



CHANGING  
*Maryland*  
*for the Better*

# DEVELOPMENTAL DISABILITIES ADMINISTRATION FISCAL YEAR 2017 BUDGET HEARING

BERNARD SIMONS, DEPUTY SECRETARY  
Department of Health and Mental Hygiene

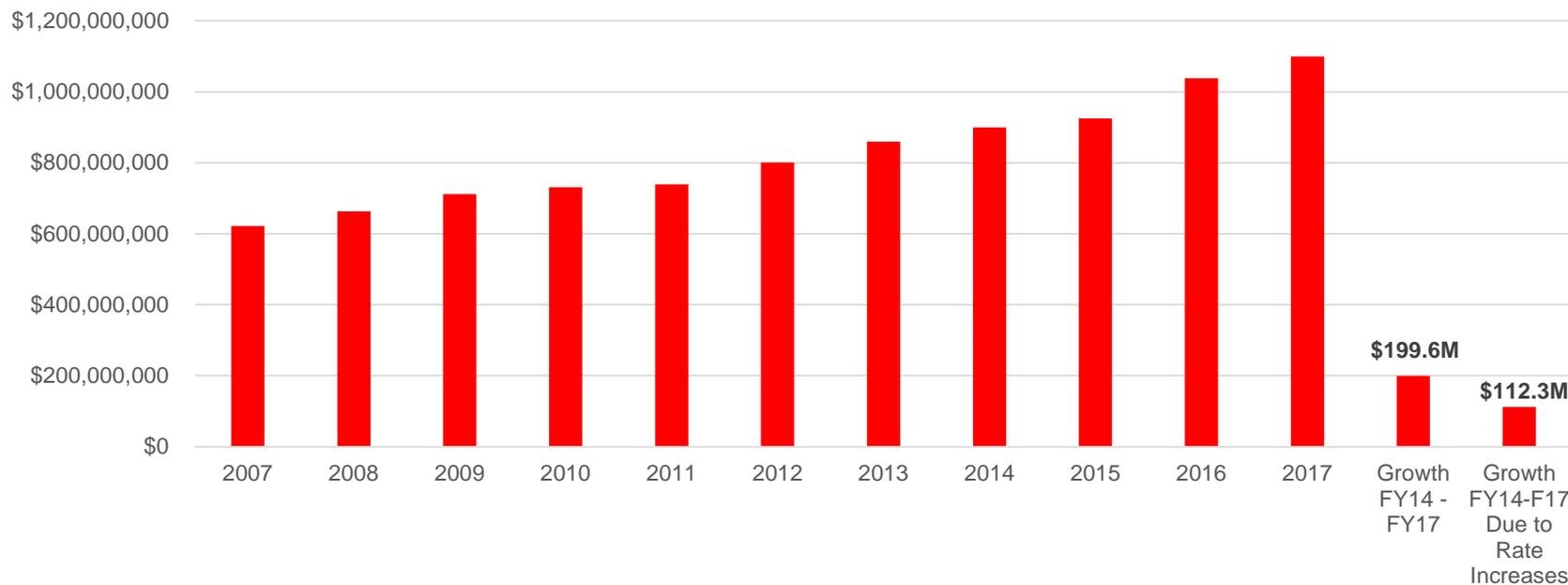
Health and Human Resources Subcommittee  
February 24, 2016



# Historical and Projected Expenditures

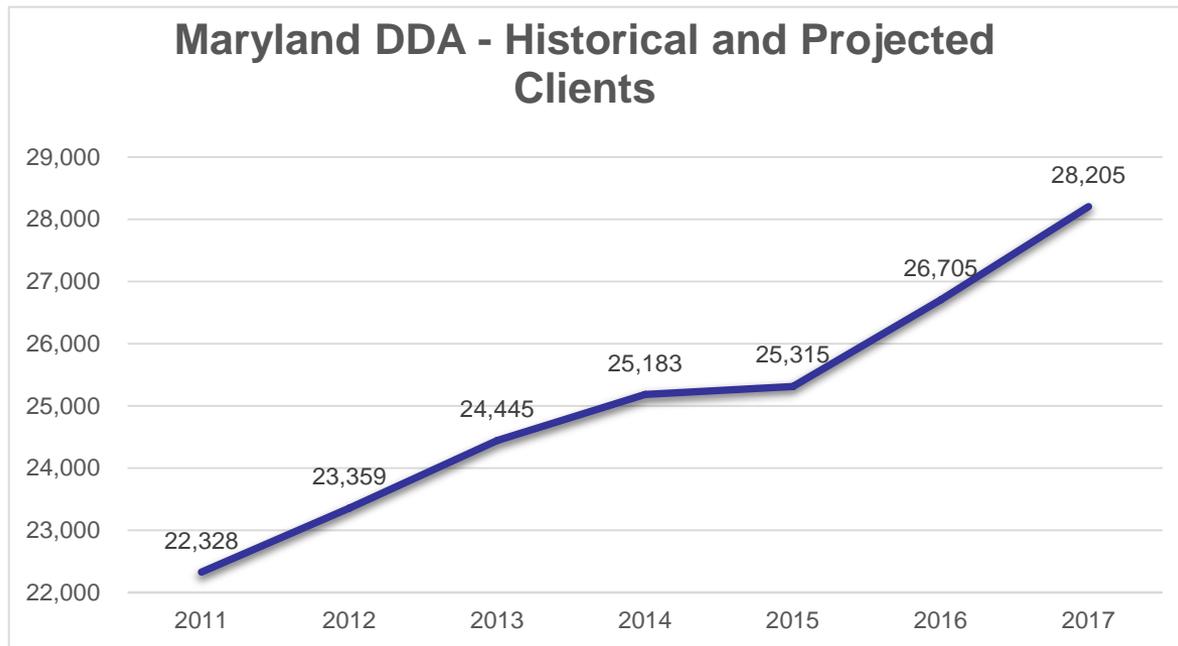
- Below are DDA community services expenditures from FY 2007 through the FY 2017 Budget
- The Fiscal Year 2017 community services budget is estimated to increase approximately 5.9% to \$1,099M from FY 2016

## DDA Historical Expenditures



# Number of Individuals in Service by Fiscal Year

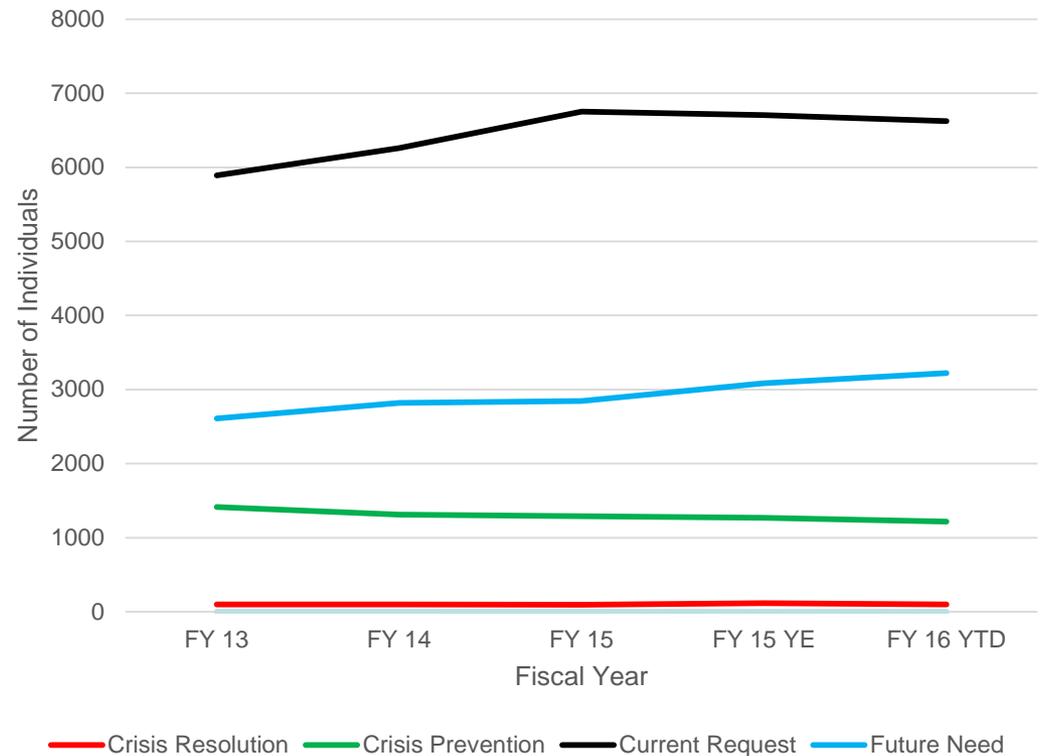
- The FY17 Budget is projected to increase the total number of people served by 5.6% bringing the total program participant count to 28,205



# Individuals on the Waiting List and Future Needs Registry

- While spending and the number of individuals served by the DDA is at an all time high, the waiting list continues to grow
- The waiting list and future needs registry are defined as follows:
  - The waiting list is defined as individuals with a current need for services and COMAR defines the requirements for each of the priority categories:
    - Crisis Resolution
    - Crisis Prevention
    - Current Request
  - The future needs registry includes individuals with a future need for services (service needed in 3+ years)

## Maryland DDA - Historical Waiting List and Future Needs Registry



# FY16 Crisis Resolution Placements

## Status of Crisis Resolution Placements

August 2015 – 123 Total – 109 DD Eligible and 14 Supports Only

109 DD Eligible

Emergency	22
Started Services	20
In Process	34
Priority Category Changed	18
Nursing Home	6
Deaths	2
Moved out of state	4
Unable to locate	2
Community First Choice	1

Additions to CR category since August 2015 - 46



# FY 2017 Budget Highlights

## Major Drivers:

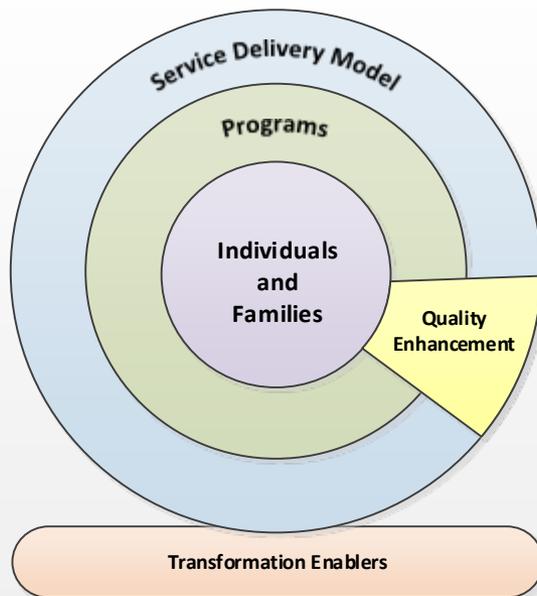
- Annualization of FY16 placements
- Placement of additional individuals into services including people on the Waiting List:
  - 161 Emergency
  - 113 Crisis
  - 24 Waiting List Equity Fund
  - 17 Court Involved
  - 602 Transitioning Youth
- Annualization of the FY16 3% provider rate increase as well as annualization of the 2% mid-year rate increase in FY15
- The FY17 3.5% provider rate increase

Maryland DDA FY 2017 Budget by Fund as of 2/22/16 - M10102						
PCA	Service	Federal Funds	General Funds	Other Funds	Total Funds	Federal Funding Percentage
P201	Residential	\$273,695,146	\$293,023,943	\$363,776	\$567,082,865	48.30%
P202	Day	\$86,336,535	\$94,554,292	\$2,856,796	\$183,747,623	47.00%
P203	Supported Employment	\$37,161,460	\$48,064,786	\$38,889	\$85,265,135	43.60%
P204	Coordination of Community Svcs	\$18,477,260	\$23,138,190	\$0	\$41,615,450	44.40%
P205	Purchase of Care	\$0	\$0	\$0	\$0	0.00%
P206	Summer Programs	\$0	\$371,682	\$0	\$371,682	0.00%
P207	Self Directed Services	\$14,180,696	\$14,418,069	\$0	\$28,598,765	49.60%
P208	Family Support Services	\$466,082	\$2,267,915	\$0	\$2,733,997	17.00%
P209	Individual Family Care	\$3,464,060	\$3,464,058	\$0	\$6,928,118	50.00%
P210	Individual Support Services	\$10,616,706	\$29,476,601	\$0	\$40,093,307	26.50%
P211	Behavioral Support Base	\$4,713,397	\$5,631,603	\$0	\$10,345,000	45.60%
P214	CSLA/Personal Supports	\$48,854,965	\$65,639,951	\$28,650	\$114,523,566	42.70%
P217	SB633	\$0	\$0	\$0	\$0	0.00%
P250	Central Regional Office	\$1,533,789	\$2,074,956	\$0	\$3,608,745	42.50%
P251	Southern Regional Office	\$1,282,436	\$1,734,931	\$0	\$3,017,367	42.50%
P252	Western Regional Office	\$606,109	\$819,965	\$0	\$1,426,074	42.50%
P253	Eastern Regional Office	\$622,715	\$842,415	\$0	\$1,465,130	42.50%
P255	Utilization Review	\$2,719,203	\$3,694,011	\$0	\$6,413,214	42.40%
P298	Prior Year Grant Activity	\$0	\$0	\$2,500,000	\$2,500,000	0.00%
<b>Total</b>		<b>\$504,730,559</b>	<b>\$589,217,368</b>	<b>\$5,788,111</b>	<b>\$1,099,736,038</b>	



# Overview of DDA Transformation Effort

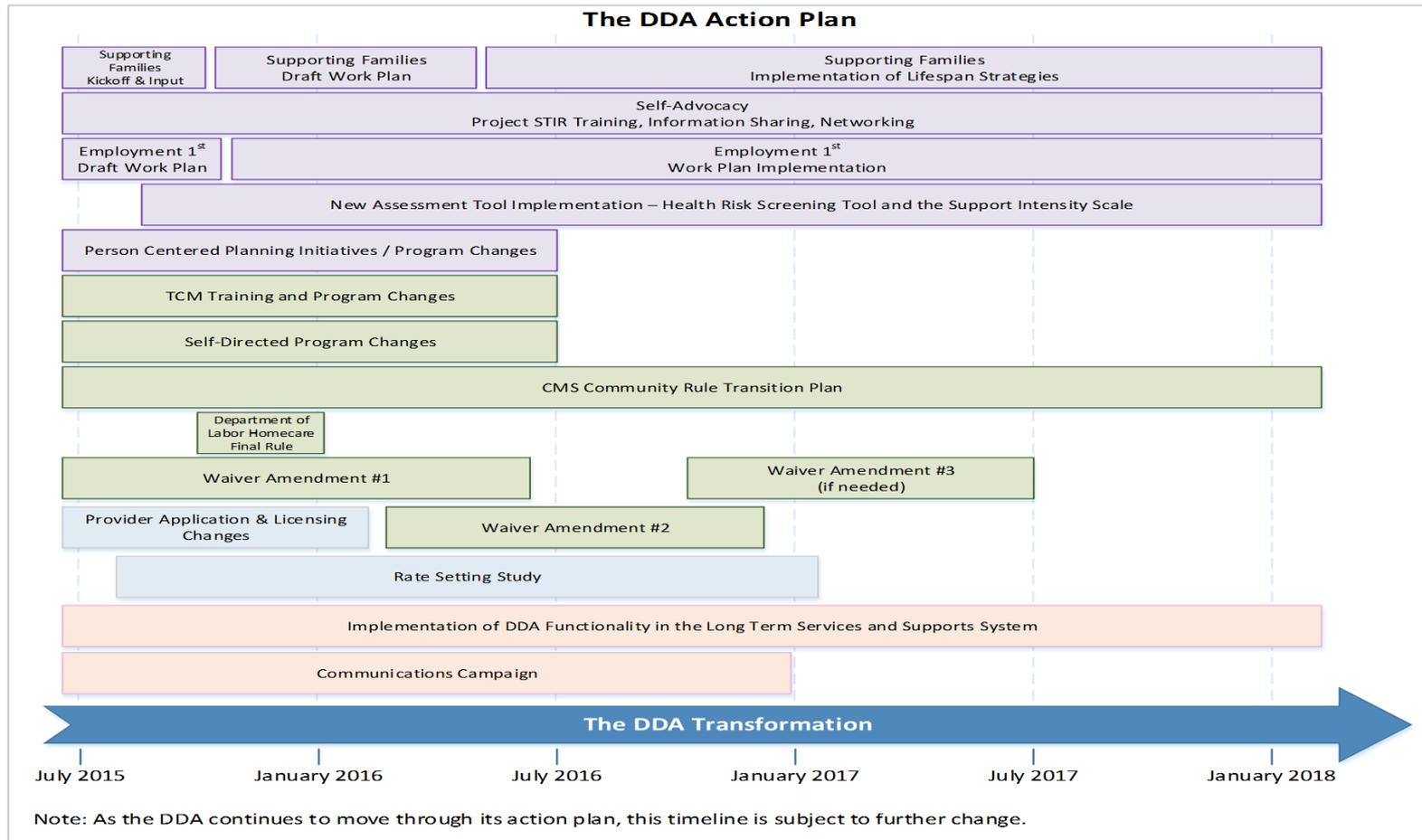
## DDA Restructuring – Focusing on Individuals and Families through Transformation



Transformation Efforts		
Individuals and Families	Programs	Service Delivery Model
<ul style="list-style-type: none"> <li>• ✓ Supporting Families</li> <li>• ✓ Self-Advocacy</li> <li>• New Assessment Tools (HRST and SIS)</li> <li>• Enhanced Person Centered Planning</li> <li>• Additional Opportunities for Self-Direction</li> </ul>	<ul style="list-style-type: none"> <li>• ✓ Waiver Transition</li> <li>• ✓ Public Listening Sessions</li> <li>• ✓ Services Review</li> <li>• ✓ TCM Review</li> <li>• ✓ Self-Direction Review</li> <li>• Community Rule Settings Implementation</li> <li>• Waiver Amendments</li> </ul>	<ul style="list-style-type: none"> <li>• Provider Licensing</li> <li>• Rate Setting</li> <li>• DDA Funding / Payment System Changes</li> <li>• Increased Transparency</li> <li>• ✓ Waiver Management</li> </ul>
Quality Enhancement (QE)		
<ul style="list-style-type: none"> <li>• ✓ Clear Responsibilities for QE and PR</li> <li>• Provider Training</li> <li>• Service Utilization Review</li> </ul>	<ul style="list-style-type: none"> <li>• ✓ Monitoring DDA Service Delivery through Survey Tools (i.e. NCI)</li> <li>• ✓ Quality Advisory Committee</li> </ul>	
Transformation Enablers		
<ul style="list-style-type: none"> <li>• ✓ HQ and Regional Office Re-Organization</li> <li>• ✓ Transformed DDA Business Processes</li> <li>• Migration from PCIS2 to the Medicaid Long Term Services and Support (LTSS) IT System</li> </ul>		



# Transformation Timeline



# Transformation Highlights

## Completed and Underway:

- Self-advocates are employed by DDA to assist individuals in navigating the support system and training others to better advocate for themselves
- Working with DD Council to establish a family to family network to provide information and referrals
- Implementing nationally recognized assessment tools to enhance person centered planning.
- Implementing training curriculum for Coordinators of Community Services and Direct Care Workers
- Assessing existing services to determine compliance with the CMS Community Setting Rule
- Medicaid and DDA are conducting Town Hall meetings in each region to share information about the CMS Community Setting Rule



# Transformation Efforts

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## Underway (cont.)

- Working with stakeholders to update service definitions based on listening sessions conducted around the state last year
- Rate setting contractor is reviewing General Ledgers submitted by DDA funded providers
- Design and development of DDA functionality in the LTSS system has begun



**Department of Health and Mental Hygiene  
Developmental Disabilities Administration  
M00.M01**

**Response to Recommendation**

**1. Given the actual IIRS expenditures from fiscal 2013 to 2015, the fiscal 2016 and 2017 appropriation for the IIRS and the SIS appears to be over budgeted. DLS recommends reducing the fiscal 2017 appropriation for the SIS and the IIRS by \$500,000.**

The Department Concur. The contract to implement the Supports Intensity Scale online tool is scheduled for the 2/24 BPW meeting. Once approved, this will allow the IIRS contractor to begin doing SIS assessments in FY'16. The costs associated with the SIS assessment tool includes licensing for the online tool and the actual assessment.

**Department of Health and Mental Hygiene  
Developmental Disabilities Administration  
M00.M01**

**Response to Issues**

**1. The agency should comment on the increased cost per client at the Potomac Center and brief the committees on the community's ability to provide the necessary supports in order to phase out one or both of the facilities.**

a. The increase in the cost per client is due to increase in acuity of individuals who require line of sight or 1:1 staffing, overtime, and increased cost of food services.

61% of the current census is or was forensically involved. 19% are dually diagnosed with a developmental disability and mental illness.

b. It should also be noted that the steepest increase in Exhibit 3 is in FY15 when the average cost per residential patient at Potomac Center reached \$317,000 - in FY14 it was approximately \$250,000. One of the principal factors driving the average cost was the drop in census and the corresponding large deposit the Potomac Center had to make into the Waiting List Equity Fund (WLEF). Per statute, a lower actual census (or Average Daily Population) versus budget requires a deposit into the WLEF and is recorded as an expenditure. In FY15, Potomac Center deposited \$951,000 into WLEF because actual average census was 42 and the budgeted census was 52. Without this deposit, the average cost per patient drops to \$294,000 per person. If the budgeted census was accurate, i.e. 52, the average costs would have dropped to \$227 per person, barring that all other variable costs, such as overtime, remained constant.

c. The Potomac Center serves people with developmental disabilities, including those with court involvement and mental illness. The Holly Center serves people who have a developmental disability, accompanied by a serious or multiple medical conditions. Most of the residents at the Potomac Center are from west of the Bay Bridge, while most of the residents at the Holly Center are from the Eastern Shore.

The Written Plan of Habilitation report submitted to the General Assembly on February 7<sup>th</sup> outlines barriers that inhibit people's ability to transition from a SRC to community based services. Those barriers include guardian opposition and provider capacity to serve the certain populations such as forensics and medically fragile individuals.

DDA has taken steps to address these barriers. A self-advocate is employed in each regional office to assist people with transitions and to improve their skills so they can better articulate their desires. DDA is also working with current providers and recruiting out of state providers to increase provider capacity for people with challenging behaviors and have complex medical needs.

**2. The agency should comment on the status of the building feasibility study and the timeline for the design phase of the new SETT.**

The feasibility study showed about a 6% cost increase for new construction more than the renovation costs. A renovation would upgrade existing 40+ year old buildings by placing the

desired SETT space allocations into the gutted areas of the existing structure. For about a 6% difference, constructing a new building of the same square footage at that to be renovated would provide layouts specifically designed to meet the SETT needs. Additionally, new construction could likely be completed in a shorter amount of time as phasing would not be part of the program.

The Department of Health and Mental Hygiene will be conducting Phase II of its institutional review in spring 2016.

**3. The agency should comment on its timeline for submitting this report to the committees.**

The report is being reviewed internally and should be submitted to the Joint Chairmen within the next 2 weeks.

**4. The agency should comment on how it intends to spend down the balance of the fund and whether there may be a better use of the fund.**

The Waiting List Equity Fund is difficult to use because the statute regarding its use (Health-Gen., §7-205) is very prescriptive. The DDA has consulted with its legal counsel as to the use of the WLEF and has been advised that the WLEF can only be used for the initial year of individual's placement and cannot be used to fund on-going community services. This creates a General Fund obligation in future years.

Recognizing the finite availability of funding, the DDA will continue to support the transition of individuals from institutions to community supports, as required by Olmstead, but will limit the use of WLEF to place individuals from the waiting list into community supports. DDA currently works with Medicaid to identify people in institutions who qualify for Money Follow the Person funds. This funding source provides an enhanced match that is used to support re-balancing activities such as the Regional Advocacy Specialists and training for direct care staff.

In order to make better use of these funds, the DDA will meet with the stakeholders during the interim to explore ways to make better use of these funds. Any changes to the use of these funds will require legislative action.

**5. The agency should comment on the status of the report.**

DDA is working on this report. 140 providers submitted cost reports for FY' 14. Of those 140 providers, 67% indicated that 51 to 70% of their operational expenses are related to direct care workers. 27% indicated that less than 50% of their operational expenses are related to direct care workers and 5% indicated that more than 71% of their operational expenses are related to direct care workers.

**6. The agency should comment on the impact of the proposed regulation on support-only eligible individuals.**

Targeted case management is an optional service under Medicaid rules. DDA's statutes do not address case management or resource coordination. The DDA regulations state that "Resource coordination **may be provided** to individuals determined to be eligible for services from the Administration, including individuals on the waiting list." (COMAR 10.22.09.03)

Based on an analysis of the utilization of case management services used by those who are eligible for supports only on the Waiting List, DDA believes there to be a minimal impact. The analysis shows that approximately 8% of people in this category did not use any services during the first half of Fiscal Year 16. During the same period, 43% used 1 to 5 hours of service, 31% used 5 to 10 hours of service, while 15% used 10 to 15 hours of service, and 3% used more than 15 hours of service.

The services provided are limited to information and referral.

**7. The agency should comment on how it ensured that funded services were actually provided when no utilization review audits have been performed since fiscal 2013.**

As noted in the analysis, no utilization review audits have been conducted since 2013. DDA is currently preparing a Request for Proposal to contract with a Quality Improvement Organization (QIO) to execute strategies to enhance the quality of life and ensure the health and wellbeing for people receiving DDA funded services. The QIO will also be required to conduct utilization reviews to verify the hours of services and the actual services for which DDA has contracted and/or paid for are being provided to people receiving DDA funded services.

**8. The agency should comment on how this break between contracts will impact the current timeline for financial system restructuring.**

There is no impact on the rate setting study being done by Johnston, Villegas-Grubbs and Associates (JVGA) nor on the financial system restructuring.

**9. The agency should comment on the potential payout and timing of the federal funds claim.** The DDA contracted with outside counsel to assist in preparing a response to CMS disputing the finding issued by the Office of the Inspector General (OIG) of the federal Department of Health and Human Services (DHHS). A letter was submitted on September 24, 2015 to the CMS consortium outlining why Maryland disagrees with the DHHS OIG finding. They have confirmed receipt of the letter but no additional contact has occurred.

**10. The agency should brief the committees on the timeline for disposing of the property to MDVA and what the cost would be to remediate Parcels 2 and 3 for that use.**

As noted in the earlier response to #2, the DHMH will be conducting Phase 2 of its Institutional Review. As for the disposition of the Rosewood property, the DHMH has been working with the Department of General Services.

**11. The agency should comment on its timeline for regional office reorganization including changes made to clinician involvement.**

As noted in the DLS analysis, the DDA is working on standardizing its operations across the state by reorganizing and restructuring the four regional offices to mirror the new organizational structure of DDA's headquarters. The functional areas that will align with headquarters include: Advocacy Support, Professional Development, Provider Relations, Quality Enhancement, Federal Programs, Clinical Support, and Individual & Family Support. The new program structure will allow the regions to provide effective and efficient business processes that will support the individuals and their families as well as enhancing our provider oversight. We

are in the process of finalizing the staffing ratios for each department based on functionality, number of participants, and the volume of daily business process under each specific area. The full region reorganization is expected to be completed in the fall of 2016.