MONTANA LEGISLATIVE BRANCH

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DATE: March 1, 2006

TO: Legislative Finance Committee

FROM: Senators Cobb and Williams

RE: The Bulldog Report: Overtime costs and reduction of the population at The Montana Developmental Center in Boulder

Senators Cobb and Williams were assigned the "Bulldog" task of monitoring the issue of overtime at the Montana Developmental Center (MDC) in Boulder. Tangential to the overtime issue are concerns related to the goal of reducing the population of MDC, removing 15 individuals from the waiting list, and the implementation of provider rates.

Item #1: Mitigation of overtime expenses at Montana Developmental Center

Items that contribute to overtimes include:

- The federal mandate to investigate allegations of client to client and/or staff to client abuse –
  - Employees must be put on administrative leave when there is an investigation of consumer abuse/neglect. An overtime employee must be hired to cover that position because of the mandate to protect clients from harm and maintain health and safety. MDC therefore maintains a 1:1 staff to consumer ratio for general clients, or a 2:1 staff to consumer ratio for residents with behavioral and/or "protection from harm" issues. (NOTE: since July 1, 2005, 35 employees have been placed on administrative leave for a total of 119 days [average 3.1 days] which calculates to 952 hours of overtime to cover these shifts.)
- A general shortage of nursing staff leads to overtime during vacancies and time off
- A need for relief staff to cover:
  - Unanticipated days absent or vacation (especially if the employee works the night watch shift)
  - Unplanned vacancies due to Family Medical Leave Act for employees, Industrial Accidents, and resignations
  - Shifts while employees attend required training

At the September LFC meeting, it was reported that the overtime portion of MDC personal services for FY2006 were projected to be approximately $1.2 million. This amount was based upon an average of 2,505 overtime hours over ten pay periods for an employee with an annual pay rate of $27,575.

Since that report, MDC established a maximum overtime amount of $10,500 per pay period, and implemented the corrective actions listed below. These actions lowered the average overtime hours to 762 for five pay periods from December to February and resulted in a decrease in the FY 2006 "overtime" estimate from $1.2 to $.6 million.

Figure 1
Overtime Costs and the Medicaid Match

Actual	Overtime Costs	Medicaid Match	Covered by GF
FY 2001	$430,088	$309,663	$120,425
FY 2002	364,138	262,179	101,959
FY 2003	591,961	426,212	165,749
FY 2004	778,436	560,474	217,962
FY 2005	943,464	679,294	264,170
Projected			
FY 2006	630,175	351,176	278,999
FY 2007	520,000	275,106	244,894

Figure 1 shows MDC historical and projected overtime costs. The amount of general fund for FY 2006 and FY 2007 increases over past years because of the increase in clients that may not receive "active treatment" and are not eligible for Medicaid. The department is waiting for federal clarification on the definition of "active treatment" with regard to MDC population. An update will be provided at the next LFC meeting.

Management actions taken to mitigate overtime costs include:

- Set minimum staffing for each unit and not allow overtime unless the unit is below minimum staffing
- Transfer available staff from other units or areas and not hire overtime staff
- Limit the number of staff that could have a day off on short notice
- Do not hire professional (higher wage) staff to work overtime in the units
- Utilize support staff to supplement unit staff for client outings
- Hire overtime staff (other than direct care) only as a last resort

Possible impacts to MDC staff and clients under the restricted "overtime" amount of $10,500 may occur when additional staff is needed but unable to be hired to:

- Allow a staff member to attend training sessions
- Support an unplanned need for active treatment of a new or current resident
- Help with consumer outings in the community

Three issues that could cause MDC to surpass the $10,500 maximum overtime amount are:

1) If the secured unit is at capacity, (and it most often is) and a new person entering MDC has a greater need to reside in the secured unit, another current resident must be moved out of the secured unit into the general population at MDC. The individual that is moved may not be fully prepared to enter life with the general MDC population. In this situation, MDC must hire extra staff to ensure all "protection from harm" issues are addressed, and may have to staff at the 2:1 staff to client ratio.
2) Although the MDC population is decreasing, the dynamics of recent consumers are changing toward those with more challenging behaviors, which could result in an occasional increase in overtime.
3) In accordance with the MDC goal to ensure safety for both the staff and consumers, MDC is currently monitoring all staff and/or consumer injuries to see if there is any correlation of the staffing level to injuries, and to understand minimum staffing situations that could be dangerous. If a particular situation is identified, the overtime maximum may be waived.

As shown in Figure #1, the projected overtime need for FY 2007 is $520,000. However, MDC believes this amount can be reduced by taking positions assigned to Residence 16AB and reassigning them to the other units when that unit closes. This action would provide for staff relief for time off, staff training, active treatment and more residential activities at the base rate instead of at overtime rate. There is further discussion about the Residence 16AB closure below.

Item #2 – Relocation of individuals at MDC into the community and reduction of the waiting list for disability services by 15 individuals

The department plans to complete the closure of Unit 16 AB by the end of December 2006 even though the settlement of the Travis D. lawsuit does not require closure until December 30, 2007. The first four individuals will be moved into the community by the end of June 2006, and the remaining 15 individuals will move into the community by the end of December. This action will generate general fund savings of $8,333 per month in utility costs of Unit 16AB, for a total savings of $50,000 over the remaining six months of the biennium.

Additionally, as soon as space is available with community providers, the department will move 15 individuals from the waiting list as requested and funded by the legislature in the 2005 session.

Ideally, the department would have moved the Unit 16AB clients into the community earlier, but only two community providers, Aware, Inc. (various locations), and Little Bitterroot (Plains) have agreed to take these clients even though there is a substantial amount of funding that follows the client into the community. The clients choose the provider and location. (The legislature provided $2.15 million over the biennium, to help with costs for training, crisis assistance, additional FTE case managers, and $500,000 for start-up construction / renovation costs to community facilities.)

The shortage of provider response is primarily due to:

- The potential volatility of these clients, which often involves higher management risk to the providers already facing shortage of direct care workers and case managers.
- The federal mandate for investigation of possible client to client and/or staff to client abuse.[1] (See the discussion on page one.)
- The population coming into MDC with criminal or sex officer records is harder to place because of their history and the intensity of the individual's needs as well as the potential to have to conduct an investigation in the provider's community.

The department is investigating ways to assist the community providers with their investigations. However, this relationship is not developed as of this writing.

[1] Although the federal rules governing investigations are not now in the state administrative rules, the process will be formalized in the next few months, and providers are reticent to take on individuals with the potential for a higher degree of volatility because of the likelihood for cost overruns due to overtime and because there is presently not a state-wide structure in place to address how the providers investigate their own staff without a conflict of interest.

Item #3 – Implementation of the new provider payment system

Along with the concern about moving people out of MDC, there is concern about the new provider payment system. The system is federally mandated to change from a provider contract to a formula-based system with an established price structure for services selected by the consumer. This system corrects the previous issue where some providers received more funding yet provided the same services to clients as other providers that received less. The new funding formula pilot is being tested in Region II and will expand across the state in the next few years.

This is a huge issue. Both providers and the department are concerned that there is not enough money in the system to pay for the individual treatment as required by the new funding formula.

The department is collecting information on the costs of services from providers. By the end of this March they should have a better idea of what cost will be to the state for adequate support for providers in the new system. However, there is going to likely be a shortfall between what currently is being funded in the system and what the new system needs to make all providers close to whole.

There are going to be providers that face greater losses than other providers. The complete financial impact is unclear. At this time DD staff believes that the Montana rates are in the top 50 percent of rates nation wide paid to providers for similar services. They plan to survey colleagues nation-wide as soon as Montana's rates are finalized to ascertain correct comparisons. It is evident that some providers will have to make more management adjustments than others. It is going to be some years before the system is worked out across the state.

Meanwhile, it could be difficult to relocate MDC's clients that are harder to serve while there is an overhanging issue of reimbursement. (This issue was discussed somewhat last legislative session by the subcommittee. The nursing homes had to go through a new rebasing system such as the DD providers are now going through. In the nursing home case though it was done over several years and additional money was added to the system. Still there were some losers in that case.)

There was concern that the appropriation for taking clients off the waiting list might have to be used to help pay for MDC overtime costs. Luckily, this has not had to happen. That appropriation is untouched, and ready to be implemented as described earlier. Again though, there is going to be a problem taking care of more hard to serve clients when providers are unclear of how the new system of reimbursement will affect each of them.

Bottom line:

- The department is committed to moving people out of MDC and reducing the waiting list
- There are problems due to federal mandates of investigations, which are the primary cause of overtime cost overruns at MDC and also affect how rapidly the system can take more clients from the waiting lists thereby reducing the population at MDC
- The new reimbursement system is still being tested and the total financial impact on the state is unclear as of this writing

- When the financial impact is known, there will be impact on the providers. How much the administration and the legislature want to put into the system to assure that all providers are adequately reimbursed will make a difference as to how the system maintains itself in the future
- The state must also address the low salaries in case worker jobs if we wish to keep the system afloat, and reduce the waiting list
- The quality of service in rural areas may be reduced as consolidation takes place because of a potential loss of enough providers due to not only to a lack of clients but costs involved per client

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