders’ reintegration into the community, and decreasing the rate of recidivism).¹⁰

Proposal #46: *Innovation and prevention, state corrections*

Explanation. The commission determined proposals # 44 and 45 could be implemented in the short-term because it believes there are evidence-based models out there that could be fairly easily replicated that have demonstrated to reduce recidivism and save money. One obstacle discussed was local opposition to siting community-based residential facilities.

CORRECTIONS LONG-TERM

Proposal #47: Explore the ***privatization of Inmate Medical Services in DOC***

¹⁰ See the analyses by the Pew Center on the States, including One in 31 (2009), and “Right-Sizing Prisons: Business Leaders Make the Case for Corrections Reform” (January 2010), both available at www.pewcenteronthestates.org

Public Hearing Testimony on Corrections

The Connecticut Business and Industry Association supports programs that cut the rate of recidivism like “character-based” prison models, alternatives to incarceration for non-violent offenders, and enhanced community re-entry services. The Capital Workforce Partners also supports prevention programs such as better alignment of employment and training services with client needs, and developing programs for high school dropouts and ex-offenders.

The Department of Mental Health and Addiction Services, NAMI-CT, and CCPA, and CNPHSC, the nonprofit human services cabinet, all support enhanced community services in the corrections area, but indicate that they must adequately address needs (like mental health) and cover costs.

MHM Correctional Services, a private firm in the area of correctional consulting and services supports privatizing some correctional services, and public/private partnerships in implementing other correctional programs.

Tasks To Develop and Refine Proposals

- Determine how Department of Corrections provides services (including medical) now, and what evidence-based models exist for these services to be privatized and/or provided in community.
- Explore obstacles that might exist to privatizing services, (e.g., security issues like locked units).
- Review Pew Center on the States Report entitled One in 31 cited in footnote 10.

DEPARTMENT OF CHILDREN AND FAMILIES SHORT-TERM

Proposal #48: *Enhance community prevention and intervention efforts by DCF*, to support and preserve families, keeping children at home when safe, and using foster care, rather than congregate care, when children must be removed from their families. Short-term savings result because foster care board and care payments should be less than per child costs for congregate care. And there should be longer-term savings because kids are far more likely to get adopted out of foster homes than congregate care.

Explanation. The commission determined that this proposal could be implemented in the short term, recognizing that many of these programs already exist in the state have been demonstrated to be less expensive and in many cases more effective. The use of these less costly alternatives could be expanded within the executive branch.

Public Hearing Testimony on Department of Children and Families

The Commission on Children supports prevention programs for children

Tasks To Develop and Refine Proposals

- Determine how DCF provides child welfare and prevention services now, what are the determining factors and what evidence-based models exist for these services to be privatized and/or provided in community?

EDUCATION COSTS SHORT-TERM TO LONG-TERM

Proposal #49: *Promote regionalization of elementary and secondary education* to more efficiently use state education funding.

Tasks To Develop and Refine Proposals

- Work with Blue Ribbon Commission on Municipal Opportunities and Regional Efficiencies (MORE) to assess what proposals it is exploring that would promote regionalization of elementary and secondary education.

STATE OWNED MENTAL HEALTH FACILITY IMMEDIATE

Proposal #50: Use City of *Middletown to provide water service* to Connecticut Valley Hospital (CVH)

Tasks To Develop and Refine Proposals

- Discuss idea with the Department of Mental Health and Addiction Services to understand DMHAS concerns.

SOCIAL SERVICES DELIVERY LONG-TERM

Proposal #51: Undertake *rigorous cost/benefit analysis of transferring most or all social services clients from state institutions to not-for-profit private providers and closing state institutions*. Agencies including the Department of Developmental Services and the Department of Mental Health and Addiction Services will be reviewed to determine the timetable and savings from transferring clients to the private providers.

Miscellaneous (Suggestions from December 14, 2009 Public Hearing)

- Do not rebid contracts with nonprofits; already providing services at less than state services
- Accept suggestions from SEBAC members on providing more effective and efficient services
- Eliminate the Connecticut Resources Recovery Authority

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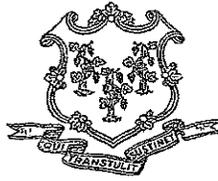
Appendix A
Persons/Organizations That Testified or Submitted Testimony at Commission on Enhancing Agency Outcomes Public Hearings
April 27, 2009 New Haven
Cynthia Clair
Fritz Jellinghaus and Ann Scheffer
Helen Higgins
John Herzan
Larry Bingaman
Nancy Ahern
Rachel Gibson
Robert Dunne
Ryan Odinak
April 30, 2009 Danbury
Jeffry Muthersbaugh
T.H. Martland
Tom Nelson
December 14, 2009 Hartford
Alicia Woodsby, NAMI-CT
Alyssa Goduti, Community Providers Association
Barry Kasdan, Bridges in Milford
Brian Ellsworth, Connecticut Association for Hospice & Homecare
Chancellor David G. Carter, Connecticut State University System
CIO Diane Wallace, Department of Information Technology
Commissioner Amey Marrella, Department of Environmental Protection
Commissioner Patricia Rehmer, Department of Mental Health & Addiction Services
Commissioner Robert Galvin, Department of Public Health
Comptroller Nancy Wyman
Connecticut Hospital Association
Connecticut Nonprofit Human Services Cabinet
Department of Administrative Services
Elaine Zimmerman, Commission on Children
Hal Smith, MHM Correctional Services, Inc
Heather Gates, President & CEO of Community Health Resources
Jon P. FitzGerald, Office of Public Hearings, Commission on Human Rights & Opportunities
Julia Evans Starr, Commission on Aging
Leigh Walton, Pitney Bowes
Peter Gioia, Chief Economist, Connecticut Business & Industry Association
Ron Cretaro, Connecticut Association of Nonprofits
Sal Luciano, AFSCME Council 4
Senator Dan Debicella, 21 st District
Shelia Amdur, Keep the Promise Coalition
Thomas Gullotta
Thomas Nelson, TTT Transformations, LLC
Thomas Phillips, Capital Workforce Partners
VP & CIO Barry Feldman, University of Connecticut
Brian Anderson

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Appendix B

Senator Debicella Proposals (12/11/09 Letter)

Senator McLachlan Proposals (4/23/09 Letter)



State of Connecticut

SENATE

STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

SENATOR DAN DEBICELLA
DEPUTY MINORITY LEADER
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RANKING MEMBER
APPROPRIATIONS COMMITTEE
HIGHER EDUCATION & EMPLOYMENT
ADVANCEMENT COMMITTEE
PUBLIC HEALTH COMMITTEE

MEMBER
REGULATIONS REVIEW COMMITTEE

December 11, 2009

Dear Senator Slossberg and Representative Spallone:

Per your request at the November 30th meeting of the Commission on Enhancing Agency Outcomes, I am submitting additional ideas for consideration. Having reviewed the preliminary ideas generated for consideration, I believe that many are worth pursuing. However, only a few of these ideas reach the fundamental type of government restructuring needed to address the fiscal crisis facing Connecticut in the next 3-5 years. Most of the ideas will result in savings of less than \$5 million, which will not make a dent in the multi-billion dollar deficit projected for FY11-FY14.

If our commission is to be more than just another political distraction, we must face the task of restructuring government to save money head-on. Therefore, I am offering several additional ideas that I believe our commission should adopt. Most of these ideas were discussed in the budget process of 2009, but require a multi-year effort to implement. I believe these are the types of long-term changes our commission should work to implement.

When taken together, the following recommendations would save over \$250 million per biennium (based on OFA estimates) without diminishing the quality of service provided by government. Most of the recommendations will result in a reduction of the state work force, as redundancies are eliminated and functions are transferred to more efficient providers. While the state work force cannot be reduced until FY11 at the expiration of the SEBAC agreement, I believe we need to start planning now.

This commission has an opportunity to reinvent government by changing how we operate—saving the taxpayers money while maintaining the outcomes we desire. Anything short of this approach will result in massive tax increases and additional borrowing. My hope is that we can join together in a bipartisan fashion to stand up to special interests, truly change how Connecticut government operates, and set us on a fiscally sustainable course.

Sincerely yours,

Dan Debicella
State Senator

Proposals for Reinventing Government

1) Transfer DDS and DHMAS Clients to Non-Profit Community Providers

Total Savings: \$100 million per year (post-SEBAC agreement)

Background: Currently, 80% of DDS and DHMAS clients are served by non-profit community providers, ranging from day services to full hospital care. The remaining 20% of clients are served by state institutions. Quality of care is widely recognized to be excellent at both community providers and state institutions. However, state institutions cost between 2-3 times more per client than community providers. While part of this is due to more severe cases being handled by the state, a large portion of the cost comes from higher labor cost and overhead in state institutions.

Proposal: Transfer all clients from state institutions to private providers (along with 50% per client funding) and close state institutions. Take a multi-year approach to the transfer to ensure community providers can build capabilities to handle the wider array of client needs.

2) Merge 23 State Agencies into 6 New Agencies, and eliminate unnecessary overhead

Total Savings: \$19 million (post-SEBAC agreement)

Background: As state government has grown, state agencies have developed with overlapping responsibilities and management structures. Management layers can be eliminated and redundant positions reduced by merging and streamlining agencies.

Proposal: Merge similar agencies and eliminate redundant managerial, supervisory, and front-line positions. Potential mergers are as follows:

- a. Move CI, CDA and CHFA into DECD
- b. Combine DPH, DCF, DDS, DMHAS and DSS into a Department of Human Services
- c. Consolidate all permanent and minority-based commissions into one new Commission on the Status of Protected Citizens
- d. Merge DPW into DOT and DAS
- e. Merge DMV into DOT
- f. Consolidate DOL into DECD
- g. Move DEMHS into DPS
- h. Merge Department of Aging into various agencies

3) Consolidate Cedarcrest Hospital with Connecticut Valley Hospital

Total Savings: \$8 million

Background/Proposal: With under-utilization of both hospitals, merging them and eliminating labor and overhead associated with hospitals would maintain client quality while saving costs.

4) Prohibit any state agency from having more than 3 layers between Commissioner and front line personnel, and have every manager responsible for at least four direct reports.



State of Connecticut
SENATE
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 HARTFORD, CONNECTICUT 06106-1591

SENATOR MICHAEL A. McLACHLAN
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MINORITY WHIP

RANKING MEMBER
 GOVERNMENT ADMINISTRATION AND ELECTIONS
 COMMITTEE

MEMBER
 FINANCE, REVENUE AND BONDING COMMITTEE
 JUDICIARY COMMITTEE
 LEGISLATIVE MANAGEMENT COMMITTEE
 TRANSPORTATION COMMITTEE

April 23, 2009

Honorable Gayle S. Slossberg, Co-Chair
 Commission on Enhancing Agency Outcomes
 Legislative Office Building #2200
 Hartford, CT 06106

Honorable James Field Spallone, Co-Chair
 Commission on Enhancing Agency
 Outcomes
 Legislative Office Building #2200
 Hartford, CT 06106

Dear Senator Slossberg and Representative Spallone:

I am writing to offer ideas for consideration by the Commission on Enhancing Agency Outcomes as we work to identify opportunities for operational efficiencies in state government. Clearly the challenge of any designing government reform and streamlining plan is to identify operational synergies that can foster departmental mergers. I present to you the following consolidation ideas for consideration by the Commission:

- Connecticut Innovations., Inc., Connecticut Development Authority and the Connecticut Housing Finance Authority consolidated into the Department of Economic and Community Development.
- Department of Labor consolidated into the Department of Economic and Community Development.
- Department of Public Health, Department of Children and Families, Department of Developmental Services, Department of Mental Health and Addiction Services and the Department of Social Services consolidated into a new created Department of Human Services.
- Department of Public Works consolidated into the Department of Transportation and the Department of Administrative Services.
- Department of Motor Vehicles consolidated into the Department of Transportation.

- Department of Emergency Management & Homeland Security merged with the Department of Public Safety.

The Commission on Enhancing Agency Outcomes should offer the General Assembly government reform plans that address long-term goals of reducing state government spending. Substantive consolidations as suggested above will demonstrate that government does not have to be a gigantic and inefficient bureaucracy and that an entrepreneurial spirit can truly transform our state government. I look forward to our deliberations over the next several weeks.

Sincerely yours,



Michael A. McLachlan
State Senator
Member - Commission on Enhancing Agency Outcomes

Cc: Commission on Enhancing Agency Outcomes Members
Honorable John McKinney, Senate Minority Leader
Honorable Leonard A. Fasano, Senate Minority Pro Tempore

Government Administration & Elections Committee
Senator Gayle Slossberg, Chair
Representative James Spallone, Chair
Legislative Office Building, Room 2200

May 11, 2009

Dear Senator McLachlan,

Thank you for your letter dated April 23, 2009. We appreciate your thoughts and are delighted to give your proposals consideration. We thought it would be most helpful to the Commission's work if you could provide some of your analysis as to how each merger would improve services to our constituents, save money, and reduce redundancies. Specifically, for each proposal, with the exception of the Human Services merger, please provide the following to the extent that you are able:

- Potential cost savings and how you would effect those savings
- The number of layoffs, job eliminations or changes in personnel
- Changes in processes
- New locations to house merged agencies and the associated costs
- Basis for your conclusions
- Any potential conflicts created by the merger
- Any loss of federal dollars associated with the merger
- Legal impediments to the merger
- Any recent merger or reorganization-type activity within the agencies

We look forward to receiving your response and reviewing the feasibility of your proposals.

Warm Regards,

Senator Gayle Slossberg

Representative James Spallone

Due to an oversight, this letter, originally sent via email, was omitted in error from the February 1, 2010 CEAO Initial Report

APPENDIX B
Statistics on Back Office Functions and Manager/Supervisor Positions in CT State Government

Agency*	Total # of Employees	# of HR Positions	# of Payroll Positions	# of EEO Positions	# of Fiscal Positions	# of I.T. Positions	# of Managerial + Supervisory Employees	# of Non-Managerial/Supervisory Employees
General Government								
Board of Accountancy	5	0	0	0	0	0	2	3
Dept of Administrative Services	331	50	4	4	45	24	69	262
Div Crim Justice	495	1	1	1	5	4		
Department of Public Works	169	0	1	0	16	3	32	137
Department of Revenue Services	710	5	5	2	44	52	166	544
Department of Special Revenue	110	1	1	0	16	8	21	89
Dept of Veterans Affairs	338	3	1	1	11	4	35	303
Elections Enforcement Comm	49	0	0	0	12	7	12	37
Ethics Comm	18	0	0	0	3	1	3	15
Freedom of Information Comm	20	0	2	0	1	1	7	13
Governor's Office	29	0	0	0	0	0	0	29
Dept of Information Technology	231	5	0	0	21	184	80	151
Judicial Selection Comm	1	0	0	0	0	0	1	0
Lt. Governor's Office	5	0	0	0	0	0	0	5
Off of Attorney General	328	1	1	0	6	3	218	110
Office of Policy and Management	131	2	0	0	44	4	57	74
Office of State Comptroller	264	3	9	1	64	67	71	193
Office of State Treasurer	142	1	0	0	36	7	33	109
Off of Workforce Competitiveness	3	0	0	0	0	0	2	1
Secretary of the State	85	1	0	0	5	5	7	78
TOTAL	3464	73	25	9	329	374	816	2153
Regulation and Protection								
Dept of Agriculture	62	0	0	0	0	0	8	54
Office of Consumer Council	14	0	0	0	0	0	1	13
Dept of Consumer Protection	156	0	0	0	4	2	29	127
Department of Motor Vehicles	750	7	3	2	28	29	88	662
Dept of Banking	116	3	0	0	28	3	41	75
Department of Insurance	140	2	1	0	6	5	30	110
Department of Labor	800	5	2	1	29	40	125	675
Department of Public Safety	1678	11	7	2	14	17	277	1401
Emergency & Homeland Security	48	0	0	0	8	3	8	40
Fire Prevention	72	0	0	0	1	3	4	68

APPENDIX B
Statistics on Back Office Functions and Manager/Supervisor Positions in CT State Government

Agency*	Total # of Employees	# of HR Positions	# of Payroll Positions	# of EEO Positions	# of Fiscal Positions	# of I.T. Positions	# of Managerial + Supervisory Employees	# of Non-Managerial + Supervisory Employees
Board of Firearms and Permits	1	0	0	0	0	0	0	1
Comm Human Right and Ops	74	0	0	0	0	1	5	69
Office of Healthcare Advocate	9	0	0	0	0	0	2	7
Military Department	107	1	1	0	13	1	17	90
Office of Child Advocate	8	0	0	0	0	0	3	5
Protect/Advocacy Prsns Disab	45	0	0	0	0	0	7	38
Office of Victim Advocate	4	0	0	0	0	0	0	4
Police Officer Stnds/Training	22	0	0	0	0	1	7	15
Department of Public Utility	124	0	0	0	6	4	16	108
Workers Comp Comm	116	1	0	0	8	3	8	108
TOTAL	4346	30	14	5	145	112	676	3670
Conservation and Development								
Agricultural Exp Station	83	0	0	0	3	0	9	74
Arts Tourism Culture History Film	47	0	0	0	0	0	4	43
Council Environmental Quality	2	0	0	0	0	0	1	1
Dept Environmental Protection	946	10	4	2	41	22	168	778
Economic and Community Dev	117	1	0	0	17	3	21	96
TOTAL	1195	11	4	2	61	25	203	992
Health and Hospitals								
Office of Chief Medical Examiner	61	1	0	0	4	2	4	57
Dept of Developmental Services	4355	27	20	3	56	17	437	3918
Dept of Public Health	809	8	3	1	30	20	112	697
Dept of Mental Hlth & Addctn Svcs	3490	43	16	6	56	41	415	3075
Psychiatric Sec Review Board	4	0	0	0	0	0	0	4
TOTAL	8719	79	39	10	146	80	968	7751
Transportation								
Dept of Transportation	3078	23	0	8	173	39	415	2663
Human Svcs								
Dept of Social Services	1921	14	2	1	87	51	236	1685
Soldiers Sailors Marine Fund	9	0	0	0	1	0	0	9
TOTAL	1930	14	2	1	88	51	236	1694

APPENDIX B
Statistics on Back Office Functions and Manager/Supervisor Positions in CT State Government

Agency*	Total # of Employees	# of HR Positions	# of Payroll Positions	# of EEO Positions	# of Fiscal Positions	# of I.T. Positions	# of Managerial + Supervisory Employees	# of Non-Managerial + Supervisory Employees
Corrections								
DCF	3518	39	10	4	62	36	705	2,813
DOC	6252	46	24	5	98	23	752	5,500
TOTAL	9770	85	34	9	160	59	1457	8,313
Education								
Bd State Acdmc Awds (Charter Oak)	79	0	0	0	0	0	0	79
CCCS (provided by CCCS Chancellor Herzog)	2,322	33	33	1	106	147	116	2,206
Comm Deaf Hearing Impaired	38	0	0	0	0	0	3	35
CT State Library	101	1	0	0	5	3	17	84
CSUS	3,489	37**	16**	8**	151**	191**	80*	3,409
DHE	44	0	0	0	0	0		44
BESB	121	0	0	0	4	4	6	115
SDE	2001	8	2	1	79	18	70	1,931
Teachers Rtrmnt Bd	24	0	0	0	11	3	4	20
UHC (provided by UHC)****	4,715	39	13	4	58	134	149	4,566
UConn (provided by UConn)****	4,559***	39	23	7	86	172	105	4,454
TOTAL EDUCATION	17,493	157	87	21	500	672	550	16,943
Judicial****								
Child Protection Commission	9	0	0	0	0	0	0	9
Judicial Branch (provided by Judge Quinn)	4,362	25	9	2	19	185	187	4,175
Public Defender Services Comm	402	0	1	0	0	0	0	402
TOTAL JUDICIAL	4773	25	10	2	19	185	187	4586
* Provided by CSUS								
** Based on location description								
*** OPM reported 4,925 and PRI found 5,621 full time/>.49FTE employees								

B-3

Appendix C
COMMISSION ON ENHANCING AGENCY OUTCOMES

**Ratio Of Human Resources Workers¹ To Number Of State Employees in
Other States and Industry Standards**

- Georgia has one human resources staff person for every 115 state employees, except for Georgia’s smaller state agencies, which have one human resources staff person for every 88 state employees.²
- New Jersey has one human resources staff person for every 63 state employees, with a range from one for every 48 state employees in the Human Services department, to one for every 140 state employees in the Public Defender department.³
- A general rule in the HR field is one human resources staff person for every 100 employees.⁴
- A study by the Society of Human Resource Management⁵ reported the average HR staff to employee ratio by organization size to be:

No. of Employees	Average HR Staff to Employee Ratio
Fewer than 100	2.70
100 to 249	1.26
250 to 499	1.07
500 to 999	0.82
1,000 to 2,499	0.79
2,500 to 7,499	0.53
7,500 or more	0.42

These ratios may vary depending on such factors as degree of centralization of the HR function, geographic distribution of employees, degree of outsourcing, and level of regulatory oversight, among others.

¹ Human Resources workers are often responsible for managing personnel recruitment and selection, compensation, job classification, and administering employee benefits and insurance. Definitions of the human resources function vary, and the ratios described above may or may not include payroll, affirmative action/EEO, and/or training positions.

² Georgia State Senate Budget Task Force Final Report, March 16, 2010.

³ Human Resource Management in New Jersey State Government, Report prepared for the State of New Jersey Department of Personnel by John J. Heldrich Center for Workforce Development, Rutgers University, April 2006.

⁴ Russell, R., & Harrop, D. (2009). Staffing the Human Resources Function. (<http://mcgladreypullen.com/Issues/hrstaffing.html>)

⁵ Society for Human Resource Management Capital Benchmarking Study, March 2000.

Appendix D

Commission on Enhancing Agency Outcomes

Statistics for Human Services Agencies

November 22, 2010

Overview

- CT State Human Services Agencies (N=14,252):
 - Department of Developmental Services (N=4,355)
 - Department of Public Health (N=809)
 - Department of Mental Health and Addiction Services (N=3,490)
 - Department of Social Services (N=1,921)
 - Department of Children and Families (N=3,518)
 - *Commission on the Deaf and Hearing Impaired (N=38)
 - *Board of Education and Services for the Blind (N=121)

- Source of Information: CORE-CT (as of 7-23-10)

- Includes state employees who:
 - > .49 FTE
 - Considered Active, on Leave, or Suspended
 - Received pay between 7-23-09 and 7-23-10 from GF or other fund
 - Excludes students, national guard personnel, prisoner/client workers, temporary/seasonal workers

- * Part of SmART Unit

D-2

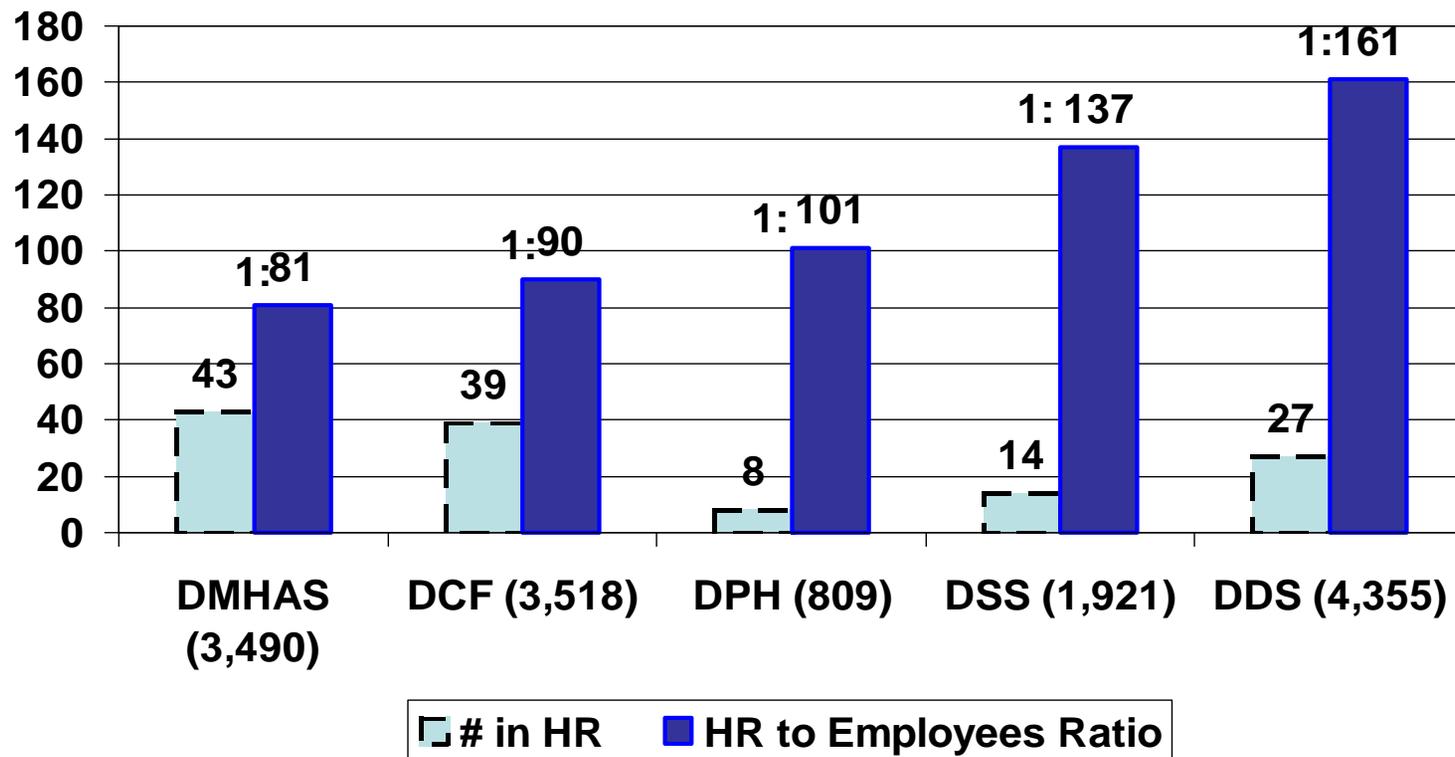
Support Function Positions

- Human Resources Positions: **131** (0.9% of 14,252 H.S. agency employees)
- Payroll Positions: **51** (0.4% of employees)
- EEO Positions: **15** (0.1% of employees)
- Fiscal Positions: **295** (2.1% of employees)
- I.T. Positions: **169** (1.2% of employees)

D-3

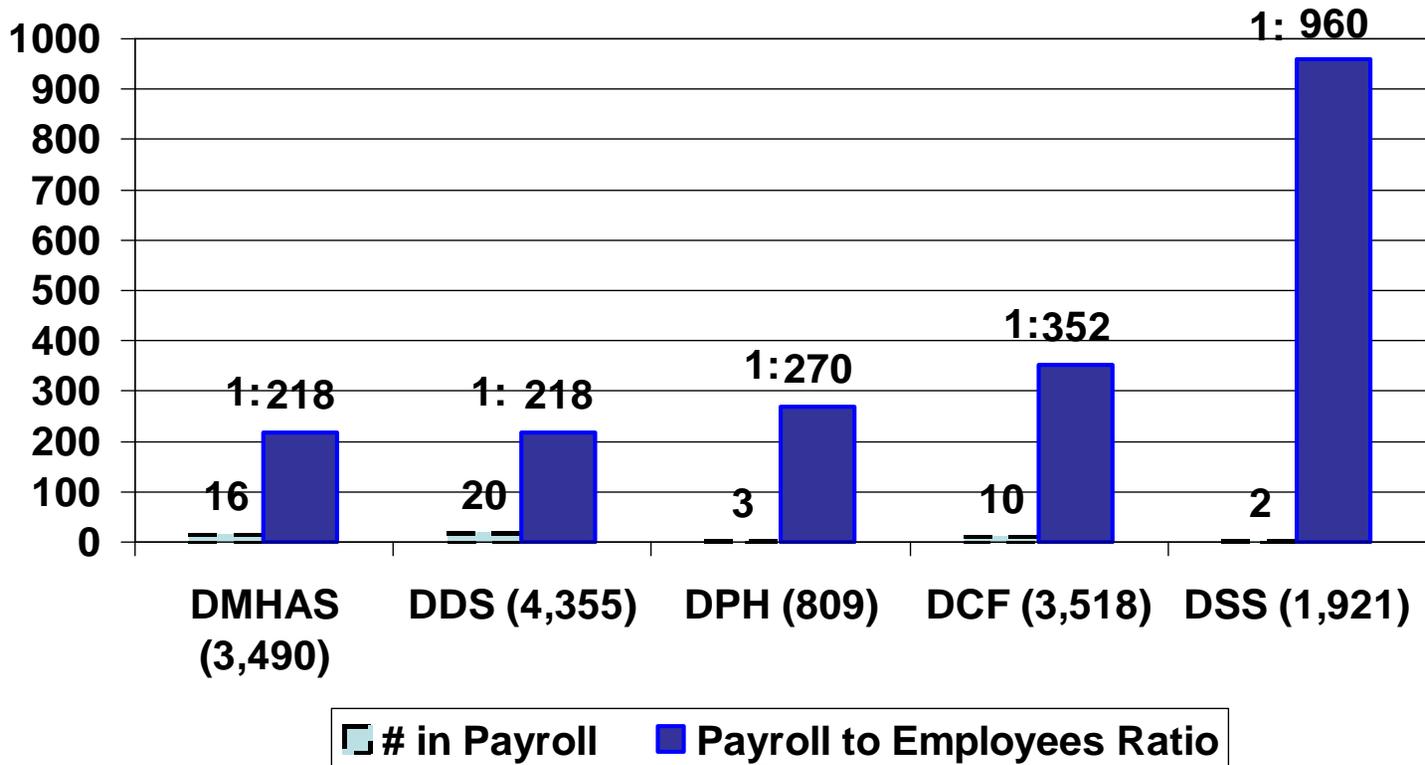
Human Resources Positions in Human Services Agencies

D-4



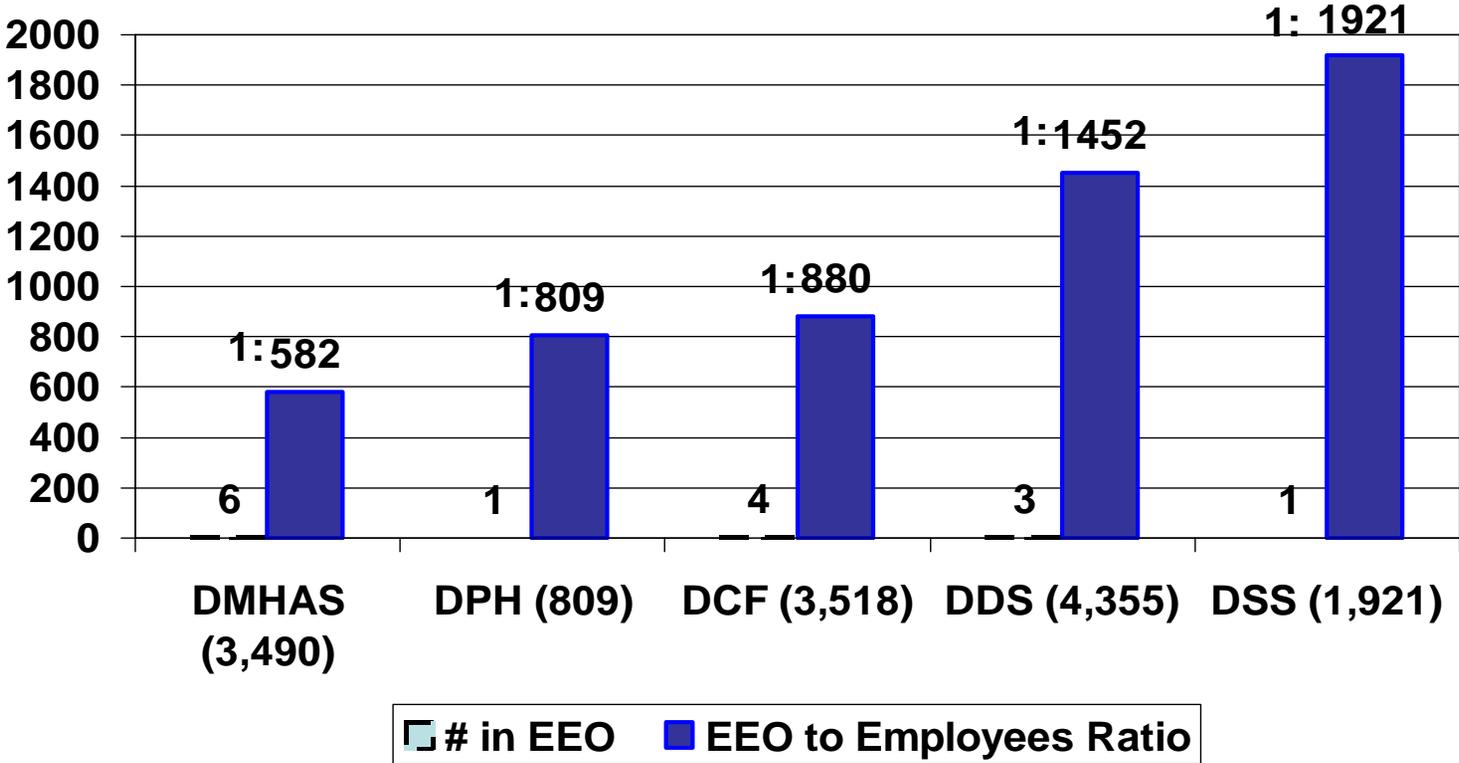
Payroll Positions in Human Services Agencies

D-5



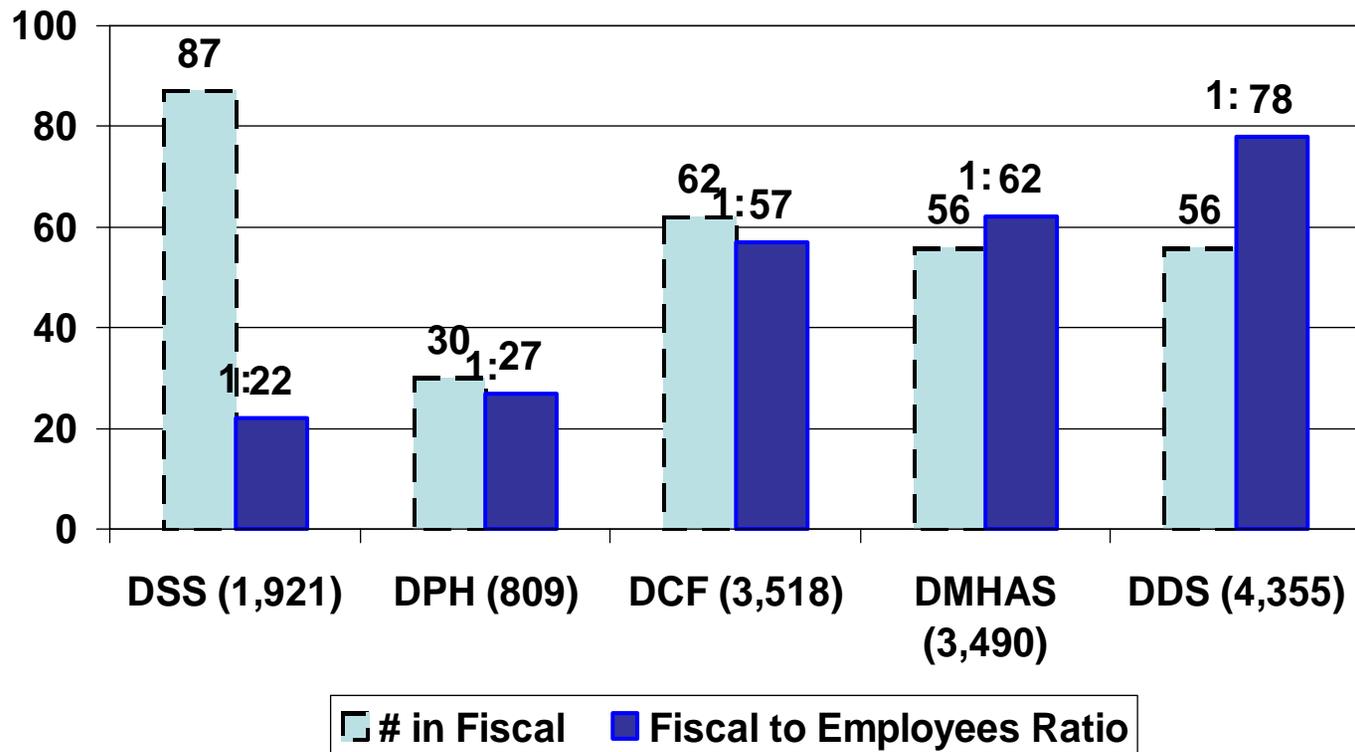
EEO Positions in Human Services Agencies

D-6



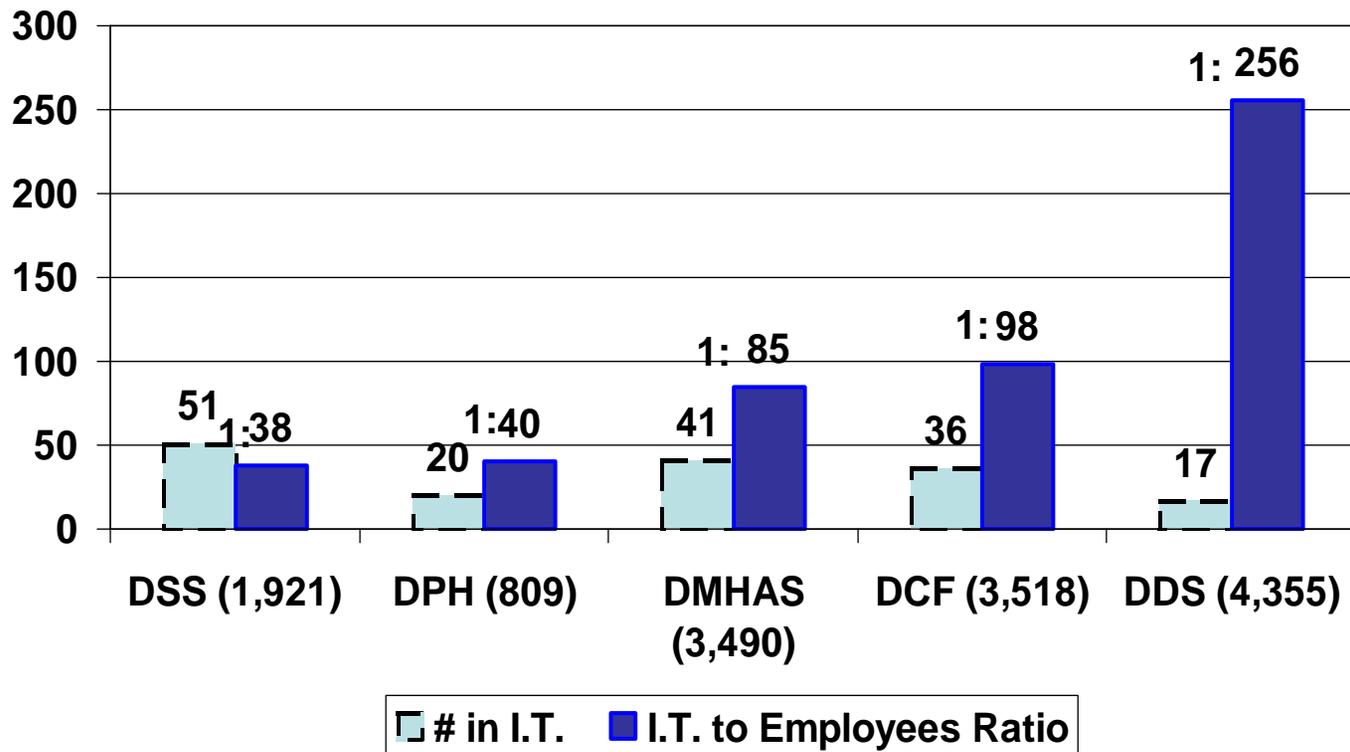
Fiscal Positions in Human Services Agencies

D-7



I.T. Positions in Human Services Agencies

D-8



Personnel Staffing of Human Services Agencies					
Agency	HR	Payroll	EEO	Total # Staff	HR+Payroll+EEO to Employees Ratio
DMHAS	43	16	6	3,490	1:54
DCF	39	10	4	3,518	1:66
DPH	8	3	1	809	1:67
DDS	27	20	3	4,355	1:87
DSS	14	2	1	1,921	1:113
Total HS Agencies	131	51	15	14,093	1:72
Current SmART Unit	11	5	4	1,048	1:52

Pennsylvania Consolidation of Back Office Functions

- Pennsylvania recently created “HR Shared Services Center”
 - Serves Executive Branch employees (76,000 salaried employees)
 - Center handles all HR and payroll transactions, has customer service activities including phone center and electronic self-service system
 - Goal of Center to do more with less
 - Provide higher level of service through consolidation
 - Saved \$3.5 million (eliminated approx 70 positions)

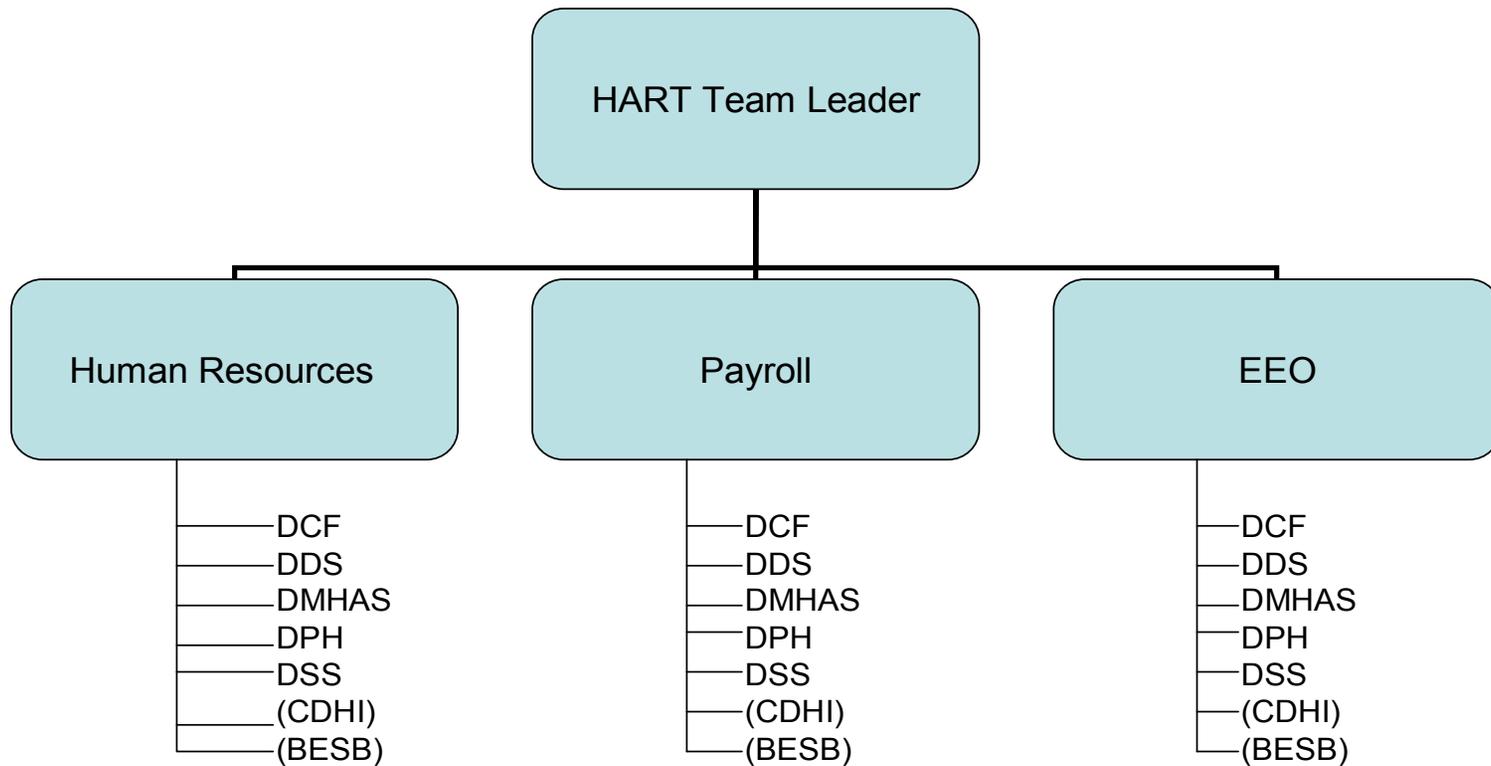
D-10

Kentucky Office of Human Resource Management

- Administers internal personnel programs for state's Health and Family Services Agencies
- Services include:
 - Hiring, disciplinary procedures
 - Payroll
 - EEO investigations, ADA compliance
 - Exit interviews
 - Satisfaction surveys

D-11

Human Service Agency Resource Team (HART)



D-12

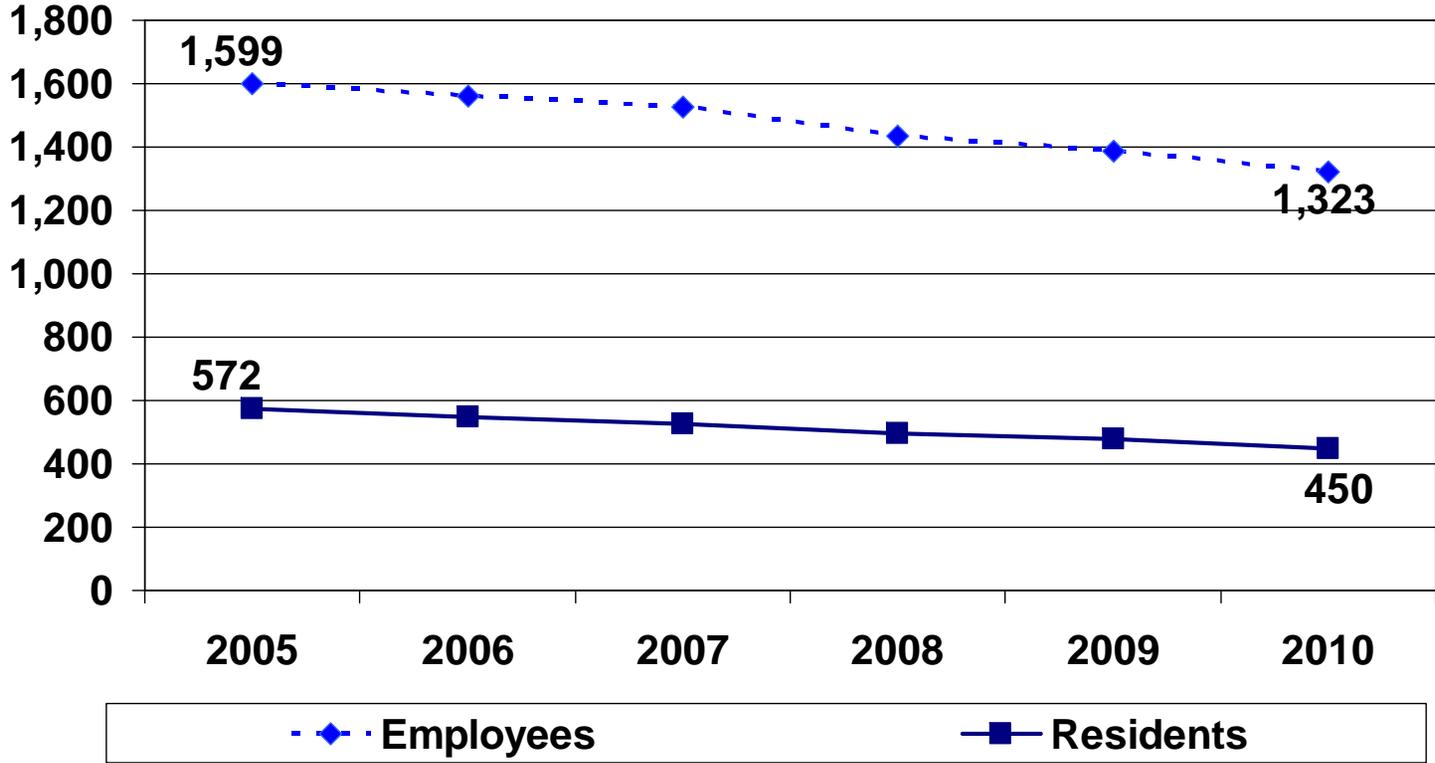
HART Potential Savings

Function	Current # of Positions	Current Annual Base Salaries	Savings if 10% Reduction
Human Resource	131	\$9,975,245	\$997,524
Payroll	51	\$2,801,978	\$280,198
EEO	15	\$1,183,042	\$118,304
TOTAL	197	\$13,960,265	\$1,396,026

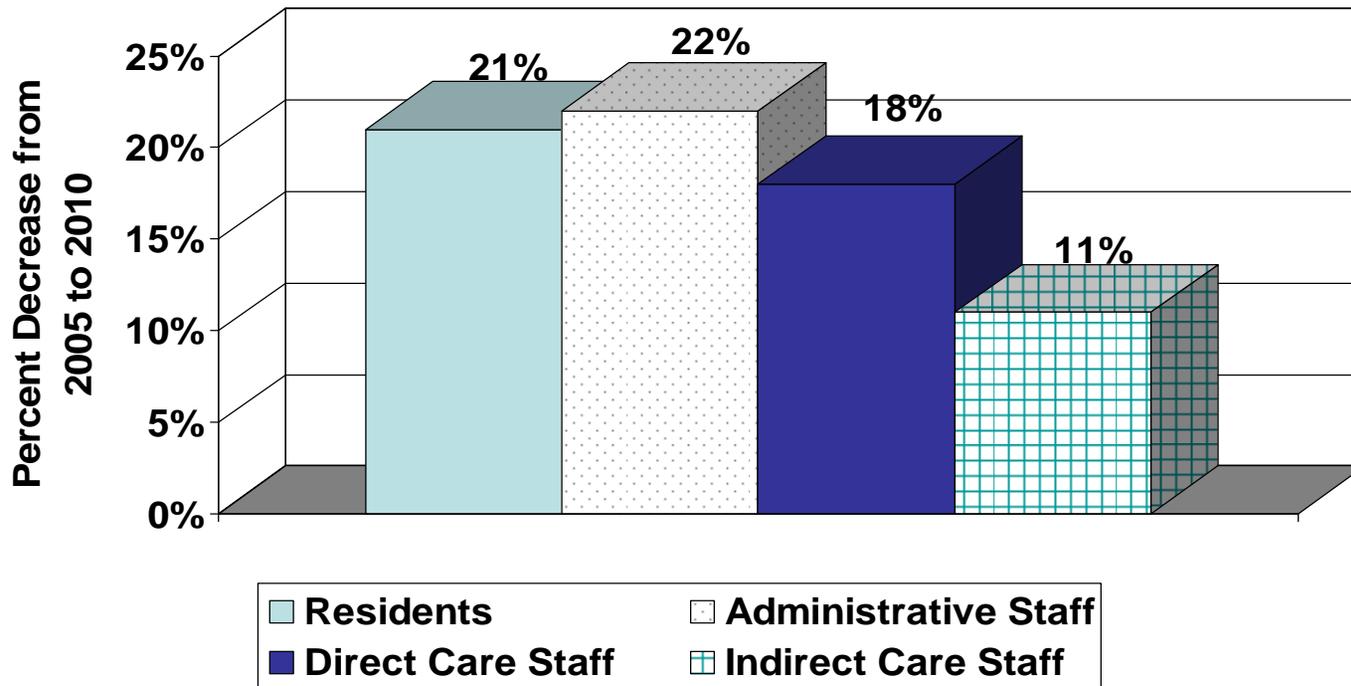
D-13

Number of Employees and Residents at Southbury Training School: 2005-2010

D-14



Percent Decrease from 2005 to 2010 in Number of Southbury Training School Residents and Staff



Direct Care staff includes health professionals and non-professionals, and education staff.
Indirect Care staff includes protective services and maintenance.
Administrative staff include clerical, payroll, human resources, and managerial.

Southbury Training School Indirect and Administrative Staff

Area	2005	2010	Change
Protective Services (e.g., firefighters)	14	14	0%
Cooks/Kitchen	50	43	-14%
Boiler Tender/Water Treatment	9	8	-11%
Payroll	10	11+1=12	+20%
HR	8+2=10	9+5=14	+40%
Total Employees	1,599	1,323	-17%
Total Residents	572	450	-21.3%

D-16

Southbury Training School

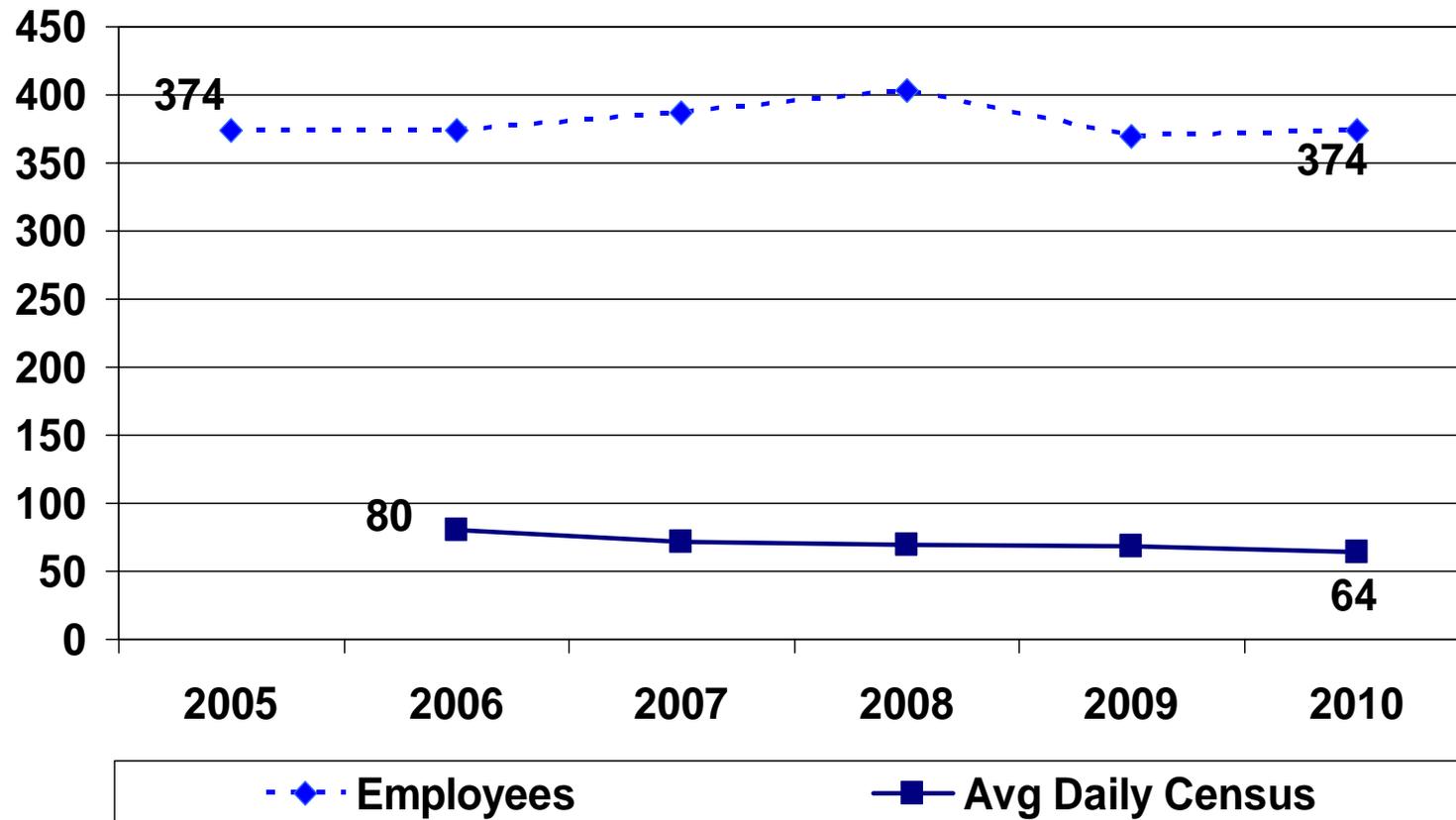
	2005	2010		
# Residents	572	450 (a 21.3% ↓ from '05)	# of staff if ↓ by 21.3%	Difference from Actual
# Direct Care Staff	1,376	1,133	1,083	Over by 50 (\$2,406,350) ¹
# Indirect Care Staff	152	135	120	Over by 15 (\$748,530) ²
# Administrative Staff	71	55	56	Under by 1, BUT:
➤ Payroll	10	11+1=12	8	Over by 4 (\$211,312)
➤ HR	8+2=10	9+5=14	8	Over by 6 (\$354,090)
Total	1,599	1,323	1,259	Savings from eliminating 75 positions: \$3,720,282

¹(median 2010 annual base sal of direct care staff=\$48,127)

²(median 2010 annual base sal of indirect care staff=\$49,902)

Number of Employees and Residents at Riverview Hospital: 2005-2010

D-18



Riverview Hospital

	2005	2010		
Average Daily Census	80	64 (a 20% ↓ from '05)	# of staff if ↓ by 20%	Difference from Actual
# Direct Care Staff	302	304	242	Over by 62 (\$4,069,432) ¹
# Indirect Care Staff	35	32	28	Over by 4 (\$185,456) ²
# Administrative Staff	37	38	30	Over by 8 (\$439,464) ³
Total	374	374	300	Savings from eliminating 74 positions: \$4,694,352

¹(median 2010 annual base sal of direct care staff=\$65,636)

²(median 2010 annual base sal of indirect care staff=\$46,364)

³(median 2010 annual base sal of administrative staff= \$54,933)

Supervisors + Managers

- “Managerial Employees” and “Supervisory Employees” are defined in statute (CGS Sec. 5-270(f))
- DAS identified managerial positions as having a labor code of “02” (managerial)
- DAS identified supervisory positions according to job classes designated as supervisory pursuant to statute
 - Have full-time supervisory responsibility over employees
- NOTE: No actual activity assessment done; further work would be needed
- With note in mind, scenarios were developed to explore options

D-20

“Manager Ratios”

- Until 1986 (P.A. 86-411) Connecticut had a cap on the percent of managerial employees (4% in executive, judicial branches; 7% in higher ed constituent units)
- Managers usually refers to combination of “managerial” and “supervisory” positions
- Iowa Department of Human Services restructured to increase manager:employees ratio from 1:9 to 1:14
- Texas manager:employees guideline for state agencies (with more than 100 employees) in executive branch 1:10 (exempts DCF)

D-21

Manager Staffing at Human Services Agencies

Agency	# of FT Employees	# Mgrs¹	% of Employees Who Are Mgrs
CDHI	38	3	7.9%
DMHAS	3490	232	6.6%
DCF	3518	221	6.3%
DPH	809	42	5.2%
DSS	1921	77	4.0%
DDS	4355	105	2.4%
BESB	121	1	0.8%
Total	14,252	681²	4.8%

¹DAS identified managerial positions as having a labor code of “02” (managerial).

²If 4% cap in place, there would be 111 fewer managers for human services agencies.

D-22

Manager/Supervisor Staffing at Human Services Agencies

Agency (# of employees)	# Mgrs ¹	# Suprs ²	# Mgrs + Suprs	Mgr/Supr:Non- Mgr/Supr Ratio
DCF (N=3,518)	221 ^a	484	705 (20%)	1:4
DPH (N=809)	42	70	112 (13.8%)	1:6
DSS (N=1,921)	77	159	236 (12.3%)	1:7
DMHAS (N=3,490)	232	183	415 (11.9%)	1:7
DDS (N=4,355)	105	332	437 (10%)	1:9
CDHI (N=38)	3	0	3 (7.9%)	1:12
BESB (N=121)	1	5	6 (5%)	1:19
Total (N=14,252)	681	1,233	1,914	1:6

¹DAS identified managerial positions as having a labor code of “02” (managerial)

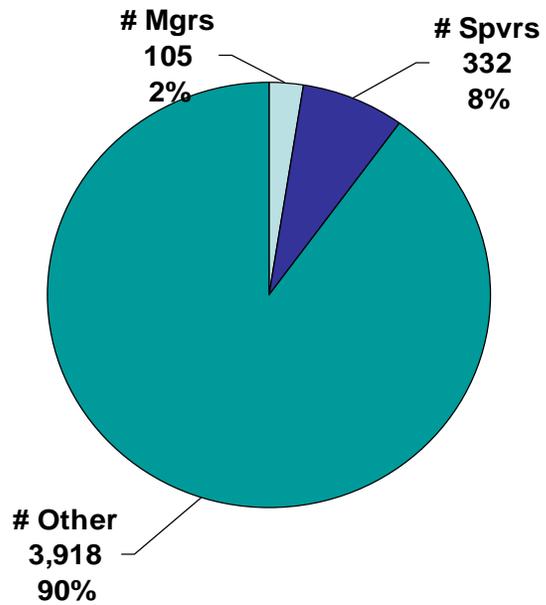
²DAS identified supervisory positions according to job classes designated to be supervisory pursuant to statute (CGS Sec. 5-270(f))

^aBased on fiscal note in 2009-2011 State Budget Book, DCF was to reduce managerial positions by 25% (66 positions of 264 managerial positions), which would have resulted in 198 managerial positions.

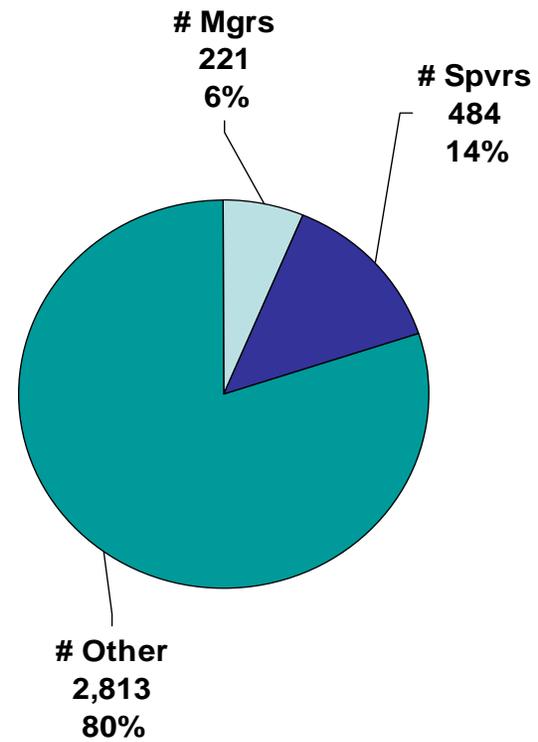
Different Staffing Patterns at Human Services Agencies

D-24

DDS



DCF



Manager¹ Scenarios for Human Services Agencies			
Scenario A: Reduce Managers to 5% of Agency's Employees			
Agency (# mgrs/Total employees)	# of mgrs if 5% of employees	Reduced # of Mgrs to Reach Target:	Estimated Savings²
DMHAS (232/3,490)	174	58	\$103,245 x 58= \$5,988,210
DCF (221/3,518)	175	46	\$93,304 x 46= \$4,291,984
Scenario B: Reduce Number of Existing Managers by 5%			
Agency (# mgrs/Total employees)	# of mgrs if reduced by 5%	Reduced # of Mgrs to reach target	Estimated savings²
DMHAS (232/3,490)	220	12	\$103,245 x 12= \$1,238,940
DCF (221/3,518)	210	11	\$93,304 x 11= \$1,026,344
Scenario C: Rebalance Ratio of Mgrs to Non-Mgrs by Exchanging Mgr Positions for Non-Mgr Positions			
Agency (# mgrs/Total employees)	# of mgr positions converted to non-mgr positions	Difference in salaries of non-mgrs vs. mgrs	Estimated savings²
DMHAS (232/3,490)	58	\$45,238 Less	\$45,238 x 58= \$2,623,804
DCF (221/3,518)	46	\$25,537 Less	\$25,537 x 46= \$1,174,702

¹DAS identified managerial positions as having a labor code of "02" (managerial)

²Using median annual base rate of pay, excluding benefits.

Manager¹ Scenarios for Human Services Agencies			
Scenario D: Reduce Managers to 4% Cap of Agency's Employees			
Agency (# mgrs/Total employees)	# of mgrs if 4% of employees	Reduced # of Mgrs to Reach Target:	Estimated Savings²
DMHAS (232/3,490)	140	92	\$103,245 x 92= \$9,498,540
DCF (221/3,518)	141	80	\$93,304 x 80= \$7,464,320
DPH (42/809)	32	10	\$110,202 x 10= \$1,102,020
DDS (105/4,355)	174	(69)	
DSS (77/1,921)	77	0	
BESB (1/121)	5	(4)	
CDHI (3/38)	1	2	\$61,927 x 2= \$123,854
Total HS Agencies (681/14,252)	570	184 (73)	\$18,188,734
Source: PRI staff analysis using CORE-CT information from CTW_EMPLOYEES as of 7-23-10.			

Appendix E

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
999 ASYLUM AVENUE, CONNECTICUT 06105



Jeanne
Milstein Child
Advocate

June 25, 2009

Susan Hamilton, Commissioner
Department of Children and Families
505 Hudson St.
Hartford, CT 06106

Dear Commissioner Hamilton,

The Office of the Child Advocate has completed a two-year (June 2007-June 2009) process of monitoring progress at Riverview Hospital as DCF and the Hospital have responded to recommendations for improvement contained in several 2006 reports. These included the draft David B. report (March 27, 2006), the Riverview Hospital for Children and Youth Program Review (December 1, 2006), and Supplementary Recommendations (December 11, 2006) from the Office of the Child Advocate.

Because monitoring ends on June 30, 2009 and does not allow for report preparation after the close of the last quarter, this is a final summary of the Hospital's progress during the two-year period and encompasses information obtained through May 31, 2009. The intent of the summary is to discuss areas of positive progress, the status of significant areas of concern, and continuing recommendations for improvement.

As the monitor began her activities in June 2007, she reviewed the reports noted above, as well as summaries of the Hospital's 2006 consultation with outside experts and a variety of other Hospital documents. The Riverview administration and DCF Central Office, prior to the monitor's arrival, had developed a comprehensive two-year Strategic Plan in response to the many recommendations contained in the 2006 reports. As the monitor arrived, the Hospital was taking steps to implement its new management structure, develop an Implementation Committee to guide work on the Strategic Plan, and create multiple avenues for engagement and communication with staff. There was also a beginning effort by the DCF Central Office and Hospital to develop goals, time frames, data sets and reports for measuring progress in implementing the Strategic Plan.

As summarized in the report below, Hospital staff has made a good faith effort to address multiple concerns and has worked intensively to create progress in a number of areas. The Hospital operates in an organized manner, has developed effective communication processes, and has improved its treatment planning, clinical review, and staff development processes. There have been beginning improvements in the Hospital's quality improvement process, but these have not developed further over the past several months and thus remain an area of concern.

Appendix E

While there has been progress, significant concerns remain that Riverview is a facility that uses excessive restriction and consequence-driven measures in treating and caring for children with significant behavioral health needs. There have been positive trends in shifting away from specific types of interventions, but the rate of overall use of methods for restricting the physical being of children has not declined. There have additionally been significant and continuing issues regarding the Hospital's ability to properly apply the definition of seclusion. Children continue to be restricted to a room, sometimes for several hours or more, without the proper doctors' orders, procedures, or oversight. During this past year, the Hospital also invited a greater police presence into Riverview and then did not take adequate steps to address multiple instances of pepper spray use by these police on children in the Hospital's care. CMS (The Centers for Medicare and Medicaid Services) became involved and cited the Hospital for not addressing police use of weapons in its treatment process. Riverview then took steps to revise its procedures and clarify its intent and process when it calls for police assistance. There have been no further instances of pepper spray use, but OCA remains concerned that the Hospital may not recognize the seriousness of incidents and address them without a monitoring or regulatory presence on-site.

These are less than expected outcomes during a period when the Hospital has had maximum resources internally and a monitored focus on improving its services. The OCA has understood that following the reviews and reports in 2006 there were Hospital management/staff issues to be resolved, as well as levels of mutual respect and communication to rebuild. OCA also recognizes the many challenges involved in providing care and treatment for children who have significant levels of disruption in their lives. However, while the Hospital has applied a high level of energy to addressing the goals of the Strategic Plan, expectations for change have been fairly modest. Many of the states and organizations that have significantly reduced use of restraint and seclusion have accomplished rapid declines within a much shorter time frame than the two-year period in which the OCA monitor has been present (or the many years prior in which the use of restraint and seclusion at Riverview was targeted for improvement/reduction). Riverview has taken a very incremental and "long view" approach to culture change around levels of aggression within the facility, but maintaining high levels of energy and focus for incremental change can sometimes be difficult.

OCA strongly encourages the Hospital to devote ongoing intensive effort to the utilization of positive approaches to patient care and prevention of restraint, seclusion and other types of restrictive and consequence-driven interventions.

Riverview Hospital Areas of Positive Progress

Efforts to Address the 2006 Reports and Issues Raised by the Monitor

The management and staff of Riverview Hospital have made a good faith effort to respond to the many recommendations contained in the 2006 reports and additional concerns raised by the monitor during the two-year period in which she has reviewed progress at Riverview. Prior to the arrival of the monitor in June 2007, a new Superintendent, Medical Director, and Director of Program Operations had been selected to manage Hospital operations and lead efforts to improve the functioning of Riverview and its approaches to children in its care. Additionally, Hospital leadership and DCF Central Office had developed a Strategic Plan to guide Riverview through the improvements it was expected to make in response to the recommendations of the 2006 comprehensive Program Review carried out by the Office of the Child Advocate, the Court Monitors Office and the DCF Central Office Ombudsman and Continuous Quality Improvement Offices. The Plan laid out goals, time frames for meeting them, and proposed data sets for measuring progress. The administration also implemented a management reorganization that placed increased management resources on patient care units and sought to define and increase unit-based accountability for delivering effective, strengths-based patient care. This increased management presence was designed to positively impact on crisis prevention and management interventions, the review and revision of the ABCD (Autonomy, Belonging, Competency, and Doing for others) milieu program, and interdisciplinary treatment planning/coordination of care.

Appendix E

Finally, the Hospital created a Strategic Plan Implementation Committee to guide its improvement process. This Committee has been productive, with early participation and representation from all patient care units and various staff classifications. There have been regular discussions about Strategic Plan goals/progress and multiple areas of concern, including reduction in restrictive measures, staff development, data gathering and review, review of job descriptions and unit program descriptions, review of staff and child survey tools and results, etc. The Implementation Committee also formed working sub-committees to focus on family involvement, risk and safety assessment, nursing "pulled" time, and hospital-wide scheduling. The group later created a Trauma Reduction subcommittee, charged with developing approaches for reducing the use of restrictive interventions.

The Implementation Committee process has been positive and helpful as the Hospital worked to meet its goals. The Executive management recognizes that it is now time to "re-charge" this Committee with new members and a focus on developing strategic goals for the next two years. Riverview is working with its NASMHPD (National Association of State Mental Health Program Directors) Trauma Reduction consultant to formulate goals going forward. These will be based on the six core strategies outlined by NASMHPD for preventing the use of restraint and seclusion.

Open Executive Management Style, Improved Communication and Efforts to Create Leadership

The administration has communicated cohesive leadership around collaborative management/staff problem-solving and communication processes. Members of the Hospital leadership are open to hearing about the needs and problems of staff and have made active efforts to respond to feedback. Multiple lines of communication have been developed, including all-staff meetings, newsletters, the DCF Online system, emails, committee meetings, management meetings, unit-based meetings, and minutes for all of these. Efforts to create a more effective leadership capacity at Riverview have included adding management resources to patient care units, working on more effective staff supervision processes, beginning development of fidelity measures for the revised ABCD milieu program, creating mechanisms for supporting/supervising nurse, unit and program managers, ensuring the creation of discipline forums (forums for psychologists, nurses, rehabilitation staff, etc), and developing methods for information flow between executive management and all other management levels.

Staff Development

The Executive management group has recognized that the Hospital must employ best practice approaches if it is to move its treatment culture to a more supportive, strengths-based and less restrictive array of interventions. The Hospital has devoted the necessary resources to several staff development goals. The review, revision, and curriculum development for the ABCD milieu program has been completed, as well as the first phase of training, development of patient care unit strategic plans for implementing ABCD, and initiation of fidelity measures to assess whether training is effective for staff. The Hospital has also provided in-depth training and developed internal consultation teams for use of Dialectical Behavioral Therapy (DBT), which is a variation of Cognitive Behavioral Therapy. Beginning in January 2008, Riverview provided a series of training opportunities for Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint. Follow-up training for supervisors included: Developing a Best Practice Framework for Implementing Strength-based and Trauma Informed Care Approaches. Training has also been provided to a more limited degree in Functional Behavior Assessment/Analysis and the Hospital has regular and varied training through Grand Rounds and the staff development program.

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Treatment Planning

In a subsequent section of this summary, there is a discussion about concerns related to treatment planning in the area of child and family involvement. However, the Hospital has made progress on several of its goals related to the planning of care. It has recently completed a significant revision of the structure and content of its treatment plan documentation. The new format is closely tied to the revised ABCD milieu program and therefore has a much clearer focus on crisis prevention, management, and recovery. The new form also incorporates several different treatment plans that have been in use at Riverview – the treatment plan, the intensive care plan, and the safety plan. The use of all three of these at the same time has been confusing and ineffective. In creating one tool, the Hospital's goal is to produce a more integrated and usable plan. The new format has not yet been implemented, but has the potential to focus the work of staff in a different way.

There have been meaningful efforts by the Executive group to improve the Hospital's process for directly reviewing the care it provides by establishing various case review processes. These include clinical reviews of significant events, intensive treatment planning for children who have frequent or difficult to manage aggressive or self-injuring behaviors, reviews of use of mechanical restraint, and consultation regarding difficult treatment issues.

Additionally, the Hospital and the CT BHP have focused on discharge delay and length of stay at Riverview Hospital for those children who receive care under the guidelines of the Partnership. The work of Riverview staff with ASO Intensive Care Managers has contributed to a decline in the percentage of Riverview Hospital days during which children are in "discharge delay" (meaning that they no longer need a hospital level of care, but have no immediate discharge alternatives available and remain in the hospital beyond the time needed).

The data regarding average LOS (length of stay) for children who have been discharged from Riverview shows that LOS increased during 2007 and hit a high point of approximately 200 days during the first quarter of 2008. Over the remainder of the calendar year, the LOS declined to a range of around 150 days. Children who are referred to Riverview by the court system stay at the Hospital an average of 60 days.

Finally, as noted in the last quarterly summary (January-March 2009), the monitor reviewed discharge data from July 2007 through January 2009 and noted that the number of children discharged to home was trending upward. This was a very welcome change and showed a commitment on the part of the Hospital (and the Partnership) to family involvement and having children return to their families with services where possible. Also, the number of discharges to in-state residential facilities and group homes increased, while placements out of state continued to decline as of January 2009. In-state placements include residential treatment facilities, group homes, Connecticut Children's Place (CCP) and High Meadows.

Treatment/Program

At the beginning of the monitoring process in June 2007, there was uncertainty about the role of Riverview in relation to the various populations of children served by the Hospital. There was concern about youngsters coming from the court system and whether they were contributing to higher levels of aggression in the Hospital. There was also a lack of clarity about whether Riverview is primarily a long-term residential program or an intermediate inpatient setting. It is apparent from restraint and seclusion rates that children referred by the court are less (rather than more) likely to be restrained or secluded than children referred for psychiatric reasons. Additionally, the Hospital has gradually defined itself as an (intermediate) inpatient level of care and has worked to bring admission, treatment, and discharge planning processes in line with that definition. There is no longer an automatic assumption upon admission that children will stay at Riverview for six or more months.

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The Hospital has also worked on program descriptions for each unit and a beginning process of more clearly bringing best practice approaches to the care of children. As noted in a previous section, Riverview has taken steps to implement its ABCD milieu program, which is viewed as its value system, a guide for establishing therapeutic, supportive, and strengths-based interactions with children. The Hospital has also provided extensive training in DBT (Dialectical Behavioral Therapy) programming and consultation Hospital-wide. Recently, the unit serving the youngest children has worked to implement CPS (Collaborative Problem-Solving Approach), which has been successfully used on the Yale child inpatient unit. This approach provides a framework for effective and individualized intervention with highly oppositional children and their families.

Finally, there have been efforts to strengthen the documentation process for responding to complaints by children or their families, as well as support for re-activating the work of the Legal and Ethics Committee. Included in this process have been efforts to set time frames and strengthen responses to patient complaints, assign patient advocates to patient care units, and work effectively with the Executive group to seek resolution of various patient rights questions or concerns.

Status of Significant Areas of Concern During the Monitoring Process

During the two-year period in which OCA has placed a monitor at Riverview Hospital, there have been several identified areas of significant concern. These are summarized below, including the quarter in which issues were first noted and a discussion of why they were introduced and their status at the end of the monitoring process.

1. The Need for Physician's Orders and the Definition of Seclusion (July-September, 2007)

During her first months at Riverview, the OCA monitor identified significant issues regarding restrictive or intrusive interventions carried out without physician authorization. At least one teenage girl was undergoing repeated body searches by staff without required doctor's orders. These searches were included in the youngster's treatment plan and were completed as needed at the discretion of nursing staff. This was unacceptable practice and pointed to a lack of understanding on the part of patient care staff that the treatment plan cannot be a substitute for doctor's orders. The requirement for physician involvement each time such an intervention is used is intended to protect both the rights of children at Riverview (to be free from unnecessary physical intrusions or restrictions) and their safety.

In addition to unauthorized body searches, the monitor also found that Riverview used room restriction as a means to ensure safety. At times, restriction to a room was for many hours over the course of several days or weeks. While it was understood that the Hospital was trying to address unsafe behaviors, it was very problematic for any child to be restricted to a room without the physician orders, monitoring, and reviews that would result from accurately identifying this as seclusion. Connecticut State Statutes define seclusion as "the confinement of a person in a room, whether alone or with staff, in a manner that prevents the person from leaving."

OCA recommended that the Hospital take immediate organization-wide steps to clarify, in writing and via training, that treatment plans do not replace the need for doctor's orders when restrictive or intrusive interventions are being utilized. This included the use of room restriction (seclusion) and body searches without doctors' orders. It was noted that physician oversight is necessary to ensure that high-risk interventions are controlled, monitored and applied properly.

Current Status: The OCA monitor made repeated recommendations to Hospital administration to address this area of concern as a hospital-wide issue, clarify requirements, train staff, and document these activities. OCA did not receive documentation about completed action steps.

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The Administration also clearly expressed its preference to deal with this informally and as a unit-based concern. While there have been no further identified issues related to body searches, issues around the definition of seclusion and use of room restriction have been discussed in six of the seven previous quarterly summaries and have again been noted during the last two months. In early May, the monitor reviewed a medical record in which a youngster's treatment plan included a plan to restrict her to her room for 8 hours if her behavior warranted this in the view of staff. Upon hearing this from the monitor, the Superintendent at Riverview finally wrote a clarifying memo to staff saying that the use of behavior plans should never take the place of a doctor's order and that a plan for room restriction for a set period of time must be a seclusion. The monitor at the same time wrote to the Hospital administration, requesting action regarding improper room restriction:

- A request for a hospital-wide review of Intensive Care Plans and the use of room restriction, with documentation of results. (At the request of the OCA monitor, a similar review had been carried out once before during the July-Sept 2008 period after a child complaint regarding excessive room restriction, with no written report produced).
- A recommendation that the Hospital formalize a process for addressing this serious issue, including regularly collecting data hospital-wide, aggregating, analyzing, and reporting information to hospital staff; and acting on the information to make improvements until there is clear data to indicate that seclusion without doctor's orders is no longer happening.
- A review of the management and staff decision-making process that led to such a plan being developed and used.
- A request that the results of the Hospital-wide review be given to OCA in writing.

As of the writing of this final summary, approximately six weeks after the above actions were requested, there has been no written response from the Hospital and therefore no documentation that the Hospital has responded to these requests. Clearly, Riverview Hospital and DCF have yet to take steps to seriously address seclusion of children without adequate safeguards, physician involvement/orders, and required documentation.

2. The Use of Restraint and Seclusion (July-September, 2007)

As noted in the first summary, the Centers for Medicare and Medicaid Services (CMS), within the Hospital Conditions of Participation, state that "the patient has the right to receive care in a safe setting" and the "the patient has the right to be free from all forms of abuse or harassment". Additionally, "restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff member, or others from harm".

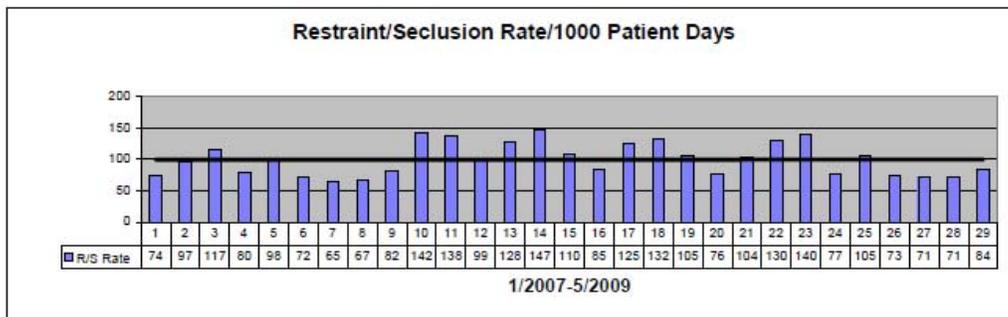
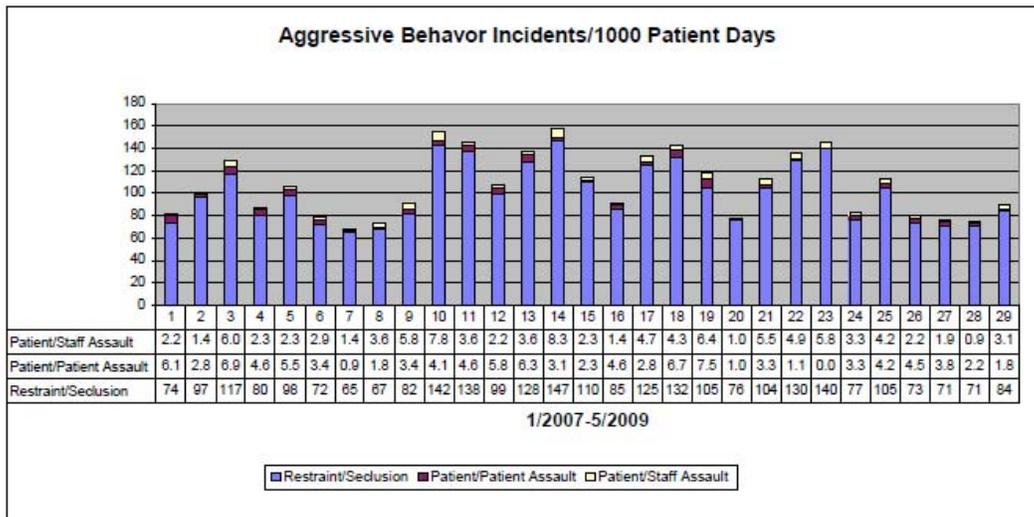
While the Office of the Child Advocate believes it is the intention of DCF and Riverview Hospital to abide by these requirements, there have been significant concerns about the use of these interventions prior to and during the OCA monitoring process. The OCA monitor identified this area as problematic after reviewing Riverview rates of restraint, particularly in comparison to the Hospital's Joint Commission comparative database. Additionally, there were early monitoring concerns about a lack of clarity around the roles of the physician and nurse in the authorization of restraint and seclusion, as well as whether restraint and seclusion were used as compliance measures rather than emergency interventions to ensure safety.

Current Status- Prevention/reduction in use of restraint and seclusion: During the two-year period in which an OCA monitor has been present, Riverview has focused its energy intensively on issues related to restraint and seclusion. The Hospital has secured a national consultant from NASMHPD to provide training, help the Hospital develop a framework for change, and review the Riverview Strategic Plan and its integration with the six core strategies recommended by NASMHPD for trauma reduction and the prevention of restraint and seclusion. Hospital Leadership has communicated its goal of reducing restrictive interventions and has provided intensive staff development, in particular related to the revised ABCD program and DBT,

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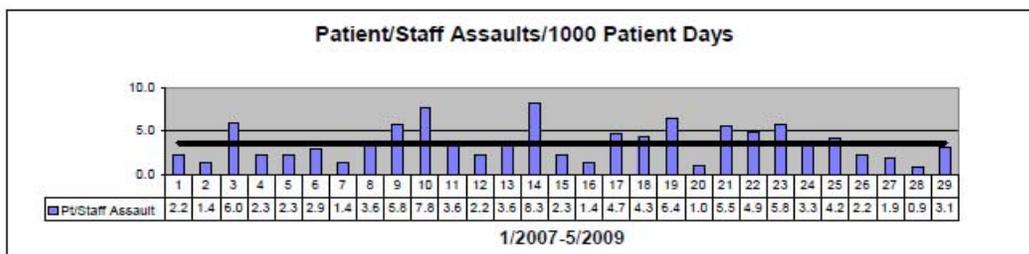
To provide staff alternative skills for working with children more collaboratively. These skills are focused on prevention of crises and are intended to help staff identify with each child the "triggers" that produce anxiety or anger and find ways to work together to keep these from escalating. The leadership has also targeted particular types of restraint for reduction, including mechanical restraint and use of face down floor holds, which place staff and children at high risk of injury.

There has been little progress in reducing the overall rate of restraint and seclusion. As can be seen from the data below, which covers the period from January 2007 through May 2009, the trend line for restraint and seclusion has remained flat. This essentially means that Riverview has very consistently stayed within the same rate of use pattern for over two and a half years despite its stated goals for improvement, high level of staffing resources, and staff development efforts.

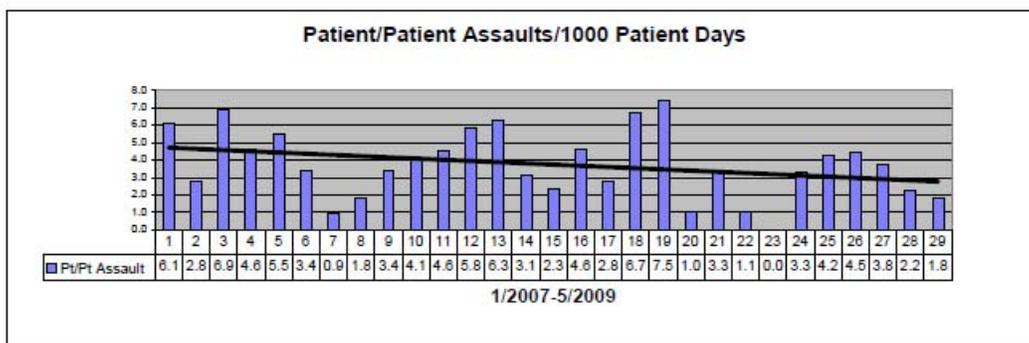


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The OCA monitor has also reviewed patient/staff and patient/patient assault data, as these give further information about levels of aggression at Riverview. The rates for children assaulting staff have remained within the same rate pattern during the 29 months that the OCA monitor has reviewed this data.



The trend for patient assault directed at other patients is moving down. This is a positive development, indicating that children have a lower rate over time of assaulting each other while at the Hospital.

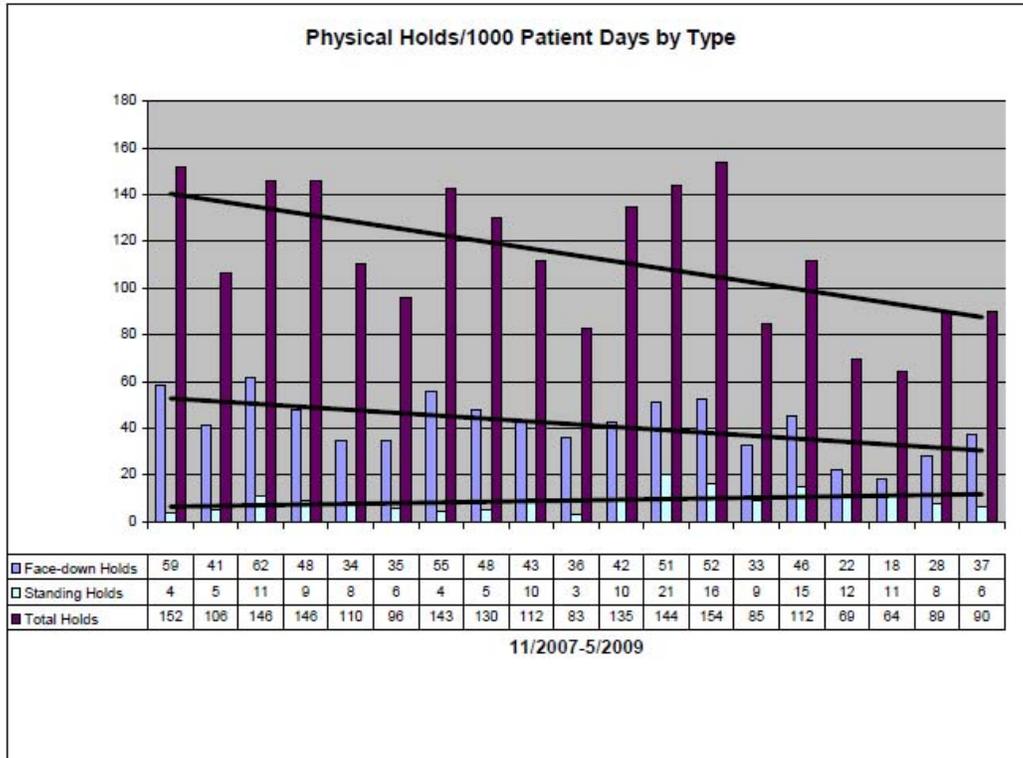


In addition to a decline in patient/patient assault, Riverview has reduced its use of certain types of restraint. Among these are 2-point restraint (which has essentially been eliminated), mechanical restraint and the use of physical holds. However, since the overall rate of use for all restraint and seclusion has remained flat, this reduction in some types of restrictive interventions is accompanied by increases in other types, such as seclusion.

Physical holds encompass escort holds (during which children and adolescents are moved from one place to another through staff maintaining a controlling hold on the youngster) and holds intended to immobilize (face down, face up, basket, and standing holds). Each of these was originally developed to ensure the safety of the child or others. However, there has been a substantial discussion nation-wide about the trauma and danger associated with physically intervening to restrict people's freedom of movement. Putting hands on a person often escalates rather than calms behavior and can result in injuries to both the child and staff.

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From November 2007 through May 2009, there has been a continuing trend down in use of holds overall. There is also a trend downward in use of face down floor holds and slight trend up in use of face up floor holds.



Current Status -The appropriate level of staff is authorizing/monitoring the initiation/continuation of restraint or seclusion and restricting use to emergency situations: One of the early concerns of the OCA monitor was that it appeared that restraint and seclusion could be initiated by a CSW (Children's Service Worker) without authorization from a nurse on the unit. A second concern involved the requirement that a physician assess a child within one hour of the initiation of restraint or seclusion. A review of medical records showed that a physician signature indicating an assessment was present. However, a medical record note to document the assessment and reasons for ordering/continuing restraint or seclusion was sometimes absent. Hospital administration had indicated that it did not require such a note and the OCA questioned the adequacy of a procedure that permitted a signature as the only documentation of an assessment. Further, the OCA suggested that fully participatory nurse and physician roles would lead to greater accountability and fewer restrictive measures over time.

The Hospital has made progress in both areas. Nursing leadership has become more involved over time in reviewing and taking action around the initiation of restraint and, at the end of the October-December 2008 quarter, started to actively review the content of Emergency Safety Intervention (ESI) forms and provide feedback to staff, including information about the roles of the nurse and CSW in initiating restraint and seclusion. During the past several months, the Nursing Leadership group has intensified this effort and spent part of each meeting reviewing Emergency ESI forms or Milieu Progress notes for quality and completeness. The group also reviewed Centers for Medicare and Medicaid Services (CMS) regulations after the February CMS visit to

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Riverview to review use of pepper spray on children by CVH police and Hospital procedures for other restrictive interventions.

The Medical staff had taken earlier steps to document initial assessments for restraint and seclusion for certain types of restraint, such as mechanical restraint, and under certain circumstances, such as when restraint resulted in a patient injury. Following the CMS visit, the Hospital quickly implemented revisions to the ESI form and instituted a requirement that physician's document their initial assessments for every type/incident of restraint or seclusion.

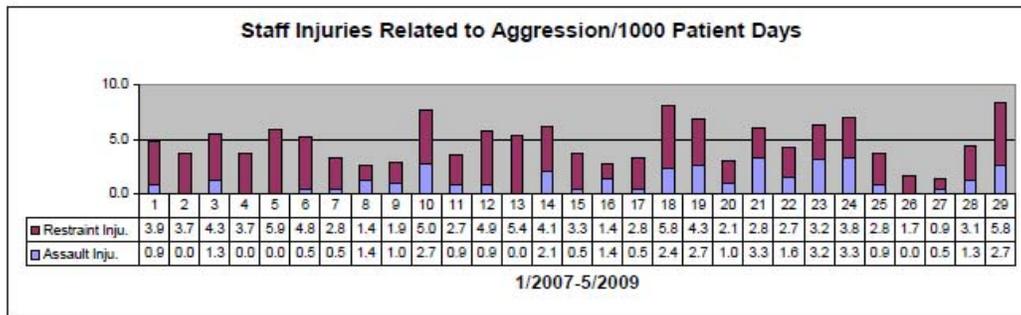
Additional procedure revisions following the February CMS visit were: a stated preference for face-up rather than face-down holds; incorporation of a prior change from a 1 hr order for mechanical restraint to a 30 minute order; clarification that accountability and responsibility for initiation of mechanical restraint rests with a nurse or psychiatrist; revision of the process and content for physically monitoring a patient when the person is restrained in mechanical restraint; a requirement that de-briefing after a restrictive intervention take place within 24 hours as required by CMS, and revision of procedures for Clinical Response and Review following a High-Risk Event.

The Hospital also revised its patient de-briefing procedures following restraint and seclusion and these now include all elements of the CMS regulation. Treatment plans are to be revised to include alternative interventions to prevent further use of restraint or seclusion. Revised documents for de-briefing require time of debriefing, triggers leading to the cause for the intervention, alternative techniques utilized, steps to prevent reoccurrence, the outcome of the intervention, the staff involved, and whether a parent or guardian is included in the de-briefing process. Also, systems for monitoring improvements have been developed.

Current Status: Rates of patient and staff injury due to aggression are effectively monitored and reduced where possible:

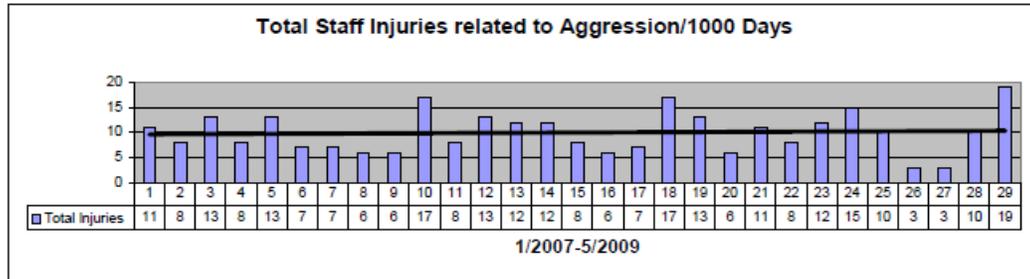
Staff Injuries Related to Aggression:

The majority of staff injuries related to aggressive behavior (chart below) continues to take place during the restraint process, though there has been a slight trend down in restraint-related staff injuries and a slight trend up in patient-to-staff assault injuries.

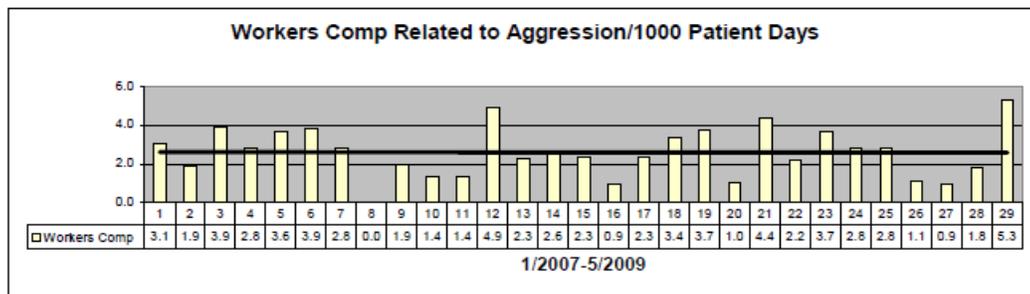
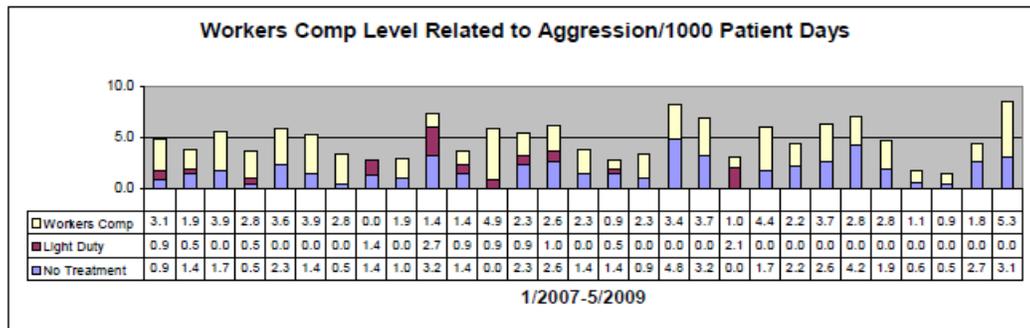


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As can be seen from the data below, the rate of staff injuries due to aggression, which had been trending down somewhat, is now flat for the period from January 2007 through May 2009 (due to a higher injury rate in May).



The charts below summarize the worker's compensation response/level during the 29-month period. There have been no injuries resulting in light duty since August 2008. Those injuries resulting in no treatment have increased, pointing to less significant injuries. And those resulting in workers comp time away from work, after having started to move downward, are now flat for the period from January 2007- May 2009.



Patient Injuries related to aggression:

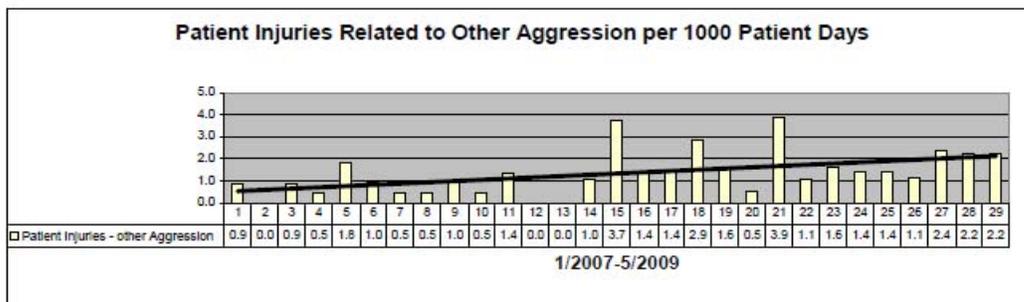
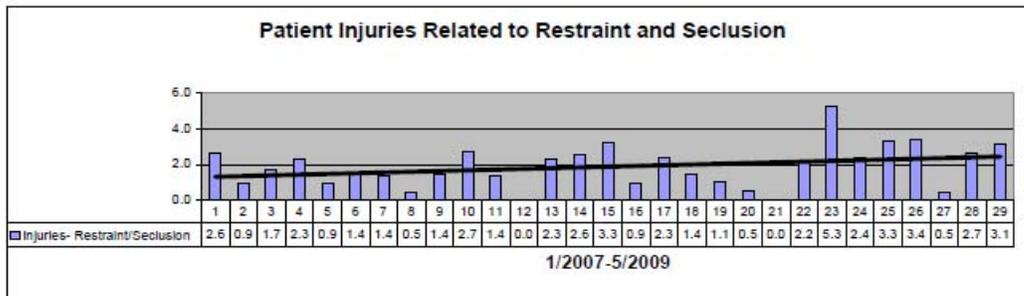
The OCA continues to review data provided by the Hospital regarding injuries to children resulting from either the restraint/seclusion process or other types of aggressive behavior. Unfortunately, the trend for rate of injury to children during aggression-related incidents has risen during the period from January 2007 – May 2009. This is a significant issue that the Hospital should address more intensively.

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During calendar year 2007, there were 57 such injuries to children at Riverview, of which four resulted in visits to the local Emergency Department. Three of these visits were for evaluation of possible hand fractures and one of the three was positive for a fractured finger. The fourth ED visit was to treat a laceration. 67% of these child injuries were an outcome of the restraint process itself and 33% were due to other types of aggression (punching walls, one child hitting another, punching furniture, etc).

During calendar year 2008, there were 89 reported aggression-related injuries to children, of which five resulted in visits to the Emergency Department. One was for evaluation of a possible fracture, with a negative result. Another was for a head injury sustained during the restraint process (a concussion). Two ED visits resulted from youngsters punching walls or windows. One had a laceration that was sutured and one had a fractured finger. Finally, during the last quarter of 2008, there were two ED visits for one youngster to correctly diagnose and treat a dislocated clavicle, an outcome of the restraint process. 54% of injuries were associated with the restraint process and 46% were due to other types of aggression, most frequently a child punching against walls, windows or equipment.

As seen below, during the January-May 2009 period, child injury rates/1000 patient days for injuries related to aggression continued to trend upward for both restraint and seclusion and patient/patient assault or patient hitting of walls, doors etc. During the first five months of 2009, there were 47 patient injuries. Of these, four (all in April) required visits to the ED. One was a serious laceration that resulted from head banging during restraint and required several sutures. The other three were for possible fractures following children hitting objects. 57% of injuries during 2009 YTD were an outcome of the restraint process and 43% were due to other types of aggression, such as children punching walls and slamming doors.



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3. Treatment Planning, including Transition Planning/Opportunities for 17-year old youth at Riverview (July-September, 2007)

The Office of the Child Advocate has had significant concerns over time about the lack of well-coordinated, timely, and participatory treatment and discharge planning for children who are admitted to Riverview Hospital. There were particularly significant discharge issues for 17-year-old youth at Riverview with complex behavioral problems or significant histories of aggressive behavior. The planning for these youth appeared to encounter multiple barriers: confusion as to whether DMHAS or DCF would provide services when youngsters turn 18, a lack of services within Connecticut for children with complex needs (frequent referrals to New York and Massachusetts), and a very real lack of timeliness in decision-making, leading to youth within a few months or weeks of their 18th birthday not knowing what their next steps are. The lack of timeliness appeared to relate not only to the lack of adequate in-state options, but also to fragmentation within the various parts of DCF. DCF area offices, the Central Office, and Riverview were not able to act in concert to bring about decisions and seek alternatives in a timely way. Time frames for action became unacceptably long. The discharge process also didn't adequately involve the views of the young people affected or their families.

There were a number of recommendations in the Program Review of 2006, as well as other reports, which focused on this fragmented process. In response, the Hospital's Strategic Plan included improvement goals in several aspects of the child-centered treatment planning. Among these was: effective coordination among Hospital personnel and between the Hospital and DCF Area Offices regarding the needs of and follow-up plans for each child; full participation of children and their parents or guardians in the planning process; enhanced coordination and communication in the referral process for young adults transitioning from the DCF to the DMHAS system of services, availability of treatment alternatives for children who are no longer in need of an inpatient level of care but have no identified follow-up care, and a full review and revision of the treatment planning process and documentation used at Riverview.

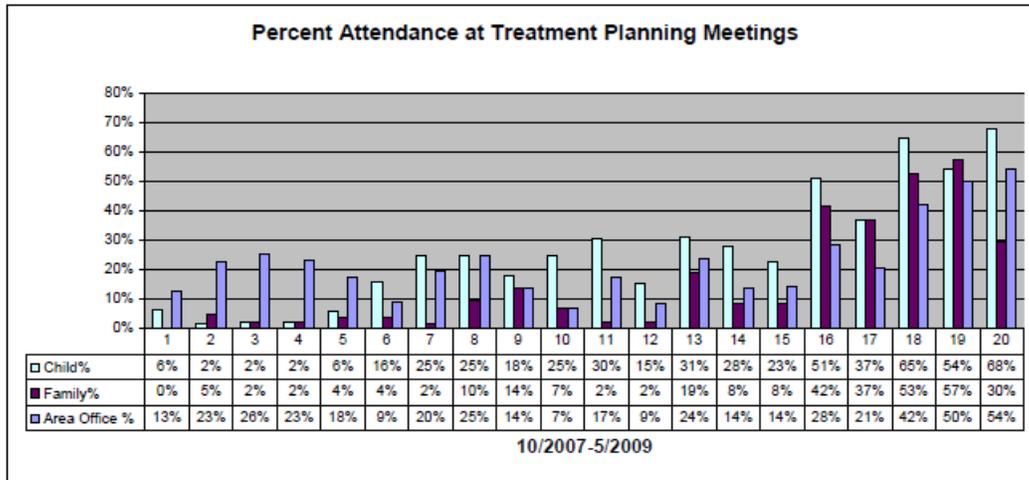
As noted in a previous section on Areas of Positive Progress, Riverview has recently completed a significant revision of the structure and content of its treatment plan documentation, has made meaningful efforts to improve the Hospital's process for directly reviewing the care it provides by establishing various significant incident and case review processes, has partnered with the CT BHP to focus on discharge delay and length of stay at Riverview Hospital for those children who receive care under the guidelines of the Partnership, and has worked with ASO Intensive Care Managers to contribute to a decline in the percentage of Riverview Hospital days during which children are in "discharge delay" (meaning that they no longer need a hospital level of care, but have no immediate discharge alternatives available and remain in the hospital beyond the time needed), as well as a decline in length of stay. Finally, the number of children discharged to home is trending upward and discharges to in-state residential facilities and group homes have increased, while placements out of state continued to decline as of January 2009.

Current Status: The Hospital continues to struggle with engaging children and their parents/guardians in meaningful discussion during the treatment planning process. Riverview recently made changes in how data about this issue is collected, with the new process crediting documented participation in the formal treatment planning meeting or discussion within 48 hours before or after the formal meeting via a discussion with the clinician or physician. With this revised method for measuring participation, as can be seen in the chart on the next page, there has been gradual but solid improvement in the participation levels of children, families, and DCF area office staff in the treatment planning process.

There are two notes of caution, however, in looking at this data. One is that discussion with the clinician and/or psychiatrist within 48 hours before or after the treatment planning meeting does not mean that there is mutual discussion among the involved parties, as there would be if people were in the same room. The other caution is that staff may stop encouraging actual participation in meetings if credit is given for a discussion outside of the meeting itself. This concern seems to be highlighted by recent data. For credited participation of children, families, and the area office in

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February 2009, 72% was for actual participation in the meetings and 28% was for discussion before or after the meeting. In March, only 44% was for actual participation, while 56% was for discussion outside the meeting. In April, a smaller 22% was for actual participation and in May the number was 28%. Despite the improved data, this effectively means that Hospital practice is shifting back toward a lack of participation in meetings where decisions are made. The Hospital should therefore continue to focus on this area of performance and evaluate whether the planning process is really working for children and their families.



4. Documentation in the Medical Record (October-December, 2007)

During the monitoring process, the OCA encouraged the Hospital to develop a more structured format for documenting staff interventions and patient progress. Existing progress notes were problematic in several ways. They lacked documentation of interventions and whether these interventions were effective; risk management issues were not properly communicated to staff with the expertise to address them; staff used language reflective of frustration with patient behavior, resulting in notes with negative or blaming language; and notes reflected interventions that were not helpful, with a lack of awareness that an intervention may be escalating behavior rather than calming the situation.

Current Status: The Hospital has made good progress in reviewing and revising its medical record documentation. Progress note formats have been developed for nursing, including a structured milieu progress note, and psychiatric staff. The nursing leadership group has been actively reviewing medical record documentation for progress in using the expected format. Staff is better able to structure notes around presenting behaviors, staff interventions, and responses to interventions. They are also more effectively using language that is descriptive rather than blaming when discussing child behaviors. A new Emergency Safety Intervention (ESI) form has been implemented and was recently reviewed and substantially revised following the Centers for Medicare and Medicaid Services (CMS) site visit in early February. The form now combines the Emergency Safety Intervention and Incident Report aspects of the restraint and seclusion process. It also includes a place for physicians to document their assessments for every restraint and seclusion event and clarifies documentation requirements regarding de-briefing. The OCA monitor recently suggested to the Hospital Executive group that they review the portion of this form related to patient injury during restraint and the need for documentation around physician assessment of the injury.

Program Managers are completing a monthly management report for the patient care units under their supervision and are including a qualitative review of patient treatment plans in order to ensure that each child's milieu treatment goals are reflected in the overall Individual Treatment Plan (ITP). Individual DBT therapists have also been working in conjunction with DBT expert

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consultants to develop an ITP that reflects and supports DBT programming for children who are receiving this treatment.

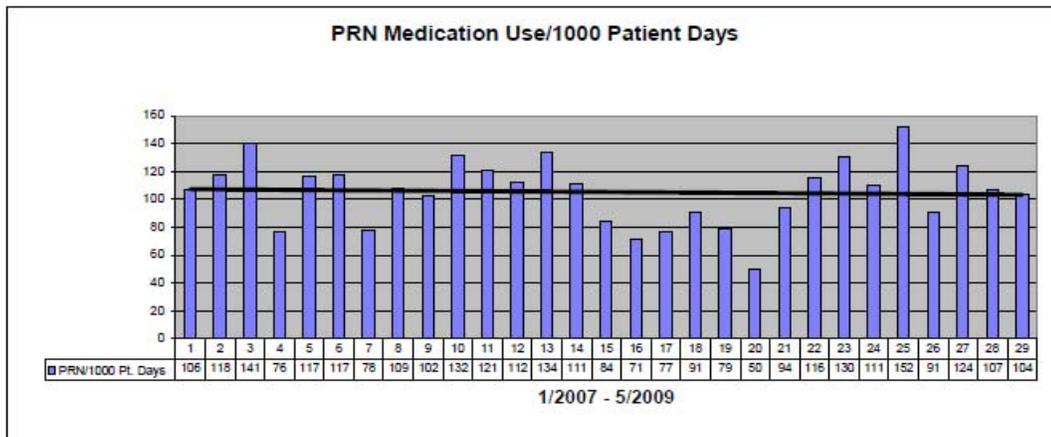
As noted in a prior section, the Hospital has also completed the development of revised treatment plan documents, though they have not yet been implemented.

The OCA monitor continues to encourage the Hospital to regularly audit the quality of the medical record. There have been a variety of efforts in this direction. Physician peer review of medical records takes place and there are processes to review quality via nursing progress note reviews, multi-disciplinary clinical incident reviews, and beginning ABCD fidelity measures. All of these efforts are positive, but it would likely be more efficient and more helpful to carry out one qualitative record review that is client-centered and multi-disciplinary. This would involve the disciplines developing common standards of excellence or fidelity measures for the medical record as a whole. This type of review would give broader insight into staff approaches to care and provide continuous feedback regarding ongoing staff training and support needs.

5. Use of PRN (as needed) Medication (July-September, 2008)

This area of focus was added in the fifth quarter and was initially highlighting a downward trend in use of as needed medication given to children who are agitated or aggressive. The use of PRN medication for calming children is potentially both an alternative to restraint and seclusion and another way of restricting behavior. The trend for use during the period from January 2007-May 2009 is now flat, though this partly reflects changes in how data is compiled. The change in data collection began in December of 2008 and involved counting all PRN use, including a single use, rather than counting only multiple PRN use. Thus, the rate would have been expected to increase.

Current Status: The OCA had also expressed concern about an increase in the use of IM PRN medications for behavior management during the October-December 2008 quarter. There had been 1 IM PRN injection in September; 10 in October; 12 in November and 17 in December 2008. This was an area of concern that the Hospital was asked to address quickly to ensure that use of involuntary IM medication is prevented where possible. Use of injections continued to increase to 23 in January, but has since dropped to a range of 3-7 incidents/month in the February-May 2009 period. The Hospital is encouraged to continue its focus on preventing involuntary injections where possible and monitoring use of this intervention.



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6. Use of Pepper Spray and the role of CVH Police at Riverview Hospital (October-December, 2008): Children at Riverview were pepper sprayed by CVH police three times in a period of three months as a behavioral intervention. The OCA monitor had noted in the January – March 2008 quarterly summary that there was a greater CVH (Connecticut Valley Hospital) police presence at Riverview and expressed concern to the administration about the role of the police. In the April-June 2008 quarterly monitoring summary, the OCA noted an incident (of pepper spray use) involving the police that warranted an immediate review by the Hospital and a conversation with the police, both of which were completed. The OCA encouraged the Hospital to assert its intentions regarding how the police should approach children when the police enter the Hospital at staff's request. Unfortunately, there were two subsequent incidents involving police use of pepper spray on children. The Centers for Medicare and Medicaid Services (CMS) are clear in their interpretive guidelines that weapons (including pepper spray or mace) cannot be used as a treatment intervention.

Current Status: The Child Advocate and Commissioner Hamilton formally communicated about this area of deep concern and DCF indicated that it would take immediate action to address the police role at Riverview Hospital. Additionally, Riverview had an unannounced site visit by CMS representatives in early February to review its restraint and seclusion policies/procedures. The Hospital was cited for failing to ensure that its emergency safety intervention policy and procedure addressed a law enforcement response that would ensure protection of residents. Also cited were deficiencies in the post-restraint/seclusion de-briefing process for staff and children. The Hospital response to these citations included revision of its policy and procedures to include identifying that "law enforcement will only be utilized for criminal actions and are not to be utilized for treatment interventions. Staff are required to request that police do not use any weapons (including pepper spray/foam) during a response to calls for assistance". Also, revised procedures clarify circumstances under which Riverview staff may call for CVH police assistance and reinforce the role of supervisory personnel in initiating and managing the police intervention process. In addition to dealing internally with procedural changes and staff training, Hospital executive staff members met with DMHAS/CVH police to review procedure changes, obtain police feedback, and discuss police training needs. These are improvements the OCA has sought and there have been no further incidents of pepper spray use on children at Riverview during the January-May 2009 period.

7. Condition of patient rooms and stripping of rooms (October-December, 2008): During the October-December 2008 quarter, the OCA addressed the issue of the poor condition of patient bedrooms at Riverview and other DCF facilities. In a letter to Commissioner Hamilton, the Associate Child Advocate expressed concern that patient rooms "lack color, cleanliness, warmth, and cheerfulness. In too many cases, they are stripped down to a plastic institutional mattress, coarse institutional blankets and ill-fitting sheets, bare flooring and nothing on drab cinderblock walls". The OCA recognizes that there are safety issues involved in the set-up of any particular room. However, this should not mean that rooms are cold and bare. Also, the practice of stripping rooms in order to address safety should be thoroughly reviewed, with a recognition that institutionalization in a locked setting already strips children of much of their freedom and individuality.

Current Status: While there have been some efforts toward improvement in the condition of patient rooms, they have not been significant nor have they been coordinated across the Hospital or reviewed by the Executive Committee for effectiveness. Additionally, the OCA monitor has asked the Executive group several times since December of 2008 to take steps to review the practice of stripping rooms in response to patient behavior. This practice is lacking in consistency across the Hospital, with each unit making decisions about what to remove and how long to keep belongings from children. The practice unfortunately appears to be punitive in nature. As with all restrictive interventions, stripping of rooms should be time-limited, based on clinical assessment rather than arbitrary decision-making, and take place only through a doctor's order.

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8. Response to Self-harming behaviors during Restraint or Seclusion (May 2009)

Riverview had an unannounced visit in May 2009 by the Department of Public Health, which acts on behalf of CMS to investigate possible areas of non-compliance with CMS standards. This visit focused on whether the Hospital was responding adequately to self-injurious behaviors of children who are in restraint or seclusion. Among the findings were: a lack of response to patients when self-harming behaviors are occurring and a lack of evidence of staff actions (i.e. RN assessment, changes to treatment plan, etc) when patients engage in self-harmful acts such as tying items around their necks, self-cutting, and banging their heads or hitting themselves until injury occurs. An additional concern was unclear documentation regarding actions taken by staff when a patient is hurting him/herself.

Current Status: The Hospital's stated corrective actions include the following: in-service education on self-harming behaviors and interventions; auditing of all patient charts to ensure that an admitting history of self-harming behaviors is identified and that a plan is in place for response; improved communication (via the white boards, daily report forms, safety plans and treatment plans) on patient care units for all staff regarding patients identified as at risk for self-harming behaviors and plans for responding. Additionally, the Hospital will audit patient medical records to ensure effective documentation going forward. In June, the Hospital Leadership communicated to staff that DPH nurses had met with the Executive Committee in early June and were satisfied that all corrective actions regarding their original concerns had been implemented.

Continuing Recommendations for Improvement

The Hospital has made improvements and responded to many of the recommendations contained in the 2006 reports. Much of the improvement has centered on concrete tasks relating to organizational process. These are necessary, but have not resulted in the needed transition from a coercive and consequence-driven culture to one in which care is supportive, based on strengths, and collaborative. The "top down" nature of Riverview remains in place, with children and their families having little influence on the care they receive and their future planning.

There has been work to address this via an intensive staff development effort during the two years in which the OCA monitor has been at Riverview. However, the leadership of the Hospital, while meeting many process goals, has failed to set or communicate clear and significant expectations and standards about outcomes. As a result, the focus of care at Riverview continues to be about control and restriction.

The Office of the Child Advocate remains very concerned about the children at Riverview and is particularly cognizant that there will no longer be a monitoring presence on site. This raises concerns about both the sustainability of the incremental gains made and whether there will be any further improvement going forward. Final recommendations address these concerns.

Leadership Toward Change

As noted in this summary, the Hospital has moved forward and made improvements in several areas, particularly those involving organizational structure, staff development, revision and improvement in medical record documentation, communication and other routine Hospital processes. However, the Leadership has taken a very incremental approach to change around the core outcomes that all agree must improve – the prevention of punitive and restrictive interventions with children receiving care. It has been clear to the OCA that the Leadership has worked hard to achieve staff buy-in. However, the focus on this has been to the exclusion of even minimal efforts to achieve child and family partnership in care and to set clear standards and expectations about the behavior of staff. Until DCF Central Office and Hospital Leadership communicate much stronger and more focused beliefs around the rights and needs of children, the improvements being sought are unlikely to take place.

Appendix E

Prevention of the Use of Restrictive Interventions

This has been and remains a core area of concern about Riverview Hospital. There are several aspects to this concern, but the OCA agrees with the Hospital's NASMHPD consultant that Riverview has more than adequate resources to aggressively and quickly reduce its use of restrictive interventions and provide a more caring and collaborative treatment environment. Among the more pressing concerns about this area of functioning are the following:

Definition of Seclusion

Connecticut State Statutes define seclusion as "the confinement of a person in a room, whether alone or with staff, in a manner that prevents the person from leaving." This definition has been in place for several years and should be well understood by staff at the Hospital. The improper restriction of children in rooms without the correct safeguards for assessment, limited time frames, and physician's orders is unacceptable. The monitor has raised concerns about this in all but one of the quarterly summaries produced since June 2007 and staff has yet to receive the expected training and supervision to resolve this issue. Additionally, as noted in this summary, the Department of Public Health (DPH), acting on behalf of the Centers for Medicare and Medicaid Services (CMS), has recently expressed concern that staff is not adequately responding to children who are harming themselves while in restraint or seclusion. The Hospital has taken corrective action but should now determine whether this action is effective.

Prevention of the use of Restraint and Seclusion

The trend line for overall use of restraint and seclusion is flat over a two - year period. This is a very disappointing result during a period in which the Hospital has both been monitored and had more than adequate staff resources. The use of 2-point restraint, mechanical restraint, and physical holds, including face down holds, has trended downward. This is positive, but the use of seclusion has increased. In addition, the seclusion rate is likely higher than the data shows. This is due to the fact that the Hospital has failed to follow seclusion procedures in at least some portion of room restrictions carried out via incorrect treatment plans or improper use of time-out. The Hospital leadership and staff have made incremental gains, but have not accomplished a major shift in the culture of the Hospital. There is an urgent need to reduce use of restrictive interventions of all kinds and to communicate clear expectations that staff use more positive, preventive, and supportive alternatives.

Stripping of Patient Rooms

The stripping of patient rooms is another form of restrictive intervention, though it does not appear to be viewed as such by the Hospital. The OCA monitor has asked for review of this practice for several months, but the Hospital has not responded. Based on staff discretion, a child can be deprived of all personal possessions and the entire contents of his/her room if staff determines that there is a safety issue. The OCA understands that there may be times when this is a prudent action to take. However, Riverview does not have consistent, hospital-wide guidelines for how this is to be done, who can authorize this intervention, the extent of what is to be removed, and expectations for reassessment of the child for the return of belongings. The OCA strongly encourages the Hospital to review this practice and develop procedural safeguards for its use.

Quality Improvement

Riverview has made sporadic improvements in refining reports, creating the "Share Point" intranet, reviewing and measuring several problem areas, and creating a rudimentary dashboard system for presenting data. However, Leadership has not developed a sustained or comprehensive quality improvement program. The Hospital does not regularly identify, assess, measure, or improve problematic areas of functioning. In order to function well, Riverview must take steps to openly monitor high-risk practices, address issues that staff or patients identify as

Appendix E

problems, make changes in practice, and measure effectiveness of these changes. This process should be shared with and transparent to all staff working at the Hospital. The OCA is also concerned that Riverview has depended on the OCA monitor's quarterly summaries for aggregation, trending and analysis of data. These summaries will now end and, while Riverview has stated its intention to continue monitoring the areas of concern that the monitor has addressed, there is no concrete indication at this time that this will happen.

Staff Development and Supervision

The strengthening of staff development and supervision have been important goals within the Hospital's Strategic Plan. Riverview has worked intensively to implement the revised ABCD program and DBT approaches to care. Grand Rounds and other staff development offerings have been frequent and varied. However, there is ongoing need for intensive staff development effort around positive and strengths-based approaches to children. Additionally, the staff needs more effective training in approaches to the treatment and care of children with significant development disabilities. The OCA has consistently recommended more comprehensive training in this area, but training opportunities have declined in the last year. The OCA is also concerned that Riverview has not yet implemented an effective staff supervision process. New approaches learned in training are only sustained when the expectations for behavior change are clear, there are supports for ongoing application of new learning, and supervision actively and concretely addresses the need for change.

The OCA acknowledges the efforts and progress of staff at Riverview Hospital and anticipates that there will be further resources focused toward improvement during the coming months. The Hospital Leadership and staff have been cooperative and helpful during the OCA monitoring process and have clearly stated their desire and intention to improve the lives and treatment of children who receive care in this locked setting for several months at a time. Significant improvements will only happen, however, if the Leadership and staff at Riverview strengthen their resolve and attend more effectively to the needs and well being of children and families as the Hospital's core concern and mission.

Sincerely,



Jeanne Milstein
Child Advocate

Appendix F
Economic Competitiveness in
Connecticut

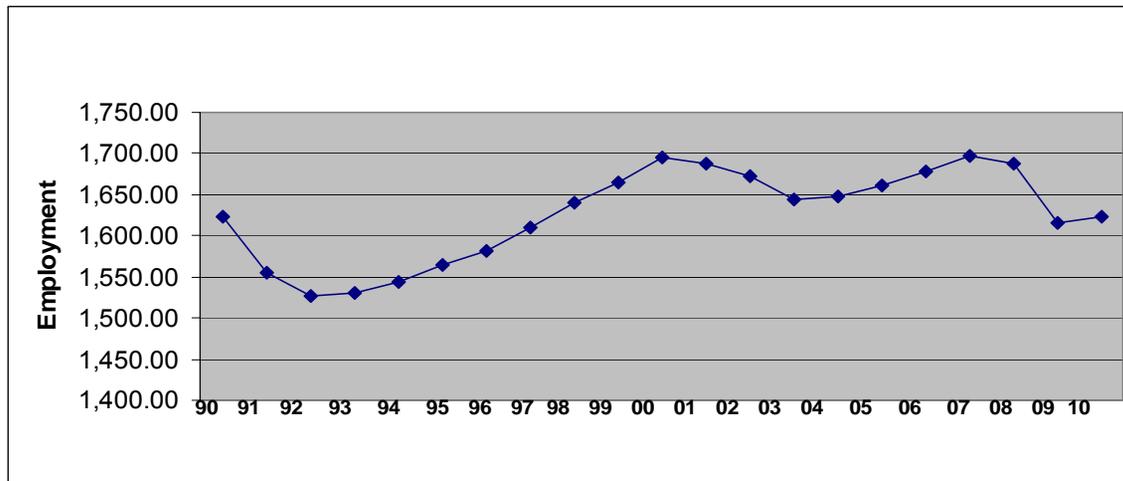
Commission on Enhancing
Agency Outcomes

November 22, 2010

The Economic Picture in CT

- No overall job growth over the past 2 decades
- About 1.62 million jobs in 1990; same in 2010

F-2



Economic Picture in CT:

Not all Bad . . .

- UConn's CCEA reports that from 1999-2009:
 - Some **losses** in professional/ high earning jobs like CEOs, doctors, lawyers (almost **17,000**)
 - Income losses of **\$1.9 billion**
- **BUT**
 - **Gains** in employment of almost **51,000** in professional/high earning jobs like nurses, teachers, financial services, computer technology, engineers, and physical therapists
 - Income growth of **\$4.8 billion**

Connecticut's Economic Rankings

- Depends on Categories Ranked
 - Higher on Technology and Innovation (2008)
 - 6th in New Economy Index (Kaufmann)
 - 7th in State Technology and Science (Milken)
 - Recent UConn study ranks CT 8th-lowest in per-unit manufacturing costs

 - Much Lower on Regulatory Environment and Costs
 - 45th in Business Costs (Forbes, Milken) 47th (CNBC)
 - 40th in Regulatory Environment (Forbes)
 - 23rd “Business Friendly” (CNBC)

Economic Competitiveness

- **Virginia** consistently in top 10 on rankings:
 - ❑ Economic growth potential
 - ❑ Best business climate
 - ❑ Employment leader
 - ❑ Education climate (CT ranks high here, too)
 - ❑ Workforce health and safety (CT high here, too)
-

Economic Competitiveness

- Virginia placed 2nd in nation in ***Enterprising States***, a 2010 overall rating by U.S. Chamber of Commerce and national Chamber Foundation
- **UConn study** – Virginia 3rd-lowest costs in manufacturing

Enterprising States Study

- **Conclusion: The States have the Power to Lead the Jobs Imperative**
- **Ultimately, states and localities are best qualified to meet the jobs imperative**

Enterprising States Study

- Evaluated what states will need in post recession to thrive and create (high quality) jobs:
 - Entrepreneurship and innovation
 - Exporting and international trade
 - Infrastructure development
 - Workforce development and training
 - Taxes and regulation reform

What does Virginia have ... that we don't (mostly)?

- Created 135,000 jobs in professional and technical area – growth of 20% from 2002
- Ability to execute successful initiatives
- Work with individual businesses in three areas:
 - New businesses
 - Technology-based
 - Industry cluster development

F-9

What does Virginia have ?

- Virginia has higher incomes but a slightly below average cost-of-living – Connecticut has high income but high cost of living
- Cost of business is lower in VA – in addition to labor costs, a key expense is **energy**:
 - Virginia's total energy costs in 2008 were slightly lower than the national average
 - Connecticut's were almost 35% higher
 - Gap worse if just electricity costs – VA's 18% lower; CT's 82% higher

What's Virginia Got that CT Doesn't?

- Lower health care costs:
 - Average premium nationwide for family coverage in 2008 was \$12,298
 - CT's was \$13,788 – almost 10% higher than national average – 5th-highest
 - VA's was \$11,935 –about 3% lower than average and 12% lower than CT's

F-11

What else does Virginia have?

- Developed a streamlined permitting process
- One-stop service for new businesses and business who wish to expand
- A representative (case manager) who works with company to get what they need
- Business Development Approach that focuses on key economic areas and international trade
- Advanced e-government services (VA ranks 3rd – CT 37th)
- A performance assessment of services provided to businesses in VA – CT does not

F-12

Job Creation: Primary

- CT Legislation in 2010 – addressed programs and financing for business:
 - \$15 million Small Business Loan Program -- up to \$500,000 per business **DECD**
 - \$5 million pre-seed for innovative concepts **CII**
 - Angel Investor Tax credit for investments in bioscience, information technology, green technology **CII**
 - Sales Tax exemption for machinery, supplies and fuel used in renewable and clean energy industries **DRS**

F-13

2010 Legislation – Program/Financing

- Expands Job Creation Tax Credit program to **small business (DECD)**
- Refocuses and expands **DECD** attention and financing directed to **exporting**
- Expands **enterprise zones** – UCHC and Bradley International

F-14

Legislation – Economic Development Organizations

- Statutorily (re) created the **Connecticut Competitiveness Council** – business, labor, higher education
- **Permit reform** legislation that shortens environmental regulatory permitting
- Establishes a **permit ombudsman** within DECD

Status of Implementation of Legislation

- As of November 1, 2010:
 - CII has qualified 13 businesses as investments for Angel Investor Tax Credits
 - Six angel investors have claimed tax credits for investments and six have reserved tax credits
 - DECD has designated a staff person as the permits ombudsman but currently no projects are being expedited
 - Not all appointments to Competitiveness Council have been made, and Council has not met

Business Development: Organization

BUT

- The way government is structured to provide services and funding to businesses was left untouched
- Several bills (sSB 308, SB 160, SB 327, proposed bill 79) introduced in 2010 but none passed

Business Development: Organization

- Still a patchwork
- No single point that serves as a broker
- All agencies operating programs but little attention on assisting business to identify or navigate them
- Each agency markets its own programs – when budget is tight – all suffer



Technical Asst:

- DECD
- CCT (tourism)
- ConnSTEP
- CERC (Business Resource Center)
- CCAT
- SBDC(5)
- US DOC Export Asst.
- SCORE
- ITBD (@CCSU)
- PTAP (@SECTER)
- Connecticut Business Incubator Network (7)
- Institute for Sustainable Energy (@ECSU)
- Ct Center for Entrepreneurship and Innovation (@UConn Business)



Funding

Federal:

- SBA

State:

- DECD
- DRS (tax credits)

Quasi publics:

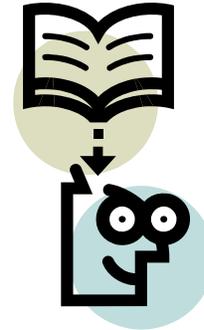
- CDA
- CII
- CHEFA
- CHFA

Regional:

- Regional Revolving Loan Funds (13)

Energy Funding:

- CEEF
- CCEF
- OPM
- ECLP (DECD/CHIF)



Workforce Development/Training

- CT DOL
- OWC
- Workforce Investment Boards
- CETC
- Community Colleges

Other Ec Dev Organizations/Assns:

- CBIA
- Cluster Organizations (7 active)
- Chambers of Commerce (approx. 90)
- Regional Planning Organizations
- Business Council of Fairfield County
- Metro Hartford Alliance
- Women's Business Development Center
- Angel Investors' Forum
- Entrepreneurial Women's Network
- Ct. Economic Development Assn.
- Regional Growth Partnership (South Central CT)



Businesses Accessing these programs

Business Development: Organization

- Difficult for businesses to navigate
- Fragmented program delivery
- Duplicative and expensive

Business Development – State’s Organizational Structure

- **DECD = 117**
 - Executive – 3
 - Managers -15
 - Community/Economic Development (&film) – 52
 - Administrative/support (engineer, accounting, fiscal, IT)- 47
- **CDA= 26**
 - Executive - 11
 - Business Development - 6
 - Support – 9
- **CII = 25**
 - Executive - 1
 - Investments-10
 - External/marketing-6
 - Administrative/support-8
- **Clean Energy Fund -19 (also in CII)**
 - Executive - 1
 - Energy projects - 12
 - Admin/support - 6
- **CHFA = 133**
 - Executive - 3
 - Asset management – 34
 - Finance – 27
 - Housing -3
 - Underwriting -27
 - Support (legal, IT) -39
- **CHEFA= 22**
 - Executive – 5
 - Project Dev. -17

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Business Development

- **Address** the organizational piece
 - **lessen** the economic development **patchwork**;
- **Require an online single point of entry for business**

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Organizational Options

OPTION ONE:

- ❑ Move business development part of DECD to a merged quasi-public;
- ❑ DECD no longer operate financial assistance;
- ❑ 16 business development staff from DECD would serve as case managers/ brokers to businesses, but operate no programs;
- ❑ Case managers would be to provide **technical assistance to businesses** – could be organized by industry cluster area, with special emphasis on exporting activity and small business

Organizational Options

OPTION TWO:

- All Agencies and programs merged and operated into **one quasi-public** – still operating same programs -- as well as current DECD programs-

But

- Would be **single entity offering state financial assistance** to businesses
- Could be **bureaus of a single quasi-public** but with executive and administrative staff reduced
- DECD Business Development Staff would serve as business case managers in either scenario

Option Two: One Merged Quasi-Public

- ❑ Current total staff of 6 Economic Development-type agencies – 342
 - Currently 21 Executive level staff and 15 managers= 36
 - ❑ If limited to 5% = 17 positions **Saves 19 positions**
 - Currently 109 administrative support type positions
 - ❑ If limited to 20% = 69 positions **Saves 40 positions**

Appendix G

COMPARISON OF BILLS TO CONSOLIDATE ECONOMIC DEVELOPMENT AGENCIES

sSB 308 PRI BILL	<u>Aspects of Consolidation</u>	<u>Profiles of Agencies Involved</u>
	<p>Original bill consolidated CII and CDA into one quasi-public, the Connecticut Economic Innovations Authority and would transfer responsibility for direct financial assistance for businesses from DECD to this new entity</p> <p>Public Hearing. March 1, 2010. Committee received testimony form DECD indicating that this would fragment economic development further, and that a broader approach with a single point of entry might be preferable. DECD suggested reviewing the proposal in SB 160.</p> <p>Status: At PRI JF meeting on March 11, 2010 voted to draft substitute language that would broaden the consolidation to a full merger of DECD, CDA, CII and CHFA. This would be a new Connecticut Economic Development Authority.</p> <p style="padding-left: 40px;">➤ JFS to Floor.</p> <p>Purpose: Create one agency where businesses could go for any economic and community development assistance. There should be some though to a broker/case-manager approach at the front end to ensure that businesses receive actual service, and are not just referred to another part of the authority.</p> <p>Benefits: Single service, one point-of entry Businesses could receive more individualized service if broker model is implemented. Economies of scale in a merged agency. Should not be the need for the same number of executive, administrative and managerial staff.</p>	<ul style="list-style-type: none"> • Agency. DECD is a state agency. Its mission is to promote and attract businesses and jobs, revitalize neighborhoods and communities, and ensure quality housing and foster appropriate development. • Established. 1995 (As currently structured) • Executive. Commissioner and a Deputy Commissioner. • Staff. Pre-RIP DECD had 139; now 116 positions, many are in collective bargaining. Almost all are General Fund positions. • Board. DECD currently has no oversight advisory board. SB 308 would create a Competitiveness Council to do that. • Agency. Connecticut Housing Finance Authority (CHFA) is a quasi-public agency, which provides low-interest loans to first-time homebuyers, issues bonds to finance development of affordable housing in the state, and manage state housing assets. • Established. 1969 • Executive. CHFA has one Executive Director. • Staff. CHFA has 129 staff, not covered by collective bargaining. CHFA staff are paid through CHFA funds, not in state budget. • Board. CHFA has a 15-member board of directors. • Agency. Connecticut Development Authority (CDA) is a quasi-public agency that provides financing to help businesses, sometimes in combination with private lenders but often when business cannot obtain financing in the private sector. • Established. 1973 • Executive. CDA has a President and an Executive Director. • Staff. CDA has 26 employees. All staff at CDA are funded though CDA funding not through the state budget. • Board. CDA has an 11-member board.

COMPARISON OF BILLS TO CONSOLIDATE ECONOMIC DEVELOPMENT AGENCIES

		<ul style="list-style-type: none"> • Agency. Connecticut Innovations Inc. (CII) is a quasi-public agency that provides financing and other assistance to high-tech, innovative businesses, especially in the early start-up phase. • Established. 1989 • Executive. CII has one Executive Director. Staff. CII has 25 employees, paid through CII funds (state Bonds funds, and return on investments.) • Board. CII has a 15-member board. • Agency. CT Clean Energy Fund (CCEF) is to increase installed renewable energy capacity; promote clean energy technologies; and enhance public awareness about renewable energy. Exists under the umbrella organization of CII. • Established. 1998 • Executive. CCEF has an Executive Director. • Staff. CCEF has 19 staff. Funding for programs and staff comes from a customer surcharge on electricity bills. • Board. CCEF has a 15-member board.
<p>SB 160 – Proposed Bill</p>	<p>➤ Commerce (Franz) SB 160</p> <ul style="list-style-type: none"> • Bill proposes one quasi-public that combines DECD, CDA, CII, and CHFA. • The bill has not been drafted. 	
<p>Commerce RSB 327</p>	<p>➤ Commerce RSB 327</p> <p>This bill implements the same consolidation as the original PRI bill SB 308, which would have merged CDA and CII and transferred the business development functions from DECD to the new authority, the Connecticut Economic Innovations Authority.</p>	<p>Involves some of the same agencies discussed above, but not all.</p>

COMPARISON OF BILLS TO CONSOLIDATE ECONOMIC DEVELOPMENT AGENCIES

Proposed Bill 79	<p>Status: Public Hearing held March 2, 2010. Still in Commerce Committee.</p>	
	<p>Introducers: Senators Roraback, Fasano and McKinney</p> <ul style="list-style-type: none"> ➤ This bill proposes a broad, comprehensive consolidation of many state agencies. One of those mergers would be DECD and the Department of Labor. ➤ Status: Bill has not been drafted; referred to GAE on 2/9/10. No hearing 	<p><u>Profile of Agencies Involved</u></p> <p>DECD described above</p> <p>Department of Labor (DOL). To assist both workers and employers to become more competitive in a global economy. Assistance to workers through income support between jobs, protection on the job, training and job search assistance. For employers, access to workplace data and labor market information, worker recruitment and training assistance.</p> <p>Established: 1873</p> <p>Executive: Commissioner and one Deputy Commissioners (currently deputy is Acting Commissioner)</p> <p>Staff: Pre-RIP was 783; now 715. Many of these are in collective bargaining, and many are funded through federal Employment Security Administration Fund (administering unemployment)</p>

Appendix H Longevity Payments to State Employees

All state employees who have been with the state 10 years or more are statutorily required to receive “longevity payments” twice a year. In 2009, about 35,000 unionized employees and managers received such payments, although the number is likely smaller since the RIP. The payments are required to be made on the last regular pay day of April and October. For state employees who are in collective bargaining unions, the payments are also required in current contract language.

For managers, the longevity payments are calculated as a percent of salary and are made twice a year. The table below shows the payment percentages for the four different lengths of time an employee has been employed with the state.

Longevity Payments for Managers – Twice a year		
Years	Percent of salary	Range of payments
10-14	2%	\$413-\$1,408
15-19	2.5%	\$826-\$2,817
20-25	3%	\$1,238-\$4,225
25+	3.5%	\$1,651-\$5,633
Source: Management Pay Plan: Longevity Schedule		

For unionized employees, the amounts are flat amounts (not a percent of salary), and vary depending on number of classes and salary groups in the bargaining unit, but the longevity groupings by years are the same as for managers. Some typical payments are shown in table 2 below.

Longevity Payments for Unionized Employees – Twice a year	
Years	Range of Payments
10-14	\$75- \$499
15-19	\$150-\$533
20-25	\$225-\$1,497
25+	\$300-\$1,938
Source: Longevity Schedules from 3 Collective Bargaining Contracts	

According to Office of State Comptroller information, the breakout of total payment in October 2009 (post-RIP) was:

Employee Status	Number	Total \$ Amount
Bargaining unit employees	26,792	\$11,841,885
Non-Bargaining	3,447	\$6,494,067
Total	30,239	\$18,335,952
Source: Office of State Comptroller Information		

Thus, total costs annually for longevity are about \$36.6 million. Payments for managers could be terminated or suspended by statute, while it appears changes would have to be made to contracts for unionized employees. Attached is a listing of the 13 collective bargaining contracts with their expiration dates. Changes to the April 2010 longevity payments would have to be made by April 1, 2010.

Calculation of Longevity into Retirement: Statutorily (Sec 5-154 (h)) longevity payments are calculated into an employee’s “base salary” for retirement purposes.

Attachment

13 Current collective bargaining agreements and contract dates:

State Police – 2007-2010
Maintenance Workers – 2005-2008
Administrative and Clerical –2006-2009
Corrections Officers 2008-2011
Protective Services 2008-2011
Paraprofessional – Health- 2005-2009
Correctional Supervisors – 2205 2008
Professional Healthcare 2005-2009
Social and Human Services -2006-2009
Educational Administrators 2005-2009
Educational Professionals 2005-2009
Engineering, Scientific and Technical 2005-2009
Administrative and Residual -2007-2011

Source: Department of Administrative Services website.

Appendix I

State Employee Compensation Compared to the Private Sector

Examined this in two parts: 1) overall average difference in compensation; and 2) difference in monetary compensation in several selected positions.

PART ONE: OVERALL COMPARISON INCLUDING BENEFITS

State Compensation. First, in overall terms, the average state employee salary for 2008 was \$65,746

¹, which is a gross average using all payroll for all active SERS employees divided by the number of active SERS employees, which covers most state personnel. The benefit package value is costed-out below.² In using 2008 as the year for calculations, it assumes an annual payroll including payment of merit pay, all cost of living increases, etc., and prior to SEBAC agreement imposing furlough days, pay freezes, etc.

Table 1. Average State Employee Compensation		
	Amount	% of Salary
All monetary compensation -- Salary, longevity, overtime, merit bonuses	\$65,746	
Medical/Health Insurance -- Employer's Share (89%) for subscriber + 1 (POE) (Employee contribution \$1,517 (11%))	\$12,173	18.52%
FICA – Social Security	\$4,076	6.2%
FICA – Medicare	\$960	1.45%
Unemployment	\$190	0.29%
SERS – Retirement	\$22,353	33.99%
Value of benefits ³ (and % of salary)	\$39,752	60.5%
Total Compensation Package for Average State Employee	\$105,498	

Private Sector Compensation. In the private sector, staff used average private sector wage for Connecticut in 2008 (CT DOL) and applied the same percentages for FICA (required by federal law). Staff used the premiums for health care for employee plus one for CT. from Kaiser Family Foundation⁴. Retirement benefits are based on results from CBIA 2008 survey of member employers. Since most of the respondent businesses⁵ indicated they had a 401k, (defined

¹ This is the average salary used in the FY 08 SERS valuation report, prepared by Milliman Actuarial Consulting.

² This analysis does not place a value on more intangible benefits like number of vacation days, number of personal days, number of sick days, or the ability to carry them over from year to year, or in cash-out value when state employment terminates. Typically, for state employees, cash-out value would be the value of all unused vacation time (up to a 120-day maximum) any time an employee terminates and 25 percent of all unused sick time (capped at 60 days), paid only at time of retirement, not other termination. The analysis does not place a cash value on severance packages, more common at termination in the private sector.

³ The value of benefit package will be less for newer state employees who will be assessed a 3% of salary contribution for retiree health care until they reach 10 years of employment (refundable if leave state service prior to 10 years)

⁴ These premium amounts and % contribution would be for all plans – both public and private -- and therefore may be somewhat higher than for private sector plans alone. Supporting that is the information from a 2007 CBIA benefit survey indicating that the employer % of premiums covered was 62%

⁵ 41% of CBIA respondents indicated they had a 401K plan, but only about 75% match employee contribution, which is not reflected in the \$2,990 figure.

contribution plan) and the typical employer contribution was 85 percent of the first 6.2% of salary, that is what is used for this analysis.

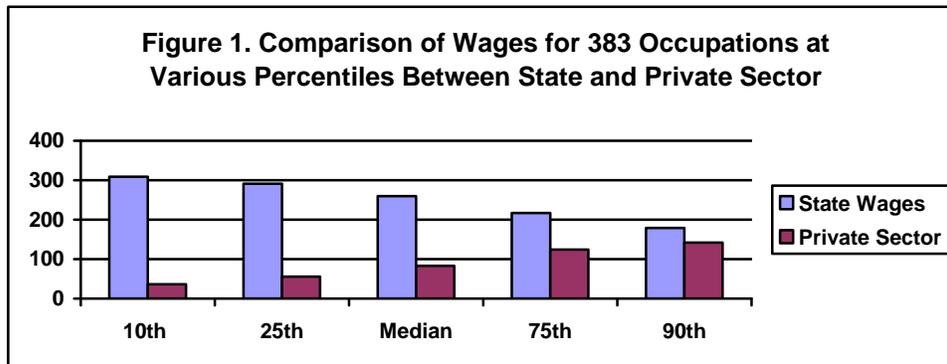
Table 2. Average Private Sector Employee Compensation		
	Amount	% of Salary
All monetary compensation -- salary, overtime, merit bonuses	\$59,313	
Medical/Health Insurance -- Employer's Share (79%) for subscriber + 1 employee's contribution is \$2,380 (21%)	\$6,925	11.7%
FICA – Social Security	\$3,677	6.2%
FICA –Medicare	\$860	1.45%
Unemployment	\$409	0.69%
Retirement	\$2,990	5.0%
Value of benefits (and % of salary)	\$14,861	25%
Total Compensation Package for Average Private Sector Employee	\$74,174	

Difference in the two sectors. Therefore, the difference in average monetary compensation between state employees and the private sector is not that great -- \$6,433 – about 10 percent higher for state employees. However, it is the difference in the cost of the benefit package between the state and private employment that is substantial -- \$14,861 in the private sector (or about 25% of the average wage) versus \$39,752 in state employment (or about 60% of the average wage). The dollar value difference of the benefit packages in the two sectors then is about \$24,891 (or about 167% higher for state employees).

PART TWO: COMPARISON FOR SELECTED POSITIONS

Earnings comparison between state government and the private sector are from the Connecticut Department of Labor 2009 wage data for 383 occupational titles. The data identify base wage rates by occupation, including such things as cost-of-living allowances, guaranteed pay, hazardous-duty pay, incentive pay including commissions and production bonuses, tips, and on-call pay. Excluded are jury duty pay, overtime pay, severance pay, shift differentials, nonproduction bonuses, employer cost of supplementary benefits, and tuition reimbursements.

CT DOL analysis of the data for the 383 occupational codes at five levels is shown in Figure 1



As the figure indicates, state wages were higher for more occupations at all levels, but at the 75th and especially at the 90th percentile, that tended to level out. Complicating this analysis, however, is the fact that nonproduction bonuses are not reflected in compensation, and these types of bonuses are more typically provided to higher salaried private sector workers. Similarly, overtime

pay is also not included which could have an impact on wages in both sectors, but more likely at the lower levels.

Several occupations that would be used in both sectors were selected for wage comparison. They are listed below. The median annual salary from the CT DOL compensation data were used, except as noted in the table below. In general, with the exception of the information and technology area, state salaries tend to be higher than those in the private sector.

	Private Sector	State Employment	
Health Care/Social Services			
Registered Nurse	\$70,623	\$70,263	↔
Nurse Aide	\$26,863	\$40,945	↑
Child/Family Social Worker	\$47,709	\$69,571	↑
Information Technology⁶			
Computer Systems Manager/Director	\$125,008	\$127,822	↔
Information Technology Operations Manager	\$111,877	\$105,055	↓
Computer Software Engineer	\$88,819	\$76,770	↓
Computer Database Analyst (senior 7-9 years)	\$90,654	\$83,828	↓
Clerical/Administrative			
Executive Secretary/Admin Asst	\$45,905	\$59,127	↑
Payroll Clerk	\$41,152	\$45,370	↑
Paralegal	\$48,738	\$56,485	↑
Engineering			
Civil engineer	\$75,364	\$79,906	↑
Plant Facilities Engineer (non-manager) ⁷	\$88,824	\$90,932	↔
Plant Facilities Engineer (manager)	\$89,824	\$101,015	↑
Director/Chief Engineering	\$116,375	\$127,822	↑
Business/Financial/Administrative			
Accountant	\$66,320	\$71,785	↑
Fiscal/Administrative Manager	\$101,602	\$105,724	↑
Human Resources Manager	\$100,630	\$100,712	↔
Purchasing Agent	\$62,638	\$76,676	↑
Management Analyst	\$77,594	\$75,217	↔
Administrative Services Manager	\$75,669	\$96,454	↑
Education Administrator –Postsecondary	\$84,920	\$122,670	↑

⁶ For most of the occupations in the information technology and engineering areas (exceptions are the computer software engineer, and civil engineer), staff used compensation data from the state compensation plans compared to Economic Research Institute (ERI) data for similar job descriptions, as the CT DOL data was more generic and contained no specific job descriptions.

⁷ Similarly, the plant facilities engineering positions and director of engineering data were taken from the state current compensation plans and Connecticut Business and Industry Association survey and ERI data, and not CT DOL data. The positions are for more specific classes than the DOL data offers.

Appendix J
Commission on Enhancing Agency Outcomes
Connecticut Retirement and Pension Summary

Benefit payments. Annual retirement benefit payments currently total more than \$1.2 billion annually. (These do not include cost-of-living adjustments – two since FY 08).

When Retired	Number 6/30/08	Average Retirement Salary	Total \$ Annually (000) FY 08	COLA on Pension: Annual wage adjust. on all retirement wage
Pre-1980	2,750	\$15,710	\$43,202	5%
1980-1997	20,480	\$26,855	\$549,998	3%
1997 and after	14,863	\$30,564	\$454,278	Choice of 3% or formula below, except after June 30, 1999 formula below
2009 (RIP)	3,898	\$45,700	\$168,861 (FY 09)	Formula -- 2.5%-6% depending on CPI
Total	41,991	\$28,966	\$1,216,339	

Sources: FY 2008 SERS Actuarial Report and the Office of State Comptroller for 2009 RIP Data

Overall, Connecticut's state retiree benefits are generous. Comparison Nationally 2008

¹: **Private Sector -- \$13,222 Public Sector --\$24,147**

When Hired	# of Current Employees	Average Salary (June 2008)	Tier	Employee Contribution (Pre-tax)	Age to Retire (Generally)
Pre-1984	353	\$98,028	Tier I – Hazardous Duty	4% to Social Security Taxable Wage Base plus 5% earnings above	Any -20 years of service
Pre -1984	6,512	\$84,987	Tier 1 (plan B or C)	2% to 5% of earnings depending on Social Security participation	55
1984-1997	5,400	\$80,282	Tier II Hazardous	4%	Any (20 years of service)
1984 -1997	16,924	\$71,670	Tier II	0%	60
1997 and after	5,692	\$59,516	Tier II –A Hazardous	5%	Any -20 years of service
1997 and after	18,315	\$50,623	Tier II-A	2%	62
Not date- driven; primarily in higher education	9,800	Unknown	Alternative Retirement Plan	5%	

Sources: 2008 Milliman Actuarial Report of SERS and other Office of State Comptroller Information

¹ Employee Benefits Research Institute. Figure 5 Mean Annual Income from Pensions and Annuities in Constant 2008 Dollars for Population Over 50. May 2010 Notes, Vol. 31. No 5., p. 17

Retiree Health Care Costs. In FY 09, actual expenditures for retiree health care costs totaled almost **\$435 million, and estimated to be more than \$542 million in FY 10.** The table below outlines the monthly premiums for current retiree health care benefits. The retiree health plans have the same coverage, co-pays and benefit structure as those for active employees. By comparison, monthly premiums for active employees are generally between \$105 and \$220 for subscriber+1, depending on plan chosen. (Approximated since payments are made each pay period; most expensive plan which is about \$500 a month, closed after 2009 SEBAC agreement).

Table II – CT Retiree Health Insurance Benefits	
When Retired	Post-retirement healthcare premiums (monthly)
Pre-1980	\$0
1980-1997	\$0
1997-1999	\$0 for most plans
1999 and after	Depends on plan -- \$0 for many plans –others vary typically about \$30 a month for 2 not on Medicare

Until 2009, all payments for retiree health care were made on a pay-as-you go basis. However, as part of the 2009 SEBAC agreement, employees with less than five years of state service must pay 3 percent of their salaries for 10 years into a fund for their post-retirement health care (refundable if the employee leaves state service before 10 years.)

Comparison on Contributions to Pension: Only 7 states have required employee contributions equal to Connecticut’s current 2% or below; five of those states require no contributions from employees.

ISSUES

Unfunded liability or legacy costs: The employer contribution rate for SERS is currently **24.96%** of state payroll, or **\$944 million.** However, of that, 15.96% of payroll (\$603m) is funding the unfunded portion of current retirees (because of prior unfunded or underfunding pension payments), while about **9% of payroll (\$341m)** is funding for current employees. This does not include payments for retiree health care benefits, which are currently on a pay-as-you-go basis, and in FY 10 is about **\$542 million** annually for current retirees and their dependents. Also, this does not include funding for employees in the alternative retirement system – which includes approximately **9,800 employees – and in FY 10 the state’s contribution was \$33.4 million.**

It is important to note that only about 1/3 of the current annual retirement contribution (ARC) is for current employees, while 2/3 of the ARC goes for retirees. However, the unfunded liability may continue to grow if underestimating the payments required to pay for future retirees occurs. This may be likely for a few reasons:

- Connecticut’s actuarial estimates of investment income are among the highest of any state’s pension plan – 8.25%. Only six other states had the same estimate; only three had higher (8.5%) compared to about 7-7.5% nationwide²; without investment returns that closely match estimates, the unfunded liability will grow.
- Connecticut’s 2008 funding ratio³ was slightly less than 52%, meaning that only a little more than half of estimated obligations (at present value) were being funded – only Illinois was less at 46%; Since the economic downturn, the actuarial assessment of the funding ratio is now in the mid-40% range;
- Assumptions on wage inflation (4%) may be too low. According to the June 2008 actuarial valuation report, the compensation for active SERS had increased from \$3,107.9 billion in FY 06 to \$3,497.4 billion in FY 08, an increase of 12.5% in two years alone. If state employee wage inflation is looked at over a longer period, (between FY 00 and FY 10) state payroll has grown at

² Wisconsin Legislative Council. 2008 Comparative Study of Major Public Employee Retirement Systems.

³ Funding ratio is ratio of two numbers – the value of benefits earned compared to the value of assets to support the benefits

a greater rate than 4 percent (compounded) a year. Given the payroll amounts, even a small fraction of a percent difference can be important.

- The contribution levels from current employees cited above, the relatively optimistic interest rate assumptions, and low wage inflation assumptions raise questions as to whether the state retirement system is chronically underfunded, not just because of prior liability but also because current funding does not adequately cover the current and future benefit obligations.

The commission consulted reports such as the Pew Center on the States' report entitled *State Pensions and Retiree Health Benefits: The Trillion Dollar Gap*, (February 2010), which cites Connecticut as being one of eight states with more than one-third of total pension liability unfunded. **It seems clear based on the PEW study and other reports that Connecticut's pension fund and its future financial stability is a matter of great concern.**

SPECIFIC CONCERNS WITH CONNECTICUT'S SERS PENSION PLAN

A great number of current employees (about 14,000 TIER II post-RIP) make no contributions to their pension plan. While Tier II-A employees do contribute, the 2% is also low compared to other states. Based on estimated payroll data of about \$1 billion for Tier II, \$10 million could be generated for every 1% of employee contributions (prior to investment returns).

There is no cap on the retirement salary a retiree can be paid -- either by amount or by percentage of final average salary. (CT Teachers' Retirement has a cap of 75% of FAS). Connecticut does have a cap in the calculation of the FAS, which is no one year of the three-year calculation can be more than 130% of either of the other two. The two factors may contribute to retirement salaries increasing.

The average retirement salary for the 2009 RIP is over \$45,000 as shown in Table 1. This is more than \$15,000 greater than the average of those retiring after 1997 but before June 2008 (date of last actuarial valuation).

The COLA adjustments are generous compared to other states. Connecticut's COLA adjustment is a minimum of 2.5% (or 60% of CPI up to a cap of 6%) of total retirement salary annually. Since 2000, the 2.5% threshold has always been greater than 60% of CPI, and in 2010, the CPI actually decreased (- 0.4). Most states do not have a minimum % COLA, but rather use CPI with a max. Massachusetts, Rhode Island, and New York also cap the amount of retirement income the COLA applies to (e.g. the first \$15,000) rather than the total amount. Other states have a waiting period before a retiree begins receiving a COLA adjustment; Connecticut does not. On the other hand, some states (e.g., MA and NY) exempt retirement benefits from state income tax, while Connecticut does not.

While COLA adjustments of 1% above or below CPI may not seem considerable, on annual retirement payouts of \$1.2 billion, 1% is \$12 million. Further, when there is a minimum COLA, in a year like 2010 when CPI actually declined, the COLA payments of \$30 million are adding to the base payout -- in the payout year and for years to come -- but for non-existent inflation. Further, Social Security recipients have not received a COLA increase in two years. Most active Connecticut state employees did not receive a COLA adjustment in FY 09 and many did not for either FY 09 or FY 10.

The percent of active members in hazardous duty is increasing. Overall the percent of employees in hazardous duty employment as of June 2008 was **11,445, which was 21.5%** of SERS active membership. This is in contrast with **3,306 hazardous duty retirees, which is only 13.7%** of retirees. This may have implications for future retirement costs and liability: longer time in retirement; COLAs over a longer period, and more difficult final average salary to predict because of overtime.

Further, the average annual benefit paid in FY 08 to regular **SERS retirees ages 60 to 64 was \$36,467**, while the average benefit paid to those **hazardous duty retirees** in the same age category, the average

annual benefit was **\$47,273**, a more **than \$10,000 difference**.⁴ The difference in annual average benefits between the two groups is even greater at younger ages, and the average annual retirement payment difference between the two groups overall was more than **\$15,000**.

Other than increasing employee contributions, actual retirement provisions for hazardous duty employees have not changed over time: 20 years to retire at half the FAS which is the final average salary⁵; method of calculating the FAS which includes overtime⁶. Studies and reports have found that the use of overtime can be a salary “spiking” issue.

EFFORTS AT REFORM

Pursuant to Executive Order 38, a Commission on State Post-Employment Benefits was established in February 2010. The commission completed its work, issuing a final report on October 28, 2010. The Executive Summary of the report is attached. The full report can be accessed at

www.ct.gov/opm/lib/opm/secretary/opeb

⁴ Summary Statistics (p.47) from FY 2008 SERS Valuation Report

⁵ Final average salary for SERS is 3 highest-paid years, including overtime and longevity

⁶ New York Times, July 7, 2010. *Cuomo Finds Pattern of Workers’ Inflating Pensions*

Appendix K
Commission on Enhancing
Agency Outcomes

Contracting, Purchasing, and
Other Expense Information

November 22, 2010

Contracting and Purchasing

- Many state services and products are purchased
- Variety of ways to purchase and contract
 - Purchase of Service Contracts
 - Personal Services Agreements
 - Other (e.g., routine bids for products; design-bid-construct)
- Many of the state's contracting and purchasing processes seem outdated, duplicative, inefficient, and expensive

K-2

Purchase of Service Contracts

- Client Services: Overall more than \$1 billion
 - Board and Care of clients currently about \$750 million
 - Typically purchase of service (POS) contracts – by their name are **buying human services** (not products) for clients
 - Six agencies use – DCF, DDS, DSS, DPH, DMHAS, and DOC

K-3

Purchase of Service Contracts

- In FY 08 – 1,942 contracts totaling **\$1.14** billion
- In FY 09 – 2,077 contracts totaling **\$1.37** billion
- In FY 10 – 1,572 contracts totaling **\$1.40** billion

K-4

Purchase of Service Contracts

- Number of contracts reduced by 370 from FY 08 to FY 10
- but 358 of that reduction was due to DSS going to multi-year contracts;
- and total \$ amount increased by about \$300 million in 2 years
- includes large DSS contract amounts to Community Action Agencies for:
 - Fuel assistance
 - Social Services Block Grant (e.g., day care, transportation assistance, etc)
 - Weatherization
 - Federal requirements restrict which agencies states can contract with

K-5

Purchase of Service Contracts

- Standard contract language mostly achieved
- Consolidation of state POS contracting process among agencies has not been achieved
- For example, even in one state agency (DDS):
 - 339 separate POS contracts
 - 160 different contracting providers
 - thus on average 2 contracts per provider
 - one provider has 9 POS contracts w/DDS alone
 - one has 8, and two have 6 each
- Not efficient, duplicative for provider, and the state agency

K-6

Purchase of Service Contracts

- Most are multi-year contracts
- Interest in providing stability for clients
- Most are not competitively bid, but depends on agency
 - only 19 of 339 DDS contracts were competitively bid
 - many of DCF contracts are bid
 - DPH bid 85 of 237 contracts

K-7

Personal Services Agreements

- One of the state's primary procurement processes
- Typically for "infrequent" or "non-routine" services or end products
- By law agencies must execute a PSA before hiring a contractor
- Standards include:
 - Evaluating need for a PSA
 - Developing a RFP
 - Advertising for contractors
 - Evaluating submitted proposals
 - Selecting contractor
 - Monitoring and evaluating PSA contractor performance
 - Documenting the entire process for selecting and managing

Personal Services Agreement

- PSAs not required for:
 - Contracts for **routine products** like supplies, materials and equipment
 - Contractual **routine services** like cleaning or laundry, security, pest control, rental, repair and maintenance of equipment, or other service arrangements where services are provided by persons other than state employees
 - Certain **consultants hired by DPW** like architects, engineers, surveyors, accountants – must be selected by Construction Services panel
 - Federal, state or local **government agencies**
 - Certain consultants hired by **Department of Information Technology**
 - Certain consultants hired by the **Department of Transportation** like architects, engineers, land surveyors, accountants, management and financial specialists – must be selected by DOT consultant services evaluation and selection panel

K-9

Use of Personal Services Agreements

- FY 08 – **2,116** contracts -- totaling **\$369,136,220**
- FY 09 – **2,235** contracts – totaling **\$320,577,509**
- FY 10 – **1,914** contracts – totaling **\$376,999,121**
- **40 agencies used PSAs in FY 10**
- **Fewer contracts in FY 10, but more money**

K-10

Use of PSAs

- Majority are **not competitively bid**:
 - 75% were not in FY 08;
 - 76% were not in FY 09
 - 76% were not in FY 10
- Even if cited as competitively bid, often not:
 - Long-term contracts (5 years)
 - Extended by amendments to 10-12 years or longer
 - Millions of dollars over life of contract
- Contracts and process not very transparent – OPM has reports on website, but contracts themselves not available

K-11

Personal Service Agreements

- Prime examples of these long-term contracts in DSS in Medicaid program supports:
 - Center for Medicare Advocacy -- total contract \$24 million; FY 10 payments total \$3.4 million
 - Craig Lubitsky Consulting LLC (Medicaid nursing home cost systems for rate setting, audits)\$23.5 million, FY 10 payments total \$3.6 million
 - ACS (HUSKY B administration) -- \$9,678,668 in FY 10 alone

- Another example is State Department of Education contracts with Measurement Incorporated:
 - 2 separate contracts – each run from June 2005 to October 2014 (almost 10 years)
 - One contract worth \$51.2 million – FY 10 payments of \$5.7million
 - Other contract worth \$103.2 million– FY 10 payments of \$11.6 million

K-12

Other Expense Areas: Medicaid Administration

- All contracted areas – does not include DSS administration:
 - \$55.9 million in FY 08
 - \$63.2 million in FY 09
 - \$65.7 million in FY 10
 - Almost \$10 million increase over 2 years
- 7 contracts including HP (\$21.3 million in FY 10) for Medicaid information and payments, Mercer, Value Options, and Dental Benefits Management

K-13

Other Areas: Higher Education Operating Expenses

	FY 08	FY 09	FY 10	2-year % change
Regional Community/ Technical Colleges	\$139,779,057	\$114,000,000	\$104,500,000	-25.2%
State University System	\$190,601,190	\$197,966,561	\$194,464,189	2.03%
UConn Health Center	\$272,953,325	\$286,364,912	\$299,721,459	9.81%
University of Connecticut	\$245,000,000	\$310,000,000	\$300,000,000	22.45%
TOTAL	\$848,333,573	\$908,331,473	\$898,685,648	5.94%

K-14

Higher Education Operating Expenses

- Little oversight of how money is spent
- At time when facing budget deficits – and many areas have been cut -- most of these higher education operating expenses have increased
- Exception – community/technical colleges

K-15

Legal Area

- Outside legal services – not provided by state employees – 14 categories of payments:
 - Juvenile court stand-by attorneys
 - Fees for legal services, arbitration, referees
 - Contract attorneys
 - Serving of papers
- Costs are growing in this area:
 - \$40,794,082 in FY 08
 - \$41,419,245 in FY 09
 - \$41,690,844 in FY 10

K-16

General Office Expenses

- Included areas such as:
 - equipment rental,
 - general office supplies,
 - office equipment maintenance and repair
 - other equipment rental and maintenance
 - stationery
- Decreased over last 2 years:
 - \$36,209,157 in FY 08
 - \$35,140,925 in FY 09
 - \$31,663,719 in FY 10
- Decrease of almost \$5 million (12.5%)
- But \$30 million still a substantial amount
- Might be reduced further by applying more modern purchasing practices such as purchasing cooperatives, reverse auctions, and on-line bid submissions

K-17

Printing:

	FY 08	FY 09	FY 10
Printing and Binding contracts	\$5,765,923	\$5,519,088	\$3,978,034
Printing supplies	\$967,156	\$684,834	\$565,403
Photocopying	\$242,059	463,500	\$188,865
Printing legal briefs	\$173,149	\$149,004	\$188,639
Total	\$7,148,288	\$6,816,426	\$4,920,941

K-18

General Commodities

- General supplies and products that don't fit under other categories:
 - Wood, plastics, textiles, paints, janitorial supplies
 - Spending in this expense category has decreased from \$15.9 million in FY 08 to \$15.1 million in FY 10
 - Potential for further reductions if more modern and efficient procurement practices were used

K-19

Phone Services

- Used various expense categories:
 - Phone equipment, cell phone services, long distance phone service, phone installation, repair and services, TV and cable services, and beepers and pagers
- Expense has decreased but still high:
 - \$45.7 million in FY 08 to \$34.7 million in FY 10 (\$20.6 million for local and long distance)
 - Further reductions if need is reevaluated
 - Ensure obtaining best rates for long-distance

Online Legal Information Services

- Several agencies contract with Lexis-Nexis and/or subsidiaries
- Total payments in FY 10 were \$1.3 million for that service alone
- Better oversight of multiple contracting for similar services to negotiate a better price

K-21

Regular Postage

- Increased over last 2 years:
 - \$17,619,051 in FY 08
 - \$19,301,076 in FY 09
 - \$20,040,688 in FY 10
- If decreased by 10% by more on-line services and notices would save **\$2 million**
 - Reductions from other recommendations – business filings in SOS's office
 - Electronic deposit of unemployment compensation and other checks

K-22

Buildings and Grounds

- Includes 16 categories of payments such as:
 - Construction and repair of institutional buildings, government buildings, rent for premises, contracted property management, plant equipment, cleaning services and supplies
 - **Expenses overall reduced** significantly from \$395.9 million in FY 08 to \$255.4 million in FY 10
 - Mostly because no new construction projects
 - But certain categories like **rent increased**– from \$40.1 million to \$45.8 million
 - Contracted property management increased from almost \$9 million to about \$10.4 million
 - Further reductions if use modern purchasing practices

K-23

Security Services

- Included categories of expenses:
 - Security supplies
 - Security services –state and non-state facilities
 - Alarm systems
 - Security guards
- Costs increased from \$11,359,298 in FY 08 to \$13,075,853 in FY 10
- Costs might be further reduced if procured through reverse auction or cooperatively purchased for all agencies

K-24

Transportation

- Largest expense categories are:
 - Public Transit payments: \$251.6 million in FY 08 to \$290.9 million in FY 10
 - Highways (excluding town payments): \$341.2 million in FY 08 to \$507.6 million in FY 10 –
 - But largely due to increase use of ARRA funds

K-25

Transportation

- Other expense areas not as great but may provide opportunity for some savings:
- Highway supplies:
 - \$16.7 million in FY 10, including \$10.2 million for road salt alone
 - Costs could be reduced if products could be purchased through reverse auction or purchasing with other states

Employer-Type Payments

- As an employer state is required to make wage and medical payments for workers injured on the job.
- Those costs have increased significantly:
 - \$93.8 million in FY 08
 - \$108.6 million in FY 10
 - Almost \$15 million increase (16%) in 2 years
- State must also pay unemployment insurance costs
- Those have also increased:
 - From \$4.7 million in FY 08 to \$7.2 million in FY 10
 - A \$2.5 million increase
 - But more than 50%

K-27

Proposals for Reducing Costs in Purchase of Service Contracting

- Probably a need to keep longer-term contracts in POS to ensure stability for clients
 - BUT
- Reduce the number of contracts among human services agencies through consolidation of back office administrative functions
- This would reduce the administrative burden of providers to have different systems to accommodate different human service agencies

Personal Service Agreements

- No longer than three-year contracts
- Outside evaluation by OPM on the need to continue the contract before rebid
- Discontinue use of amendments for PSAs

Other Contracting

- DAS and other purchasing agencies must modernize their procurement practices to include:
 - Reverse auctions
 - Job-order contracting
 - Submission of bids on-line for routine products and services
 - Expand use of purchasing through an existing contract with another state, town, nonprofit, or other public purchasing consortia
 - Expand use of contingency contracting

Reverse Auctions

- A **reverse auction** is a purchasing tool by which the buyer seeks the lowest price for what is being bought through an **online bidding process**. In contrast to a paper-based bid, in which the bidder makes a best-guess offer that is static throughout the competitive bidding process, in online, real-time reverse auctions, a supplier can re-evaluate and adjust its bid in response to offerings from other bidders. (See Attachment A)
- OPM has used reverse auctions to purchase electricity and natural gas – estimated savings of 20%
- DAS has had the ability to use reverse auctions for products since 2008, and has not used it, and 2010 legislation now allows reverse auctions for certain services
- DAS staff indicated that the state would have to own the online systems to operate the auctions, but a vendor is contracted to operate the auctions with the winning bidder paying the fees
- For products and routine services (cleaning, janitorial) **require that DAS and any other state agency use reverse auctions for at least 25% of purchases**

K-31

Job-Order Contracting

- Procurement method that uses a single competitively bid contract that uses a set of customized, pre-priced construction tasks (catalogue of prices)
- Often used for facility repair, alteration, and minor new construction needs
- Eliminates time, expense and staff burden normally connected with design-bid-construct for each project

K-32

Job Order Contracting

- Currently being used by:
 - U.S. Postal Service
 - New York State Transportation Department
 - Georgia Department of Administrative Services
 - New York State Offices of General Services
 - Pennsylvania Department of General Services
- And in Connecticut:
 - Capitol Region Council of Governments on behalf of member towns – estimated savings of 15%-20%

On-line Bid Submission

- Currently DAS sends out electronic notices of bid solicitation but does not have an electronic system for bid submission
- Since 2007, Capitol Regional Council of Governments has had a streamlined web-based system allowing registered members and vendors to participate in this efficient procurement process

K-34

Existing Contracts and Purchasing Cooperatives

- Until 2010, Connecticut could not use existing contracts of other states or purchasing cooperatives unless the state was part of the original contracting process
- Public Act 10-3 now gives DAS the authority to purchase through already established contracts

Existing Contracts and Purchasing Cooperatives

- DAS has used this authority (effective May 2010) by joining the Western States Contracting Alliance (WSCA) contract for maintenance, repair, and operational products
- Contract is managed by State of Nevada
- Estimated to save 30% on products

Contingency Contracts

- DAS and other procurement agencies should expand use of contracts whereby the vendor is paid from savings:
 - Energy performance contracting
 - Collection activity
 - Revenue enhancement
 - Case transfer or cost avoidance
 - DSS currently has in place a contract for third party liability that operates like this

K-37

Savings from Routine Purchases

- If procurement practices were modernized as recommended:
- Estimated savings of 10% in areas like general office supplies, phone and phone services, cleaning products and services, property management would be **\$38 million**

K-38

Other Proposals

- If just **5% savings** in **purchase of service** contracting could be achieved by consolidating human service contracts, and relieving providers of administrative burdens of dealing with multiple agencies
- Estimate savings of **\$70 million**

K-39

Other Proposals

- If more competition were introduced to personal service agreements:
 - fewer long-term contracts
 - restrictions on amending contracts,
 - outside evaluation of continued need,
 - and greater use of contingency or performance contracting
- Estimate savings of 10% -- **\$37.6 million**

Vendor Payments

- Improving efficiencies and modernizing practices also apply to way vendors are paid
- Currently Office of State Comptroller pays about 1,100 vendors through electronic deposit (issuing 67,686 payments that way in FY 10)
- OSC states that since 1999 it has been seeking to put more vendors on electronic payments

K-41

Vendor Payments

BUT

- Office of State Comptroller still paying **155** commercial vendors – (does not include towns) that individually receive more than **100 payments** a year by paper check
- Altogether these vendors were issued 45,429 paper checks in FY 10
- Some of the state's largest-volume vendors still getting paper checks:
 - CT Light and Power (2,497 checks)
 - Ikon Office Solutions (2,688 checks)
 - Staples (2,141 checks)
 - ADT Security (1,107)
 - Yale-New Haven Hospital (957)

K-42

Vendor Payments

- Require OSC to put all vendors (not including towns) receiving at least 100 payments a year on electronic payment
- Costs about \$1.00 to process a paper check vs. \$.03 for an electronic payment
- Savings about **\$44,000**
- Does not include reduction in staff needed to process
- Will improve perception that Connecticut is modernizing business practices, speed up vendor payments and lessen chances for lost payments -- all improved outcomes

K-43

Areas That Need Further Exploration

- Higher Education Operating Expenses
 - Greater oversight may produce substantial savings
- Medicaid Billing
 - DAS billing to DSS appears duplicative
 - Other DAS collections might be done through a contingency contract (one already in place at DSS)
- Explore why workers' compensation costs have increased by \$15 million in one year

K-44

Total Savings

- **\$70** million in Purchase of Service area
- **\$38** million in purchase of routine products and services
- **\$37.6** million in Personal Services Agreements
- **\$2** million in postage reduction
- **\$44,000** through electronic vendor payments
- **Total \$148 million**

K-45

Appendix L P-Card Program and Electronic Invoices

OVERVIEW

The State's Purchasing Card (P-Card) Program is designed to offer State agencies an alternative to the existing State procurement processes. It allows agencies to quickly and conveniently purchase approved items directly from a vendor that accepts credit cards. The State Comptroller, in conjunction with the Department of Administrative Services, issues the State of Connecticut Agency Purchasing Card Coordinator Manual, which sets forth the State's guidelines and procedures on the use of the purchasing cards by State agencies.

The Comptroller may allow budgeted executive branch agencies to use purchasing cards for purchases of \$10,000 or less (4-98(c)). The Comptroller can also establish specific limits for use of the purchasing card within the limits established by the statute.

The following guidelines are included in the State of Connecticut Agency Purchasing Card Coordinator Manual:

- State agencies are required to pay the full amount of the P-Card invoice by the due date so no interest is accrued on the account. After the bill has been paid, the Department should review the amounts charged to the P-Card to determine whether they were appropriate State purchases and whether there is adequate documentation on hand to support the purchase.
- If the product or service being ordered is available from a State contract supplier, the order must be placed with the State contract supplier.
- No personal expenses such as meals, personal telephone charges and movie rentals should be charged to the P-Card.
- Travel expenses that are charged to the P-Card should be purchased through the State contracted travel agent and should be for State business only.

COST OF PURCHASE ORDER VS. PURCHASING CARD (From the Comptroller's Office)

Fiscal Year 2008

During Fiscal Year 2008, the total number of purchase orders issued was 124,883. Of these purchase orders, 75,133 were issued for purchases less than \$1,000. Using the industry standard cost of \$89.21 per transaction, the total annual cost for processing these transactions using a purchase order is estimated to be \$6,702,615. *If these purchases had been made using the*

purchasing card, using the industry standard of \$21.83 per transaction, the annual cost would have been \$1,640,153.

Of the 124,883 purchase orders issued during Fiscal Year 2008, 93,036 were issued for purchases less than \$2,500. Using the industry standard of \$89.21 per transaction, the total annual cost for processing these transactions using a purchase order is estimated to be \$8,299,742. *If these purchases had been made using the purchasing card, using the industry standard of \$21.83 per transaction, the annual cost would have been \$2,030,976.*

Fiscal Year 2009

During Fiscal Year 2009, the total number of purchase orders issued was 99,471. Of these purchase orders, 60,432 were issued for purchases less than \$1,000. Using the industry standard cost of \$89.21 per transaction, the total annual cost for processing these transactions using a purchase order is estimated to be \$5,391,139. *If these purchases had been made using the purchasing card, using the industry standard of \$21.83 per transaction, the annual cost would have been \$1,319,231.*

Of the 99,471 purchase orders issued during Fiscal Year 2009, 75,099 were issued for purchases less than \$2,500. Using the industry standard of \$89.21 per transaction, the total annual cost for processing these transactions using a purchase order is estimated to be \$6,699,582. *If these purchases had been made on the purchasing card, using the industry standard of \$21.83 per transaction, the annual cost would have been \$1,639,411.*

REBATE (source: Comptroller's Office)

Each year the State of Connecticut receives a rebate check from the purchasing card vendor based on the annual charge volume generated with the state Purchasing Card Program. For calendar years 2008 and 2009, the state received a total of \$315,000, which was deposited in the State's general fund.

POTENTIAL SAVINGS (source: Comptroller's Office)

Statewide

The potential savings for the State of Connecticut for Fiscal Year 2008 could have been \$5,062,462 if state agencies had used the purchasing card for all transactions less than \$1,000. If the parameters were expanded to include all purchases up to \$2,500, the potential savings would have increased to \$6,268,766.

The potential savings for the State of Connecticut for Fiscal Year 2009 could have been \$4,071,908 if state agencies had used the purchasing card for all transactions

less than \$1,000. If the parameters were expanded to include all purchases up to \$2,500, the potential savings would have increased to \$5,060,171.

The total estimated savings for FY 2008 and FY 2009, if state agencies had utilized the purchasing card program instead of using a purchase order for transactions less than \$1,000, would have been \$9,134,370. If purchases up to \$2,500 were included, the total estimated savings for FY 2008 and FY 2009 would have increased to \$11,328,936. (Exhibit C)

Office of the State Comptroller

The State Comptrollers Office would benefit from an additional savings in the operating budget in the costs associated with check stock, envelopes and postage.

Best Practices:

Using the purchasing card provides an option that will reduce an agency's workload and reduce the costs to produce payments to vendors. In addition, controls over purchasing are increased by allowing administrators to set dollar limits per transaction and to restrict types of purchases made. Efficiencies are achieved because the number of transactions to pay vendors is reduced by requiring one purchase order for all transactions monthly and one monthly payment. This provides staff the time to focus on more value added activities. In accordance with Federal Acquisition Regulation 13.201 (b), the government-wide commercial purchase card is the preferred method to purchase and to pay for purchases \$2,500 or less by the federal government.

The State of Connecticut purchasing policy prior to the implementation of Core-CT in 2003 did not require a purchase order for purchases less than \$1,000. The purchasing authority used was "reservation 7," which allowed an agency to make a purchase without having to issue a purchase order. This reduced the number of purchase orders issued. Prior to the implementation of Core-CT, the State of Connecticut recognized this as a best practice. With the implementation of Core-CT, all transactions now require a purchase order. When using the purchasing card, all of the individual transactions are on one purchase order in Core-CT.

AUDITING P-CARD PROGRAMS

During an agency audit, the Auditors of Public Accounts examine P-Card Program usage and compliance. The auditors told us that they have not encountered major program abuses. Below are the Auditors' findings concerning the P-Card Program in two agencies: the Department of Public Safety and Office of Protection and Advocacy for Persons with Disabilities. These findings seem to be consistent with those in other agencies.

**DEPARTMENT OF PUBLIC SAFETY
FOR THE FISCAL YEARS ENDED JUNE 30, 2005 AND 2006**

We reviewed monthly P-Card activity in the fiscal year ended June 30, 2006. This testing disclosed the following:

- Numerous instances in which required documentation (either the P-Card log (Form CO-501) or the Statement of Account) was either not completed, did not contain the required supervisory approval, or was not submitted by the 20th of the month.
- One instance in which a restricted, personal charge was made on a P-Card.
- One instance in which no supporting documentation was submitted as required.
- Two instances in which both the employee and their supervisor did not sign the Statement of Account.

**DEPARTMENT OF PUBLIC SAFETY
FOR THE FISCAL YEARS ENDED JUNE 30, 2005 AND 2006**

▪ We reviewed ten purchasing card invoices during the audited period; three from the fiscal year ended June 30, 2005, and seven from the fiscal year ended June 30, 2006. During our review, we noted the following:

- Five instances in which the purchasing card logs detailing purchases made by two employees were not signed by respective supervisors, indicating their approval.
- One instance in which it appeared that a single purchase was split into multiple purchases, which by-passed the \$1,000 single purchase limit established by the Comptroller's Purchasing Card Cardholder Work Rules Manual.
- One instance in which a purchasing card was used to purchase meals during a State business trip, which is prohibited by the State Comptroller's Purchasing Card Cardholder Work Rules Manual.

APPENDIX M
COMMISSION ON ENHANCING AGENCY OUTCOMES
SUMMARY SHEET

Update on Proposal to Implement LEAN Processes

What is LEAN? A process improvement approach used to **reduce waste** and focus on **value to the customer**.

Examples of Waste				
Document errors	Completing work not needed	Waiting for the next step	Searching for information	Backlogs
Source: CT DOL				

Originating in manufacturing, LEAN techniques are increasingly being used to identify and eliminate redundancies, decrease the number of steps and processing time, and otherwise improve efficiency in government service and administrative processes.

What LEAN efforts have occurred in CT government?

- **CT DOL** established Center for LEAN Government in May 2004 * 19 LEAN projects at DOL to date * estimate saved \$1,199,929 in worker hours
- **CT DEP** undertook 19 LEAN projects * reduced processing time for loan applications for municipal wastewater treatment projects from 294 days to 113 days
- **DAS** awarded a contract for procurement of professional services to facilitate LEAN government methodologies and services (Estimated to have a total value of \$1.6 million, seven companies are named in the award; however, use of the consultant companies is dependent on agencies having funding available for this expense from their individual budgets.)
- **Bill** to require state agencies to implement LEAN techniques to improve current processes was introduced by GAE this year (SB 467: AAC LEAN Government)

Examples of LEAN Projects at State Agencies	
LEAN Project	\$saved
DOL - Streamline process to recoup Unemployment Insurance overpayments <ul style="list-style-type: none"> • Eliminated or re-engineered 18 steps • Eliminated 10,000 duplicate forms sent to employers annually 	\$13,200
DEP - Streamline Inland Water Resources Division Permit Sufficiency Review <ul style="list-style-type: none"> • Shortened response time to regulated community • Reduced # of copies CT DOT has to make for processing the permits 	\$57,000
BESB – Streamline process to deliver low-vision aids <ul style="list-style-type: none"> • Reduced time to deliver low-vision aids to Adult Services Division clients • Changed from individual to bulk ordering, with blanket purchase order approved by state comptroller's office 	\$54,000
Also: Cost per large print calendar (produced for clients) reduced from \$15 (using private vendor) to \$4.70 (using DAS print shop)	\$10,300
Source: CT DOL Report on Cost Savings Through LEAN, 3/16/2010; BESB personal communication.	

Summary: The **total cost savings** that can be attributed to LEAN is currently **unavailable**; the above individual project savings **range from \$10,300 to \$57,000**; however, some LEAN projects may result in efficiencies and better customer service, but not financial savings.

APPENDIX N

August 17, 2010

The Honorable Michael Starkowski
Commissioner
Department of Social Services
25 Sigourney St.
Hartford, CT 06106

Dear Commissioner Starkowski:

As you may be aware, the Commission on Enhancing Agency Outcomes per Public Act 09-7 Sept. Sp. Sess. has identified many proposals for further review to fulfill its goal of reducing state costs and enhancing the quality and accessibility of state services.

Two of the commission proposals involve actions by your agency: 1) a multi-state bulk purchasing cooperative for Medicaid pharmaceuticals; and 2) fully implementing drug recycling for Medicaid clients in nursing homes and other institutional settings. The commission is interested in the status of each of these.

Public Act 09-206, which became effective July 1, 2009, required DSS to submit a plan to the legislature by December 31, 2009, on the pharmaceutical purchasing initiative. The plan was to include: a timetable for implementation, anticipated cost savings, and recommendations for legislative changes necessary to carry out the plan. In December 2009, you (and then-DAS-Commissioner Sisco) submitted a letter to the governor indicating the plan would be issued in April 2010. However, to date no plan has been issued and staff to the commission has been informed by your agency that the plan will probably not be ready until September.

It is now over a year since the legislation mandating the plan was passed, and more than seven months have passed since the deadline for submittal of the plan required in the legislation. The commission is concerned the opportunities to save the state, and its citizens, considerable amounts of money are being delayed or missed altogether because of agency lack of action. Would you please advise us if the plan will be submitted to the legislature by September 1, 2010?

Another area under DSS purview is the full implementation of drug recycling for Medicaid clients in residential settings. DSS staff attributes part of the sharp decline in quarterly savings from the drug recycling program to the increase in participants in Medicare Part D, not currently part of the drug recycling program. However, DSS further reported in June that guidance from CMS indicated that it would be allowable to include Medicare Part D participants in Connecticut's drug recycling program. It was further reported that DSS intended to meet with stakeholders to determine next steps for this program expansion, but has not done so yet. Finally, DSS reported receipt of a proposal by HP (formerly EDS) to expand the drug recycling program to other populations.

APPENDIX N

Please provide a status report on the drug recycling program (e.g., when the next steps will occur, when the drugs for Medicare Part D participants will be included, proposed dates for broader program expansion, and anticipated cost savings.)

Thank you in advance for your cooperation.

Regards,

Senator Gayle Slossberg
Co-Chair, Government Administration
and Elections Committee
Co-Chair, Commission on Enhancing Agency
Outcomes

Representative James Spallone
Co-Chair, Government Administration
and Elections Committee
Co-Chair, Commission on Enhancing
Agency Outcomes

cc: Members, Commission on Enhancing Agency Outcomes

APPENDIX O



MICHAEL P. STARKOWSKI
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

TELEPHONE
(860) 424-5053

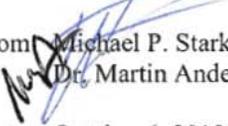
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To: The Honorable Jonathan A. Harris, Co-Chair, Public Health Committee
The Honorable Elizabeth B. Ritter, Co-Chair, Public Health Committee
The Honorable Dan Debicella, Ranking Member, Public Health Committee
The Honorable Janice R. Geigler, Ranking Member, Public Health Committee
Members of the Public Health Committee

The Honorable Paul R. Doyle, Co-Chair, Human Services Committee
The Honorable Toni E. Walker, Co-Chair, Human Services Committee
The Honorable Robert J. Kane, Ranking Member, Human Services Committee
The Honorable Lile R. Gibbons, Ranking Member, Human Services Committee
Members of the Human Services Committee

From: Michael P. Starkowski, Commissioner, DSS

Dr. Martin Anderson, Commissioner, DAS

Date: October 6, 2010

Re: Prescription Drug Purchasing Program Report

Pursuant to PA 09-206, we are pleased to submit the Prescription Drug Purchasing Program Report to the Connecticut General Assembly. The legislation required that several state agencies, in addition to the Office of the State Comptroller, develop a plan for implementing a drug purchasing program in Connecticut, as well as for joining a multistate Medicaid pharmaceutical purchasing pool.

This has been a long and detail-oriented process that began in late summer 2009, when the Commissioners and/or designated staff of the Departments of Social Services, Administrative Services, Insurance, and Public Health, as well as the Office of State Comptroller and the Office of Policy and Management, met on a number of occasions. In the initial meetings, members shared information about pharmaceutical purchasing in their respective agencies, discussed strategies for cost containment and savings, and shared research on national pharmacy purchasing pools. As the committee delved deeper into the issue, the members grew to appreciate the complexities. Therefore, due to the significant amount of work required to ensure that all possible approaches were considered, the committee decided to continue to meet into the current year.

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Prescription Drug Purchasing Program Report
October 6, 2010
Page 2

This report summarizes the committee's work and its findings, including options available to the state for implementing a Pharmacy Bulk Purchasing Pool, the savings that may be achieved, and the factors that must be considered in choosing a particular option. The report defines the challenges as well as the cost savings that may result. Because some of the options require legislative action, further review and analysis by the legislature will be the next step in the development of a plan.

Feel free to contact me at 860-424-5053 or Evelyn Dudley, DSS Pharmacy Manager at 860-424-5654 if you would like any additional information.

Thank you and regards.

cc: The Honorable M. Jodi Rell, Governor
The Honorable Brenda L. Sisco, Acting Secretary, OPM
The Honorable Nancy Wyman, Comptroller
The Honorable J. Robert Galvin, Commissioner, DPH
The Honorable Thomas J. Sullivan, Commissioner DOI
Dr. Mark Schaefer
Evelyn Dudley
Anne Foley

Public Act 09-206

Report on Multistate Purchasing Pools and Pharmacy Bulk Purchasing

Presented to the Public Health and Human Services Committees

October 6, 2010

Introduction

This plan is submitted to the Public Health and Human Services Committees of the Connecticut General Assembly pursuant to Public Act 09-206, An Act Concerning Health Care Cost Control Initiatives. The act charges several state agencies with the responsibility of creating a plan for pharmaceutical bulk purchasing in Connecticut.

Specifically, it requires the Commissioners of Social Services and Administrative Services and the Comptroller, in consultation with the Commissioners of Public Health and Insurance to carry out two specific directives: 1) to implement a prescription drug purchasing program and procedures to aggregate or negotiate the purchase of pharmaceuticals for pharmaceutical programs, including HUSKY B, Charter Oak, ConnPACE, as well as for Department of Corrections inmates and individuals eligible for group hospitalization and medical/surgical insurance plans under CGS Sec. 5-259 and 2) to join an existing multistate Medicaid pharmaceutical purchasing pool.

The act requires that the plan be submitted to the Public Health and Human Services Committees and include 1) a timetable for implementation, 2) anticipated costs or savings resulting from its implementation and maintenance, 3) a timetable for achievement of any such savings, and 4) proposed legislative recommendations necessary to implement the plan.

Background

Currently, the Department of Social Services reimburses retail pharmacies for pharmaceuticals written and filled for individuals enrolled in any one of the Connecticut Medical Assistance Programs (e.g., HUSKY, Medicaid, ConnPACE, etc.). The department does not purchase these pharmaceuticals directly, but rather, the pharmacies purchase pharmaceuticals for clients of these programs from wholesalers/manufacturers who are then reimbursed by the department at a rate defined in state statute for brand name drugs.

Approximately \$920 million are spent annually by the Department of Social Services (DSS), the Office of the Comptroller, and contracted for by the Department of Administrative Services (DAS) for pharmaceuticals for the unique populations they serve. Each agency has individualized methods of purchasing, reimbursement and rates

for the pharmaceuticals prescribed for the specific populations under their purviews. The intent of this legislation was to explore savings opportunities which may be available to the state by aggregating the purchase of pharmaceuticals across agencies and/or by joining an existing multistate pharmacy purchasing pool.

Purpose

This report summarizes the options available to the state for implementing a Pharmacy Bulk Purchasing Pool (PBPP), the savings that may be achieved, and the factors that must be considered in choosing a particular option. The report defines the challenges as well as the cost savings that may result. Because some of the options require legislative action, further review and analysis by the legislature will be the next step in the development and eventual implementation of a plan.

Process

Beginning in late summer 2009, the Commissioners and/or designated staff of the Departments of Social Services, Administrative Services, Insurance, and Public Health, as well as the Office of State Comptroller and the Office of Policy and Management, met on a number of occasions. In the initial meetings, members shared information about pharmaceutical purchasing in their particular agencies, discussed strategies for cost containment and savings, and shared research on national pharmacy purchasing pools. Attachment A provides a comparative analysis of state agency pharmaceutical purchasing.

As stated in the December 30, 2009, letter from Commissioner Starkowski and former DAS Commissioner Sisco to Governor Rell, the committee members decided that due to the significant amount of work required to ensure that all possible approaches were considered, the committee decided to continue to meet into the current year. Specifically, the committee decided that Connecticut could benefit greatly from the expertise of the national Pharmacy Benefits Administrators (PBA) who have experience with Pharmacy Bulk Purchasing Pools (PBPP).

There are currently five national pharmacy purchasing or supplemental drug rebate pools approved by the Centers for Medicare and Medicaid Services (CMS). These five pools harness the purchasing power of forty-four states, the District of Columbia, and the cities of Chicago and Los Angeles for Medicaid, hospitals, clinics, public employees, and various pharmacy programs.

The committee gathered information on all five CMS approved PBPPs and agreed to meet with three of the five PBAs that administer the respective purchasing pools. The two that were not chosen do not serve Medicaid or public employee programs and therefore were not deemed as meeting the intent of this legislation.

The PBPPs were offered an opportunity to present their system, their processes and the

potential financial benefits to Connecticut for joining their purchasing pool. Each entity was provided statistical and financial data for each participating state agency in order to provide more accurate financial savings for Connecticut. The meetings were held with the following entities on the dates indicated:

- Goold Health Services/Sovereign States Drug Consortium – February 25, 2010
- Provider Synergies/The Optimal PDL SolutionSM (TOPSSM) Program – March 4, 2010
- Magellen Health Services/Benefit Management Solutions – March 4, 2010

After meeting with the three PBPPs, the committee engaged in several follow up internal discussions to determine what options were viable in Connecticut. In order to enhance the comprehensiveness of this report, on August 17, 2010 the committee met with representatives of other state agencies who purchase or pay for pharmaceuticals for individuals under their care. Representatives of the Department of Correction, Department of Developmental Services, Department of Mental Health & Addiction Services, Department of Children & Families-Riverview Hospital, UConn Health Center/John Dempsey Hospital, in addition to Department of Social Services, Department of Administrative Services, and Office of the Comptroller, Department of Public Health and the Office of Policy & Management were in attendance. The purpose of this meeting was to gain an understanding of pharmacy purchasing arrangements in place outside of the retail pharmacy setting. Each entity provided an overview of the populations they serve, their individual pharmaceutical programs, the needs of their agency and the clients they serve and the venue in which pharmaceuticals are provided and reimbursed.

Based on subsequent meetings and discussions, the committee feels that the process is complete and all of the necessary information has been gathered, reviewed, and discussed. The following sections present the options available to Connecticut, the pros and cons of each, and the potential savings to be achieved.

Multi-State Purchasing Pool

Public Act 09-206 directed the committee to develop a plan to have the state join a multistate Medicaid pharmaceutical purchasing pool. In a letter dated September 16, 2010, from Commissioner Starkowski to Provider Synergies the state of Connecticut approved the implementation of Connecticut's Medicaid Preferred Drug List and supplemental rebate programs into Provider Synergies Multi-State PDL Initiative, TOPSSM - The Optimal PDL SolutionSM. DSS is preparing the appropriate State Plan Amendment for submission to the Center for Medicare and Medicaid Services to receive federal approval of this action. Savings for this state fiscal year will be contingent on the CMS approval date.

The Department of Social Services currently contracts with Provider Synergies for the design, implementation, and management of the State's Preferred Drug List (PDL). The TOPS program is a multistate Medicaid-only pharmaceutical purchasing pool with seven

states currently participating: Delaware, Idaho, Louisiana, Maryland, Nebraska, Pennsylvania, and Wisconsin. Joining this pool will produce additional savings, while also maintaining control of the existing PDL and existing DSS Pharmaceutical & Therapeutics Committee.

The anticipated savings associated with joining TOP\$ is approximately \$6 to \$7 million annually based on the preferred drug list that existed in SFY 2010. Since DSS currently contracts with Provider Synergies and has been offered the option to join TOP\$ without any modifications to the existing PDL, through the notification letter signed by DSS Commissioner Starkowski, the Department officially joined TOP\$ on September 16, 2010.

Pharmacy Purchasing Options

The committee identified two viable options for achieving substantial state savings in pharmacy purchasing.

Bulk Purchasing

State employee and retiree pharmacy programs administered through the State Comptroller's Office aggregate the purchase of pharmaceuticals through a Pharmaceutical Benefits Manager (PBM) contract with Caremark. If the participating state agencies execute a contract with a PBM, similar to that currently utilized by the state comptroller's office, they can aggregate and negotiate the purchase of pharmaceuticals across all agencies and several state programs, thereby achieving substantial savings to the state through a reduction in reimbursement to pharmacies.

In order to achieve this, DSS and the other retail purchasing state agencies could be required to join the state's existing prescription drug program administered by the Comptroller for the state employee and retiree prescription drug plan. Specifically, these programs would be included under the existing Caremark PBM, which would allow the State to receive greater pharmacy product discounts, reduce dispensing fees, allow for national network coverage, and enable DSS to continue to receive federal and supplemental rebates.

A financial analysis was conducted in order to determine the impact of moving DSS programs under the state employee/retiree prescription drug plan administered by Caremark on behalf of the Comptroller. The State Comptroller's Office requested basic claims information from the Department of Social Services in order to have its actuarial consultant, Milliman, conduct an analysis. DSS provided current reimbursement methodologies, current dispensing fee, total pharmacy expenditures, and total scripts filled, in order for Milliman to project potential savings from joining the Caremark PBM. Based on existing terms included in the Caremark contract with the Comptroller's Office, Milliman concluded that potential annual savings in the area of **\$70 million** could be achieved. These potential savings are based on deeper pharmacy reimbursement

discounts and a lower dispensing fee, as compared to the existing DSS reimbursement rates.

As stated previously, the committee met with three national PBAs that administer purchasing pools and carefully considered the option of joining one of those pools. However, in our meetings, the three national PBAs expressed their concerns and identified potential problems that might occur by joining one of their purchasing pools. These state purchasing coalitions are primarily Medicaid-based and thus provide a limited network and only include pharmacies located in the states represented in the coalition. This could pose a problem for Connecticut given the significant numbers of state retirees who relocate to other states, as this creates a need for the State employee and retiree pharmacy purchasing to have access to a seamless national network of retail pharmacies.

Another challenge posed by joining one of the three national PBAs stems from the fact that Medicaid plans are eligible for both federally negotiated rebates and coalition negotiated supplemental rebates from the drug manufacturers that the employee and retiree plans are not eligible to receive. While rebates are required for federal programs and some state administered programs such as ConnPACE, no mechanism presently exists for the employee and retiree plans to receive rebates.

Given the concerns raised by the national PBAs, the committee determined that it would not recommend joining a multi state PBA. In lieu of this alternative, if the legislature's intent is to obtain the maximum savings, it can consider having all state agencies join the existing prescription drug program administered by the Comptroller for the state employee and retiree prescription drug plan (Caremark) or statutorily change the reimbursement rates paid by state agencies to pharmacies.

Contracting with Caremark for this purpose poses its own set of challenges, some of which were raised by CMS, with whom the committee also consulted as part of this process. The following concerns with regard to contracting with Caremark were raised:

- This would in effect be a "sole source" contract which would require the approval of the Office of Policy and Management.
- "Sole sourcing" could add additional costs to the contract with Caremark.
- Caremark is affiliated with CVS which could create the perception that CVS would be the only network pharmacy, which in reality, would not be the case.
- CMS advised that if we did merge all programs under Caremark, they would be required to maintain the state employees/retirees separate and distinct from the programs administered by DSS for purposes of claims adjudication/drug rebate processing.
- Caremark would need real time access to client eligibility for point of sale processing of pharmacy claims. This would be burdensome and costly and require interfacing with DSS' fiscal intermediary Hewlett Packard (HP).
- For federal claiming purposes, it may be necessary for claims to be adjudicated through the Medicaid Management Information System (MMIS); meaning that

Caremark may have to establish a distinct interface with their system, participating pharmacies and the DSS HP MMIS.

- At a minimum, for rebate purposes, claims must be passed through the Medicaid Management Information System (MMIS); meaning that Caremark would adjudicate the claim and would need to set up an interface with HP to pass along the claims for rebate purposes. While DSS has not costed out the individual interfaces required and the systems changes necessary to meet the federal reporting/claiming requirements, it should be noted that determining the specifications for these automated system enhancements, developing these enhancements and implementing these enhancements would require funding, staff resources and time.

Adjust DSS' Reimbursement Rates

Given the challenges presented by aggregating all state pharmaceutical purchasing under Caremark, CMS advised the committee that making adjustments to our existing state statutes and state plan to mirror the rates of the state employee and retiree program would be a more efficient and less burdensome way to achieve savings.

Thus, another option that could be considered by the legislature to achieve significant savings in pharmacy purchasing, is to adjust DSS' reimbursement rates in statute to mirror the reimbursement rates paid on behalf of state employees. Should the legislature direct DSS to adjust its reimbursement rates to align with those of paid on behalf of participating state employees, DSS could achieve savings in the range of the Milliman projections.

As stated above, CMS informed the department that were we to aggregate all state pharmaceutical purchasing under Caremark, the implementation of rebate invoicing/collection would require that pharmacy claims be passed through the Medicaid Management Information System (MMIS). If pharmacy claims were no longer processed and adjudicated through our current claims processor, HP, an interface would need to be established between the PBM and the MMIS (HP). As stated above, this would require funding, staff resources and time for the significant programming that would be required to implement such an interface.

In addition, CMS pointed out that DSS obtains savings not only from rebates, but also from reduced reimbursements to pharmacies. In Connecticut, the discounts received from local pharmacies are set either by statute or by negotiation at the state or coalition level. For the State employee and retiree plan, the prescription drug discounts are established through competitive bidding among the largest Pharmacy Benefit Managers in the nation. In Connecticut, the State employee and retiree prescription drug purchasing discounts with Caremark are currently substantially greater than the discounts established by statute for programs administered by the Department of Social Services.

Accordingly, adjustment of DSS' rates without involvement of a PBM is in line with CMS' advice and addresses the concerns they raised with regard to bulk purchasing.

An amendment to our existing state statutes and Medicaid state plan would be required to implement reimbursement rate changes.

Either the bulk purchasing option through a pharmacy benefit administrator or the reimbursement rate adjustment through a statutory change option has the potential for significant savings, achieved, in both cases, through the adjustment of pharmacy reimbursement rates. A decision on the appropriate course of action to pursue to achieve the savings now lies with the legislature. Only with the proper statutory authority can the participating agencies amend existing contracts and achieve anticipated savings. Should the legislature choose to merge all pharmacy purchasing under Caremark, sole-sourcing authorization would also be required from the Office of Policy and Management before we could move forward with implementation.

With either option, the savings identified will significantly reduce reimbursement rates to participating chain and local pharmacies. With either option, we estimate that savings can begin to be achieved within the first quarter after implementation.

Additional Savings Opportunities

After holding meetings with representatives from various other state agencies that provide/ dispense/pay for pharmaceuticals for individuals they serve, the committee has identified other opportunities for savings that may be available and should be pursued. Unlike DSS and the State Comptrollers Office, the prescription drugs prescribed for the individuals served by these agencies are not dispensed in the retail pharmacy setting. Rather, there are two distinct arrangements under which these agencies purchase pharmaceuticals.

First, several agencies purchase and dispense medications to patients while they are in an inpatient setting. These agencies also purchase and dispense medications for patients receiving outpatient services in their clinics, such as chemotherapy treatments.

The second purchasing arrangement is through a contract with a wholesaler, Cardinal Health. For instance, John Dempsey Hospital purchases the majority of its medications through this wholesaler. The hospital receives a discounted price due to the large volume of their purchases. Most of the contracts for the pharmaceuticals that are purchased are negotiated through the Novations group purchasing organization. Novations group represents 40% of the staffed hospital beds in the country. With this arrangement, there are millions in savings to the hospital through the Cardinal contract.

The following state facilities with pharmacies are included in the Cardinal contract – Connecticut Valley Hospital, Blue Hills Hospital (orders separately but is now under Connecticut Valley Hospital); Southwest Mental Health Systems (which includes Bridgeport Mental Health Hospital and FS DuBois Center); Capitol Region Mental Health Center; CT Mental Health Center; Department of Public Health; UCONN

Infirmary; John Dempsey Hospital and Correctional Managed Health Care. The Department of Mental Health and Addiction Services (DMHAS) and Department of Public Health (DPH) also benefit from the savings that John Dempsey Hospital receives through their contract with Cardinal Health/Novations. Memorandums of Understanding (MOUs) have been in place between those agencies and UConn Health Center (UCHC) since 2004 enabling those agencies to reap the same discounts/savings.

Additionally, in April 2009, John Dempsey Hospital qualified for 340b status. Hospitals with 340b status are able to purchase medications for their outpatients at highly discounted prices. In order to receive these 340b discounts, the individual must be a patient of a physician on the John Dempsey staff. Since qualifying for 340b status, the state has realized savings of approximately \$3.4 million; \$2.4 million by John Dempsey Hospital and \$1 million by the Correction Managed Health Care (for prison inmates).

A financial benefit may be gained by agencies that purchase pharmaceuticals from non-retail sources to join forces by joining the Novation group purchasing organization or a similar entity. The committee and representatives from these agencies will continue to meet to discuss and pursue any further opportunities that may be available to them.

Conclusion

This report presents one provision that has been completed by the Department of Social Services and two options available for consideration that would achieve significant savings in the purchase of pharmaceuticals for state programs.

- Multi-State Purchasing Pool - In a letter dated September 16, 2010, from Commissioner Starkowski to Provider Synergies, the State of Connecticut approved the implementation of Connecticut's Medicaid Preferred Drug List and Supplemental Rebate Programs into Provider Synergies Multi-State PDL Initiative, TOP\$SM - The Optimal PDL SolutionSM. The anticipated savings associated with joining TOP\$ is approximately **\$6 to \$7 million** annually.

The following two options would result in estimated savings of approximately \$70 million each. While only one can be selected, we present them to the legislature for further review and consideration. It should be noted that in choosing either option, the legislature should take into consideration the impact that it will have on the participating pharmacies.

- Bulk Purchasing - State employee and retiree pharmacy programs administered through the State Comptroller's Office aggregate the purchase of pharmaceuticals through a Pharmaceutical Benefits Manager (PBM) contract with Caremark. If the Comptroller's Office executes a contract amendment with Caremark to include DSS through their existing contract or if DSS enters into a contract with another PBM, similar to the Caremark contract terms, they can achieve substantial savings to the state through a significant reduction in reimbursement to

pharmacies. Milliman concluded that potential annual savings in the area of **\$70 million** could be achieved in DSS. With potentially other state agencies participating, greater savings could be achieved.

- Adjust DSS' reimbursement Rates - Adjust DSS' reimbursement rates in statute to mirror the reimbursement rates paid on behalf of state employees (in line with the terms of the Caremark contract). Savings could be achieved in the range of **\$70 million in DSS**.

With the release of this report, the committee has fulfilled its obligations under PA 09-206 and awaits the legislature's action. Department representatives are available to discuss the report and answer any questions you may have.

Bulk Purchasing Report Attachment

State Agency	Total # of Scripts	Total Expenditures	Reimbursement Methodology	Brief Descriptive Overview of Program
DSS	8,984,216	\$599,480,082.85	For Brand Drugs: AWP-14% For Generic Drugs: AWP-50% Dispensing Fee: \$2.90	Provides outpatient prescription drug coverage managed internally by the Dept. for all CT Medical Assistance Programs (Medicaid fee-for-service, HUSKY A/B, ConnPACE, CADAP, and Charter Oak. Current reimbursement is AWP-14% for brand drugs and AWP-50% for generics with \$2.90 dispensing fee. We receive federal and supplemental rebate from manufacturers. The supplemental rebate is received from those manufacturer's whose drugs are on our Preferred Drug List. Last year we received \$188 million in federal plus supplemental rebate. Cost saving controls currently in place include prospective and retrospective drug utilization review, a preferred drug list, prior authorization for brand medically necessary, early refill, preferred drug list, optimal dose, and certain high cost drugs.
DCF	12,947	\$849,339.09	For Brand Drugs: AWP-20% For Generic Drugs: AWP-50% Dispensing Fee: \$2.75	DCF Riverview Hospital purchases prescription drugs as well as frequently used over the counter medications through an outside pharmacy via a DAS Purchasing contract (09PSX0052) as awarded through the state competitive bidding process. Riverview Hospital does not have an in-house Pharmacy. The contracted pharmacy adheres to all Hospital rules/regulations and the Medication Management standards of the Joint Commission. A registered consultant pharmacist provides oversight and supervision of the pharmacy services and the prescribing practices of the hospitals LIP's The pharmacy services are available to the hospital 24/7/365 year. All other DCF service recipients are on HUSKY A/B.
UCONN/John Dempsey	N/A	\$14,266,381	Reimbursement for hospital services varies widely by payor, for example, Medicare pays for inpatient hospitalization based on a DRG amount, HMO's may pay a per diem or case rate amount for similar services. For outpatient services, Medicare will pay a set	JDH purchases and dispenses medications for inpatient use and for patients receiving treatment at UCHC outpatient clinics (ie. chemotherapy treatments). The JDH Pharmacy does not purchase pharmaceuticals for patients to be administered in the home setting. JDH has a contract with Cardinal Health Wholesale to provide the vast majority of medications for the hospital and CMHC inmate population. In addition, the UCHC contract pricing is available to DMHAS, DPH and the UConn Infirmary. Contracting services are provided by "Novation" through the University Health Consortium. JDH qualifies for 340B pricing enabling the Hospital to purchase medications for outpatients at highly discounted prices.

Bulk Purchasing Report Attachment

DMHAS	<p>Annual Inpatient Pharmacy Orders - CRMHC: 14,534 CVH: 150,432</p> <p>Annual Outpatient Scripts - CRMHC: 4,313 CMHC: 10,381</p>	<p>CY09 \$8,269,953.16</p>	N/A	<p>Drugs for DMHAS clients (inpatient and some outpatient) at the four large facilities CVH (Blue Hills Hospital), CMHC, CRMHC and SWMHS are paid through the UCHC/DPH/DMHAS agreement with Cardinal/Novation. Some DMHAS outpatient clients at our three small facilities (RVS, SMHA, WCMHN) use a retail pharmacy. retail pharmacy is told to bill either Medicaid or Part D Medicare where applicable. outpatient client does not have an entitlement, DMHAS pays the retail pharmacy through a DAS contract or a Purchase Order. DMHAS expenditures have decreased SFY10 over SFY09 due to increased use of generic drugs, increase in client entitlements and the closing of Cedarcrest Hospital.</p>
DDS	N/A	N/A	N/A	<p>During the period noted above, DDS did not incur any prescription drug costs since DDS clients receive Title XIX benefits which covers the cost of their prescriptions. clients receive their drugs via pharmacy delivery on a regular and STAT basis. As of June, 2010, we have been informed that certain food supplements that were previously covered by Title XIX will no longer be covered, which will result in DDS purchasing those types of pharmaceuticals utilizing DDS funds. At this time, we do not know the overall impact on the DDS budget.</p>
DOC	<p>CMHC pharmacy estimates 24,000 prescriptions for discharge and Half way house patients annually in addition to filling 100% of the orders for the inmate population</p>	\$13,700,828	<p>CMHC does not bill any 3rd party payors. The MOA between UCONN CMHC and DOC explains the invoice reimbursement</p>	<p>CMHC pharmacy participates in the Cardinal Health contract with JDH and uses the same pharmacy group purchasing organization for contract management. CMHC pharmacy accesses 340b pricing for JDH outpatient inmates as a child account linked to the JDH DSH qualified 340B account with Cardinal Health. CMHC provides prescription services for the inmates in the custody of the Department of Correction housed in jails, prisons, halfway houses and a 2 week discharge program. CMHC pharmacy manages a state wide formulary and participates in both medical and mental health pharmacy and therapeutics committees overseeing the formulary. CMHC pharmacy packages all solid oral dosage forms in a tamper evident packaging to ensure for maximum recovery of discontinued prescription orders and maximizing savings on the dispensing of these recovered medications. No employee or non inmate prescriptions are filled by the CMHC pharmacy.</p>

Bulk Purchasing Report Attachment

State employee and retiree program	3,540,000	\$315,000,000	For Brand Drugs: AWP-18.5% For Generic Drugs: AWP-68% Dispensing Fee: \$1.50	OSC contracts with a PBM (Caremark) for prescription drugs through retail pharmacies nationwide, specialty pharmacy, and mail order. Hospital, physician and other institutionally dispensed drugs are paid by the medical plan. Caremark contracts directly with the retail and specialty pharmacy groups and pays claims directly to those groups. OSC is invoiced twice per month for claims. Manufacturer's rebates are processed through Caremark and are allocated to each script filled.
DPH	1,000,000	\$8,895,843	none...all 340b pricing	DPH provides pediatric vaccines to health care providers at no cost. Providers can not bill insurance or patients for the vaccine but can bill DSS up to \$21.00 for administration. DPH also provides medication to TB patients that are unable to pay and do not have health insurance. ALL medications that DPH provides are free to clinics/hospitals/providers.

APPENDIX P

Long-Term Care “Rebalancing” Opportunities abound!

Presentation before the
Commission on
Enhancing Agency Outcomes

August 11, 2010

By: Julia Evans Starr
Executive Director
CT Commission on Aging



CoA: *Turning Research
into Action*



CT Commission on Aging *Nonpartisan, objective, results-oriented*

- Created in 1993
- CT General Statutes 17b-420
- Statute modified in 2009 to embed RBA (PA 09-7)
- Independent, citizen-driven
- Part of the Legislative Branch of Government

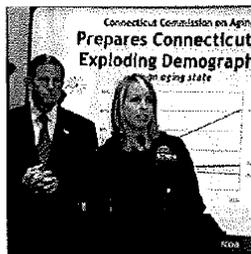


CoA Mission

*prepares the state for an aging population,
serves as an objective, credible source of
information on issues affecting older adults of
today and tomorrow, and provides accountability
within state government.*

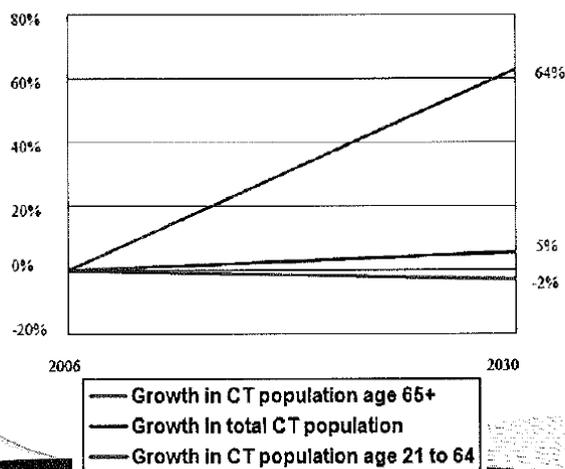
Graying Demographics In Connecticut

- The 7th Oldest State in the Nation
(New Census 3rd oldest for non-Hispanic whites)
- 600,000 People Age 60 or Older
- One Million Baby Boomers:
Nearly 1/3 of CT's Total Population
- From 2006 to 2030: 65+ population will increase by 64%



Press Conference: National Falls Prevention Awareness Day

Graying Demographics



Unprecedented Longevity

- In the early 1900's life expectancy was 47 years of age
- Flash forward to now, life expectancy has increased by 30 years
- 800 people in CT lived to be Centenarians (2000 census)
 - Roughly 664 of those were women
- A new term for age is generated -
 - "Super-Centenarians"



Ms. Emma Tillman

The Impact of an Aging and Long-lived
Demographic on Local, State and
National Government

Is Tremendous!

LTC Expenditures

The Need for Action

LTC Medicaid Expenditures (\$2.4 Billion)

set to more than double by 2025 (without action)

- 13% of the overall state budget.
- 49% of the entire DSS budget.
- 53% of the Medicaid budget.

Research and Planning

The CGA mandated and funded the Long-Term Care Needs Assessment (PA 06-188) 32 legislative co-sponsors of the original bill / in consultation with the CT Commission on Aging, the LTC Advisory Council, and the LTC Planning Committee.

LTC Needs Assessment conducted by UConn Health Center, Center on Aging. *"The most comprehensive study conducted in any state."*



Photo by Felix Plans

State LTC Plan developed every three years by the LTC Planning Committee (state agencies) and the LTC Advisory Council (consumers, providers, and advocates). Most recent plan submitted in January 2010.

LTC: The Modern Definition

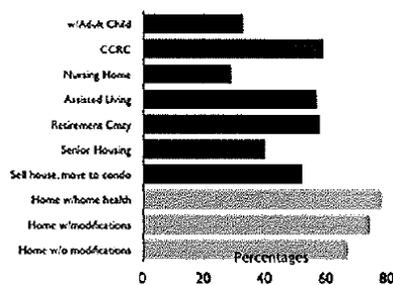


- Not Just Nursing Homes
- Not Just Insurance
- Not just for older adults

The entire range of assistance, services, or devices provided over an extended period of time to meet medical, personal, and social needs in a variety of settings and locations.

LTC: Knows no Age or Disability Boundary!

Connecticut's Residents Want to Stay in Their Homes & Communities



- 80% of people want to stay in their homes (and communities)
- Living with an adult child is just slightly more appealing than moving to a nursing home

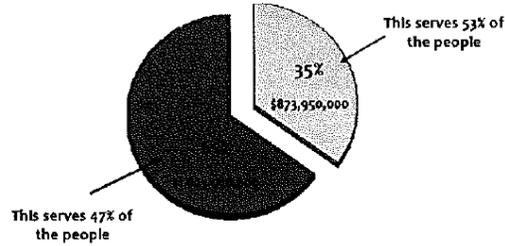
Source: LTC Needs Assessment

CT Medicaid LTC Expenditures HCBS & Institutional Care

Percent of Medicaid LTC Dollars - FY 2009

⊗ Medicaid HCBS Expenditures

● Medicaid Institutional Care Expenditures



CT Ranks 34th in HCBS Spending

Percent of Medicaid LTC Spending for HCBS
FY 2007

State	Percent	U.S. Rank
U.S.	41.7	
New Mexico	72.9	1
Oregon	72.7	2
Arizona	64.0	3
Maine	51.4	11
New York	47.4	12
Rhode Island	45.6	14
New Hampshire	39.6	25
Massachusetts	38.7	28
Connecticut	35.5	34
Pennsylvania	28.3	48
North Dakota	25.6	49
Mississippi	12.7	50

Source: Brian Burwell et al; Medicaid LTC Expenditures FY 2007; September 2008

Long-Term Care Reform or “Rebalancing”

Changing the focus and funding priorities to home and community-based supports.

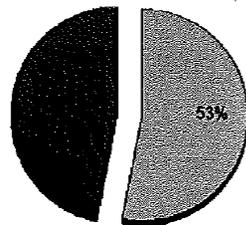
- *CT would spend \$600 - 900 million less every year - with a more progressive system.
- honors individuals’ rights and their desires - 80% of CT residents want to age in their homes & communities
- is consistent with the ADA, the US Supreme Court Olmstead Decision and Connecticut law (PA 05-14)
people have the right to choose and receive care in the least restrictive environment.
- is consistent with national trends/policy directions
- Problem: Medicaid rules require states to pay for nursing home care while home and community-based services are “optional”

Sources: LTC Needs Assessment & CT LTC Plan 2010

% of People in CT Receiving Medicaid LTC HCBS vs. Institutional Care

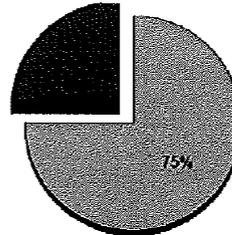
FY 2009

- ◉ Home and Community-Based Services (HCBS)
- Institutional Care



CT Rebalancing Goals by 2025

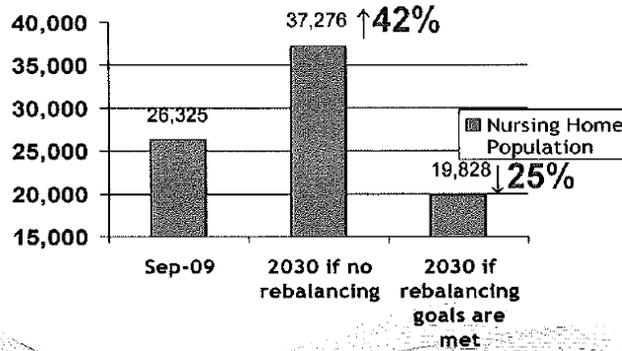
- ◉ Home and Community-Based Services (HCBS)
- Institutional Care



Sources: LTC Plan & LTC Needs Assessment

Nursing Home Projections for 2030

The need for nursing home beds in the future is dependent upon policy decisions made both federally and in our state.



Source: UConn Health Care Center, Center on Aging, August 2010

Money Follows the Person

MFP: A multi-million dollar demonstration grant from the federal *government...rebalancing in action.*

255 persons transitioned from 96 different nursing homes.

- The highest number of persons transitioned from any single nh was 11.
- 60% people under the age of 65.

1356 applications received, representing residents in 170 different skilled nursing facilities

CoA: Helps bridge the gap between Executive and Legislative Branch / Chairs the MFP Steering Cmte. / Chairs and manages the Workforce Subcommittee: developing a strategic plan with a goal of 9,000+ HCBS jobs within the next 5 years.

Guiding Principles Long-Term Care Needs Assessment

Guiding Principles: Create parity among age groups, across disabilities, and among programs through allocating funds equitably among people based on their level of need rather than on their age or type of disability.

Break down silos that exist within and among state agencies and programs. Use the model of systems change grants such as the Money Follows the Person Grant and the Medicaid Infrastructure Grant to foster integration of services and supports.

LTC Needs Assessment Recommendations

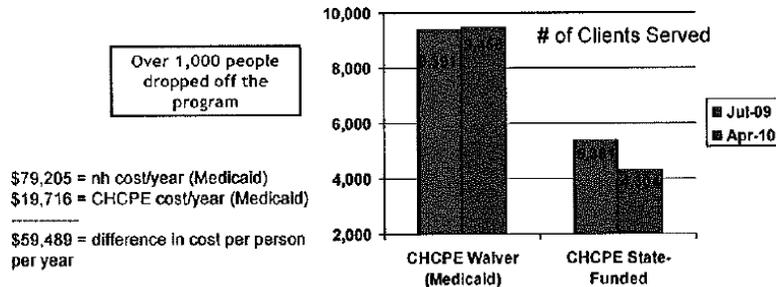
1. Create a single point of entry or no wrong door.
2. Provide a broader range of community-based choices.
3. Foster flexibility in home care delivery.
4. Address scope and quality of institutional care.
5. Provide true consumer choice and self-direction to all LTC users.
6. Simplify CT's Medicaid structure.
7. Create greater integration of functions at the state level and consider alternative configurations of state government structure. Establish a consolidated, efficient all ages human services approach to LTC in CT.

LTC Needs Assessment Recommendations

8. Address education and information needs of the CT public.
9. Increase availability of ready accessible, affordable transportation (and housing).
10. Address LTC needs of persons with mental health disabilities.
11. Address access and reimbursement for key Medicaid services.
12. Expand and improve vocational rehabilitation for persons w/ disabilities.
13. Address the LTC workforce shortage.
14. Provide support to informal caregivers.
15. Continue to expand efforts to build data capacity and systems integration in the service of better management and client service.

Build HCBS Implications of Policy Decisions

CT Home Care Program for Elders



Over 1,000 people dropped off the program

\$79,205 = nh cost/year (Medicaid)
 \$19,716 = CHCPE cost/year (Medicaid)
 \$59,489 = difference in cost per person per year

Beginning January, 2010, as a result of PA 09-5, a 15% cost-share was required for CHCPE state-funded clients. (Effective July 2010 it was reduced to 6% based on PA 10-179).

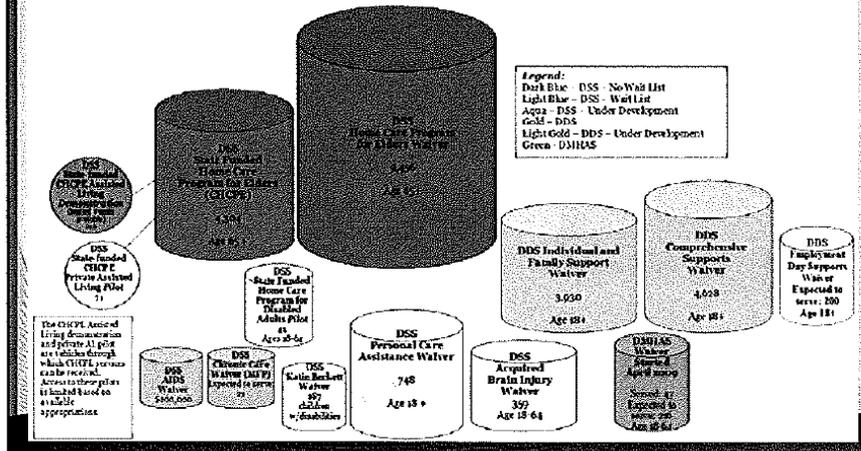
If one estimates that 15% of those that dropped off the (state-funded) CHCPE entered nursing homes, the cost to the state is approximately \$9.6 million more than if they had continued on the CHCPE. *Note: OFA estimated 15% cost-share would save \$10 million.*

Chart source: DSS, July 2009, & April 2010 CHCPE Monthly Report

Break Down the Silos

Streamline the Home and Community-Based System

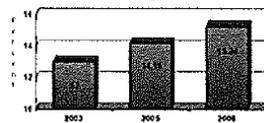
To utilize Medicaid to pay for HCBs, you must fit into one of these narrowly defined waivers (or related state-funded pilots)
National experts say "CT has too many waivers."



Target areas ripe for improvement & cost savings

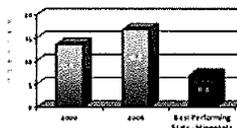
featured in CoA's Results-Based Accountability Report to the Legislature (PA 09-7)

Percent of all hospital discharges to nursing homes vs. home settings



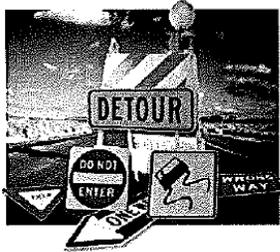
Story Behind the Baseline: 15% of people leaving hospitals in 2008 were discharged into institutions instead of a home setting, a trend that has increased over the years. Data show that 66% of individuals on Medicaid who enter nursing homes are still there after six months. Additionally, discharge placements vary widely depending on the hospital.

Percent of long-stay nursing home residents with a hospital admission



Story Behind the Baseline: In 2006, almost 17% of nursing home residents in CT had to be hospitalized for a health condition, leading to disruption, decreased quality of life and increased costs. Unfortunately, CT is headed in the wrong direction—with a 22% increase this data point from 2000. If CT performed at the level of the best-performing state (MN), it would have increased quality of care and saved an estimated \$17 million.

Major Roadblocks to Reform



Complexity / Turf
Fragmented system / Avoidance
Interest Group Lobby
Gaps in Services
Confusion / Fear Factor
Limited Choices / Personal Cost
Two Year Election Cycle
Adult Children's Expectations

Potential Motivators

- Commission on Enhancing Agency Outcomes
- The movement to streamline state systems
- Opportunities for LTC Reform contained in Affordable Care Act
- New state leadership at the very top
- Elevated interest by the business community
CT Regional Institute for the 21st Century & CBIA
- Movement to maximize state and federal \$\$
- RBA
- The economy



21st Century
Presser



Co/ALTCAC Affordable Care Act Forum

CT Commission on Aging Fact Sheet

Money Follows the Person (MFP): The Whole Picture!

MFP is a 56 million dollar federal demonstration grant, received by the CT Department of Social Services, that is intended to rebalance the long-term care system so that individuals have the maximum independence and freedom of choice where they live and receive services.

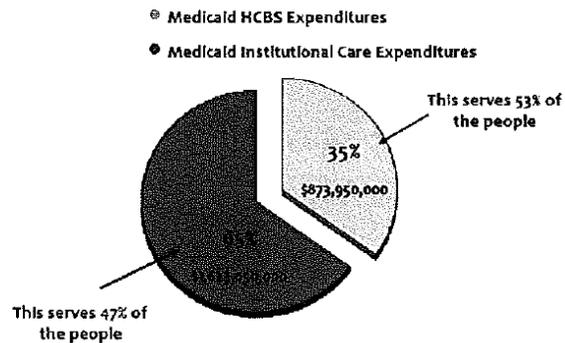


MFP is a systems change project aimed at rebalancing the long-term care system. While very important, transitioning 890 (up to 5,000) people with disabilities and older adults out of nursing homes and back into the community is only one of five major goals of MFP.

Five Major Goals (benchmarks) of MFP:

- Increase dollars spent on home and community based services.** *This increase will help ensure that community-based options are available to help all people, not just MFP participants.*
- Increase the number of people living in community:** Increase the percentage of people receiving long-term care services in the community relative to the number of persons in institutions.
- Increase hospital discharges to community:** Decrease the number of hospital discharges to nursing facilities among those requiring care after discharge. *Data available through MFP shows that people who are Medicaid eligible have a high likelihood of never being able to leave an institution once discharged from a hospital.*
- Increase the probability of returning to the community:** Increase the probability of people returning to the community within the first six months of admission to an institution.
- Transition people from institutions to the community:** Transition 890 (up to 5,000) individuals out of institutions back into the community. 60% of those transitioned will be younger persons with disabilities, 40% will be people over the age of 65+.

Percent of Medicaid LTC Dollars - FY 2009



Major Systems Change Initiatives: The MFP steering committee and staff are working on major systems change initiatives that will help the project meet its benchmarks. These initiatives include:

- **Workforce Development** (CoA serves as chair) – developing a strategic plan to address the home and community-based workforce shortage. MFP will begin implementing low-cost activities based on the plan;
- **Hospital Discharge Planning** – training and piloting nursing home diversion activities with hospital discharge planners;
- **Quality Improvement** – creating emergency back-up systems for MFP participants. In addition to providing proper emergency back-up services, data collected through this system will be used to identify and address challenges of community living;
- **Housing** – working with other state agencies to increase the amount of available accessible housing.

**For more information, please contact the Connecticut Commission on Aging, at 860-240-5200.
The CoA's Executive Director serves as co-chair of the MFP steering committee.**

May 7, 2010

Facts about Connecticut Nursing Homes (August, 2010)



General Statistics

- There are 240 nursing homes, also known as “skilled nursing facilities” in the State of Connecticut. The break-down is as follows¹:

	For Profit	Not for Profit	Total
Unionized Staff	71	12	83
Nonunionized staff	114	43	157
Total	185	55	240

- As of 9/30/09, there were 26,325 nursing home residents in Connecticut.²
- As of 9/30/09, there were 28,994 nursing home beds in our state, with an average occupancy rate of 91%. This occupancy rate varies by region: Windham County has the highest average occupancy rate (95%), while Hartford, Middlesex and New London counties' occupancy rate is 90%.³
- Age of residents: 12% under the age of 65, 39% between 65 and 84, 49% aged 85+.³
- Payment source: 69% are covered by Medicaid, 16% by Medicare, 11% by private “out of pocket” funds and the remainder by private insurance or the VA.³
- Average Medicaid rate per day: \$217 (~\$79,205 annually) in FY ‘09.⁴ The state spends \$1.3 billion in Medicaid funds on nursing home care annually.
- Average Private Pay rate per day: \$341 (~\$124,000 annually)³

Oversight

- Skilled nursing facilities are licensed by the state Department of Public Health, which conducts inspections at least once per year.
- The federal Center for Medicare and Medicaid Services (CMS) also certifies nursing homes for both Medicare and Medicaid.
- Medicaid rates are determined by the state Department of Social Services.
- The state Long-Term Care Ombudsman Program protects the health, safety, welfare and rights of long-term care residents. The office investigates complaints and concerns made by residents, or on behalf of residents, in a timely and prompt manner and helps residents voice their concerns directly to public officials on issues affecting their lives.

¹ Deborah Chernoff, SEIU 1199

² 2010 State of Connecticut Long-Term Care Plan.

³ State of Connecticut Annual Nursing Facility Census (September 30, 2009)

⁴ Presentation by Commissioner Michael Starkowski (October, 2009)

CT Commission on Aging Fact Sheet

Trends

- Number of beds: declined by 3% since 2004³
- Number of residents: decreased by 5.3% since 2004³
- Resident demographics: Gender split has remained consistent. However, since 1999, age has trended downward: the number of residents aged 55-64 has increased by 49%, while the number of residents aged 75-84 has decreased by 24%.³
- Occupancy rate: decreased for all eight counties over the past five years³
- For-profit status: 3% more facilities are for-profit than were five years ago³

Financial Distress

- In the past several years, nursing homes have faced increasing financial difficulties, leading to bankruptcies, closures and uncertainty. Six nursing homes have closed across the state since September, 2008.
- DSS must approve all closures. Courtland Gardens (in Stamford) was recently denied its application to close.

Projected Need

- There is currently a moratorium on new nursing home beds.
- The need for nursing home beds in the future is dependent upon policy decisions made both federally and in our state.

New projections from the University of Connecticut Health Center, Center on Aging demonstrate huge shifts in nursing home population based on the percentage of individuals receiving long-term care in home-care settings vs. nursing home settings.

Currently, 53% of individuals receiving long-term care through Medicaid receive home- and community-based care, while 47% receive care in nursing homes. Connecticut's goal, articulated in the 2010 Long-Term Care Plan, is to "rebalance" the system so that, by 2025, 75% of individuals receive care in the community, while 25% are in nursing homes.

Their projections, based on a number of assumptions, are:

Nursing Home Population in CT (9/30/09)	Projected NH Population in 2030 WITH NO REBALANCING	Projected NH Population in 2030 IF REBALANCING GOALS ARE MET
26,325	37,276 (increase of 42% from 9/30/09)	19,828 (decrease of 25% from 9/30/09)

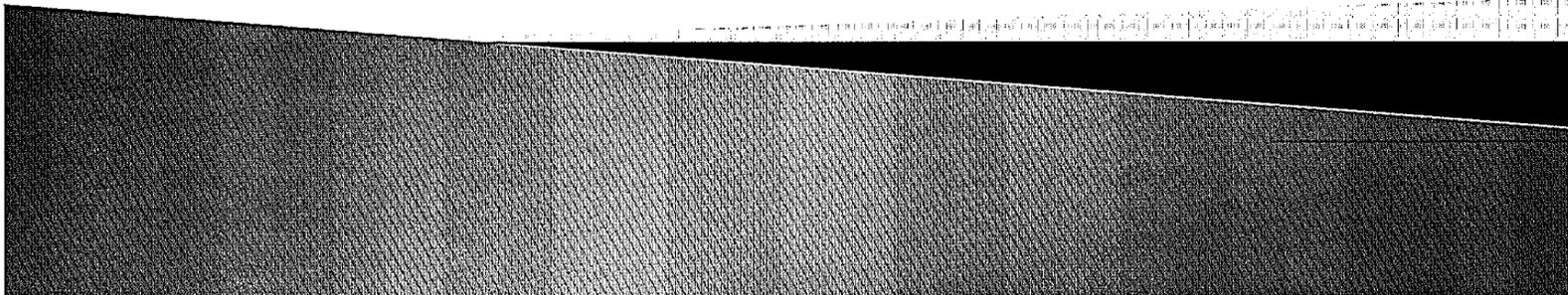
Presentation for

Connecticut Regional Institute for the 21st Century

Assessment of Connecticut's Long-Term Care System March 8, 2010

BlumShapiro

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Contents

- ▶ Project Background and Approach
- ▶ Definition of Long-Term Care
- ▶ Long-Term Care Challenges
- ▶ Rebalancing the System
- ▶ Connecticut's Long-Term Care System
- ▶ Recommendations and Goals
- ▶ Examples of Other States
- ▶ Appendixes

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Background

The Connecticut Regional Institute for the 21st Century (CRI) has conducted research on a number of important state public policy issues and published results to provide information and recommendations that generate discussion and action that enhance the state's overall competitiveness.

CRI retained BlumShapiro to report on the long-term care system in the State of Connecticut. As agreed upon with CRI, BlumShapiro has followed the approach described on the next page and is pleased to provide this report as a result of our work.

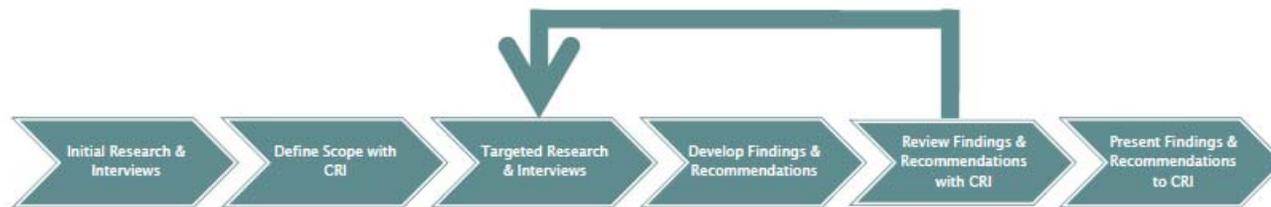
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Approach



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BlumShapiro performed extensive research of existing studies and work performed on long-term care. This research was validated by performing interviews with as many key long-term care stakeholders that agreed to be interviewed. The interviews provided a better understanding of the many different stakeholders and perspectives that effect the long-term care system in Connecticut. This research was used to develop findings and recommendations that could be used to improve the long-term care system in Connecticut.



Referenced Literature

BlumShapiro reviewed an extensive set of literature to perform this assessment. Below are the major works we reference in this report. The list of research literature evaluated by Blum Shapiro is long and extensive and located at the end of this document.

- ▶ Connecticut Long Term Care Advisory Council, *Legislative Update*, February 5, 2010.
- ▶ Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010.
- ▶ University of Connecticut Health Center’s Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007.
- ▶ University of Connecticut Health Center’s Center on Aging, *Long Term Care Needs Assessment Legislative Briefing – Follow-up to Questions Asked*, January 16, 2008.
- ▶ Connecticut Department of Social Services, *Money Follows the Person Rebalancing Demonstration Legislative Status Update*, October 2009.
- ▶ Source: Connecticut Commission on Aging, *Break Down the Silos – Streamline the Home & Community Based System*, December 9, 2009.
- ▶ Washington State Department of Social and Health Services, *Fact Sheet – A Successful Vision*, December 2009
<http://www.aasa.dshs.wa.gov/about/factsheets/default.asp>
- ▶ AARP Public Policy Institute, *A Balancing Act: State Long-Term Care Reform*, July 2008, Oregon.
- ▶ AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.



Interviews

- ▶ David Guttchen, Chair of Connecticut LTC Planning Committee, OPM
- ▶ Dr. Julie Robison, UCONN Health Center's Center on Aging
- ▶ Noreen Shugrue, UCONN Health Center's Center on Aging
- ▶ Julia Evans Starr, Executive Director, CT Commission on Aging
- ▶ Debra Polun, Legislative Director, CT Commission on Aging
- ▶ Mag Morelli, President, Connecticut Association of Not-for-profit For The Aging
- ▶ Matthew V. Barrett, Executive Vice-President, CT Association of Health Care Facilities
- ▶ Brian Ellsworth, President, CT Association for Home Care and Hospice
- ▶ Bill Cibes, Former Director of OPM
- ▶ Brenda Kelly, State Director, AARP
- ▶ Claudio Gualtieri, Program Coordinator, AARP
- ▶ Dawn Lambert, Money Follows the Person (MFP), CT Department of Social Services
- ▶ Marc Ryan, Former OPM
- ▶ Lorraine Aronson, Former CFO UCONN
- ▶ Senator Jonathan Harris, Public Health Committee



Long-term Care is Broad and Affects Everyone

- ▶ Long-term care (LTC) refers to a broad range of paid and unpaid supportive services for persons who need assistance due to a physical, cognitive or mental disability or condition. LTC consists largely of personal assistance with the routine tasks of life as well as additional activities necessary for living independently. Unlike medical care where the goal is to cure or control an illness, the goal of LTC is to allow an individual to attain and maintain the highest reasonable level of functioning in the course of everyday activities and to contribute to independent living.
- ▶ Long-term care will affect all of us at some point in our lives. Whether it is because we need services and support ourselves, or we are providing care for someone in need, regardless of age, health or wealth, it is unlikely that we will be able to escape the issue of LTC.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, page 2.

Providers of Long-term Care

- ▶ Informal/unpaid home and community care is the largest provider of long-term care.

Long-term Care in Connecticut in 2006

Providers	With state Medicaid	Without state Medicaid	Total Residents
Receiving care in nursing homes	18,700	9,000	27,700
Receiving care in the Community (formal/paid)	21,300	116,000	137,300
Receiving care in the Community (informal/unpaid)	N/A	200,000	200,000
Total	40,000	325,000	365,000

Source: Connecticut Long Term Care Advisory Council,
Legislative Update, February 5, 2010.

Providers of Long-term Care

▶ Families/Informal Caregivers

- Informal caregivers are family and friends who provide care without pay, and are the primary source of long-term care. There are an estimated 44 million informal caregivers in the United States. The importance of unpaid care provided by family and friends cannot be overemphasized, as it constitutes the backbone of the long-term care system. The total estimated annual economic value of unpaid care to people with disabilities age 18 and older in 2004 was \$306 billion. This figure exceeds public expenditures for formal health care (\$43 billion in 2004) and nursing home care (\$115 billion in 2004).

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 6.

▶ Formal Caregivers

- Defined as paid direct providers of LTC services in a home, community-based or institutional setting.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 7.

- Home and Community-Based Care (HCBS) encompasses home care, adult day care, respite, community housing options, transportation, personal assistants, assistive technology and employment services.
- Institutional Care includes nursing facilities, intermediate care facilities for people with mental retardation (ICF/MRs), psychiatric hospitals and chronic disease hospitals.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan - A Report to the General Assembly*, January 2010, pp 3.

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Sources of Long-term Care Financing

- ▶ Medicaid is the primary payer of LTC nationally and in Connecticut.
- ▶ Medicare does not generally pay for long-term care, with minor exceptions – it will pay for 100 days post-hospital discharge in a nursing home and for very limited home care services. Medicare coverage is focused on rehabilitation.

Top Financing Sources (US 2004)	Percent (%)
Medicaid	42%
Out-of-pocket by individuals	23%
Medicare	20%
Private insurance	9%
Other public sources	3%
All other	3%
Total	100%

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 13.

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Sources of Long-term Care Financing

- ▶ Historically, Medicaid did not pay for long term care in the community except by waiver, hence it is “institutionally biased”.
- ▶ Individuals paid for nearly one-quarter of long-term care costs in 2004, including direct payment of services as well as deductibles and co-payments for services primarily paid by another source.
- ▶ Over the past 10 years, the market for long-term care insurance has grown substantially. In 1990, slightly fewer than 2 million policies had been sold in the U.S. to individuals age 55 and older. By 2000, however, this figure had tripled and the number of policies sold either on an individual basis or through employer-sponsored group plans had increased to more than six million.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 13.



Connecticut Medicaid Expenditures are Significant

- ▶ In SFY 2009, the Connecticut Medicaid program spent \$2,498 million on long-term care. These Medicaid long-term care expenses account for 53% of all Medicaid spending and 13% of total expenditures for the State of Connecticut.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 37.

Connecticut Medicaid LTC Clients and Expenditures SFY 2009

	SFY 2009 Medicaid LTC Clients Monthly Average	SFY 2009 Medicaid LTC Expenditures (millions)
Community-based Care	21,275 (53%)	\$ 886 (35.5%)
Institutional Care	18,822 (47%)	\$1,612 (64.5%)
Total	40,097 (100%)	\$2,498 (100.0%)

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 45, Table 8

- ▶ These costs do not include private financing and informal care and other services and supports for adults with psychiatric disabilities funded by the Department of Mental Health and Addiction Services.
- ▶ This \$2,498 million is offset 50% by federal funds. The net cost of Medicaid LTC to Connecticut is about \$1,249 million.

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The Demand for Medicaid in Connecticut is Growing

- ▶ In Connecticut over the next 15 years (2010 to 2025), the total population is projected to increase 3%. Although this increase in population is modest there are 2 extraordinary trends:
 - The number of adults between the ages of 18 and 64 will actually decrease by 5%. These are the primary people who provide formal and informal care in the LTC system.
 - The number people over 65 years of age will increase by 40% (207,745), due to the aging of the baby boom generation.
- Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 42, Table 5.
- Projections of future demand for long-term care services based on population growth indicate that total demand for ages 40+ will increase by nearly 30% by 2030, with far higher percentage increases among the older age groups.
- Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 5.
- ▶ The increasing population of 65+ years of age residents and the reduction of the age group that can provide care will drive a significant increase in demand for LTC in Connecticut.

Medicaid Expenditures in Connecticut are Growing

Projections of Connecticut Medicaid Long-Term Care Expenditures by Current Client Ratios of Community and Institutional Care SFY 2009 and SFY 2025

	Current Client Ratio	2025 Expenditures with Current Client Ratio (millions)	Increase from 2009 to 2025 (millions)
Community-Based Care	53%	\$2,073	\$1,188
Institutional Care	47%	\$3,774	\$2,162
Total	100%	\$5,847	\$3,350

Note: Expenditure projections include 5% annual compound rate of increase.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 48, Table 11.

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The Current System is Out of Balance.

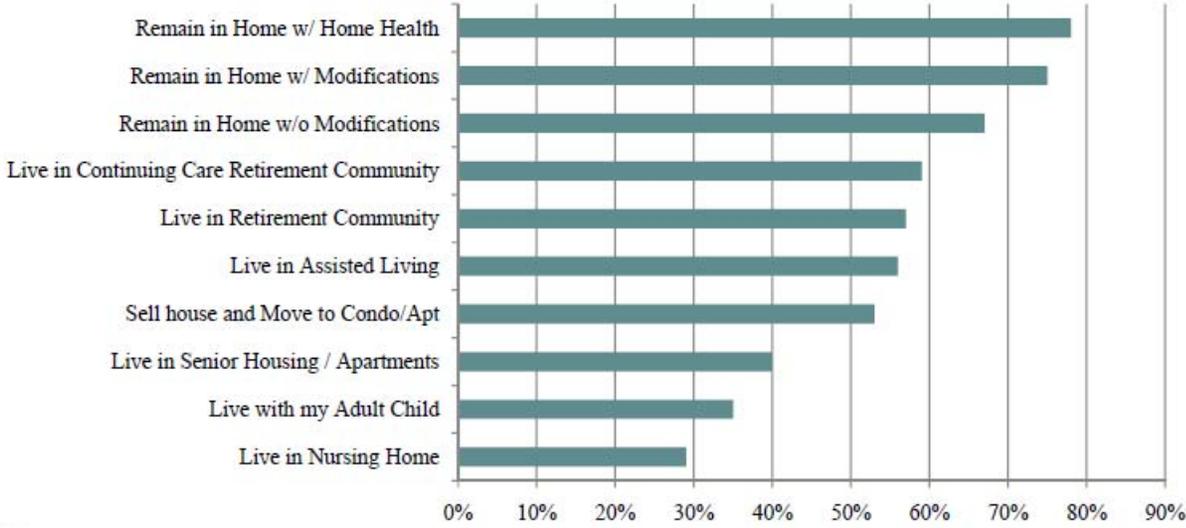
- ▶ Connecticut's Long-term care system has many positive elements and has made great strides over the last several years in providing choices and options for older adults and individuals with disabilities. Despite these gains, the system is still fundamentally out of balance in two important areas.
 1. Balancing the ratio of HCBS and Institutional Care – Traditionally, in Connecticut and nationwide, Medicaid has made access to institutional care easier than to home and community-based care. Largely, this is a result of federal Medicaid rules and regulations. Consequently, the ratio between care and support provided in the home and the community and those provided in institutions has consistently been out of balance and skewed towards institutional care.
 2. Balancing the ratio of public and private resources – The second area of imbalance involves the resources spent on long-term care services and supports. The lack of Medicare and health insurance coverage for long-term care, combined with the lack of planning, has created a long-term care financing system that is overly reliant on the Medicaid program. Medicaid, by default, has become the primary public program for long-term care. However, in order to access Medicaid, individuals must first impoverish themselves. Therefore, we have a system that requires individuals to spend all their savings first in order to receive government support for their ongoing needs.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 3,4.

Connecticut's Residents Prefer to Receive Long-term Care in their Home

- ▶ Almost 80% of people would like to continue living in their homes with home health or homemaker services provided at home.

Future Living Arrangements
(percent reporting very likely or somewhat likely)



Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 17, Figure 7.

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HCBS Have a Lower Average Cost to Connecticut

- ▶ On average, Medicaid dollars can support more than two older people and adults with physical disabilities in a home and community based setting for every person in an institutional setting.
 - \$32,902 – the SFY 2006 average cost per client for HCBS.
 - \$74,637 – the SFY 2006 average cost per client for institutional care

Source: University of Connecticut Health Center's Center on Aging, *Long Term Care Needs Assessment Legislative Briefing – Follow-up to Questions Asked*, January 16, 2008, Question 2.

- ▶ There are various estimates for the average cost depending upon the year, state, etc. However, they do agree that home based care is about 50% of the cost of institutional care.
- ▶ There are additional costs related to HCBS for room and board that are borne by the recipient or other state and federal programs. These costs are included in the institutional average.
- ▶ The average costs do not take acuity into account.

Benefits of Rebalancing

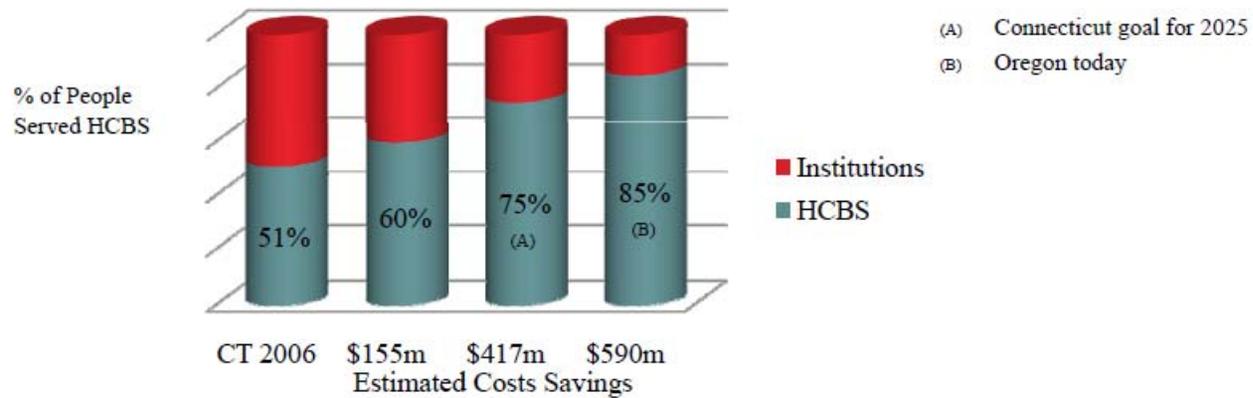
- ▶ Rebalancing provides residents more
 - choice,
 - parity among groups,
 - access,
 - efficiency and
 - quality.

- ▶ Constituent preferences align with fiscal savings.

Source: Connecticut Long Term Care Advisory Council,
Legislative Update, February 5, 2010.



Benefits of Rebalancing



Source: University of Connecticut Health Center's Center on Aging, *Long Term Care Needs Assessment Legislative Briefing – Follow-up to Questions Asked*, January 16, 2008, Question 2.



Rebalancing can Slow Growth of LTC Spending

- ▶ The number people in Connecticut over 65 years of age will increase by 40% in the next 15 years significantly increasing demand for LTC
- ▶ Total future costs and institutional care costs will both increase even with rebalancing
- ▶ Rebalancing significantly avoids costs in the future

Projections of Connecticut Medicaid Long-Term Care Expenditures by Current and optimal Client Ratios of Community and Institutional Care SFY 2009 and SFY 2025.

	Current Client Ratio SFY 2009	SFY 2009 Actual Expenditures (millions)	2025 Expenditures with Current Client Ratio (millions)	Increase from 2009 to 2025 (millions)	Optimal Client Ratio (A)	2025 Expenditures with Optimal Client Ratio (millions)	Increase from 2009 to 2025 (millions)
Community-based Care	53%	\$ 886	\$2,073	\$1,188	75%	\$2,930	\$2,045
Institutional Care	47%	\$1,612	\$3,774	\$2,162	25%	\$2,010	\$398
Total		\$2,498	\$5,847	\$3,350		\$4,940	\$2,443

\$900 million Annual Cost Avoidance

(A) Connecticut goal.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 48, Table 11.

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Connecticut is Behind other States

- ▶ Home and Community Based Care Services (HCBS) expenditures in Connecticut were 35.5% of total LTC expenditures in FY 2007 and are still 35.5% in SFY 2009.
- ▶ The US HCBS care % national average of LTC expenditures is 42% and increases about 1-3% per year.
- ▶ Connecticut ranks 34th among the states and is below the national average.

**Percent of Medicaid LTC Spending
for HCBS FY 2007**

State	Percent	U.S. Rank
New Mexico	72.9	1
Oregon	72.7	2
Arizona	64.0	3
Maine	51.4	11
Rhode Island	45.6	14
U.S.	41.7	-
New Hampshire	39.6	25
Massachusetts	38.7	28
Connecticut	35.5	34

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 46, Table 9

Rebalancing is Difficult – Fractured Governance

- ▶ Connecticut has a fractured governance structure for providing long-term care that requires high levels of coordination between many state departments and groups.

Major Connecticut Agencies

- ▶ Department of Social Services (DSS)
- ▶ Department of Developmental Services (DDS) – formerly Department of Mental Retardation (DMR)
- ▶ Long-Term care Ombudsman Program (LTCOP) – independent office under DSS
- ▶ Department of Mental Health and Addiction Services (DMHAS)
- ▶ Department of Public Health (DPH)
- ▶ Proposal for New Department on Aging (PA 05-280)

Other Connecticut Agencies

- ▶ Office of Policy and Management (OPM)
- ▶ The Connecticut Commission on Aging (COA)
- ▶ Department of Economic and Community Development (DECD)
- ▶ Department of Transportation (DOT)
- ▶ Department of Children and Families (DCF)
- ▶ Office of Protection and Advocacy for Persons with Disabilities (P&A)
- ▶ Board of Education and Services for the Blind (BESB)
- ▶ Commission on the Deaf and Hearing Impaired (CDHI)
- ▶ Department of Veterans' Affairs (DVA)

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, Part II, pp 8-12.

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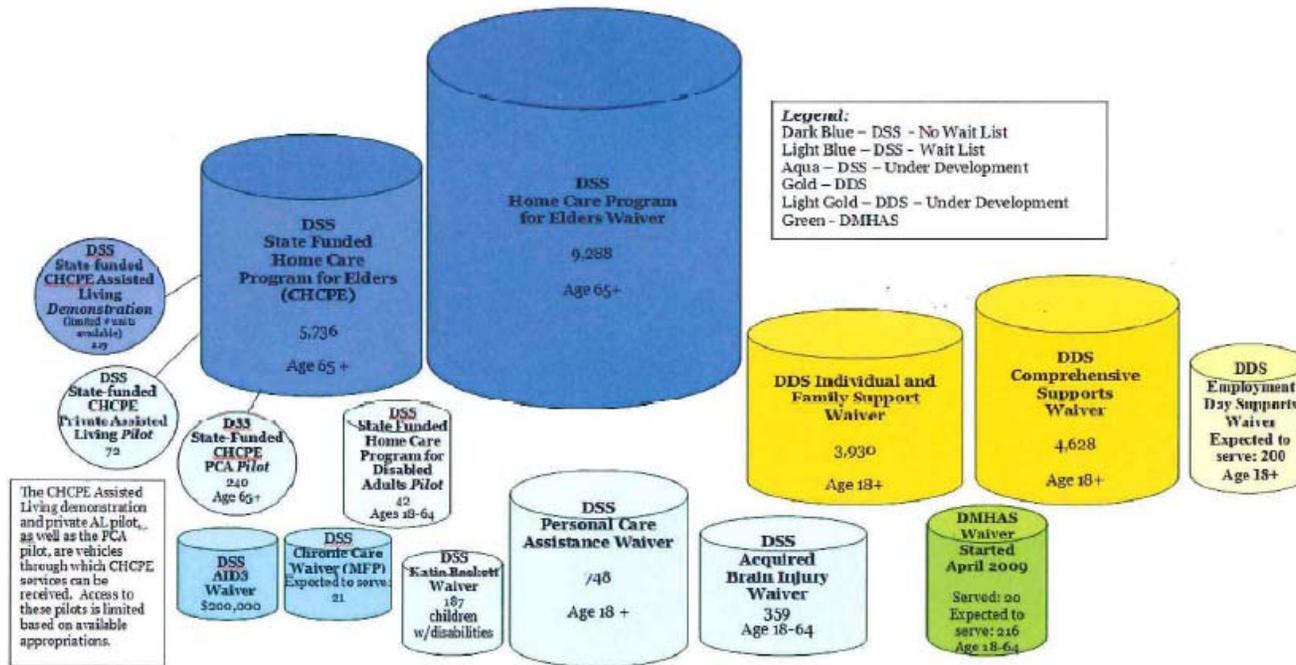
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Rebalancing is Difficult

- ▶ The Federal Medicaid program was developed and implemented when institutions were the only real care alternative. As such, Medicaid was created to enable people to get institutional care as easily as possible.
- ▶ With the growing preference, availability, and cost of HCBS for LTC there have been adjustments to Medicaid, called 'waivers', created to enable HCBS for people with very specific types of disabilities.
- ▶ LTC waivers in Connecticut are each separately managed and implemented creating a very challenging environment for persons seeking to learn about their LTC options and then acquire HCBS when appropriate.
- ▶ Implementation of rebalancing requires improvement in the ability of people to acquire HCBS at a level that is on par with institutional care so that people have a choice when HCBS is an appropriate option.

Rebalancing is Difficult – Waiver System

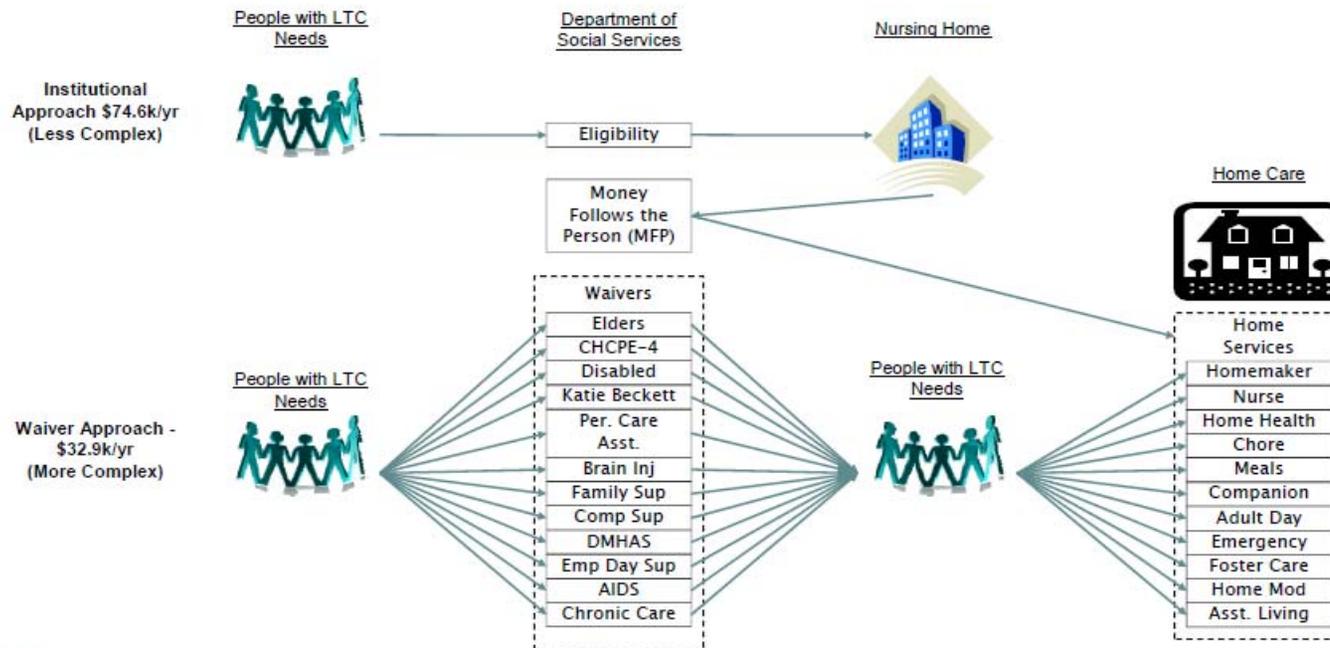
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Source: Connecticut Commission on Aging, *Break Down the Silos – Streamline the Home & Community Based System*, December 9, 2009.

Rebalancing is Difficult

– Multiple Points of Entry



Note: This is a very simplified depiction of a very complex processes. This picture is not intended to cover every way to obtain long-term care.

Connecticut's Long-term Care Philosophy

- ▶ In 2005, a broad philosophical statement was enacted in Connecticut statute to guide policy and budget decisions. It states *that Connecticut's long-term care plan and policy must provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting.* This simple statement, designed to make real choices for individuals a reality, provides a larger framework for Connecticut upon which the Plan goals, recommendations and action steps rest.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 12.

- ▶ This statute was passed on October 5, 2005 in response to the Olmstead decision handed down by the U.S. Supreme Court in 1999.

Source: Connecticut House Bill #6786 ,Year 2005, File No. 105

Connecticut Initiatives

Money Follows the Person (MFP)

- ▶ MFP is a recent Connecticut Initiative designed to promote personal independence and achieve fiscal efficiencies. It is funded by the U.S. Centers for Medicare and Medicaid Services and the State of Connecticut as part of a national effort to “rebalance” long-term care systems, according to the individual needs of persons with disabilities of all ages.

- ▶ 176 persons transitioned from 84 different nursing homes
 - Quality of life data has been collected and is being analyzed
 - Cost comparisons between MFP and institutional care has been analyzed

Source: Connecticut Department of Social Services, *Money Follows the Person Rebalancing Demonstration Legislative Status Update*, January 29, 2010.

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Connecticut Initiatives

Money Follows the Person (MFP)

- ▶ The actual cost of care for persons in the MFP program is less expensive than institutional care.

Actual Program Cost Comparison per Client

Institutional Care		Money Follows the Person	
Monthly Program Cost	\$6,658	Monthly Program Cost • MFP Services \$3,388 • Rental Assistance \$288	\$3,676
Federal Match	\$4,008	Federal Match	\$2,713
Net Cost to State	\$2,651	Net Cost to State	\$963

Source: Connecticut Department of Social Services, *Money Follows the Person Rebalancing Demonstration Legislative Status Update*, October 2009.

Note:

- Does not include Administration Costs.
- Actual service utilization of an approved care plan is estimated at 80% of the actual care plan cost.
- The group of MFP participants not eligible for enhanced FFP includes 3 persons who transitioned to group homes. Their costs are not included in the analysis.
- All participants are eligible for services under the Medicaid State Plan.

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Connecticut Initiatives

- ▶ Long-term care services and support website
- ▶ Home and Community Based Services Programs (Waivers)
- ▶ Mental Health Transformation Grant
- ▶ Aging and Disability Resource Centers (ADRCs)
- ▶ Nursing Facilities (small house)
- ▶ Connecticut Department of Aging
- ▶ Federal Stimulus Funds

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 7-11.

Recommendations

▶ Provide Strong Leadership

- The Governor and Legislature must make the Connecticut Long-Term Care System a priority.
- Rationale for Change:
 - Long-term care affects everyone
 - The system is expensive and will get worse
 - Connecticut is behind other states
- Potential Implementation Approaches:
 - Appoint a cabinet level position to lead and manage long-term care
 - Create and support legislation that does not allow short-term budget pressures to interrupt investments in the long-term care system
 - Strengthen OPM's role as a point of coordination for long-term care.
 - Aggressive pursuit of federal funding

Recommendations

- ▶ Create a Strategy and Align the Long-Term Care System
 - Under the governor's and legislature's leadership, a long-term care strategy must be developed. The implementation of this strategy must align all aspects of the long-term care system with the existing statute.
 - "individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting"*
 - Rationale for Change:
 - The existing system was created prior to the emergence of HCBS and has a bias towards institutions
 - HCBS capacity must grow to support increasing demand for long-term care
 - HCBS and Institutional Care are both important elements of the continuum of care for LTC.
 - The strategy must ensure the health and viability of HCBS and Institutional Care providers.
 - The Connecticut Long-Term Care Plan has good ideas that are a guide but there is no accountability for implementation
 - Key Elements that should be addressed in a Connecticut Long-Term Care Strategy are:
 - Organization Structure
 - Clearly Defined Goals
 - Process and Technology
 - Measurement and Accountability

Recommendations

- ▶ Consolidate and Integrate State Long-Term Care Functions
 - Establish a consolidated, efficient all-ages human services approach to long-term care in Connecticut that maximizes the impact of Medicaid dollars and Older Americans act funds rather than dividing them up.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, Part II, pp 72.

- Rationale for Change:
 - Connecticut has a fractured governance structure for providing administrative and programmatic support to older adults and person with disabilities. A number of different state departments and agencies are responsible for services and funding for different populations and programs. There are four major agencies responsible for various aspects of long-term care in Connecticut: the Department of Social Services, Mental Retardation* (including the Ombudsman programs associated with those two agencies), Mental Health and Addiction Services and Public Health. There are many more that play lesser but still significant roles. This organizational complexity poses significant challenges for both consumers and providers of long-term care services. Further uncertainty has been created by a legislative mandate to create new Department on Aging.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, Part II, pp 8.

* Now named Department of Developmental Services

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Recommendations

▶ Simplify Connecticut's Medicaid Structure

- Eligibility for long-term care services and supports should address functional needs and not exclude individuals due to age or particular disability. Policy and program changes should create parity among age groups, across disabilities, and among programs through allocating funds equitably among people based on their level of need rather than on their age or type of disability.

- Rationale for Change:
 - The Medicaid program is particularly complex, especially with regard to the separate long-term care pilot programs and home and community-based waivers that vary in terms of eligibility, services provided and types of disabilities that are addressed.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 58.

Recommendations

- ▶ Create a statewide single-point of entry (SPE) or No Wrong Door (NWD) long-term care information and referral program across all ages and disabilities.
 - An expert team comprised, for example, of State Unit on Aging staff, members for the Long-Term Care Planning Committee and Advisory Council, consumers and providers should develop a plan to implement a centralized SPE/NWD in Connecticut. The SPE/NWD should encourage equity in allocation of services and support across ages and across disabilities. Many of the 43 jurisdictions throughout the U.S. with existing Aging and Disability Resource Centers (ADRCs) present models for doing so. The SPE/NWD should also inform the hospital discharge planning process to avoid unnecessary institutionalization, and should consider the creation of common applications for program eligibility to avoid the necessity of giving the same information multiple times.
 - Rationale for Change:
 - Survey respondents, providers and state agencies all reported that it is difficult for Connecticut residents who need long-term care to find basic information about the types of care that are available to them and who will provide this care.

Source: University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, Part I, pp 32.

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Goals

- ▶ Balance the Ratio of Home and Community-Based and Institutional Care
 - Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional setting, and increases the proportion of individuals receiving Medicaid home and community-based care from 53 percent in 2009 to 75 percent by 2025, requiring approximately a one percent increase in the proportion of individuals receiving Medicaid long-term care in the community every year.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 53.

Goals

- ▶ Balance the Ratio of Public and Private Resources
 - Increase the proportion of long-term care costs covered by private insurance and other dedicated sources of private funds to 25% by 2025. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses.

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan - A Report to the General Assembly*, January 2010, pp 55.



Recommendations

- ▶ Other specific recommendations that should be considered can be found in:
 - Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, pp 57-78.
 - University of Connecticut Health Center’s Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007, pp 32-35.

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Other States - Washington

- ▶ Washington has one of the nation's most balanced LTC systems for older people and adults with physical disabilities. It is one of the few states that spend more on HCBS than on nursing homes—in 2006, 54 percent of Medicaid LTC dollars were allocated to HCBS. From FY 2001 to FY 2006, Medicaid spending on HCBS increased significantly from \$439 billion to \$642 million, while spending on nursing homes decreased from \$614 million to \$558 million. Faster, more efficient access to HCBS is available through the following:
 - Single state agency administering and funding for institutional and HCBS;
 - Presumptive Medicaid financial eligibility process that allows a caseworker to approve and begin services while detailed paperwork proceeds;
 - Expedited eligibility determination process; and
 - Computerized assessment tool used to determine functional eligibility and development of care plans.

- Washington State Department of Social and Health Services, *Fact Sheet – A Successful Vision*, December 2009 <http://www.aasa.dshs.wa.gov/about/factsheets/default.asp>

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

Other States - Oregon

- ▶ Oregon has the nation's most balanced LTC system for older people and adults with physical disabilities, and recent trends indicate that the state is continuing to make even more progress toward balancing. About three times as many Medicaid participants receive HCBS increased from 1999 to 2004, while the number of participants in nursing homes decreased by nearly 12 percent. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was more than twice the increase in spending for nursing homes. Oregon is one of the few states that spend more on HCBS than on nursing homes.
- ▶ Oregon was awarded one of the largest Money Follows the Person grants in May 2007 – 114.7 million over five years. In their proposal, state officials said they would use the grant to demonstrate that “long-term institutionalized populations of people with complex medical and LTC needs can be served in their communities with wrap-around packages of supports and services.” The 780 people whom the state will assist to move to the community account for 16.5 percent of Oregon's institutionalized Medicaid population. Of the total, 300 are older people with end-stage dementia.

Source: AARP Public Policy Institute, *A Balancing Act: State Long-Term Care Reform*, July 2008, Oregon.

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Other States - Vermont

- ▶ Vermont illustrates a state that is balancing its LTC system by combining nursing home and HCBS funds into a “global budget” to fund a consumer’s entitlement to either nursing home or home and community care. The state implemented “Choices for Care” program in October 2005. Before program implementation, 2,286 people were in nursing homes, 1,207 were receiving home and community based services, and 207 were on a waiting list. As of December 2007, the number of nursing home residents had dropped to 2,070, while the number of people receiving HCBS had increased to 1,875. As of April 2008, 31 people were on a waiting list for services.
- ▶ In 1996, the Vermont legislature enacted Act 160, which required the state to shift dollars saved from reduced Medicaid nursing home utilization to HCBS. The original goal was to serve a minimum of 40 Medicaid home and community-based clients for each 60 Medicaid-funded nursing home residents per county. In 2008, the state set a new target of 50-50.13 When Act 160 was passed, 88 percent of Medicaid LTC dollars were allocated to nursing home care and 12 percent to HCBS. In 2008, the allocation is 62 percent for nursing homes and 38 percent for HCBS.

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

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Other States - Minnesota

- ▶ Minnesota – 2001 – Enacted Comprehensive Legislation (S.F. 4, 1st Special Session) to Rebalance the state’s LTC system, building on the recommendations of a Long-Term Care Task Force. The results were:
 - Minnesota’s nursing home utilization rate was one of the nation’s highest in the 1990s—84 beds per 1,000 people age 65 and older in 1993—despite a statewide moratorium on new nursing facility construction since 1984. Through a number of other initiatives such as a voluntary program under which the state provides facilities with financial incentives for closing beds, the ratio of beds to 1,000 people age 65 and older dropped to 56 in 2008. (This compares to a national average of 45 beds per 1,000 people age 65 and older in 2007.)
 - In 2001, Minnesota allocated about 82 percent of Medicaid LTC dollars for nursing home care. By 2006, that had dropped to about 60 percent.
 - Spending on home and community-based care more than doubled between FY 2001 and FY 2006, from \$209 million to \$566 million, while spending on nursing homes decreased from \$901 million to \$853 million.
 - The state now provides LTC consultation services to help consumers and their families choose LTC services that reflect their needs and preferences. Services are available locally from county teams of social workers and public health nurses.
 - Minnesota was one of 10 states to receive a \$500,000 grant in 2007 from the Centers for Medicare and Medicaid Services to use a new State Profile tool developed to access its LTC system and to explore the development of prototype LTC balancing indicators.

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

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Other States – New Jersey

- ▶ New Jersey – 2006 – “Independence, Dignity, and Choice in Long-Term Care” Act.
 - Expansion of Aging and Disability Resource Centers (ADRCs) to ensure consumers are informed about appropriate LTC options
 - Development of a global budgeting process to expand HCBS by allowing maximum flexibility for consumer choice between nursing homes and home care options
 - Implementation of a fast-track eligibility process under which consumers can receive HCBS for up to 90 days while they are completing the full eligibility process for Medicaid coverage;
 - Creation of a web-based client tracking system that will allow care workers to more efficiently coordinate services and supports.
- ▶ New Jersey Results
 - Nearly 1,000 nursing home residents have made the transition to alternative LTC options in the community.
 - Three Medicaid waiver programs for HCBS are being consolidated to provide greater consistency of services for consumers and their caregivers.
 - Aging and Disability Resource Centers are being developed in five additional counties, and fast-track eligibility became operational statewide in 2008.
 - In 2007, the state received a \$30.3 million Money Follows the Person Rebalancing Demonstration grant.

Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

Other States – New Mexico

- ▶ New Mexico is implementing a coordinated, managed LTC program—“Coordination of Long-Term Services,” or “CoLTS”—for up to 38,000 Medicaid-eligible individuals, including those who have dual eligibility for Medicare and Medicaid, those who need a nursing facility level of care, and those who participate in the state’s disabled and elderly waiver program or receive services under the Medicaid State Plan personal care option.
- ▶ CoLTS began July 1, 2008, in selected counties and will provide primary, acute, and LTC services in one integrated program. CoLTS provides an example of a state teaming up with Medicare health plans to develop a coordinated system.

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Source: AARP / National Conference of State Legislators – Long-Term Care Leadership Project, *Shifting the Balance: State Long-Term Care Reform Initiatives*, February 2009.

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Appendixes

- ▶ Long-Term Care Stakeholders
- ▶ Research Literature

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Long-Term Care Stakeholders

Connecticut Long-Term Care Planning Committee

Legislators

- › Senator Edith G. Prague, Co-Chair, Select Committee on Aging
- › Representative Joseph C. Serra, Co-Chair, Select Committee on Aging
- › Senator John A. Kissel, Ranking Member, Select Committee on Aging
- › Representative John H. Frey, Ranking Member, Select Committee on Aging
- › Senator Jonathan A. Harris, Co-Chair, Public Health Committee
- › Representative Elizabeth B. Ritter, Co-Chair, Public Health Committee
- › Senator Dan Debicella, Ranking Member, Public Health Committee
- › Representative Janice R. Giegler, Ranking Member, Public Health Committee
- › Senator Paul R. Doyle, Co-Chair, Human Services Committee
- › Representative Toni E. Walker, Co-Chair, Human Services Committee
- › Senator Robert J. Kane, Ranking Member, Human Services Committee
- › Representative Lile R. Gibbons, Ranking Member, Human Services Committee

State Agencies Representatives

- › David Guttchen, Office of Policy and Management (Chair of Planning Committee)
- › Kathy Bruni, Department of Social Services
- › Deborah Duval, Department of Developmental Services
- › Pam Giannini, Department of Social Services
- › Jennifer Glick, Department of Mental Health and Addiction Services
- › Dennis King, Department of Transportation
- › Beth Leslie, Office of Protection and Advocacy for Persons with Disabilities
- › Fran Messina, Department of Economic and Community Development
- › Amy Porter, Department of Social Services
- › Kim Samaroo-Rodriguez, Department of Children and Families
- › Michael Sanders, Department of Transportation
- › Janet Williams, Department of Public Health

Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, Appendix B

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Long-Term Care Stakeholders

Long-Term Care Advisory Council

- ▶ Legislative Member Representative - Peter F. Villano (Co-Chair)
- ▶ CT Commission on Aging - Julia Evans Starr (Co-Chair)
- ▶ CT Association of Residential Care Homes - Sonja Zandri
- ▶ Personal Care Attendant - Debbie Legault
- ▶ CT Association of Area Agencies on Aging - Kate McEvoy
- ▶ CT Council for Persons with Disabilities - Mildred Blotney
- ▶ CT Association of Health Care Facilities - Richard Brown
- ▶ CT Assisted Living Association - Christopher Carter
- ▶ CT Association of Adult Day Care - Maureen Dolan
- ▶ Bargaining Unit for Health Care Employees/ 1199 AFL-CIO - Deborah Chernoff
- ▶ CT Family Support Council - Laura Knapp
- ▶ Consumer - Michelle Duprey
- ▶ AARP – CT - Brenda Kelley
- ▶ CT Association of Home Care, Inc. - Brian Ellsworth
- ▶ LTC Ombudsman’s Office - Nancy Shaffer
- ▶ Legal Assistance Resource Center - Joelen Gates
- ▶ CT Community Care, Inc. - Molly Rees Gavin
- ▶ CT Hospital Association - Jennifer Jackson
- ▶ CRT/CT Assoc. of Community Action Agencies - Rolando Martinez
- ▶ CT Alzheimer’s Association - Christianne Kovel
- ▶ CANPFA - Margaret Morelli
- ▶ Family Caregiver - Susan Raimondo
- ▶ CT Coalition of Presidents of Resident Councils - Veronica Martin
- ▶ American College of Health Care Administrators - George Giblin
- ▶ Consumer - Sue Pedersen
- ▶ Consumer – Vacant
- ▶ Non-Union Home Health Aid - Vacant

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Source: Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010, Appendix C

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- ▶ Connecticut Long Term Care Advisory Council, *Legislative Update*, February 5, 2010.
- ▶ Connecticut Long Term Care Planning Committee, *Long Term Care Plan – A Report to the General Assembly*, January 2010.
- ▶ University of Connecticut Health Center's Center on Aging, *Connecticut Long Term Care Needs Assessment*, June 2007.
- ▶ University of Connecticut Health Center's Center on Aging, *Long Term Care Needs Assessment Legislative Briefing – Follow-up to Questions Asked*, January 16, 2008.
- ▶ Connecticut Department of Social Services, *Money Follows the Person Rebalancing Demonstration Legislative Status Update*, October 2009.
- ▶ Connecticut Commission on Aging, *Break Down the Silos – Streamline the Home & Community Based System*, December 9, 2009.
- ▶ Washington State Department of Social and Health Services, *Fact Sheet – A Successful Vision*, December 2009.
- ▶ AARP Public Policy Institute, *A Balancing Act: State Long-Term Care Reform*, July 2008, Oregon.
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- ▶ Agency on Aging of South Central Connecticut, *Public Initiatives that Help Elders and Individuals with Disabilities Remain at Home*, October 2009.
- ▶ Department of Economic and Community Development, *Connecticut Economic and Strategic Plan*, September 2009.

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- ▶ State of Connecticut Web Site, Long Term Care Services & Supports – Aging and Disability Resource Centers, *Paying for Your Needs*, <http://www.ct.gov/longtermcare/cwp>
- ▶ Washington State Department of Social and Health Services, *Aging and Disability Services Administration Strategic Plan 2009-2013*.
- ▶ Washington State Department of Social and Health Services, *State Plan on Aging*, September 29, 2006.
- ▶ Pennsylvania’s Housing Finance Agency - Governor’s Office of Health Care Reform, *Partnership in PA – 2004 CMS Grant*.
- ▶ National Governor’s Association Center for Best Practices – Health Policy Studies Division, *Challenges and Opportunities for States in Providing Long-Term Care for the Elderly*, 2000.
- ▶ Pew Center on the States, *Special Report on Medicaid*, 2006.
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- ▶ National Association of State Units on Aging (NASUA), *State of Aging: 2009 State Perspectives on State Units on Aging Policies and Practices*, October 2009.
- ▶ Connecticut Department of Social Services, *Money Follows the Person Rebalancing Demonstration*, Revised Protocol June 27, 2008.
- ▶ Connecticut Association of Home Care and Hospice, *Home Care in Connecticut: Part of the Solution*, December 1, 2009.
- ▶ Health Affairs, *Prospects for Transferring Nursing Home Residents to the Community*, Volume 26, Number 6, November/December 2007.
- ▶ Washington State Department of Social and Health Services, *Fact Sheet – How Washington Ranks Nationally in Nursing Home Rate and Home and Community Expenditures*, December 2009.
- ▶ Washington State Department of Social and Health Services, *Fact Sheet – Developmental Disabilities Assessment and Case Management Information System*, January 2010.
- ▶ University of Hawaii Public Policy Center, *State Programs to Encourage Long Term Care Insurance*, November 2006.

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- ▶ The Milbank Quarterly, *Aging in America in the Twenty-first Century: Demographic forecasts from the MacArthur Foundation Research Network on an Aging Society*, Vol. 87, No. 4, 2009.
- ▶ HCIA Sachs, *A Guide to the Nursing Home Industry*, 2001.
- ▶ IBISWorld, *IBIS World Industry Report – Nursing Care Facilities*, December 4, 2009.
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- ▶ IBISWorld, *IBIS World Industry Report – Retirement & Assisted Living Communities*, October 6, 2009.
- ▶ Oregon Department of Human Services Seniors and People with Disabilities, *Recommendations on the Future of Long Term Care in Oregon*, May 2006.
- ▶ National Alliance for Caregiving, *Caregiving in the US*, November 2009.
- ▶ National Association of State Budget Officers, *State Expenditures Report – 2008*, Published Fall 2009.

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APPENDIX Q

**Commission on Enhancing Agency Outcomes
Room 2200 Legislative Office Building
Hartford, CT 06106**

September 2, 2010

The Honorable M. Jodi Rell
Governor
State of Connecticut
State Capitol
Hartford, CT 06106

Dear Governor Rell:

As members of the bipartisan Commission on Enhancing Agency Outcomes, we respectfully and urgently request that you use the power of your leadership to more aggressively make long-term care and its costs a priority¹. The commission recently received and concurs with the following priority action items from the Commission on Aging, the Connecticut Regional Institute for the 21st Century, the Connecticut Long-Term Care Planning Committee, and the Connecticut Business and Industry Association as logical starting points to more aggressively move forward on long-term care reform:

- Charge someone in your administration to be responsible and accountable for developing quickly a strategy based on Connecticut's 2010 Long-Term Care Plan, to determine what to do first, by whom, and by when, and then execute that strategy with reasonable speed and comprehensiveness
- Key first steps in the strategy should be:
 - develop the outline of a comprehensive system of home and community-based care, analogous to that pertaining to persons with developmental disabilities, as a viable alternative to nursing home care
 - Create a workable statewide single point of entry that is customer-friendly
 - Simplify and streamline federal waivers and related programs and pilots
 - Assist nursing homes in diversifying their business models
 - Learn from other states

Commendably, the state has taken a purposeful approach in this area to identify problems, obstacles, and solutions related to long-term care. Statewide planning has been required since 1998, with the most recent comprehensive plan completed in January 2010, based on a 2007 statewide needs assessment. As you know, the plan's central

¹ Long-term care in Connecticut is among the areas identified for potential cost savings by the Commission on Enhancing Agency Outcomes. As you know, long-term care costs represent a substantial part of the state budget; looking only at those expenditures covered by Medicaid, long-term care expenses were \$2.4 billion, or 13 percent of the state's FY 2009 budget.

**Commission on Enhancing Agency Outcomes
Room 2200 Legislative Office Building
Hartford, CT 06106**

conclusion is that Connecticut's long-term care system is out of balance, with a current over-emphasis on institutional care and public resources. This imbalance may thwart personal choice and optimum care level, and cost Connecticut taxpayers more. The plan includes a number of specific steps recommended to reach a new balance favoring home and community-based care.

We recognize and appreciate all the work done by your administration, in particular by the Long-Term Care Planning Committee, charged with the statewide planning task, and chaired and staffed by the Office of Policy and Management. The latest long-term care plan dated January 2010 includes a very informative status report on state long-term care activities since the last plan in 2007, and touches on the key steps identified above. No doubt the work to date provides an invaluable base from which to proceed. However, we look at our progress in light of the state's fiscal situation, and conclude that more focused and urgent action needs to be taken, given the potential savings to the state. Thus we make the request above.

Clearly, the long-term care system is complicated, with multiple types and levels of care needs, diverse funding, competing long-term care providers with significant investments, and a structure that needs to meet personal choice and court-mandated policy goals. We also understand that in the process of rebalancing, we must be careful not to create two parallel, expensive entitlement programs. However, given the state's fiscal situation and soaring aging population, a more urgent timetable is needed now to rapidly change Connecticut's long-term care system to favor home and community-based care and promote greater use of private resources. The current system is unsustainable.

We appreciate your assistance in achieving these measures and look forward to working with you on this crucial issue.

Sincerely,

Senator Gayle Slossberg, Co-Chair
Government Administration and Elections
Committee Chair

Representative James Spallone, Co-Chair
Government Administration and Elections
Committee Chair



Representative Mary Mushinsky, Member
Legislative Program Review and
Investigations Committee Chair

Appendix R

November 24, 2010

The Honorable Michael P. Starkowski,
Commissioner
Department of Social Services
25 Sigourney St.
Hartford, CT 06106

Dear Commissioner Starkowski:

The Commission on Enhancing Agency Outcomes met on Monday, November 22, 2010, and, as part of its agenda received your October 6, 2010 letter to leadership of the public health and human services committees along with the Prescription Drug Purchasing Program report (required by P.A. 09-206). The commission is scheduled to vote on the proposals in that report along with many others at its next meeting, on Monday November 29, 2010.

Also, the commission voted to request action of your department regarding two other commission proposals. The first concerns the drug recycling program. The commission would like written assurances that the department is fully implementing the drug recycling program, including full participation by Medicare Part D recipients, and Medicaid clients who are being cared for in residential settings other than nursing homes.

The second matter concerns the Department of Social Services applications for the TANF Emergency Contingency Fund, administered under the federal Department of Health and Human Services (DHHS). As you know, the state was eligible for approximately \$133 million in federal stimulus funds under this program. Information your department provided to CEAO showed that as of August, 2010, DSS had applied for funding in the three separate categories totaling \$56.3 million, far short of the \$133 million the state was eligible to receive. DSS indicated that program and eligible expense rules, as well as reporting requirements, limited the amounts for which the state could be approved. However, DHHS information indicates that many states, including three of Connecticut's neighboring states, have had applications approved for the full amounts for which they were eligible. The commission staff asked DSS, via e-mail, why this may have occurred, as one assumes the same eligibility rules would have applied in those states. Commission staff did not receive a response.

Given the amount of federal revenue "left on the table" (\$76.7 million), the commission is requesting the Department of Social Services seek an official interpretation from the federal Administration of Children and Families (ACF) of DHHS regarding whether the state may revise already-submitted applications to include additional programs and costs under the short-term recurring expense and the subsidized employment categories. If the state is allowed to amend its applications, the department should take immediate action to ensure the broadest interpretation

Appendix R

of program and expense eligibility and auditing and reporting requirements are used to capture all the funds for which the state is eligible.

Please provide the commission with your department's response by December 6, 2010. Thank you for your attention to these matters.

Sincerely,

Senator Gayle Slossberg, Co-Chair
Government Administration and Elections
Committee Chair

Representative James Spallone, Co-Chair
Government Administration and Elections
Committee Chair

Representative Mary Mushinsky, Member
Legislative Program Review and Investigations
Committee Chair

Appendix S

December 15, 2010

The Honorable Gayle Slossberg
The Honorable James Spallone
Co-Chairs, Government Administration and Elections Committee;
Co-Chairs, Commission on Enhancing Agency Outcomes
Room 2200
Legislative Office Building
Hartford, Connecticut 06106

Dear Senator Slossberg and Representative Spallone:

I am writing in response to your letter on behalf of the Commission on Enhancing Agency Outcomes dated November 24, 2010. You wrote to us concerning the drug recycling program and the state's application for the TANF Emergency Contingency Fund (ECF) under ARRA.

Drug Recycling Program

DSS has had a successful drug recycling program since 1999. Initially the program encompassed skilled nursing facilities with a return value of approximately \$1 million annually. Since the passage of recent legislation requiring the department to expand the program to residential care homes (RCH), DSS staff have been working with individual residential care homes and with the association of RCHs to explain the program and describe the infrastructure, processes and procedures that have been established. Due to concerns regarding the legality of accepting Medicare Part D drugs into the States recycling program there are only two RCHs who are currently participating.

In order to address the Medicare Part D issues, the department has been in discussions with the Center for Medicare and Medicaid Services (CMS). The Department has requested confirmation of the authority for the state to recover and recycle drugs paid for by either Medicare Part D recipients or the Part D participating pharmacy benefit managers. CMS has verbally advised the agency that CT has a legal right to recycle these drugs as long as the recipient is in agreement. Through DSS, the long term care facilities have requested this affirmation in writing to avoid any potential legal challenges to their participation of residents who receive their drugs through Medicare Part D. When the hard copy of CMS authorization is received, the Department will be issuing provider notification which will reiterate participation guidelines and the affirmation by CMS regarding Medicare Part D drugs. Once the provider notification is issued the department anticipates an immediate increase in participation by RCHs and an increase in recycled SNF drugs.

TANF Emergency Contingency Fund

In your letter, you inquired about the amount of federal revenue “left on the table.” I believe that you are operating under a misconception that Connecticut did not pursue all the stimulus funds that were potentially available to it under TANF ECF. Nothing could be further from the truth.

In brief, in order to qualify for TANF ECF dollars, states had to demonstrate increased expenditures above federal fiscal year 2007 expenditures for TANF-eligible purposes. Unlike other ARRA-funded programs, TANF ECF funds were available only on an increase in qualifying expenditures. In Connecticut’s case, in order to qualify for the maximum \$133 million in TANF ECF dollars, we would have needed to have \$166 million in increased expenditures (state, local or private) above our FFY 2007 TANF-eligible expenditures.

The same eligibility rules apply to all states for access to these stimulus dollars. However, the TANF program is a block grant program, so each state determines which programs are included in the state TANF Plan and funded by the TANF federal and TANF Maintenance of Effort funds. Each state has its own definition for ‘needy’ family, in compliance with 45 CFR Parts 261, 262, 263, and 265. Although the overall requirements may be the same, there are differences in the programs, services, definition of ‘needy’ TANF-eligible families, and, therefore, differences in what programs were included in other states’ TANF ECF applications.

There were three categories of expenditures that qualified for funding under TANF ECF:

1. Increases in Basic Assistance (this is our Temporary Family Assistance program) caseloads and costs. Connecticut’s TFA caseload continued to fall from 2007 levels throughout 2008 and into 2009. The caseload did not increase until July of 2009, and the increase that did occur was quite modest. Our ability to qualify for TANF ECF reimbursement under this category, as a result, was quite limited. Other states had greater increases in caseload than we did and therefore were able to claim larger amounts of TANF ECF reimbursement in this category.
2. Increases in Non-Recurrent Short Term Benefits (NRST). These are defined as services lasting no more than four months in duration and that are designed to address an emergency or crisis situation. Again, the 80% TANF ECF match was available only on any increases in such qualifying expenditures over the FFY 2007 expenditures. Connecticut had only two services in its TANF state plan that met the definitions of NRST, and the increase in those expenditures over 2007 levels was very modest.
3. Increases in Subsidized Employment. Subsidized employment has been a relatively small portion of our overall TANF employment services program, as we have emphasized real private sector employment over subsidized employment programs. This limited the potential expenditures that could be matched for reimbursement in this category. Some other states, however, have historically relied more heavily on subsidized employment in their TANF state plan and were able to qualify for more reimbursement accordingly.

Since Connecticut's basic assistance, NRST and subsidized employment expenditures showed very little growth over expenditures in FFY 2007, Connecticut needed to find a way to "grow" its TANF-eligible expenditures in order to claim TANF ECF dollars. With the 2010 state budget picture being what it was, however, the likelihood of being able to invest up to \$166 million in new General Fund spending during state fiscal year 2010 in order to draw down \$133 million in TANF ECF dollars was very slim.

Connecticut took a different approach. Connecticut reached out to foundations and to third party programs in an attempt to identify non-General Fund programs that could be added to the TANF state plan and that had an increase in qualifying expenditures over FFY 2007. Under the leadership of the Governor's Office, we invited child and family advocates, workforce boards, private foundations, municipalities and community organizations to participate in discussions, brain storming, and question and answer sessions to review programs and their potential for inclusion in Connecticut's application. We sought out hundreds of community and state programs and services that had the potential to qualify. We analyzed programs and their expenditures to determine if another federal or other funding source was claiming them, and established the amount of qualifying expenditures eligible for reimbursement. There were many programs that did not qualify based on federal requirements and guidelines, and a few programs withdrew proposals because they did not have the capacity to increase services and meet the federal requirements in such a limited period time. It is our understanding that very few other states extended programs and services to include third party providers or to serve additional TANF-eligible clients, who were not already part of the TANF assistance program.

We believe we were very successful working within the federal rules provided and the existing state conditions. We did garner significant participation from a range of individuals and organizations with our state and are most proud of the philanthropic contributions. More than 20 private foundations donated nearly \$1 million to leverage four times that amount in TANF ECF dollars for jobs, training, basic needs and services to needy families. We had over 106 third-party programs participate in identifying qualifying expenditures and helping the state to draw down the TANF ECF dollars, serving over 25,000 families with Non-Recurrent Short Term Benefits. In the subsidized employment area, we had over 800 private and public sector employers who hired and trained over 6,500 youth and adults during the summer months.

We also worked very closely with our HHS Boston office during this entire effort. In fact, our state representative spent several days here in Connecticut assisting us with our application to ensure that we were meeting all federal requirements for these dollars. The Department of Social Services (DSS) had already received clarification from the Administration for Children and Families (ACF), at the end of August, that we could not add additional programs after the September 1, 2010 ACF deadline. In response to your request, however, we have again requested a response from ACF to determine if the guidance or interpretation of the regulation has changed and would allow additional programs to be included in the TANF ECF program. We will notify you as soon as we receive a formal response.

Connecticut has been approved for a total of \$38 million.

In summary:

- This was not a grant program or a matter of \$133 million waiting to be taken “off the table.” To capture extra ARRA reimbursement funding under the TANF Emergency Contingency Fund, states had to spend **more than they usually do** under the TANF category.
- Connecticut’s Temporary Family Assistance program has not seen steady increases in terms of enrollment. In general, this meant near-flat expenditures – which, in turn, meant that we had to look for other ways to demonstrate increased spending to qualify for the extra ARRA TANF Emergency Contingency reimbursement funds.
- With the above “basic assistance” category mostly nullified in terms of big ARRA numbers because of near-flat caseload and expenditures, there were two other categories in which states could demonstrate additional spending to qualify for extra ARRA reimbursement funds under TANF Emergency Contingency: 1.) subsidized employment, and 2.) maximum four-month-long TANF-related services dubbed “non-recurrent short-term” benefit programs. In these areas, Connecticut excelled; for example, creating 6,500 subsidized summer jobs.
- The state worked with non-profit organizations and advocates to identify programs that would qualify as additional funding under TANF. This enabled Connecticut to capture our share of ARRA reimbursement funding under the TANF Emergency Contingency banner.
- The situation of being eligible for “\$133 million” in available funds under ARRA in this area is a little confusing. Since Connecticut’s TFA caseload and related spending was not increasing appreciably, we had to move quickly come up with a viable way to pursue ARRA dollars. This meant bringing together the coalition of non-profits, municipalities, workforce investment boards, state agencies, foundations, etc., to identify extra qualifying expenditures for TANF-eligible clients.
- Consequently, it is not a matter of “leaving money on the table.” While some other states may have had seen increased TANF caseloads or other qualifying programs, Connecticut – with our near-flat caseloads – had to create “new” programs to qualify – this is where the coalition came in. Eligible dollars were identified for temporary programs/services over and above what the state was already doing. In this way, ARRA paid 80% and Connecticut collectively paid 20% of this new spending. But it was not a windfall of a pot of ARRA dollars that we could just spend at will.

I hope this information is helpful to you. My staff and I would be happy to sit down with you and discuss in greater detail our efforts to fully implement the drug recycling program and to maximize our ability to qualify for TANF ECF dollars.

Sincerely,

Michael P. Starkowski,
Commissioner

Appendix T
Commission on Enhancing Agency Outcomes

Update on Proposal to Have the City of Middletown Provide Water to CVH

How Does CVH Currently Receive Water? Connecticut Valley Hospital, located in Middletown, receives water from its own reservoirs and water treatment plant. CVH’s six reservoirs also provide water to the Connecticut Juvenile Training Center, Riverview Hospital, Shepherd Home, Connection, Inc and several other neighboring facilities.

Current Expenses of the CVH Water Treatment Facility:

The cost to provide water at CVH and its neighbors is approximately **\$280,000-\$300,000**.

Current Expenses of CVH Water Treatment Facility		
Expense Category	Description	Estimated Cost
Personal Service (staffing) (not including fringe)	2 employees including 1 plant facility engineer	\$140,000-\$150,000
Operating Expenses	Chemicals, equipment, etc.	\$140,000-\$150,000
Total		\$280,000-\$300,000
Source: CVH Director of Physical Services and Plant Operations		

Current Condition of the CVH Water Treatment Facility:

Siemens Water Technologies, Corporation, Shrewsbury, MA, inspected the CVH water treatment plant and prepared a report dated January 29, 2010, describing the condition of the filtration system as “very good.” Some “minor attention [is needed] to maintain the high quality water it currently produces” (referring to minor rust and painting).

Current Proposal by the City of Middletown to Provide Water to CVH:

- Annual fee to CVH: **\$346,935** (high-end estimate), based on 94,641,800 gallons used
- There would also be an applicable meter charge to CVH depending on the size of the meter required
- Ownership of water assets would be required to pass to the City of Middletown (six reservoirs, watershed land, storage facilities, and production facilities). The City does not have enough water to supply CVH without assuming these assets.

Summary:

The Department of Mental Health and Addiction Services, and CVH are concerned about loss of control over the water for their patients. The City of Middletown has not inspected the CVH plant in 12-15 years and questioned whether costly repairs might be needed. Because current cost is not tied to the quantity of water used, CVH water expense is not impacted by an increase in the client population, as is expected to occur with the closure of Cedar Ridge Hospital.

Based on the City of Middletown projected water fee (\$346,935) and the current cost of water at CVH (\$300,000), **there would be an additional expense of \$46,935 to have the City of Middletown provide water to CVH.** DMHAS/CVH may want to explore opportunities to capitalize on this asset and distribute water more broadly, either independently or in partnership with the City of Middletown.

Connecticut General Assembly

OFFICE OF LEGISLATIVE RESEARCH

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September 15, 2010

TO: Commission on Enhancing Agency Outcomes

FROM: Judith Lohman, Assistant Director, Office of Legislative Research

RE: CREC Administrative Costs

This memo compares Capitol Region Education Council's (CREC) FY 09 administrative costs with those of four other regional education service centers (RESCs) and 111 school districts offering grades PK-12.

Background

CREC is the largest of the six RESCs in the state. It has 35 member boards of education representing school districts in the greater Hartford region. Like other [RESCs](#), CREC operates interdistrict magnet schools and special education facilities; provides transportation for the state's Open Choice interdistrict school attendance program; and furnishes such other services for member school districts as minority teacher recruitment, school employee fingerprinting, teacher professional development, cooperative purchasing, and special education and early childhood education services (see attached brochure).

In FY 09, CREC's total budget exceeded \$150 million and it had over 1,600 employees. Charts showing CREC's FY 09 revenue sources and [organization](#) are attached.

RESC Administrative Expenses

According to its [comprehensive financial report](#) for FY 09, CREC spent \$5,353,917 on administration out of total governmental activities expenses of \$132,339,687, an administrative expense ratio of 4.0%. This is the lowest of the five RESCs that included administrative expense figures in their annual reports. The table below shows the percentages for each RESC. Unless otherwise noted, the percentages are for FY 09.

Regional Education Service Center	Administrative Expense Ratio
CREC (Hartford Region)	4.0%
CES (Bridgeport Region)	5.0%
ACES (New Haven Region)	7.9%
Education Connection (Litchfield-Danbury)	8.9%
LEARN (New London region)	9.5% *
EASTCONN (Windham region)	Not available

* LEARN's most recent published annual report is for FY 08.

School District Administrative Expenses

The State Department of Education (SDE) publishes an annual list of school district expenditures by function. One of the expenditure functions is General Administration, which SDE defines as "expenditures for activities of the board [of education] and the superintendent's office and the fiscal activities of the school district, including the school business office."

A comparison CREC's administrative expense ratio for FY 09 with the percentages spent on general administration by 111 school districts offering grades PK to 12, shows that CREC has lower administrative costs as a percentage of its total budget than 69 of those districts. The table below ranks PK-12 school districts from highest to lowest according to their general administration expense ratios for FY 09.

School District General Administration Expenses, FY 09

Rank	District	Percentage for General Administration (FY 09)
1	East Haven	22.56
2	Brookfield	11.24
3	Griswold	9.66
4	Thompson	9.11
5	Bloomfield	8.03
6	North Stonington	7.54
7	North Haven	7.53
8	Watertown	7.17
9	Canton	7.06
10	Suffield	6.86
11	East Windsor	6.80
12	Wallingford	6.71
13	Hartford	6.58
14	East Hartford	6.49
15	Bolton	6.48
16	Thomaston	6.47

<i>Rank</i>	<i>District</i>	<i>Percentage for General Administration (FY 09)</i>
17	Putnam	6.37
18	Trumbull	6.24
19	Derby	6.08
20	Region 16	5.95
21	Meriden	5.94
22	Enfield	5.89
23	Stamford	5.85
24	New Haven	5.84
25	Killingly	5.74
26	Ansonia	5.68
27	Wilton	5.62
28	New London	5.55
29	South Windsor	5.49
30	Westbrook	5.38
31	Stafford	5.36
32	Manchester	5.32
33	Waterbury	5.29
34	Guilford	5.23
35	Bethel	5.16
36	Naugatuck	5.15
37	Plainville	5.15
38	East Hampton	5.14
39	Plainfield	5.02
40	Seymour	5.00
41	East Granby	4.99
42	New Canaan	4.98
43	Waterford	4.91
44	Newington	4.90
45	Berlin	4.78
46	Southington	4.78
47	Hamden	4.71
48	Region 17	4.68
49	Windham	4.60
50	Norwalk	4.58
51	Darien	4.52
52	East Haddam	4.42
53	North Branford	4.38
54	New Milford	4.36
55	New Britain	4.32
56	Region 13	4.31
57	Newtown	4.29
58	Region 6	4.29
59	East Lyme	4.27
60	Windsor Locks	4.21
61	Tolland	4.19

<i>Rank</i>	<i>District</i>	<i>Percentage for General Administration (FY 09)</i>
62	Cromwell	4.17
63	Windsor	4.17
64	Old Saybrook	4.15
65	Portland	4.14
66	Groton	4.12
67	Danbury	4.11
68	Region 12	4.11
69	Fairfield	4.07
	CREC	4.04
70	Litchfield	4.03
71	Cheshire	3.83
72	Region 18	3.80
73	New Fairfield	3.79
74	Somers	3.76
75	Colchester	3.75
76	Wethersfield	3.75
77	Region 14	3.74
78	Bridgeport	3.71
79	Glastonbury	3.65
80	Granby	3.60
81	Shelton	3.60
82	West Hartford	3.60
83	Wolcott	3.55
84	Region 15	3.55
85	Stratford	3.52
86	Bristol	3.50
87	Ledyard	3.50
88	Rocky Hill	3.47
89	Montville	3.46
90	Lebanon	3.45
91	Weston	3.43
92	Avon	3.39
93	Coventry	3.39
94	Simsbury	3.36
95	Vernon	3.35
96	Region 10	3.35
97	Plymouth	3.31
98	Torrington	3.30
99	Clinton	3.26
100	Branford	3.20
101	Westport	3.17
102	Ellington	3.03
103	Farmington	3.02
104	Middletown	2.96
105	Monroe	2.96

<i>Rank</i>	<i>District</i>	<i>Percentage for General Administration (FY 09)</i>
106	Madison	2.77
107	Greenwich	2.66
108	West Haven	2.56
109	Stonington	2.54
110	Milford	2.09
111	Ridgefield	2.00
	State Average	4.84

Source: State Department of Education

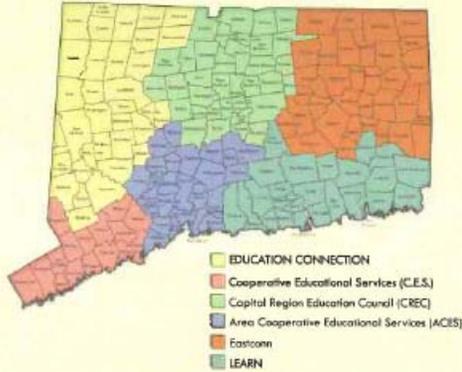
Sources of Funding*



RESCs are financially supported by the member districts they serve, as well as through federal, state and private grants. Local funding includes fee-for-service contracts to member districts. The Connecticut State Department of Education (CSDE) supports RESCs through competitive grants and contracts for statewide initiatives. Private funding sources include grants from private foundations, as well as special contracts with individuals, agencies, and businesses and outside of Connecticut. Direct state funding, which is the smallest percentage of RESC funding source categories, is unrestricted, noncompetitive funding provided by the state for general operations.

* 2008-09 Budget Analysis

RESC Alliance Regional Map



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EASTCONN
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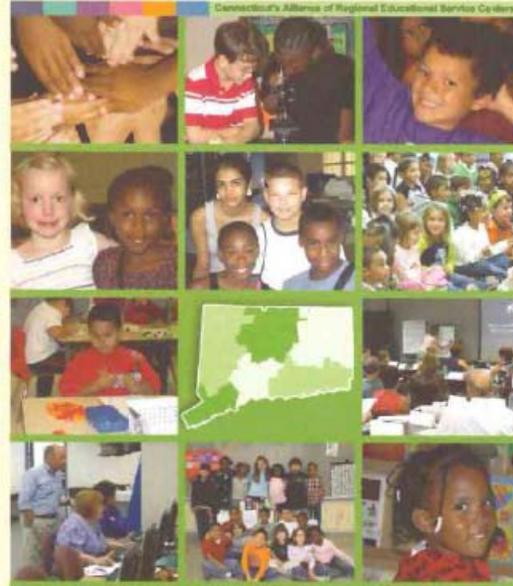


aces
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RESC Alliance



Acting as One
www.rescalliance.org

WHAT ARE REGIONAL EDUCATIONAL SERVICE CENTERS?

Regional Educational Service Centers (RESCs) are not-for-profit, free-to-service, public education agencies. RESCs offer cost-efficient, cooperative efforts for Connecticut's public school districts. RESCs have saved districts billions of dollars for the past 40 years and have enabled schools to expand services beyond what they could accomplish alone. Each RESC is:

- Locally governed by member Boards of Education
- Cost-effective in delivering programs and services to school districts in their region
- Committed to helping local school districts improve teaching and learning
- Responsive to local needs and interdistrict opportunities
- Flexible in creating, adapting and/or terminating programs

HELPING CONNECTICUT SCHOOL DISTRICTS

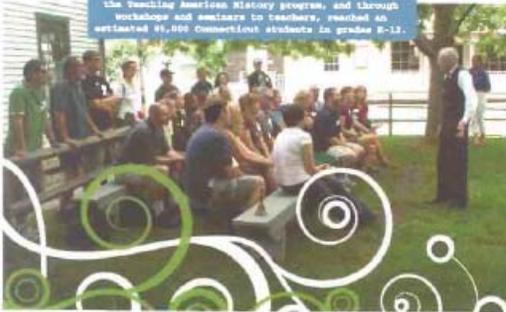
RESCs cater to the needs of their school districts. Whether instructional or operational, RESCs provide assistance in a number of ways. The following are examples of the many programs, services and support in which RESCs support school districts:

- Alternative Education
- Board Training
- Childcare
- Choice Programs
- Cooperative Purchasing
- Curriculum Development
- Early Childhood Services
- Fiscal Management
- Interdistrict Programs
- Job Training
- Literacy: Adults & PreK - 12
- Magnet Schools
- Media Centers
- Minority Recruiting
- Priority School Assistance
- Professional Development
- Program Assistance
- School Construction
- Special Education
- Statewide Data Collection
- Strategic Planning
- Technology Support
- Technology Training
- Therapy Services
- Transportation

Bringing Grant Dollars to Districts

In 2008-09 RESCs secured over \$14 million dollars in federal grants for educational programs in Connecticut school districts. One such grant, the U.S. Department of Education's Teaching American History Grant funds professional development that equips teachers with primary, local and national resources to make the story of America's past come alive in the classroom. RESCs apply for and administer Teaching American History Grants for their district teachers.

In 2008-09, RESCs received a \$2 million grant from the Teaching American History program, and through workshops and seminars to teachers, reached an estimated 45,000 Connecticut students in grades K-12.



Comprehensive Teacher Training IMPROVING STUDENT LEARNING

RESCs work with local schools in a variety of ways to improve student learning. Professional development, coaching and mentor activities are critical strategies for improving behavior and the student learning it is designed to produce. RESCs offer regional workshops as well as on-site, sustained training for a wide range of educators, from bus drivers to teachers to superintendents.

In 2008-09, RESCs trained an estimated 19,500 educators in more than 2,500 different workshops.

CONNECTICUT ACCOUNTABILITY LEARNING INITIATIVE

In 2008-09, RESCs provided more than 1,100 days of CAU training to educators in schools throughout the state.

RESCs joined with the Connecticut State Department of Education and Learning, LLC to train all identified schools in data-driven decision-making, curriculum development, effective teaching strategies, and common formative assessment.

RESCs are currently expanding CAU through the development and delivery of making it Effective Teaching Strategies and Scientific Research-based Interventions.

MINORITY TEACHER RECRUITMENT



The Minority Teacher Recruiting Program (MTR) services local schools in recruiting, hiring and retaining a diverse teaching and administrative staff that more closely represents the diversity of the student population. Program activities focus on recruitment activities, retention programs and pre-eligibility programs to encourage students to consider teaching as a career.

In the past four years, more than 450 minority teachers were employed by MTR school districts.

ENHANCING EDUCATION THROUGH TECHNOLOGY

The Alliance operates an initiative aimed at providing intensive professional development to support the effective integration of technology across the curriculum in Connecticut's public schools. RESC work in collaboration with both the Connecticut Department of Education as well as local school districts to design programs that best meet local needs.

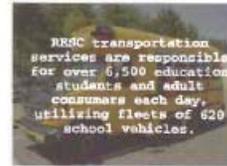
In 2008-09, RESCs provided 457 days of NET2 professional development to Connecticut educators.



Cost Savings to Districts

transportation services

The RESC Alliance provides transportation of students and adults to and from facilities around the state as a controlled service to local school districts and agencies.



RESC transportation services are responsible for over 6,500 education students and adult commuters each day, utilizing fleets of 620 school vehicles.

cooperative purchasing

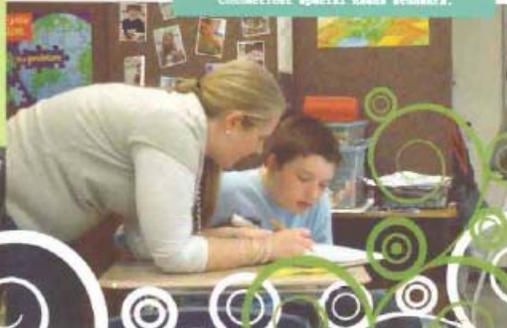
The Alliance provides a collaborative cooperative purchasing initiative to ensure strong cost of products and services used by schools and municipalities. Cooperative purchasing allows districts to purchase goods and services at the lowest prices available.

RESC cooperative purchasing services have more than 210 Connecticut schools and districts an estimated \$2 million dollars annually.

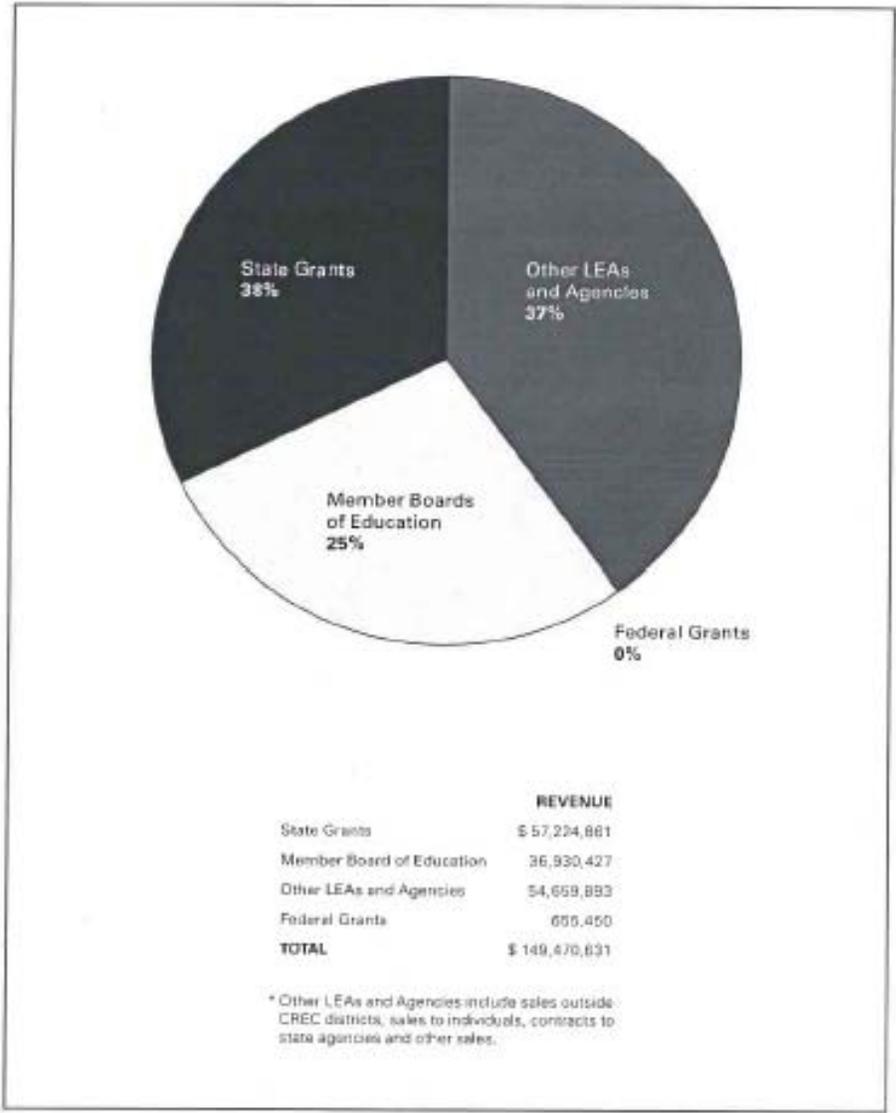
special education

RESC special education and support services are both home and school-based. Established to assist local school districts in their quest to provide quality educational programs for their students with special needs, RESCs offer highly specialized school programs at a significantly lower cost than several alternative and private school programs and services in the region.

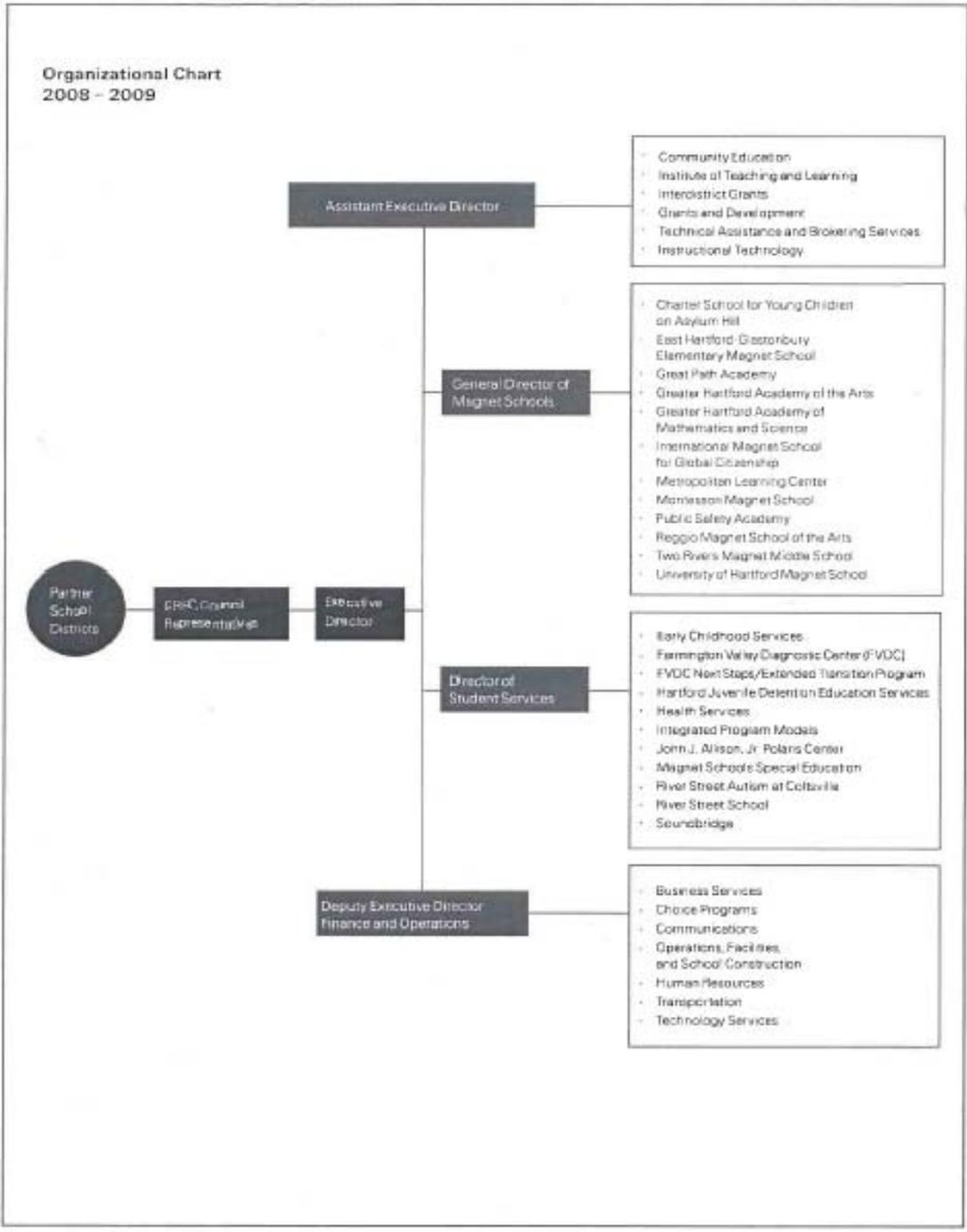
RESC special education schools and program services serve an estimated 4,200 Connecticut special needs students.



CREC
 Revenue by Source 2008-2009



CREZ





OLR RESEARCH REPORT

October 6, 2010

2010-R-0418

OLR BACKGROUNDER: DEPARTMENT OF REVENUE SERVICES AUDIT AND COLLECTION AND ENFORCEMENT STATISTICS

By: Rute Pinho, Associate Analyst

This report describes employment and audit and collection statistics for the Department of Revenue Services' (DRS) Audit and Collection and Enforcement (C&E) divisions. It updates OLR report [2009-R-0270](#) to include employment figures for both divisions before and after the 2009 retirement incentive program (RIP) and collection statistics for FYs 09 and 10.

DRS' AUDIT AND COLLECTION AND ENFORCEMENT DIVISIONS

Table 1 shows the number of Audit and C&E division employees before and after the 2009 RIP. According to DRS, the divisions lost 29 employees due to the RIP. It refilled 11 of these positions and transferred an additional employee from within the agency, resulting in a current balance of 362 employees across both divisions, down from 379 before the RIP. DRS also transferred several audit employees to the C&E division due to an internal reorganization. As a result, there are currently 22 fewer employees in the Audit Division and 5 additional employees in the C&E Division.

Table 1: DRS Audit and C&E Employees

	<i>Audit</i>	<i>C&E</i>	<i>Total Both Divisions</i>
Pre- RIP	301	78	379
Post- RIP	279	83	362

Source: DRS

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Audit Division Statistics

DRS' Audit Division determines the accuracy of tax returns. If, after an audit, it finds taxpayers have made errors or underpaid taxes owed, it imposes an assessment for unpaid taxes. Table 2 shows statistics on the number of audits and amount of unpaid taxes assessed in the past two fiscal years. In FY 09, the Audit Division conducted 40,780 audits with an average assessment of \$11,738. The division increased its audits by approximately 6.5% in FY 10 to 43,437, but the average assessment decreased by \$437 to \$11,301. Total assessments, however, increased 2.5%, from \$478.7 million to \$490.9 million.

Assessments can be appealed to the DRS' Appellate Division where they may be reduced. Thus, the assessments do not correspond to amounts collected.

Table 2: Audit Division Statistics, FYs 09 - 10

	<i>FY 09</i>	<i>FY 10</i>
Number of Audits	40,780	43,437
Total Audit Assessments	\$478,676,003	\$490,868,113
Average Assessment per Audit	\$11,738	\$11,301

Source: DRS

C&E Division Statistics

DRS refers cases to the C&E Division after a delinquent taxpayer's appeals have been exhausted or appeal deadlines have expired. The revenue agents in this division use various means to collect the taxes owed, including:

1. establishing written, phone, or personal contact with taxpayers;
2. establishing payment schedules for taxpayers with unpaid tax liability;
3. placing liens on taxpayers' property and using tax warrants to attach wages and other income; and
4. making arrests as a result of criminal investigations by DRS enforcement personnel.

Table 3 shows C&E division statistics for FYs 09 and 10. As the table shows, revenue collections from FY 09 to FY 10 increased from \$122.2 million to \$148.1 million, a 21% rate of change. The division opened fewer criminal investigations, with 805 in FY 10 as compared to 976 in FY 09, but more than doubled the number of arrests from 179 to 398. It also increased the number of tax warrants issued by 60%, from 6,280 to 10,057. The number of permit suspension hearings remained relatively stable. (DRS issues permits to allow businesses to sell items subject to state sales and excise taxes.)

Table 3: C&E Division Statistics, FYs 09 - 10

	<i>FY 09</i>	<i>FY 10</i>
Criminal investigations opened	976	805
Arrests	179	398
Tax warrants	6280	10,057
Permit suspension hearings	838	845
Revenue collected	\$122,235,123	\$148,077,777

Source: DRS

RP:df

Appendix W



STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

OFFICE OF THE SECRETARY

December 20, 2010

Senator Gayle Slossberg, Co-Chair
Representative James Spallone, Co-Chair
Commission on Enhancing Agency Outcomes
Government Administration and Elections Committee
Legislative Office Building, Room 2200
Hartford, Connecticut 06106

Dear Senator Slossberg and Representative Spallone:

As I mentioned at the Commission on Enhancing Agency Outcomes (“Commission”) meeting on December 15, 2010, it was with deep regret that I had to cast my vote in opposition to the Commission’s final report. While it is overall a very good report and lays out a road map for the Governor and legislature to use in tackling the deficit next year, I could not in good conscience support it because of the proposal to make a generic reduction in the number of state managers.

While I believe the true intent of the Commission is to address the *management structure* of agencies, unfortunately the proposal is not drafted that way. First, I believe that the Commission is not using the appropriate definition of “manager”. By the Commission’s definition, every person that works at the Legislative Office Building and even judges at the Judicial Department would be managers. Clearly this is an unfair characterization of these individuals’ true work, but it is equally unfair to apply the same generic standard to agencies in the executive branch. This mischaracterization leads to the application of reduction numbers that are completely arbitrary and have no relevance to the structure of each agency. Superficial comparisons with other states or the private sector further exacerbate the problem because it ignores the realities that exist in Connecticut, such as the fact that there is no county government here and Connecticut has a highly unionized workforce and a unique collective bargaining system.

Furthermore, the generic reduction proposal intimates that the entirety of the problem rests with only one small component of an agency. If the state is to be successful in implementing true structural change, an agency *in its entirety* must be studied in great detail. State statutes and federal regulations must be reviewed. Consent decrees and union rules must be considered. The mission of the agency has to be taken into account, as well as how the agency delivers those services. Technology implications have to be addressed. Also, the entirety of the agency workforce must be evaluated, not just a small percentage. These and a host of other considerations must be evaluated before needed structural changes are undertaken.

Regardless of the intent of the Commission or the report, it sends a very negative message about, and to, state managers. As you are aware, the managers in this state are a very dedicated group of state employees who are struggling with issues like compression and have actually seen their salaries decrease over the last few years because of a wage freeze and increased medical costs. Having them singled out in this report, plus the tone of the discussion, does them a tremendous disservice.

The Commission *never* had any discussion on reducing managers in non-human service agencies and the savings number being presented is misleading and dangerous if applied in the manner put forward in the report. There has been no discussion on who is being included in this number (for example, the report proposes eliminating 188 attorneys at the Attorney General's Office and 45 of the 125 people who work at OPM, 36% of the workforce). Had the Commission had an opportunity to review this proposal and hear the implications of an arbitrary reduction such as this, I believe there would not have been support for the inclusion of this proposal in the report. Furthermore, the report itself is silent on the implications of making a reduction of this nature.

Again, it is with regret that I had to cast a vote against the report, but the inclusion of this proposal, and the lack of any real discussion about it, damages the overall credibility of the report and calls into question the other proposals contained therein.

Sincerely,



Michael J. Cicchetti
Deputy Secretary

CC: CEAO Members

Appendix X



State of Connecticut

GENERAL ASSEMBLY

STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

December 15, 2010

Senator Gayle Slossberg
Representative James Spallone
Government Administration and Elections Committee
Legislative Office Building, Room 2200
Hartford, CT 06106

Dear Senator Slossberg and Representative Spallone

While we laud the work that the Commission on Enhancing Agency Outcomes (CEAO) has done thus far, we believe that there are additional areas in which cost savings can be achieved that we should be looking at.

In order to stay under the constitutional spending cap enacted in 1992, we need to achieve nearly \$1.4 billion in savings.

As with the proposals in the CEAO's final report, these proposals should not be viewed as setting in place a minimum floor – that is, these proposals should not be viewed as being the entirety of action that may be taken to achieve cost savings.

Specifically, we believe that the commission should consider looking at the following areas for cost savings.

1. Consider the merger of 23 State Agencies into 6 New Agencies, and eliminate unnecessary overhead
 - a. Move CI, CDA and CHFA into DECD
 - b. Combine DPH, DCF, DDS, DMHAS and DSS into a Department of Human Services
 - c. Consolidate all permanent and minority-based commissions into one new Commission on the Status of Protected Citizens
 - d. Merge DPW into DOT and DAS
 - e. Merge DMV into DOT
 - f. Consolidate DOL into DECD

- g. Move DEMHS into DPS
- h. Merge Department of Aging into various agencies

3. Consolidate state-run mental health facilities
4. Transfer DDS, DCF and DHMAS Clients to Non-Profit Community Providers.
5. Support benefit changes proposed by Post-Employment Benefits Commission including: final average salary based on 5 years not 3; COLA caps at lower levels; and maximum pension caps
6. Support increase level of employee contributions for pension proposed by Post-Employment Benefits Commission (savings calculated for 1% increase)
7. Eliminate (or suspend) twice-yearly longevity payments to state employees
8. Eliminate longevity payments in calculation for final average salary for pension
9. Reduce amount (or percent) of overtime that can be used to calculate final average salary for pensions
10. Require all state employees (not just newer) to contribute more to their retirement health care

We hope that you give strong consideration to the aforementioned recommendations. Our proposals meet the charge that has been given to this committee. Lastly, we believe that these recommendations will not only reduce costs to the state but will also enhance agency outcomes.

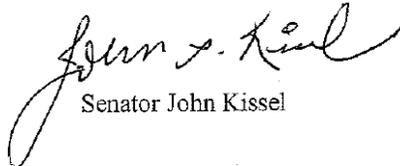
Sincerely,



Senator Dan Debicella



Senator Michael McLachlan



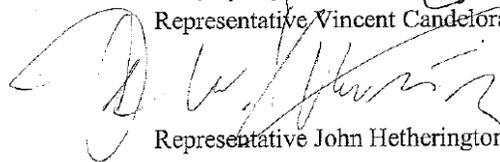
Senator John Kissel



Representative Craig Miner



Representative Vincent Candelora



Representative John Hetherington