

State of Connecticut
Commission on Nonprofit Health and Human Services

Date: March 31, 2011

To: The Honorable Dannel P. Malloy, Governor

The Honorable Anthony J. Musto and Peter A. Tercyak
Co-Chairpersons of the Joint Standing Committee on Human Services

The Honorable Joe Markley and Lile R. Gibbons
Ranking Members of the Joint Standing Committee on Human Services

The Honorable Toni Nathaniel Harp and Toni E. Walker
Co-Chairpersons of the Joint Standing Committee on Appropriations

The Honorable Robert J. Kane and Craig A. Miner
Ranking Members of the Joint Standing Committee on Appropriations

From: Robert Dakers and Peter DeBiasi, Co-Chairs
Commission on Nonprofit Health and Human Services

Subject: Final Report of the Commission on Nonprofit Health and Human Services

As you know, last year through Special Act 10-5 the Legislature created the Commission on Nonprofit Health and Human Services to bring together legislators, Executive branch staff, and leaders from nonprofit providers and labor to address a number of significant issues that challenge Connecticut's nonprofit human service delivery system.

We are pleased to submit the Commission's Final Report, as required by Special Act 10-5 to be submitted not later than April 1, 2011. Key to the Report are its forty-nine recommendations.

As you will see when you read the report, the Commission which met monthly beginning in August 2010, created four workgroups to complete much of its work. The workgroups met regularly to closely examine certain areas of the provider system as they relate to the approximately 2,000 Purchase of Service contracts in place between State Agencies and nonprofit providers with a value of \$1.4 billion this year.

As the Commission began its work, it quickly became apparent that the issues we were charged with analyzing in Special Act 10-5 are complex. The task was made even more difficult by the fact that while much data exists on the various topics, it is often inaccessible or not in a format that was useful to areas the Commission studied.

We commend the members of the Commission for their dedication and effectiveness in addressing the Commission's charge. Not only was the Commission fortunate to have high quality membership, it had the advantage of having all the key stakeholders at the table. As the twenty-eight members of the Commission explored the issues at hand, we found that we had a much more common mindset than many of us anticipated.

Considering the broad nature of Commission membership and that all of the State's major Human Service providing Agencies were represented, it can be said that the primary stakeholders in the Purchase of Service Contracting process reached consensus on a number of the recommendations in the report.

It is critical to emphasize that the implementation of these recommendations will require an ongoing and focused commitment over time by a broad group of State agencies and non-profit providers in order to work through the various issues involved. As this process unfolds, some of the recommendations may need to be modified or an alternative approach to meet the goal may have to be taken in light of programmatic, legal and funding requirements not yet identified. Additionally, in light of the large number of recommendations made and the complexities involved, prioritization will be required if true progress is to be made.

The full Report can be found on the link to the Commission on Nonprofit Health and Human Services on the OPM website at www.ct.gov/opm.

cc. Members of the Commission on Nonprofit Health and Human Services

State of Connecticut

Commission on Nonprofit Health and Human Services

Final Report as Required by **Special Act 10-5**

March 31, 2011

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I. EXECUTIVE SUMMARY

The Commission on Non-Profit Health and Human Services was created by Special Act 10-5 to analyze the funding provided to non-profit providers of health and human services under Purchase of Service contracts. The Act called for the analysis to include:

- (1) A comparison of the costs of services provided by a state agency with the costs of services provided by a private provider, including a comparison of wages and benefits for private union employees, private nonunion employees and state employees.
- (2) The cost increases associated with the provision of services by private providers under health and human services programs from 2000 to 2009 inclusive, including increases in the cost of employees' health insurance, workers' compensation insurance, property casualty insurance and utilities.
- (3) The projected costs associated with the provision of services by private providers under health and human services programs through December 31, 2014.
- (4) A projection of cost savings that may be achieved by serving individuals who are recipients of benefits under health and human services programs in their communities rather than in institutions.
- (5) Sources of revenue for health and human services programs.

The Commission was charged with holding its first meeting no later than September 1, 2010, submitting a preliminary report by December 31, 2010 and a final report by April 1, 2011.

The Commission, comprised of 28 members appointed by legislative leaders and former Governor M. Jodi Rell, met for the first time on August 31, 2010, holding a total of eleven meetings during its tenure.

The Commission established that their work would be conducted in three phases:

- Listening/Learning using currently available data
- Analyzing Data
- Recommending budget, policy and/or statutory changes that have a likelihood of being implemented

Workgroups: Due to the volume of work involved in the Commission's charge and the tight time frame to accomplish the work it was decided that a workgroup structure provided the best path to achieve the results needed. The four workgroups created were:

- Achieving Administrative Efficiencies
- Cost Comparisons - Private and State Services
- Private Provider Cost Increases, Nonprofit Agency Financial Condition, and Sources of Revenue
- Projected Cost Savings - Institutional v. Community-Based Care, Projected Cost (2010-2014)

The workgroups conducted research and analyzed data resulting in reports of their findings and recommendations that were then presented to the full Commission for inclusion in this report. The complete reports of each workgroup are contained in the appendices of this report.

Guiding Principles: In its deliberation, findings and recommendation the various working subcommittees and the full commission relied upon the following set of "Guiding Principles" related to the delivery of health and human services to shape the report.

- That the work of the Commission strengthen the public/private partnerships in the delivery of health and human services;
- That quality and effectiveness of services are predicated upon a viable and sustainable nonprofit sector;
- That program and/or funding changes result in maintained or overall improved client outcomes;
- That the pursuit of efficiency and streamlining processes is a mutual goal of both purchasers and service providers;
- That commission recommendations and future program design be supported by reliable data and analysis; and
- That services need to be client and community focused, and based on current best practice models.

Challenges: The issues and information imbedded in the Commission's charge are complex. Early in their work Commission members reported that much data exists on the various topics but is not necessarily accessible or in a format that can be applied to areas the Commission studied. Workgroups advised that the more work they accomplished the more work they uncovered. Numerous times members voiced concern about completing their charge within the timeframe allotted in Special Act 10-5.

Recommendations: The Commission endorsed **forty-nine recommendations**, all of which are contained in Section IV of this report. The Commission agreed that while all recommendations made by the Workgroups would be included in the individual Workgroup Reports that appear as appendices to this report, only those

recommendations that received a minimum of 15 affirmative votes out of a possible 28 would be included in the final report.

The recommendations adopted by the Commission generally fall within these categories:

- **Specific changes and/or additions that will lead to streamlined contract administration**
- **Needed funding and/or programmatic changes geared toward creating a more sustainable delivery-system**
- **Need for further study, data collection and analysis**

In light of the numerous recommendations made and the complexities involved, prioritization will be required if true progress is to be made. It is critical to emphasize that the implementation of these recommendations will require an ongoing and focused commitment over time by State agencies and non-profit providers in order to work through the various issues involved. Many of the recommendations will need to be modified or an alternative approach may have to be taken in light of programmatic, legal and funding requirements not yet identified.

Conclusion

In conclusion, the Commission on Nonprofit Health and Human Service was an extremely productive vehicle for vetting key issues related to ensuring for the future a sustainable State and Private Provider partnership to deliver human services to Connecticut residents in need. The wide range of stakeholders were able to reach consensus on many recommendations aimed at streamlining the service delivery system while ensuring that results for clients and the community will be maintained or improved as these changes are implemented. This reality, combined with a commitment by the new administration to move in this same direction, has provide an unprecedented opportunity to bring real, productive, lasting change to the way the State of Connecticut cares for its most vulnerable residents.

Procedures to implement many of the recommendations made by the Commission are already underway. For instance, we applaud Governor Malloy's creation of a Task Force to address issues related to improved contracting practices. Additionally, legislation to mandate some of the recommendations has been proposed and favorably reported out of the Human Services Committee at the time this report was released.

Notwithstanding these significant steps and the important work the Commission has accomplished, as mentioned numerous times in this report, often the work accomplished made it clear that more has to be done. For example, further examination of the true costs of service delivery through Purchase of Service contracts now and over

the next five years is where such work is needed. Additionally, many of the Commission's recommendations are broad in nature, so more analysis and understanding of how best to implement these recommendations must be done in order to lead to real, lasting changes that positively impact those we serve.

Toward that end, this Commission recommends that an ongoing body of this sort continue to tackle the issues before us and work to add value to the process of implementing the specific recommendations found elsewhere in this report. This body should be charged with achieving specific results over specific timeframes, and should be comprised of a similar cross-section of representatives from State Agencies, Private Providers and their representative organizations, Labor, and persons who are recipients of benefits under health and human services programs.

Connecticut has a long and nationally recognized history of wise investment in the public private partnership that is the cornerstone of providing health and human services to hundreds of thousands of Connecticut's residents in need.

Building on that cornerstone and the work of this Commission will ensure a strong future for a productive partnership between the State of Connecticut and its private provider network to the benefit of all of Connecticut's residents.

Recommendations

1. An ongoing body, similar to this Commission, should be created and charged with tackling the issues before us, working to add value to the process of implementing the specific recommendations, achieving specific results over specific timeframes, and as this Commission has been, should be comprised of a cross-section of representatives from State Agencies, Private Providers and their representative organizations, Labor, and persons who are recipients of benefits under health and human services programs.

The recommendations below are listed by the workgroups from which they originated.

Achieving Administrative Efficiencies Workgroup

Contracting and Auditing

2. POS State agencies, in consultation with OPM, should evaluate the need and feasibility of consolidation of current general fund appropriations for POS services into as few SID's as feasible and practical.
3. Raise the dollar amount definition of a "capital expense" (e.g., from \$5,000 to \$25,000).
4. Permit private providers with POS contracts to set aside POS funds for one-time "large" expenses with approval of the CT State POS contracting agency. (e.g., up to 5% of budget).
5. CT State POS agencies should collaborate to expedite Medicaid reimbursements.
6. Establish "clean audit" standards for Single State Audits that, when met by private nonprofit provider agencies, would result in a financial audit being required every two (2) years versus annually.
7. Encourage CT State POS agencies, in consultation with non-profit providers, to establish a uniform method to measure and audit program results (e.g., Results-Based Accountability (RBA)).
8. The legislature should eliminate nondiscrimination certification forms, which simply repeat language already included or referenced in all State POS contracts.
9. Allow notarized copies of current documents and certifications (not eliminated by above recommendation) to be executed only once per year, by a date specified and as updated; and have documents electronically scanned and posted on-line

- for review by any CT State POS agency, as well as compliance and auditing agencies (AG, Comptroller, CHRO, OPM, and auditors).
10. OPM should standardize and streamline all POS contract and contract compliance forms (data collection) across and within CT State POS agencies, and make them available online using standard format which can be filled in online, such as "PDF Fillable Forms."
 11. The State should develop a web-based "electronic file cabinet" known as a "Document Vault" to house all documents relevant to contracts, bids and monitoring to eliminate redundancies. The Document Vault should be maintained by a centralized state agency, such as OPM.
 12. Upon creation of a Document Vault, each nonprofit contractor would be responsible for posting their own materials.
 13. CT State POS agencies should adopt and use standard forms for collecting workforce and minority subcontractor data from POS contractors.
 14. Electronic signatures should be permissible and accepted for contracts and financial reports.

Reporting and Data

15. State agencies, under the oversight of OPM, should collaboratively develop a common reporting system that would satisfy the requirements for data reporting by private nonprofit providers.
16. OPM should conduct a review of all POS reports and protocols (data reporting) to determine that all information requested is applicable, required, being utilized, and uniformly interpreted within and across all CT State POS agencies.
17. Implementation of new data reporting "systems" should be spelled out in the POS contract language, including timing, data migration requirements and funding.
18. OPM and DOIT, in partnership with private provider trade associations and the CT Health Information Technology Exchange, should review available EHR systems with necessary data encryption protocols and identify 2 or 3 "Preferred Providers" that private nonprofit providers could utilize for their EHR. This would prevent private providers from having to perform the same due diligence while ensuring that EHR's and the State reporting requirements are aligned.
19. DOIT and AG together with representatives from nonprofit providers need to agree on the definition of which "devices" need to operate with encryption.
20. OPM should coordinate the selection of "Preferred Providers" with DOIT to ensure all CT State POS agencies can receive encrypted EHR data in a confidential and timely manner.

State Licensing and Quality Assurance

21. DCF, DDS and DPH should adopt standards allowing “deemed status” to be granted to a provider who has earned and maintained accreditation by a nationally recognized organization such as the Joint Commission on Accreditation of Health Care Organization (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA).
22. Results and findings from all visits/audits should be shared among POS agencies (both licensure and compliance) to enable reduction in number of overall visits, and eliminating redundant visits from within the same agency.
23. POS State agencies, in collaboration with non-profit providers, should conduct an examination of existing regulations, as they pertain to or impact the provision of POS services. Existing regulations that are redundant or conflicting should be repealed or amended to reduce or eliminate both conflict and redundancy and to minimize unnecessary impact on service providers. Examination of regulations and recommended changes should be completed during the upcoming biennium.
24. Regulations should be reviewed by CT State POS agencies in collaboration with private providers to determine the appropriateness of the regulation for community-based settings.
25. The State of CT should appropriately fund new mandates.
26. In cases where the licensing and QA/monitoring functions of a program are done by more than one State agency, State agencies should seek to coordinate the findings of any such reviews.
27. Consideration should be given to consolidating licensure requirements and authority into fewer state agencies.

Adoption of Best Practices

28. Encourage electronic payments, including electronic fund transfers.
29. Reduce the need for budget amendments, by not requiring them for slight (e.g., up to 5%) variances.
30. Where appropriate and allowable, use prospective payments after a one-year probationary period (for either new contractors or problematic contractors).
31. Use contract periods that allow sufficient time for contract renewals, while also preserving contractor’s responsibility for client services during transition of contracts. (e.g., 13 rather than 12 months, 25 rather 24 months, 37 rather than 36 months)
32. Encourage use of multi-year contracts and/or consolidate multiple contracts between one POS agency and one nonprofit provider.

33. Encourage nonprofit providers to take advantage of existing organizations that provide members access to discounted professional services, such as, employee benefits, business services, IT and data security, and insurance.
34. Encourage nonprofit providers to focus on service delivery, training and implementation of best practices, and align their program measures with the uniform method established by State agencies in consultation with non-profit providers, to measure and audit program results (e.g., Results-Based Accountability (RBA))
35. Non-profit providers, in collaboration with POS State agencies, should examine the feasibility and the advisability of the consolidation of functions and/or services where such consolidation will result in increased efficiencies, program stability and adequate service delivery.
36. Encourage the consolidation of state agencies and commissions where mission and clients served overlap and/or are complementary. However, consolidation should be done in a manner that preserves direct access between clients and the program's decision-makers (i.e., where funding decisions are made). For example, BESB should not be consolidated with DSS, unless there were guarantees that BESB clients, including those dually diagnosed blind and deaf, had direct access (within 24 hours response) to the decision-makers that fund their programs

Cost Comparisons Workgroup - Private and State Services Workgroup

Wages

37. While the state's current fiscal situation may preclude immediate action, the state should commit to funding Private Non-Profit providers at a level that would allow the Private Non-Profit sector to raise the wages of its lowest paid workers and to implement a salary structure that would allow the Private Non-Profit sector to recruit and retain a qualified workforce.

Health Insurance

38. To attract and retain a qualified workforce and to ensure the health of its employees, the Private Non-Profit sector needs to provide comprehensive employee health benefits. The state's contracts, rate, and fee structure need to support this goal.

Retirement Benefits

39. Through its contracting procedures, the state should provide financial incentives to Non-Profit Providers to establish or enhance retirement benefit programs. Carefully structured retirement benefits could provide an incentive for employee

longevity, reducing the costs and service discontinuity associated with staff turnover.

Private Provider Cost Increases, Nonprofit Agency Financial Condition, and Sources of Revenue Workgroup

40. We believe it is important to have data over a period of time. It is recommended that a retrospective calculation of financial ratios included in this report be conducted from 2007 to 2010, with the audits that are on hand at the OPM to determine if the results indicate trends. It is further recommended that the financial ratios be completed on an on-going basis so trends in the private providers' financial condition can be assessed over a period of time.
41. It is recommended that a special committee of providers, State officials and Labor, chaired by the Nonprofit Liaison to the Governor, be assembled to assess and report on financial trends and unforeseen expenses and analyze provider increases and fixed costs impacting the private providers' financial position and possible solutions.
42. It is recommended that when system-wide technical requirements are imposed or expected of Nonprofit providers that the OPM takes a lead role in assisting providers by investigating the options, initiating a bidding process to attempt to achieve savings and by providing technical assistance to providers. The current method results in a duplication of effort and costs and often results in providers having not acquired the required product. It also results in a system that makes communication with State agencies and other private providers inefficient which further burdens the system because of a lack of consistency amongst the State Agencies.
43. A cost benefit analysis should be conducted for all revenue producing initiatives including Medicaid services, waivers, and Private Non-Medical Institution. This analysis should be conducted with not only the State's costs being considered but also the costs to private providers. It is recommended that the State be cautious in its attempts to change the payer mix. If the new costs to the entire system, including both the State and the providers, are more than the State will receive in reimbursement it should be understood that this will not be a cost effective change for the State and may result in a need to continue to provide grant funding for non-reimbursable expenses. When providers do not have the investment dollars to establish the infrastructure necessary to successfully make the change in the payer mix, it results in audit findings and significant repayment of funds only further jeopardizing the providers' financial condition.
44. Mechanisms should be developed to compensate not for profit providers doing business with the state for necessary costs that occur outside the control of the

provider. These necessary costs most commonly occur due to vacancies, admission delays, discharge delays, transfer delays, or unfunded continued occupancy (aka overstays).

45. A break-even analysis should be done when changing service models and funding streams to determine if the funding model matches the program type and size and that the census requirements are realistic for the provider to remain financially viable. Consideration should be given to the size of the program, turnover and average billable units of care. The best practices movement to smaller settings may make previous rate setting and funding models less effective and appropriate than the larger services they were created for decades ago.

Projected Cost Savings - Institutional v Community-Based Care, Projected Costs (2010-2014) Workgroup

46. Connecticut should establish a statewide data warehouse for health and human services through a standardized, comprehensive and integrated reporting system across state agencies.
47. Additional in-depth data analysis should be performed to develop a standardized costing methodology.
48. Key fiscal staff in state health and human service agencies should meet regularly to address the recommendations identified in #1 and #2 above.
49. The state should support a robust community based system of care that provides timely and accessible services across a broad continuum. Appropriate distribution of resources among community based services and institutions along this continuum of care would allow for a more effective service balance that would reduce institutional lengths of stay while providing community based services that can divert an increasing number of individuals from our hospitals and state institutions, where appropriate. This would offer the most cost effective health and human services system to Connecticut's children and adults.

II. INTRODUCTION

The Commission on Non-Profit Health and Human Services was created by Special Act 10-5 to analyze the funding provided to non-profit providers of health and human services under purchase of service contracts. The Act calls for the analysis to include:

(1) A comparison of the costs of services provided by a state agency with the costs of services provided by a private provider, including a comparison of wages and benefits for private union employees, private nonunion employees and state employees.

(2) the cost increases associated with the provision of services by private providers under health and human services programs from 2000 to 2009, inclusive, including increases in the cost of employees' health insurance, workers' compensation insurance, property casualty insurance and utilities.

(3) the projected costs associated with the provision of services by private providers under health and human services programs through December 31, 2014.

(4) a projection of cost savings that may be achieved by serving individuals who are recipients of benefits under health and human services programs in their communities rather than in institutions.

(5) sources of revenue for health and human services programs.

The Special Act designated that for administrative purposes the Commission would be located within the Office of Policy and Management (OPM).

Members of the Commission were appointed via designated appointing authorities as established in the legislation. A list of the members and the appointing authorities is included later in this report.

The chairpersons of the Commission were selected by the Governor and President Pro Tempore of the Senate and were selected from amongst the members of the Commission. The Special Act required the Co-chairs to schedule and to hold the first meeting of the Commission no later than September 1, 2010.

The Special Act requires the Commission to issue a preliminary report of its findings and recommendations by January 1, 2011 and a final report by April 1, 2011.

While the creation of Workgroups helped bring focus on the various charges given to the Commission by Special Act 10-5 and a method for completing its work within the time

allotted, the Commission recognized that many of the individual recommendations made by each Workgroup inter-relate to those made by other Workgroups. While it was difficult to have all the recommendations, given the workgroup approach, come together in a fully consistent fashion, the goal of the Commission, as the Guiding Principles suggest, was to offer a series of recommendations that would lead, over time, to an improved public-private health and human service delivery system that results in enhanced client outcomes, cost-effectiveness, accountability and sustainability.

III. COMMISSION MEMBERS

The members of the Commission, appointed in accordance with Special Act 10-5 were:

<u>Member</u>	<u>Appointing Authority</u> ¹
Robert Dakers, Co-Chairman , Executive Financial Officer, Office of Policy and Management	Secretary of the Office of Policy and Management - Brenda L. Sisco
Peter S. DeBiasi, Co-Chairman , President/CEO, The Access Community Action Agency Representative of the Connecticut Association of Nonprofits	Senate President Pro Tempore, Donald Williams
Donna Grant , Executive Director, Thompson Ecumenical Empowerment Group Nonprofit Provider for the Department of Children and Families	
Jessica Sacilowski Representing Health and Human Services Recipients	
Cindy Butterfield , Chief Fiscal Officer, Department of Children and Families	Commissioner, Department of Children and Families - Susan I. Hamilton
Joel R. Ide , Contracts Administrator Department of Correction	Commissioner, Department of Corrections - Leo C. Arnone
Peter H. O'Meara , Commissioner Department of Developmental Services	Commissioner, Department of Developmental Services - Peter H. O'Meara
Doreen DelBianco , Legislative Program Manager, Department of Mental Health and Addiction Services	Commissioner, Department of Mental Health and Addiction Services - Patricia Rehmer
Michael J. Purcaro , MS, PT, Chief of Administration, Department of Public Health	Commissioner, Department of Public Health - J. Robert Galvin
Claudette J. Beaulieu , Deputy Commissioner, Department of Social Services	Commissioner, Department of Social Services - Michael P. Starkowski

¹ The appointing authorities listed reflect the individuals in those offices as of the summer of 2010 when the Commission appointments were made.

John Brooks , Director of Administration Court Support Services Division	Executive Director, William H. Carbone Court Support Services Division
Steven A. Girelli , PhD, President & CEO Klingberg Family Centers	Senate Chair of Appropriations, Toni N. Harp
State Representative Catherine Abercrombie	House Chair of Human Services, Toni E. Walker
Barry Kasdan , President, Bridges...A Community Support System	Senate Chair of Government Administration – Gayle S. Slossberg
Melodie Peters , First Vice President AFT Connecticut	House Chair of Public Health - Elizabeth B. Ritter
Patrick J. Flaherty , Economist Connecticut Department of Labor Appointee with Knowledge of the State’s Labor Market	Governor - M. Jodi Rell
Raymond J. Gorman , President, Community Mental Health Affiliates, Inc. Appointee with Knowledge of Medicaid Policy	
James G. Palma, Jr.	
Patrick J. Johnson, Jr. , President Oak Hill Representing the CT Community Providers Association	Speaker of the House - Christopher G. Donovan
Dr. James H. Gatling , President & CEO New Opportunities Inc. Nonprofit Provider for DSS	
Cinda Cash , Executive Director, The CT Women’s Consortium Employee of a Private Service Provider	Senate Majority Leader - Martin Looney
Marcie Dimenstein , Director of Programs and Services, The Connection, Inc. Nonprofit Provider for DMHAS	
David Pickus , Secretary Treasurer, SEIU 1199NE Representative of State Employees	House Majority Leader - Denise W. Merrill

<p>Maureen Price-Boreland, Executive Director, Community Partners in Action Nonprofit Provider for Corrections or Court Support Services</p>	<p>House Majority Leader - Denise W. Merrill</p>
<p>Lisa A. Mazzeo, LCSW, BCD Knowledge of Economics</p>	<p>Minority Leader of the Senate - John McKinney</p>
<p>William J. Hass, Ph.D. President and CEO- FSW, Inc. Nonprofit Provider for DPH</p>	
<p>Daniel J. O'Connell, Ed.D, President/CEO, CT Council of Family Service Agencies Representing CT Nonprofit Human Services Cabinet</p>	<p>Minority Leader of the House - Lawrence F. Cafero Jr.</p>
<p>Anne L. Ruwet, Chief Executive Officer, CCARC, Inc. Nonprofit Provider for DSS</p>	

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IV. GUIDING PRINCIPLES

Through Special Act 10-5, the Commission was directed to examine the funding provided to nonprofit providers of health and human services under purchase of service contracts. Five (5) specific areas were directed for examination in the Special Act. The consideration of additional items was left to the Commission's discretion.

Then Governor-Elect Malloy issued a call for a review of the existing service provision network with the goal of maximizing services, while lowering the cost to taxpayers.

In its deliberation, findings and recommendation the various working subcommittees and the full commission relied upon a set of "Guiding Principles" to shape the report. Those principles were:

- That the work of the Commission strengthen the public/private partnerships in the delivery of health and human services;
- That quality and effectiveness of service is predicated upon a viable and sustainable nonprofit sector;
- That program or funding changes result in maintained or overall improved client outcomes;
- That the pursuit of efficiency and streamlining processes is a mutual goal of both purchasers and service providers;
- That commission recommendations and future program design be supported by reliable data and analysis; and
- That services need to be client and community focused and based on current best practice models.

It was the desire of the Commission that by adhering to these quality principles in adopting its work and final report, that the Commission will contribute to the development of a model system of care for Connecticut's citizens in need.

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V. BACKGROUND

Meetings/Processes/Actions

The full Commission met for the first time on August 31, 2010 at the Legislative Office Building, Hartford, Connecticut.

At the first meeting the Commission members reviewed the Special Act, discussed the Commission's charge, the process to be used to carry out the charge and meeting schedule.

It was decided that the work of the Commission would be conducted in three phases:

- Listening/Learning using currently available data
- Analyzing Data
- Recommending budget, policy and/or statutory changes that have a likelihood of being implemented

Members determined that for the learning phase the Commission would need to identify and assemble existing data, reports, etc. that could be used in the analyzing phase of work.

The Co-chairs asked that members identify and submit to the Commission any data, reports or information that could be used to carry out the five charges. The submitted information would then be reviewed, shared with the full membership and that which was deemed more germane would be presented to and discussed by the Commission at future meetings.

The following dates were then selected for meetings for the remainder of 2010:

- Tuesday, September 21st
- Tuesday, October 19th
- Tuesday, November 16th
- Tuesday, December 14th

The Commission met for the second time on September 21, 2010. At this meeting members discussed a draft process outline that included a proposal for the establishment of five workgroups. Due to the volume of work involved in the Commission's charge and the tight time frame to accomplish the work it was decided that a workgroup structure provided the best path to achieve the results needed.

After reviewing members selected preferences as to which workgroup he/she wished to participate in the Co-chairs determined that four workgroups should be established rather than five. The four workgroups were:

- Achieving Administrative Efficiencies
- Cost Comparisons - Private and State Services
- Private Provider Cost Increases, Nonprofit Agency Financial Condition, Sources of Revenue
- Projected Cost Savings - Institutional v. Community-Based Care, Projected Cost (2010-2014)

Co-chairs Dakers and DeBiasi selected co-chairs and members for each of the workgroups. Each of the workgroup co-chairs was then allotted two additional member slots on their workgroup to fill with individuals with expertise relevant to the workgroup from outside of the Commission membership to assist the workgroup with their charge. A full listing of workgroup members can be found in the appendices of this report.

The third meeting of the Commission was held on October 19, 2010. Workgroup co-chairs reported on the progress of each group. All workgroups had met at least once as of this date.

The members discussed the possible deliverables from each group for the preliminary report due no later January 1, 2011. It was decided that at a minimum each workgroup would provide a summary of their work to date for the December meeting of the Commission for inclusion in the preliminary report.

On November 16, 2010 the Commission held their fourth meeting. Updates were provided by each of the workgroups.

Members reported that the process had provided an opportunity for an interface between state agencies and nonprofits; the more work the groups accomplish the more work is uncovered and concern continued about the tight time frame for the Commission's work.

The Commission's fifth and final meeting of 2010 was held on December 14, 2010. Members reviewed the summary reports that had been submitted by each of the workgroups. The reports provided information on work-to-date as well as next steps for each of the groups.

With the exception of the Achieving Administrative Efficiencies workgroup who concluded their work and provided recommendations for the consideration of the full Commission, the groups reported that their work was still in progress and would continue.

Co-chairs Dakers and DeBiasi noted that they had reviewed the recommendations from the Achieving Administrative Efficiencies workgroup and selected twenty-seven of them for discussion and possible inclusion in the preliminary report as they believed that there was uniform support for them. They stated that their selection was in no way linked to their priority and/or ease of implementation. The remaining twelve recommendations not considered for the preliminary report are to be considered by the Commission in the future.

Commission members discussed the 27 recommendations and agreed to include them in the preliminary report as amended during discussion at the meeting.

The Commission held its first meeting of 2011 on January 11, 2011. At this time the Commission welcomed as its guest Deborah Heinrich. Ms. Heinrich, a former state representative, recently stepped down from her elected position to join the new administration of Governor Dannel Malloy as the Nonprofit Liaison to the Governor. As the Nonprofit Liaison to the Governor she will interact and communicate directly with the nonprofit providers and to advise the Governor with regard to policy reforms and other measures that will benefit this partnership. The Nonprofit Liaison to the Governor will coordinate efforts to implement these policy reforms. Ms. Heinrich was invited by Co-chairs DeBiasi and Dakers to attend future meetings of the Commission and its workgroups.

The workgroups, with the exception of the Administrative Efficiencies workgroup who had completed their work in December, provided updates of their activities followed by a discussion of the decision making process for recommendations and development of guiding principles that should be upheld in any future health and human services delivery system.

It was decided that the Co-chairs would develop a proposal for the decision making process to be discussed at the next meeting and that the Achieving Administrative Efficiencies workgroup would reconvene to develop a vision statement and guiding principles for the full Commission's consideration.

On February 8, 2011 the Commission met again. The workgroups provided information on their work to date and future timeline.

Co-chairs Dakers and DeBiasi reviewed their proposal for a decision making process for Commission recommendations. After a discussion the members adopted the proposal on a unanimous voice vote.

A discussion of the pending Achieving Administrative Efficiencies recommendations opened with Co-chairs Dakers and DeBiasi presenting a document that listed the twelve pending recommendations as bulleted items rolled up into six broad categories. The Co-chairs explained that the categories capture the intent of the recommendation, with the specific recommendations being potential methods to achieve the intent which

would allow flexibility for the nonprofits and state agencies in developing specific solutions. Members discussed this approach with no clear consensus emerging. A straw poll vote of the twenty-three members present showed thirteen members likely to vote to accept the categorized version of the recommendations and ten members not likely to vote to accept this approach. As the categorized version of the pending recommendations did not receive the required fifteen votes to move forward, Co-chair DeBiasi advised that members should come prepared to vote at the Commission's meeting on March 1, 2011 on the twelve pending specific recommendations, as they were written and submitted by the Achieving Administrative Efficiencies workgroup in their preliminary report.

In other business Co-chair Dakers reported that OPM Secretary Benjamin Barnes had issued a memo to POS agencies regarding health and human services contracting reforms recommended in the Commission's Preliminary Report and that an internal workgroup co-chaired by Ms. Heinrich and Mr. Dakers would be working to ensure that the directives in the memo are implemented.

At the March 1, 2011 meeting the Commission members voted on the twelve remaining pending recommendations of the Achieving Administrative Efficiencies workgroup resulting in four of the recommendations being accepted for inclusion in the final report, one accepted with a change in language, four were not accepted and three were sent back to the workgroup for further discussion and consideration. A full accounting of the action taken on each recommendation is included in a Record of Action in the appendices of this report.

Also at this meeting the Cost Comparisons - Private and State Services workgroup presented their final report and recommendations to the Commission. On a vote of eighteen yes, one no and one abstention the report and recommendations were accepted as written.

On March 8, 2011 the Commission met and received the draft final report of the Project Cost Increases Workgroup.

Co-chair Kasdan provided an overview of the work of the group, the difficulty involved in collecting and analyzing cost data, and the resulting report including the findings and recommendations. Kasdan noted the workgroup was acutely aware of the difficulties related to clearly presenting data and that only a small portion of the data collected by the workgroup appears in the report.

After a thorough discussion and a number of suggestions for revisions made by Commission members regarding the presentation of data, the Commission agreed to refer the report back to the workgroup for clarification of the data and recommendations.

Members also continued their discussion of the Guiding Principles as drafted by the Administrative Efficiencies Workgroup and the remaining pending recommendations from the Administrative Efficiencies Workgroup.

On March 15, 2011 the Commission accepted the report from the Private Provider Cost Increases Workgroup, voted to accept the final three pending recommendations of the Administrative Efficiencies Workgroup and finalized the Guiding Principles.

The Commission held its final meeting on March 29, 2011 to discuss the future of the Commission and its recommendations; and to approve its Final Report due no later than April 1, 2011.

Members recommended that an ongoing body continue to tackle the issues and work to add value to the process of implementing the specific recommendations found its final report

Commission Website

A website for the Commission was established and can be accessed via a link on the OPM home page at www.ct.gov/opm. The website contains information about the Commission meetings, data collection, correspondence, workgroups and reports.

Workgroup Reports

The issues the Commission was charged with analyzing in Special Act 10-5 are complex. Much data exists on the various topics but is not necessarily accessible or in a format that can be applied to areas the Commission is studying.

As noted earlier in this report, the members of the Commission and later the workgroups discovered that much research, data gathering and analyzing had to take place to before the Commission would be in a position to issue findings and recommendations.

When presenting their summary reports to the full Commission on December 14, 2010 only one workgroup, Achieving Administrative Efficiencies, had concluded their work and was able to present findings and recommendations. The other three workgroups continue with their work. All workgroup reports are included in this document's appendices beginning on page thirty-eight.

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VI. FINDINGS AND RECOMMENDATIONS

The forty-nine recommendations of the Commission on Nonprofit Health and Human Services listed below were developed in the four Workgroups discussed earlier. Each Workgroup then presented their recommendations to the full Commission for acceptance and inclusion in this report by a yes vote of 15 or more members of the full Commission.

Some of the recommendations from the Workgroups were not accepted by the required 15 votes of the full Commission and are not included in the list below. Others were discussed by the full Commission and were revised/amended from the text originally provided by the Workgroups. The Workgroup reports which contain all of their recommendations can be found in the appendices of this report.

The implementation of these recommendations, and others, will require focused commitment by State agencies and non-profit providers in order to work through the various issues involved with these changes.

It is critical to emphasize that the implementation of these recommendations will require an ongoing and focused commitment over time by State agencies and non-profit providers in order to work through the various issues involved with these changes. As State agencies, the new Administration and non-profit providers begin work on implementing these recommendations, many will need to be modified or an alternative approach of meeting the goal of the recommendation will have to be taken in light of programmatic, legal and funding requirements not yet identified. In light of the large number of recommendations made and the complexities involved, prioritization will be required if true progress is to be made.

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Recommendations²

1. An ongoing body, similar to this Commission, should be created and charged with tackling the issues before us, working to add value to the process of implementing the specific recommendations, achieving specific results over specific timeframes, and as this Commission has been, should be comprised of a cross-section of representatives from State Agencies, Private Providers and their representative organizations, Labor, and persons who are recipients of benefits under health and human services programs.

The recommendations below are listed by the workgroups from which they originated.

Achieving Administrative Efficiencies Workgroup

The purpose of the administrative efficiency recommendations is to decrease the State and other mandated workload requirements and other administrative burdens on non-profit providers and state agencies while maintaining appropriate oversight and fiscal and programmatic accountability. The work of the workgroup and the full commission reflects the recognition of the need for the State and non-profit providers to move towards new, more efficient methods and approaches to handling these administrative functions.

The Achieving Administrative Efficiencies Workgroup organized its recommendations into four (4) groupings:

- Contracting and Auditing
- Reporting and Data
- State Licensing and Quality Assurance
- Adoption of Best Practices of POS Agencies in CT and Nationally

➤ **Contracting and Auditing:**

Issues and Findings

- POS funds are not allowed or available to be used for health and safety improvements or major repairs, such as meeting ADA compliance, roof replacement, fire suppression, and vehicle replacement. Bond funds will likely be unavailable in the near term. Thus, costs of repairs, maintenance and safety improvements will have to be borne by the provider.

² The recommendations throughout this section are in continuous numerical order to match the recommendation list in the Executive Summary of this report.

Federal Medicaid protocols allow reimbursement for such expenses. However, payment is typically made 18 months in arrears, and at times requiring multiple state agency approvals.

- Annual Single State Audit costs for nonprofit provider agencies continue to rise. Staffing challenges in POS agencies oftentimes result in long delays reviewing independent audit findings.
- There exists significant redundancy among forms, certifications for bid and contract requirements by numerous POS state agencies, including but not limited to, the Attorney General (AG), Connecticut Commission on Human Rights and Opportunities (CHRO) and OPM. This can often result in an unnecessary burden on private provider and state agencies that must provide or require data repeatedly and/or in different formats. State agencies have developed their own separate procedures and capabilities to receive, monitor and store the required data. For non-profit providers contracting with more than one State agency and/or having several State contracts, the result is that duplicate documents (or similar documents containing the same information) are being maintained by multiple state agencies.

Moreover, notarized documents and certifications, such as non-discrimination and gift affidavits, can be requested by numerous POS agencies more than once a year. This is time consuming and burdensome to both the private nonprofit provider and the state agency.

Recommendations

2. POS State agencies, in consultation with OPM, should evaluate the need and feasibility of consolidation of current general fund appropriations for POS services into as few SID's as feasible and practical.
3. Raise the dollar amount definition of a "capital expense" (e.g., from \$5,000 to \$25,000).
4. Permit private providers with POS contracts to set aside POS funds for one-time "large" expenses with approval of the CT State POS contracting agency. (e.g., up to 5% of budget).
5. CT State POS agencies should collaborate to expedite Medicaid reimbursements.
6. Establish "clean audit" standards for Single State Audits that, when met by private nonprofit provider agencies, would result in a financial audit being required every two (2) years versus annually.
7. Encourage CT State POS agencies, in consultation with non-profit providers, to establish a uniform method to measure and audit program results (e.g., Results-Based Accountability (RBA)).

8. The legislature should eliminate nondiscrimination certification forms, which simply repeat language already included or referenced in all State POS contracts.
9. Allow notarized copies of current documents and certifications (not eliminated by above recommendation) to be executed only once per year, by a date specified and as updated; and have documents electronically scanned and posted on-line for review by any CT State POS agency, as well as compliance and auditing agencies (AG, Comptroller, CHRO, OPM, and auditors).
10. OPM should standardize and streamline all POS contract and contract compliance forms (data collection) across and within CT State POS agencies, and make them available online using standard format which can be filled in online, such as "PDF Fillable Forms."
11. The State should develop a web-based "electronic file cabinet" known as a "Document Vault" to house all documents relevant to contracts, bids and monitoring to eliminate redundancies. The Document Vault should be maintained by a centralized state agency, such as OPM.
12. Upon creation of a Document Vault, each nonprofit contractor would be responsible for posting their own materials.
13. CT State POS agencies should adopt and use standard forms for collecting workforce and minority subcontractor data from POS contractors.
14. Electronic signatures should be permissible and accepted for contracts and financial reports.

➤ **Reporting and Data:**

Issues and Findings

- POS agencies often use different reporting systems to collect similar data. This results in extraordinary expense to the private nonprofit providers and to the State. While there will be ongoing needs to modify data items to be collected and reported on an as needed basis, wholesale data system changes need to be better planned.
- All healthcare providers will be required by federal law to have Electronic Health Record (EHR) systems by 2014 as well as exchange data that is encrypted.

The Nonprofit Cabinet has indicated to OPM and POS agencies that the cost of encrypting servers, laptops, mobile devices, etc. (as required under DOIT's initial rulings) will be prohibitive, especially at a time when funding is being reduced. The Legislature has recommended that the State assist providers in purchasing data encryption software through a bulk purchase not only to make the software more affordable, but also to help ensure that providers and state agencies are using the same software so that their systems can easily communicate with one another.

There are several examples now of providers being unable to communicate via email with state agencies because of differing encryption software.

Recommendations

15. State agencies, under the oversight of OPM, should collaboratively develop a common reporting system that would satisfy the requirements for data reporting by private nonprofit providers.
16. OPM should conduct a review of all POS reports and protocols (data reporting) to determine that all information requested is applicable, required, being utilized, and uniformly interpreted within and across all CT State POS agencies.
17. Implementation of new data reporting “systems” should be spelled out in the POS contract language, including timing, data migration requirements and funding.
18. OPM and DOIT, in partnership with private provider trade associations and the CT Health Information Technology Exchange, should review available EHR systems with necessary data encryption protocols and identify 2 or 3 “Preferred Providers” that private nonprofit providers could utilize for their EHR. This would prevent private providers from having to perform the same due diligence while ensuring that EHR’s and the State reporting requirements are aligned.
19. DOIT and AG together with representatives from nonprofit providers need to agree on the definition of which “devices” need to operate with encryption.
20. OPM should coordinate the selection of “Preferred Providers” with DOIT to ensure all CT State POS agencies can receive encrypted EHR data in a confidential and timely manner.

➤ **State Licensing and Quality Assurance**

Issues and Findings

- Nonprofit provider agencies often find that the program model that they have contracted for is in conflict with the regulatory standards or interpretation of another state agency, i.e. community-based residential providers could be held accountable for nursing standards more appropriate for institutional vs. community care settings.
- When state agencies adopt new regulations, interpret existing regulations differently, or revise a program model, insufficient consideration, in some instances, is given to the impact on nonprofit provider agencies. No additional funding is granted to providers for capture, e.g., changes in mandatory training for fire suppression, case load expansion, etc.
- Nonprofit providers are obligated by POS contract to comply with licensing and quality assurance standards and regulations. Oftentimes licensing and QA system

are independent of each other, resulting in duplication of efforts and inefficient use of resources.

Recommendations

21. DCF, DDS and DPH should adopt standards allowing “deemed status” to be granted to a provider who has earned and maintained accreditation by a nationally recognized organization such as the Joint Commission on Accreditation of Health Care Organization (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA).
22. Results and findings from all visits/audits should be shared among POS agencies (both licensure and compliance) to enable reduction in number of overall visits, and eliminating redundant visits from within the same agency.
23. POS State agencies, in collaboration with non-profit providers, should conduct an examination of existing regulations, as they pertain to or impact the provision of POS services. Existing regulations that are redundant or conflicting should be repealed or amended to reduce or eliminate both conflict and redundancy and to minimize unnecessary impact on service providers. Examination of regulations and recommended changes should be completed during the upcoming biennium.
24. Regulations should be reviewed by CT State POS agencies in collaboration with private providers to determine the appropriateness of the regulation for community-based settings.
25. The State of CT should appropriately fund new mandates.
26. In cases where the licensing and QA/monitoring functions of a program are done by more than one State agency, State agencies should seek to coordinate the findings of any such reviews.
27. Consideration should be given to consolidating licensure requirements and authority into fewer state agencies.

➤ Adoption of Best Practices

Issues and Findings

The Workgroup identified several best practices used by one or more POS state agencies which have already been shown to save time and money for consideration by other agencies.

Recommendations

28. Encourage electronic payments, including electronic fund transfers.
29. Reduce the need for budget amendments, by not requiring them for slight (e.g., up to 5%) variances.
30. Where appropriate and allowable, use prospective payments after a one-year probationary period (for either new contractors or problematic contractors).
31. Use contract periods that allow sufficient time for contract renewals, while also preserving contractor's responsibility for client services during transition of contracts. (e.g., 13 rather than 12 months, 25 rather 24 months, 37 rather than 36 months)
32. Encourage use of multi-year contracts and/or consolidate multiple contracts between one POS agency and one nonprofit provider.
33. Encourage nonprofit providers to take advantage of existing organizations that provide members access to discounted professional services, such as, employee benefits, business services, IT and data security, and insurance.
34. Encourage nonprofit providers to focus on service delivery, training and implementation of best practices, and align their program measures with the uniform method established by State agencies in consultation with non-profit providers, to measure and audit program results (e.g., Results-Based Accountability (RBA)).
35. Non-profit providers, in collaboration with POS State agencies, should examine the feasibility and the advisability of the consolidation of functions and/or services where such consolidation will result in increased efficiencies, program stability and adequate service delivery.
36. Encourage the consolidation of state agencies and commissions where mission and clients served overlap and/or are complementary. However, consolidation should be done in a manner that preserves direct access between clients and the program's decision-makers (i.e., where funding decisions are made). For example, BESB should not be consolidated with DSS, unless there were guarantees that BESB clients, including those dually diagnosed blind and deaf, had direct access (within 24 hours response) to the decision-makers that fund their programs.

Cost Comparisons - Private and State Services Workgroup

The Cost Comparisons - Private and State Services Workgroup was charged with undertaking a comparison of the costs of services provided by a state agency with the costs of services provided by a private provider, including a comparison of wages and benefits for private union employees, private nonunion employees and state employees. Due to limited staff and time constraints, the workgroup limited its analysis to a comparison of the wages and benefits offered by the State and non-profit providers.

Issues and Findings

The Workgroup noted that the size of the service delivery system makes a difference. Because the state service system is large, wages and benefits can be established through collective bargaining with workers receiving union protection and representation during negotiations. The Private Non-Profit sector has trade associations to represent them, but they do not engage in bargaining and contract negotiations for their individual membership agencies. Some nonprofit agencies are unionized but it is a very small percentage of the overall number of nonprofit agencies although they tend to be some of the larger agencies.

Wages: Wage information was obtained for the selected positions described below.

- **Job Title and Job Descriptions** do not easily compare between the State and Private Non-Profit Providers. The Cost Comparison Workgroup settled on five (5) job titles and descriptions to review because some similarity between positions in each sector could be addressed. They are as follows:
 - Mental Health Assistant I (DMHAS)
 - Developmental Services Worker 1 (DDS)
 - Registered Nurses
 - Social Workers
 - Information Technology (IT) workers

- **Entry Level Positions**
 - The Committee found that there were similar job descriptions and duties within the Mental Health Assistant 1 (DMHAS) and the Developmental Services Worker 1 (DDS), both on the state side. As noted in this workgroup's Preliminary Report, "The pay scale for MHA1 is \$21.35 to \$28.75 while for DSW1 is \$19.44 to \$26.35. These rates are significantly higher than comparable position in the private Nonprofit sector. A survey by DDS of the annual reports of its eight largest providers showed a high wage rate (17.03) that was below the minimum DSW1 rate." That difference over one year based on a 40 work week amounts to a difference of \$8,986 – \$24,378 in wages. The information from DDS is based on the eight largest providers. If we assume that other medium to small agencies cannot pay what the larger agencies pay, the disparity would be even more significant.

- Comparison data from DDS and CCPA's most recent Private Nonprofit salary survey on Group Home staff showed another significant wage disparity. The Developmental Services Worker 1 full time hourly average was \$25.41 compared to \$14.50 in the Nonprofit Sector. This disparity calculates a \$22,693 annual salary difference between the sectors using a 40-hour work week for 52 weeks.
- **Social Workers.** Data from the Commission on Enhancing Agency Outcomes (CEAO) showed a significant wage difference that on an annual basis amounted to almost a \$22,000 difference in annual salary.
- **Nurses and Information Technology.** With regard to both the Nursing and Information Technology staff, it was shown that each of those positions are "market driven" and each sector essentially has to pay market rates in order to employ necessary nursing and IT staff.

Benefits: The difference in benefit structure between the Private Nonprofit and State sectors is most apparent with regard to Pension, Retirement and Health Insurance.

➤ **Pension & Retirement**

Defined-benefit pensions are virtually non-existent in the nonprofit sector. The ability of the State to provide pensions adds an element to the Wage and Benefit equation that produces a significant, incomparable imbalance between the two (2) sectors.

Cost of Retirement Benefits for State Employees and Retirees

According to the audit report dated November 15, 2010^{*}, For FY2012, the normal annual required contribution will be \$296,567,797 or 9% of annual compensation, averaging 5,923.78 per active employee as of June 30, 2010. This average includes employees in all "tiers" of the employee retirement system. State normal cost contribution as percent of member payroll for Tier IIA Regular (nonhazardous) employees (those hired after July 1, 1997) is 4.6% of member payroll.

While not a cost of *current* employment, a major cost of the state retirement system is the accrued liability. Again according to the audit report, payment toward this liability should be 22.06% of payroll or \$14,519 per current employee in order to reduce the liability to 0 by the year 2032. While these ratios are of interest and are used for budgeting purposes, they do not reflect the cost of a current employee. Should the number of state employees be reduced, the required total payment toward the accrued liability would be the same and so the ratio and cost per employee would rise.

Cost of Retirement Benefits for Private Nonprofit Providers

Based on annual reports submitted to DDS for FY 2009 retirement expense was \$25,633,191 or 2.97% of total salary of all providers.

The 2008 CT Nonprofit Employee Benefits Study does not have a section on retirement benefits.

Seven of the eight largest DDS providers responded to an informal survey regarding retirement benefits. Most reported no defined benefit plan at all. The two that did, either require equal contribution from the employee or contributes 5% of annual salary. The others do make a defined contribution plan available although not all match any employee contributions. When some match is provided it is much less than dollar for dollar with the maximum employer contribution between 1% and 2.5% of employee salary.

➤ **Health Insurance**

The state provides its employees with health benefits that provide a choice that is greater than private non-profits can provide. The benefits provided by the state to its employees carry a cost structure that is high per employee. Because of the size of its budget, the state has many options to respond to an increase in health care benefits and can often absorb these increases without harming direct services provided by the state.

Cost of Health Insurance Benefits for State Employees

State employees are eligible for a comprehensive set of health insurance benefits. As of September 31, 2010 the state had approximately 52,481 permanent full-time employees. In FY 2011, the state budgeted \$524.6 million to provide its employees with health insurance or approximately \$10,000 per permanent full-time employee. (OLR 2010-R-0479)

However, Appendix I of the Commission on Enhancing Agency Outcomes reported that the average state employee compensation for Health Insurance is \$12,173 or 18.52% of salary. Data from CORE-CT show that medical insurance for DDS Employees is 17.83% of salaries and wages. Note, this is the *average* cost to the state and does not include the employee premium share.

Cost of Health Insurance Benefits for State Retirees

One significant cost to the state without a parallel in the private-nonprofit sector is the cost of retiree health insurance. According to the Office of Legislative Research (2010-R-0479) the state funds retiree health insurance on a “pay as you go” basis and the state budgeted \$595.3 million for FY11 for this expense. According to the same report there are 41,910 active retirees, so the annual cost to the state is \$14,204 per retiree. This figure includes retirees who participated

in programs offering early retirement incentives. Employees hired on or after July 1, 2009, and existing employees with less than five years of state service as of July 1, 2010 must contribute 3% of their pay to a retiree health insurance fund until they reach 10 years of service.

Cost of Health Insurance Benefits for Private Nonprofit Providers

Based on annual reports submitted to DDS for FY 2009 health and insurance expense was \$100,056,997 or 11.58% of total salary of all providers (applies to DDS only). The 2008 CT Nonprofit Employee Benefits Study reported that 92.7% of nonprofits provide group health insurance to employees and 74.4% provide dental coverage. According to this report, the average cost of all organization-paid fringe benefits was 25.3% of payroll including tuition assistance, counseling services, paid time off and applicable taxes such as Social Security.

Nonprofit providers have reported receiving regular and large increases in premium costs for the health insurance they provide their employees. When these increases occur, the providers have three options: reduce the level of benefits they provide their employees, reduce staffing levels and reduce service levels.

Recommendations

Wages

37. While the state's current fiscal situation may preclude immediate action, the state should commit to funding Private Nonprofit providers at a level that would allow the Private Nonprofit sector to raise the wages of its lowest paid workers and to implement a salary structure that would allow the Private Non-Profit sector to recruit and retain a qualified workforce.

Health Insurance

38. To attract and retain a qualified workforce and to ensure the health of its employees, the Private Nonprofit sector needs to provide comprehensive employee health benefits. The state's contracts, rate, and fee structure need to support this goal.

Retirement Benefits

39. Through its contracting procedures, the state should provide financial incentives to Nonprofit Providers to establish or enhance retirement benefit programs. Carefully structured retirement benefits could provide an incentive for employee longevity, reducing the costs and service discontinuity associated with staff turnover.

Private Provider Cost Increases, Nonprofit Agency Financial Condition, Sources of Revenue Workgroup

The Private Provider Cost Increases, Nonprofit Agency Financial Condition, Sources of Revenue Workgroup was charged with analyzing and making recommendations regarding recommendations regarding provider cost increases; financial condition of agencies; and sources of revenue. Their findings and recommendations are outlined below.

The Workgroup, using available government and industry data and indices, analyzed nonprofit private provider cost increases over the period from 1999-2009.

Issues and Findings

The Workgroup found that, over the past several years there have been changes in the business environment faced by the Non-Profit Health and Human Services providers that have challenged the provider community to meet new mandates and inflationary increases for essential expenses that have far outpaced the normal inflationary increases and represent a larger percentage of the private provider budget than would normally be represented in a typical CPI calculation. These are the type of expenses a nonprofit agency has little ability to control. Although it may be within an agency's control to improve efficiencies or scale down the quality of a commodity or service, it would not be realistic to believe these expenditures could be eliminated. The cost categories reviewed by the Workgroup include:

- **Health Care Benefits Premiums.** From the period of 1999 to 2009, health care benefits have increased by 135% in the State of Connecticut. These cost increases have been borne by providers in terms of higher costs and/or their employees in terms of higher cost sharing requirements or reduced levels of insurance. There are a number of providers that have employees in the wage categories that make the employees eligible for inclusion in the Husky Plan, representing a potential an unintended and undocumented additional cost to the State of Connecticut.
- **Electrical Utilities.** CL & P from the year 2000 to 2010 has increased rates 90.1%; UI from the year 2000 to 2010 has increased rates 87.3%
- **Motor Vehicle Expenses.** These expenses, including general motor vehicle upkeep costs, and the cost of fuel and insurance increased by 77% during the period between 1999 and 2009.
- **Insurance: Liability, and D & O; Maintenance of Technology, Staff Training and Billing; Property Maintenance and Repairs.** While cost increases have been experienced in these areas, data was not available to obtain cost trends.
- **Wage Adjustments Below the CPI.** From 1999 to 2009, Human Services contracts were increased by approximately 23.9%. The CPI increase from 1999

to 2009, has been 28.77%. Given the requirement to absorb increases beyond the CPI for the cost categories cited above, salary increases are impacted in a negative way causing private provider salary increases to not only not meet the CPI, but also not meet the State COLA percentage.

Financial Condition of Agencies

Task: To determine the financial condition of the State's Private Provider Community.

Method: The workgroup researched and selected tools to produce a comprehensive view of the financial condition of the State's non-profit providers. The workgroup selected a sample group of 101 from the 490 Health and Human Services providers with revenues over \$300,000 who receive State funds. The workgroup then proceeded with the calculation of various financial ratios specific to nonprofits to test the financial fitness of the sample group. The results were compared to a recent study done in this area by the Urban Institute.

The Workgroup split the sample group into three categories for analysis purposes: Group 1- total revenue ranging from \$300,000 up to \$2,000,000 (32.8% of agencies sampled); Group 2 - total revenues from \$2,000,000 up to \$10,000,000 (36.54% of sample); and Group 3 - total revenue over \$10,000,000 (31.68% of sample).

The calculations were performed on the data taken from the in the private providers' audits conducted by certified public accountants, and provided to the State of Connecticut, as per the State's contracting regulations. The audit period used was SFY 2009. The following financial ratios were calculated:

- $DI = \text{Cash} + \text{Marketable Securities} + \text{Receivables} / \text{Average Monthly Expenses}$
- $\text{Liquid Funds Indicator (LFI)} = \text{Total Net Assets} - \text{Restricted Net Assets} - \text{Fixed Assets} / \text{Average Monthly Expenses}$
- $\text{LFA} = \text{Dollar Value of Unrestricted New Assets} - \text{Net Fixed Assets} + \text{Mortgages and Other Notes Payable}$
- $\text{OR} = \text{Operating Reserves} / \text{Annual Operating Expenses}$
- $\text{Savings Indicator (SI)} = \text{Revenue} - \text{Expense} / \text{Total Expense}$
- $\text{Debt Ratio (DR)} = \text{Average Total Debt} / \text{Average Total Assets}$
- $\text{CR} = \text{Current Assets} / \text{Current Liabilities}$

The Workgroup's analysis, similar to results of the Urban Institute's report, indicate that a large percentage of the Connecticut non-profit providers are in a financially precarious position, operating dangerously close to their margin and likely would not be able to maintain operations if they experienced unforeseen increases in expenses or a financially detrimental incident.

The difference between smaller and larger community based nonprofit providers, as it pertains to financial fragility, requires more careful analysis given the significant variables between organization's administrative costs, capital assets, fund development capacity, and ability to leverage debt.

Sources of Revenue

In regard to sources of revenue, the Workgroup analyzed: a.) State funding of the nonprofit community during the past decade, b.) the current revenue funding mix, c.) trends in philanthropy, and d.) possible future funding mixes.

- a) State Funding of Non-Profit Providers.** The Workgroup found that the COLA of 21.7% provided to non-profit providers over the past decade to the Medical CPI (42.2%) and Consumer CPI (27.7%).
- b) Current Revenue Funding Mix.** The Workgroup found that those with State revenues per year between \$300,000 and \$2.0 million had the highest percentage of Governmental Funding at 75.82%. Those with funding over \$2.0 million had very similar levels of Governmental Funding 64.00% and 62.08% respectively. Another interesting similarity is that providers with under \$10 million in State funds have the same exact percentage of funds coming from Philanthropy efforts at 9.5%, while those over \$10 million had a much lower percentage of funds from Philanthropy, with donated funds making up only 1.7% of their overall revenues.
- c) Trends in Philanthropy.** The Chronicle of Philanthropy reported on October 17, 2010, that donations had dropped 11% at the nation's biggest charities during this last year. This is the worst decline in two decades, with this year's decrease being four times as great as the next largest annual decrease that was recorded in 2001 at the rate of 2.8%.
- d) Possible Future Funding Mixes.** There is the possibility of changing the funding mix for services, and exploring more Medicaid reimbursed services; however, this opportunity involves a number of additional administrative requirements and issues for the providers and the State that should be considered prior to switching the funding source from grant funding to Medicaid funding:

Recommendations

- 40. We believe it is important to have data over a period of time. It is recommended that a retrospective calculation of financial ratios included in this report be conducted from 2007 to 2010, with the audits that are on hand at the OPM to determine if the results indicate trends. It is further recommended that the financial ratios be completed on an on-going basis so trends in the private providers' financial condition can be assessed over a period of time.

41. It is recommended that a special committee of providers and State officials, chaired by the Nonprofit Liaison to the Governor, be assembled to assess and report on financial trends and unforeseen expenses and analyze provider increases and fixed costs impacting the private providers' financial position and possible solutions.
42. It is recommended that when system wide technical requirements are imposed or expected of Nonprofit providers that the State takes a lead role in assisting providers by investigating the options, initiating a bidding process to attempt to achieve savings and by providing technical assistance to providers. The current method results in a duplication of effort and costs and often results in providers having not acquired the required product. It also results in a system that makes communication with State agencies and other private providers inefficient which further burdens the system because of a lack of consistency amongst the State Agencies.
43. A cost benefit analysis should be conducted for all revenue producing initiatives including Medicaid services, waivers, and Private Non-Medical Institution. This analysis should be conducted with not only the State's costs being considered but also the costs to private providers. It is recommended that the State be cautious in its attempts to change the payer mix. If the new costs to the entire system, including both the State and the providers, are more than the State will receive in reimbursement it should be understood that this will not be a cost effective change for the State and may result in a need to continue to provide grant funding for non-reimbursable expenses. When providers do not have the investment dollars to establish the infrastructure necessary to successfully make the change in the payer mix, it results in audit findings and significant repayment of funds only further jeopardizing the providers' financial condition.
44. It is recommended that mechanisms be developed to compensate not for profit providers doing business with the state for necessary costs that occur outside the control of the provider. These necessary costs most commonly occur due to vacancies, admission delays, discharge delays, transfer delays, or unfunded continued occupancy (aka overstays).
45. It is recommended that a break-even analysis be done when changing service models and funding streams to determine if the funding model matches the program type and size and that the census requirements are realistic for the provider to remain financially viable. Consideration should be given to the size of the program, turnover and average billable units of care. The best practices movement to smaller settings may make previous rate setting and funding models less effective and appropriate than the larger services they were created for decades ago.

**Projected Cost Savings-Institutional v. Community Based Care,
Projected Costs (2010-2014) Workgroup**

According to Special Act No. 10-5, the Commission shall analyze the funding provided to nonprofit providers of health and human services under purchase of service contracts. As part of this analysis, the Projected Cost Savings-Institutional v. Community Based Care, Projected Costs Workgroup was charged to provide the following:

- A projection of cost savings that may be achieved by serving individuals who are recipients of benefits under health and human services programs in their communities rather than in institutions and
- The projected costs associated with the provision of services by private providers under health and human services programs through December 31, 2014. With respect to this second charge, the Workgroup was able to obtain projections done by the General Assembly's Office of Fiscal Analysis for the period up through 2014; however, this information involved an inflationary factor that applied to POS contracts for State budget projection purposes and did not reflect a deeper review of the actual costs for private providers moving forward. Additional time and resources would be needed to develop more detailed and accurate projections of private provider costs.

Issues and Findings

Overview: Historically, institutional care has provided a safe place for the provision of services to those whose disability or severity of illness required their removal from family and community and required a higher level of care. For some, long term or even lifetime confinement was deemed appropriate. Over time, advancements in treatment methodologies, expansion of community based services and psychopharmacological advances have greatly reduced lengths of stay and even negated the need for institutionalization. Increasing numbers of individuals are now safely treated and served in their local communities; remaining with family, moving toward independent living, residing in group homes, attending school and maintaining a gainfully employed status. These developments are paralleled in the healthcare industry when we look at decreased lengths of stay for hospitalizations and increased utilization of ambulatory services.

The cost of institutional vs. community-based care was the focus of the workgroup's efforts. Aggregate cost data was requested from DMHAS, DCF, DDS, DPH, DOC, and DSS for both the state government and the non-profit sector through the grant information and fiscal reporting that the state agencies have through POS contracts with private providers. The Workgroup concluded that the most useful and meaningful data to secure across various non-profit sectors would be generated by sampling cost data from DCF, DMHAS, and DDS. These agencies were requested to submit a

comprehensive worksheet, which their fiscal staff assisted in developing. The data is summarized in the workgroup's template and is included in the Workgroup's report, which report can be found in the appendix of this report. In addition, the Workgroup requested that the remaining departments (DPH, DOC and DSS) provide their data on the summary template only.

The task of providing this data has been a challenge for the various reporting agencies because each Department collects and maintains their data differently. As a result, several factors contributed to lengthy and in-depth discussions to best understand how to gather and analyze this data. Some of these factors are important to mention and include:

- The need to clarify service sector data definitions across agencies in a meaningful way.
- The variability of standardization has made this task challenging; however, this has been an important "lessons learned" experience.
- Populations served and service needs are recognizably diverse and even unique in many sectors, therefore the comparability of data/costing between departments has limited use and was discouraged.
- The Workgroup concluded that a separate analysis of data within each state agency and how it related to institutional vs. community based care was most meaningful.
- The most challenging and time consuming task for the agencies was the aggregating of nonprofit grant data for analysis and reporting in accordance with our template.

The Workgroup has gathered data in various forms from all of the reporting agencies. Not all departments were able to formulate their data into the template, thereby making the analysis challenging. State institutional cost data was more straight forward, whereas data from community non-profits was a significant challenge if departments were not already aggregating that data. Again, the lack of standardization of service definitions and levels of care for a diverse group of populations across departments was a major issue in understanding what we were asking for and then determining if a department had sufficient data to provide to the Workgroup.

While we encountered many challenges and obstacles, we were able to collect data to begin sampling the key issues that we were charged to explore. We stress the word "sampling" and do not present this report and its data as a definitive representation of all services and levels of care or funding streams that should be explored in doing a comprehensive data analysis that represents cost differences between state operated institutional care and community based services rendered by Connecticut's non-profit agencies. The cost information gathered to date, along with information about what costs are included in the various rates listed (which makes comparisons difficult), is included in the charts below.

Cost Information: Institutional, Residential and Community Services

Department of Developmental Services - Institutional Services		
Institution	Southbury Training School	Regional Center
Annual	\$357,000.00	\$361,350.00
Daily	\$980.00 per client	\$990.00
Average Daily Census	474.9	89
Level of Need	5.13	6.02
Included In This Data	<ul style="list-style-type: none"> • Health Care • Room and Board • Behavioral Health Services • Day Program/Day Services • DDS Costs: Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation Amount, Recovery Amount 	<ul style="list-style-type: none"> • Health Care • Room and Board • Behavioral Health Services • Day Program/Day Services • DDS Costs: Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation Amount, Recovery Amount

Department of Developmental Services Facilities - Residential Services		
Institution	Residential DDS Public	Residential DDS Private
Annual	\$297,110.00	\$136,371.00.00
Daily	\$814.00	\$373.62
Average Daily Census	177	2,698
Level of Need	5.26	4.92
Included In This Data	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Day Program/Day Services • DDS Costs: Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation Amount, Recovery Amount • 2009 Data prior to conversion of 17 public group homes • These do not include day programs • Non ICF 	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • No health care is included in these costs • DDS support to private sector • DDS Case Management • Provider Costs: Personal Services, Workers' Compensation, Employee Benefits, Non-reimbursable costs, total non-salary cost and A&G • 2009 Data prior to conversion of 17 public group homes • These do not include day programs • Non ICF

Cost Information: Institutional, Residential and Community Services

Department of Mental Health and Addiction Services - Institutional Services	
Institution	Inpatient Connecticut Valley Hospital
Annual	\$451,140
Daily	\$1,236.00
Average Daily Census	499.3
Included In This Data	<ul style="list-style-type: none"> • Room and Board • Physical health care • Behavioral health services • Prescriptions • Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation • Transportation • Vocation Services

Department of Mental Health and Addiction Services - Residential/Community Services					
Agency	MRO Group Home	MH Supervised Apartments	MH Supportive Housing	MH Case Management	MH Outpatient
Annual	\$52,274.60	\$46,230.90	\$11,804.10	\$6,402.10	\$2,179.05
Daily	\$144.04	\$126.66	\$32.34	\$17.54	\$5.97
Average Patient Days	183	551	663	3779	9981
Included In This Data	<ul style="list-style-type: none"> • Rent • Food • Includes Medicaid FFS payments • Provider Costs: Personal Services, Workers' Compensation, Employee Benefits, Non-Reimbursable Costs, and A&G 	<ul style="list-style-type: none"> • Case Mgmt. • Rent • Provider Costs: Personal Services, Workers' Compensation, Employee Benefits, Non-Reimbursable Costs, and A&G 	<ul style="list-style-type: none"> • Case Mgmt. • Rent • Provider Costs: Personal Services, Workers' Compensation, Employee Benefits, Non-Reimbursable Costs, and A&G 	<ul style="list-style-type: none"> • Client Support Money • Provider Costs: Personal Services, Workers' Compensation, Employee Benefits, Non-Reimbursable Costs, and A&G 	<ul style="list-style-type: none"> • Provider Costs: Personal Services, Workers' Compensation, Employee Benefits, Non-Reimbursable Costs, and A&G

Cost Information: Institutional, Residential and Community Services

Department of Children and Families - Institutional Services		
Institution	Riverview	Private Hospital
Annual	\$769,960	\$474,500
Daily		\$1,300.00
Average Daily Census	66.0	Statewide Private Hospital Capacity
Level	5	4
Included In This Data	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Medical and Dental Services • Medication • Rehabilitation Therapy • Translation Services • Education / Academic and Vocational • All Care and Custody items including clothing, personal and hygiene supplies • DCF Costs: Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation Amount, Recovery Amount 	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Rehabilitation Therapy

Department of Children and Families - Residential/Community Services				
Agency	Private Residential	Therapeutic Group Home	At Home Services	Out-Patient MH Services
Annual	\$113,592	\$208,184	\$50,691	\$687.78
Daily	\$314.61	\$570.37	\$138.88	N/A
Average Daily Census	409	267	Varies	15,800
Level	3	2	1	1
Included In This Data	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Rehabilitation Therapy 	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Rehabilitation Therapy 	<ul style="list-style-type: none"> • In home behavioral health services 	<ul style="list-style-type: none"> • Children placed at home, served at a DCF licensed clinic

Findings

- The transition from institutional to community-based care, with an appropriate balance of resources, is a work in progress for Connecticut's health and human services agencies. This appears to be a strategic objective for all the state agencies submitting data.
- A primary objective of our state and private providers is to provide the least restrictive level of care that is clinically indicated for every child, adult, and family seeking services; however, it is recognized that higher levels of care, including institutional, may always be needed as part of the service continuum.
- The data indicates that where clinically appropriate community based services can be provided at a lower per diem rate than the more restrictive higher levels of care provided in an institutional setting. Of note, other funding streams, both public and private, factor into supporting the necessary mix of community resources needed.

Conclusion

In conclusion, data trends across agencies point to the cost effectiveness of community based care vs. institutional care. For the state to save money there will need to be a carefully planned phase-down of institutional beds as spending on community services grows. This trend needs to be embraced with the recognition that true cost savings can only be generated through a thoughtful and strategic planning process that recognizes and balances, with great care, both the risks and benefits that will impact clients and providers across the continuum of care.

Recommendations

46. The Workgroup recommends that Connecticut establish a statewide data warehouse for health and human services through a standardized, comprehensive and integrated reporting system across state agencies.
47. The Workgroup recommends that additional in-depth data analysis be performed to develop a standardized costing methodology.
48. The Workgroup recommends that key fiscal staff in state health and human service agencies meet regularly to address the recommendations identified in #1 and #2 above.
49. The Workgroup recommends that the state support a robust community based system of care that provides timely and accessible services across a broad continuum. Appropriate distribution of resources among community based services and institutions along this continuum of care would allow for a more effective service balance that would reduce institutional lengths of stay while providing community based services that can divert an increasing number of individuals from our hospitals and state institutions, where appropriate. This would offer the most cost effective health and human services system to Connecticut's children and adults.

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Substitute Senate Bill No. 316

Special Act No. 10-5

**AN ACT ESTABLISHING A COMMISSION ON NONPROFIT
HEALTH AND HUMAN SERVICES.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (*Effective from passage*) (a) There is established a Commission on Nonprofit Health and Human Services. The commission shall examine the funding provided to nonprofit providers of health and human services under purchase of service contracts. For purposes of this section, "purchase of service contract" (1) means a contract between a state agency and a private provider organization or a municipality for the purpose of obtaining direct health and human services for agency clients and generally not for administrative or clerical services, material goods, training or consulting services, and (2) does not include a contract with an individual.

(b) The commission shall consist of the following members:

(1) The Secretary of the Office of Policy and Management, or the secretary's designee;

(2) The Commissioner of Children and Families, or the commissioner's designee;

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(3) The Commissioner of Correction, or the commissioner's designee;

(4) The Commissioner of Developmental Services, or the commissioner's designee;

(5) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

(6) The Commissioner of Public Health, or the commissioner's designee;

(7) The Commissioner of Social Services, or the commissioner's designee;

(8) The executive director of the Court Support Services Division of the Judicial Branch, or the executive director's designee;

(9) The Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, or the chairperson's designee;

(10) The House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to human services, or the chairperson's designee;

(11) The Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to government administration, or the chairperson's designee;

(12) The House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or the chairperson's designee;

(13) Three appointed by the Governor, one of whom shall have

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knowledge of the state's labor market and one of whom shall have knowledge of Medicaid policy;

(14) Three appointed by the president pro tempore of the Senate, one of whom shall be a representative of the Connecticut Association of Nonprofits, one of whom shall be a representative of a nonprofit service provider that is under contract with the Department of Children and Families and one of whom shall be a representative of persons who are recipients of benefits under health and human services programs;

(15) Two persons appointed by the speaker of the House of Representatives, one of whom shall be a representative of the Connecticut Community Providers Association and one of whom shall be a representative of a nonprofit service provider that is under contract with the Department of Social Services;

(16) Two persons appointed by the majority leader of the Senate, one of whom shall be an employee of a private service provider or an authorized representative of employees of private service providers and one of whom shall be a representative of a nonprofit service provider that is under contract with the Department of Mental Health and Addiction Services;

(17) Two persons appointed by the majority leader of the House of Representatives, one of whom shall be a state employee or an authorized representative of state employees and one of whom shall be a representative of a nonprofit service provider that is under contract with the Department of Correction or Court Support Services Division of the Judicial Branch;

(18) Two persons appointed by the minority leader of the Senate, one of whom shall have knowledge of economics and one of whom shall be a representative of a nonprofit service provider that is under

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contract with the Department of Public Health; and

(19) Two persons appointed by the minority leader of the House of Representatives, one of whom shall be a representative of the Connecticut Nonprofit Human Services Cabinet and one of whom shall be a representative of a nonprofit service provider that is under contract with the Department of Developmental Services.

(c) All appointments to the commission shall be made not later than July 1, 2010. Any vacancy shall be filled by the appointing authority.

(d) The Governor and the president pro tempore of the Senate shall select the chairpersons of the commission from among the members of the commission. Such chairpersons shall schedule the first meeting of the commission, which shall be held not later than September 1, 2010.

(e) The commission shall be located within the Office of Policy and Management for administrative purposes only.

(f) The commission shall analyze the funding provided to nonprofit providers of health and human services under purchase of service contracts. Such analysis shall include, but not be limited to: (1) A comparison of the costs of services provided by a state agency with the costs of services provided by a private provider, including a comparison of wages and benefits for private union employees, private nonunion employees and state employees; (2) the cost increases associated with the provision of services by private providers under health and human services programs from 2000 to 2009, inclusive, including increases in the cost of employees' health insurance, workers' compensation insurance, property casualty insurance and utilities; (3) the projected costs associated with the provision of services by private providers under health and human services programs through December 31, 2014; (4) a projection of cost savings that may be achieved by serving individuals who are recipients of benefits under

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health and human services programs in their communities rather than in institutions; and (5) sources of revenue for health and human services programs.

(g) (1) Not later than January 1, 2011, the commission shall submit a preliminary report, in accordance with the provisions of section 11-4a of the general statutes, on its findings and recommendations to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies for review and comment. Such preliminary report shall include, but not be limited to, recommendations for budget, policy and statutory changes that can be effectuated to improve funding for nonprofit providers of health and human services under purchase of service contracts.

(2) Not later than April 1, 2011, the commission shall submit a final report, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. Such final report shall include, but not be limited to, recommendations for budget, policy and statutory changes that can be effectuated to improve funding for nonprofit providers of health and human services under purchase of service contracts. The commission shall terminate on the date that it submits such final report or April 1, 2011, whichever is later.

Approved June 8, 2010

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Workgroup Membership

Achieving Administrative Efficiencies

1. Joel Ide (**Chair**)
2. Wanda Dupuy-OPM (Ide Choice)
3. Judi Jordan-DCF (Ide Choice)
4. Ray Gorman (**Chair**)
5. Dennis Keenan (Gorman Choice)
6. Deborah Ullman, Executive Director, YWCA Hartford Region (Gorman Choice)
7. John Brooks
8. James Palma
9. Anne Ruwet
10. Rep. Abercrombie
11. Jim Gatling

Cost Comparisons - Private and State Services

1. Cinda Cash (**Chair**)
2. Patrick Flaherty (**Chair**)
3. John Noonan-OPM, Budget (Flaherty Choice)
4. Margaret Glinn-DCF (Flaherty Choice)
5. Ronald Fleming, Executive Director, Alcohol and Drug Recovery Centers (Cash Choice)
6. Carolyn Parler-McRae, Chief Operation Officer, APT Foundation (Cash Choice)
7. Doreen DelBianco
8. Peter O'Meara
9. Daniel O'Connell
10. Melodie Peters

Workgroup Membership, continued

Private Provider Cost Increases, Nonprofit Agency Financial Condition, and Sources of Revenue

1. Patrick Johnson **(Chair)**
2. Cindy Butterfield, DCF **(Chair)**
3. Stephen DiPietro-DMHAS (Butterfield Choice)
4. Joe Drexler – DDS (Butterfield Choice)
5. Barry M. Simon, Executive Director, Gilead Community Services (Johnson Choice)
6. Spencer Cain, Cain Associates LLC (Johnson Choice)
7. Marcie Dimenstein
8. Maureen Price-Boreland
9. William Hass
10. Steven Girelli

Projected Cost Savings - Institutional v. Community-Based Care, Projected Costs (2010-2014)

1. Barry Kasdan **(Chair)**
2. Michael Purcaro, DPH **(Chair)**
3. Peter Mason-DDS (Purcaro Choice)
4. Melanie Sparks-DOC (Purcaro Choice)
5. Heather Gates, Pres/CEO Community Health Resources (Kasdan Choice)
6. Pamela Fields, Executive Director, ARC of Meriden-Wallingford, Inc. (Kasdan Choice)
7. Claudette Beaulieu
8. Donna Grant
9. Lisa Mazzeo
10. David Pickus
11. Jessica Sacilowski

WORKGROUP

FINAL

REPORTS

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ACHIEVING ADMINISTRATIVE EFFICIENCIES

Recommendations from the
ACHIEVING ADMINISTRATIVE EFFICIENCIES WORKGROUP

Commission on Nonprofit Health and Human Services

The Achieving Administrative Efficiencies Workgroup is a Subcommittee of the Commission on Nonprofit Health and Human Services. The membership of the Subcommittee is as follows:

Joel Ide (Chair)	Raymond J. Gorman (Chair)
Wanda Dupuy	Judi Jordan
Dennis Keenan	Deborah Ullman
John Brooks	James Palma
Anne Ruwet	Rep. Catherine Abercrombie
James Gatling	

At its initial meeting on Oct 18, 2010 it was determined that consistent with Legislative intent, the Subcommittee would explore administrative efficiencies that would decrease state mandated workload requirements and administrative burdens to nonprofit providers. Concurrently, consideration has been given to exploring those administrative efficiencies that would be realized by state Purchase of Service (POS) agencies [reference to POS agencies also includes Judicial Branch programs that fall under the Nonprofit Commission] with the adoption of the Subcommittees recommendations. Both the state POS agencies and private nonprofit providers will benefit from the adoption of these recommendations.

Additionally, the Subcommittee decided to organize its recommendations into four (4) groupings:

- Contracting and Auditing
- Reporting and Data
- State Licensing and Quality Assurance
- Adoption of Best Practices of POS Agencies in CT and Nationally

It was further discussed and agreed that the Subcommittee would utilize existing bodies of work and analysis where possible to help formulate its recommendations. Additional information gathered and utilized by the Subcommittee came from a variety of government, nonprofit and private sources. The following is a list of materials utilized by the Subcommittee in formulating its recommendations:

- 1) Purchase of Service Report – OPM, Office of Finance, 2009
- 2) Redundant Forms Report – OPM, July 2010
- 3) Purchase of Service Workgroup Findings – OPM, 2010
- 4) Contracting Best Practices – Whitepaper – Connecticut Nonprofit Human Services Cabinet, November 2010
- 5) Consolidation Proposals – James Palma, Commission Member, November 2010
- 6) “Contractor Data Collection System” – Judicial Branch, November 2010

The categorical listing of Subcommittee findings and recommendations follow.

Contracting and Auditing

A) Finding:

Providers that are funded for multiple services by most POS agencies are financed by different “Special Identification Codes” (SID’s). There is little or no flexibility for the POS agency or provider to shift dollars among SID’s to meet client’s needs in the most efficient manner. For example, a nonprofit provider may receive funds from one POS agency to serve a select set of clients, yet funding is allocated among 4 different SID’s.

Recommendation:

- POS agencies should be permitted to collapse funding for POS services into as few SID’s as possible, ideally only 1 per agency. The POS agency would retain the right to approve all budget revisions in POS contracting.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

B) Finding:

POS funds are not allowed or available to be used for health and safety improvements or major repairs, such as meeting ADA compliance, roof replacement, fire suppression, and vehicle replacement. Bond funds will likely be unavailable in the near term. Thus, costs of repairs, maintenance and safety improvements will have to be borne by the provider.

Federal Medicaid protocols allow reimbursement for such expenses. However, payment is typically made 18 months in arrears, and at times requiring multiple state agency approvals.

Recommendations:

- Raise the dollar amount definition of a “capital expense” from \$5,000 to \$25,000.
- Permit POS agencies to set aside up to 5% of POS funds for one-time “large” expenses.
- Establish MOU’s between and among all POS agencies to expedite Medicaid reimbursements.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

C) Finding:

Annual Single State Audit costs for nonprofit provider agencies continue to rise. Staffing challenges in POS agencies oftentimes result in long delays reviewing independent audit findings.

Recommendations:

- Establish “clean audit” standards for Single State Audits that, when met by private nonprofit provider agencies, would result in a financial audit being required every two (2) years versus annually.
- Encourage all POS agencies to adopt and follow “Results Based Accountability (RBA)” as a uniform method to measure and audit program outcomes.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

D) Finding:

There exists significant redundancy among forms, certifications for bid and contract requirements by numerous POS state agencies, including but not limited to, the Attorney General (AG), Connecticut Commission on Human Rights and Opportunities (CHRO) and OPM. This results in an unnecessary burden to private provider agencies to provide data repeatedly and/or in different formats. State agencies have developed their own separate procedures and capabilities to receive, monitor and store these data. The result is that thousands of duplicate documents

(or similar documents containing the same information) are being maintained by up to 20 state agencies.

Moreover, notarized documents and certifications, such as non-discrimination and gift affidavits, can be requested by numerous POS agencies more than once a year. This is time consuming and burdensome to both the private nonprofit provider and the state agency.

Recommendations:

- The legislature should eliminate nondiscrimination certification forms, which simply repeat language already included or referenced in all State contracts.
- Allow notarized documents and certifications (not eliminated by above recommendation) to be executed only once per year, by a date specified; and have documents electronically scanned and posted on-line, which can be reviewed by any POS agency, as well as compliance and auditing agencies (AG, Comptroller, CHRO, OPM, and auditors).
- OPM should standardize and streamline all POS contract and contract compliance forms (data collection) across and within POS agencies, and make them available online using standard format which can be filled in online, such as “PDF Fillable Forms.”
- The State should develop a web-based “Document Vault.” This would eliminate redundancy in the application and monitoring process by creating an “electronic file cabinet” which would house all documents relevant to contracts, bids and monitoring. The Document Vault would be a more efficient system, allowing state agencies to call up information as needed.
- Each nonprofit contractor would be responsible for posting their own materials, with the web-based Document Vault being maintained by a centralized state agency, such as OPM.
- POS agencies should adopt and use standard forms for collecting workforce and minority subcontractor data from POS contractors.
- Electronic signatures should be permissible and accepted for contracts and financial reports.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other – Exec. Order

Reporting and Data

A) Finding:

All POS agencies use considerably different reporting systems to collect basically similar data. This results in extraordinary expense to the private nonprofit providers and to the State. While there will be ongoing needs to modify data items to be

collected and reported on an as needed basis, wholesale data system changes need to be better planned.

Recommendation:

- State agencies, under the oversight of OPM, should collaboratively develop a single, web-based reporting system that would satisfy the requirements for data reporting by private nonprofit providers.
- OPM should conduct a review of all POS reports and protocols (data reporting) to determine that all information requested is applicable, required, being utilized, and uniformly interpreted within and across all POS agencies.
- Implementation of new data reporting “systems” should be spelled out in the POS contract language, including timing, data migration requirements and funding.

Adoption of this recommendation would require:

Legislative Change Regulatory Change Policy Directive Other

B) Finding:

All healthcare providers will be required by federal law to have Electronic Health Record (EHR) systems by 2014 as well as exchange data that is encrypted.

The Nonprofit Cabinet has indicated to OPM and POS agencies that the cost of encrypting servers, laptops, mobile devices, etc. (as required under DOIT’s initial rulings) will be prohibitive, especially at a time when funding is being reduced. The Legislature has recommended that the State assist providers in purchasing data encryption software through a bulk purchase not only to make the software more affordable, but also to help ensure that providers and state agencies are using the same software so that their systems can easily communicate with one another. There are several examples now of providers being unable to communicate via email with state agencies because of differing encryption software.

Recommendations:

- OPM, in partnership with private provider trade associations, should review available EHR systems with necessary data encryption protocols and identify 2 or 3 “Preferred Providers” that private nonprofit providers could utilize for their EHR. This would prevent private providers from having to perform the same due diligence while ensuring that EHR’s and the State reporting requirements are aligned.
- DOIT and AG together with representatives from nonprofit providers need to agree on the definition of which “devices” need to operate with encryption.
- OPM shall coordinate the selection of “Preferred Providers” with DOIT to ensure all POS agencies can receive encrypted EHR data in a confidential and timely manner.

- The state should utilize its bulk purchasing power and purchase data encryption software that can then be sold to providers at a reduced rate compared with them each purchasing it individually. Not only does this save money, but it also ensures that the state computers are able to communicate with its contractors computers regarding confidential and restricted state data.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

State Licensing and Quality Assurance

A) Finding:

Many nonprofit provider agencies are licensed to provide services by the Department of Public Health (DPH), Department of Developmental Services (DDS), or the Department of Children and Families (DCF). In some cases, such as clinical outpatient services, both compliance with licensure visits/reviews/audits are made by different staff at different times, yet collect similar data, which can be burdensome to the providers. Licensing reports and findings from the State are often 3-6 months post visit.

Recommendations:

- DCF, DDS and DPH should adopt standards allowing “deemed status” to be granted to a provider who has earned and maintained accreditation by a nationally recognized organization such as the Joint Commission on Accreditation of Health Care Organization (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA).
- Earning such “deemed status” would exempt the provider from routine state licensing and certification activities.
- Results and findings from all visits/audits should be shared among POS agencies (both licensure and compliance) to enable reduction in number of overall visits, and eliminating redundant visits from within the same agency.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

B) Finding:

Nonprofit provider agencies often find that the program model that they have contracted for is in conflict with the regulatory standards or interpretation of another state agency, i.e. community-based residential providers could be held accountable for nursing standards more appropriate for institutional vs. community care settings.

Recommendations:

- Regulations must be reviewed by POS agencies in collaboration with private providers to determine the appropriateness of the regulation for community-based settings.
- The Department of Public Health should conduct a thorough review of the regulations that community-based providers are required to comply with. As a result of that review, existing regulations should be amended or repealed and, where appropriate, new regulations developed that more accurately reflect the provision of community-based service.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

C) Finding:

When state agencies adopt new regulations, interpret existing regulations differently, or revise a program model, insufficient consideration is given to the impact on nonprofit provider agencies. No additional funding is granted to providers for capture, e.g., changes in mandatory training for fire suppression, case load expansion, etc.

Recommendation:

- All new mandates must be appropriately funded.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other – Exec Order

D) Finding:

Nonprofit providers are obligated by POS contract to comply with licensing and quality assurance standards and regulations. Oftentimes licensing and QA system are independent of each other, resulting in duplication of efforts and inefficient use of resources.

Recommendations:

- In cases where the licensing and QA/monitoring functions of a program are done by more than one state agency, the findings of any reviews will be consolidated into one plan of correction or compliance certification.
- Consideration should be given to consolidating licensure requirements and authority into one state agency.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

Adoption of Best Practices of POS Agencies in CT and Nationally

A) Finding:

Below are several best practices provided by one or more POS state agencies, which have already been shown to save time and money. We hope that more agencies will consider adopting these recommendations.

Recommendations:

- Encourage electronic payments, including electronic fund transfers.
- Use prospective payments after a one-year probationary period (for either new contractors or problematic contractors).
- Use 13 month contract period to accommodate time for contract renewals, while also preserving contractor’s responsibility for client services during transition of contracts.
- Reduce the need for budget amendments, by not requiring them for slight (up to 5%) variances.
- Encourage use of multi-year contracts and/or consolidate multiple contracts between one POS agency and one nonprofit provider.
- Encourage nonprofit providers to take advantage of existing organizations that provide members access to discounted professional services, such as, employee benefits, business services, IT and data security, and insurance. One such group is The Alliance for Nonprofit Growth and Opportunity (TANGO).

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

B) Finding:

There are over 700 nonprofit POS providers that vary in scope, size, and geographic coverage across Connecticut. Their expertise and performance vary, with well run organizations not likely to merge with or take over troubled organizations. There appears to be great redundancy in the administration of POS contacts across the 700 providers, which collectively are required to spend scarce resources on administration rather than care of the client.

Any consolidation of state agencies and nonprofit providers should be done with care so that the client’s needs are met, if not improved.

Recommendations:

- The state should consider identifying one lead POS agency to provide similar services, programs, and operations across all POS agencies. For example, one state agency could contact for all POS Case Management services.
- POS agencies should foster and facilitate the consolidation of nonprofit providers, while maintaining full coverage geographically across the state. For example, a POS agency could provide special financial assistance to bring a “troubled” nonprofit’s

facility up to code to encourage a “healthy” provider to take over the troubled program, without diminishing their service outcomes. Note that there may be private funding opportunities to help finance these types of transitions.

- Encourage the consolidation of state agencies and commissions where mission and clients served overlap and/or are complementary. However, consolidation should be done in a manner that preserves direct access between clients and the program’s decision-makers (i.e., where funding decisions are made). For example, BESB should not be consolidated with DSS, unless there were guarantees that BESB clients, including those dually diagnosed blind and deaf, had direct access (within 24 hours response) to the decision-makers that fund their programs.
- Consolidate the POS contracting, oversight and payment functions into an integrated procurement system. Some elements of such a system already exist within the CT Department of Administrative Services online “State Procurement Marketplace.” This could be expanded as is being done in Florida, Wisconsin and New York City, to include POS services.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

C) Finding:

Increasingly more and more time and effort must be spent on contract administration, compliance, audit review, IT and data security which makes it difficult for nonprofit providers to maintain, much less improve client care and services. In short, client services suffer, especially when funds are tight.

There may be administrative efficiencies in having a centralized, select staff handle the contract administration, with separate and dispersed staff to provide actual POS care and services.

Recommendations:

- Encourage nonprofit providers to focus on service delivery, training and implementation of best practices, and improving service outcomes through Results Based Accountability.
- Encourage POS contract administration to be consolidated within 1 to 5 nonprofit enterprises or a consortium, where the consortium will be the single point of contact with one or more POS state agencies and subcontract with multiple nonprofit providers.

Adoption of this recommendation would require:

- Legislative Change Regulatory Change Policy Directive Other

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COST COMPARISONS - PRIVATE AND STATE SERVICES**Commission on Non-Profit Health and Human Services****Workgroup: Cost Comparisons – Private and State Services****Narrative Cost Comparison Considerations****February 28, 2011****Introduction – Points of Interest**

1. The charge of this workgroup is Cost Comparisons of Wages and Benefits as they relate to the Non-Profit Sector's health, i.e., meaning financial health as it relates to service delivery to many of Connecticut's most vulnerable citizens. The focus of the Cost Comparison Workgroup is the human service Non-Profit sector that receives funding from a variety of state agencies such as DMHAS, DDS, DCF and DSS and the federal government.
2. The Nonprofit Sector is a group of small businesses that receive taxpayer dollars from a variety of state agencies, especially those mentioned above. They are site visited and monitored for compliance to the state rules and regulations by each agency from whom they receive funds.
3. Some Non-Profit agencies report that some of their staff in certain occupations are paid so little that they qualify for the HUSKY program and food stamps and that they take advantage of those services to be able to live. These staff are working with clients who are also on HUSKY and receiving food stamps, making the separation between staff and client quite marginal at best.
4. The workgroup in no way assumes that either the delivery of services of the Nonprofit and State Sector provides better services than the other. Rather, there are environmental/cultural considerations that display an imbalance in the environment in which each sector exists.
5. The Non-Profit providers have received no increase in three (3) years and over a 15-year period have received annual increases of about 1.2% on average. Because the state offers better long-term benefits than the Non-Profit Providers are able to offer given funding levels, the state is better able to maintain staff.

More employee stability provides state employees with higher wages due to automatic annual salary increases.

Size of the service delivery system makes a difference

1. Because the state service system is large, wages and benefits can be established through collective bargaining with workers receiving union protection and representation during negotiations. The Private Non-Profit sector has trade associations to represent them, but they do not engage in bargaining and contract negotiations for their individual membership agencies. Some nonprofit agencies are unionized but it is a very small percentage of the overall number of nonprofit agencies although they tend to be some of the larger agencies.
2. Because the nonprofit human service system consists of a large number of separate, community, grass roots organizations, each organization has a separate set of missions, operating principles, staffing patterns. They have developed as a result of communities within the state wishing to address the social service needs for citizens of their communities. As a result, most nonprofit agencies have developed a patchwork of funding streams to support the delivery of their services. For example, an agency may receive funding from a variety of state agencies such as DDS, DMHAS, DOC, CSSD, federal dollars through Medicaid, NIDA, NIAAA, CDC, DOJ. In addition, the agency will often have a significant donor-based fundraising activity.

Wages: Due to limited staff and time constraints, the workgroup limited its analysis to the following items:

- **Job Title and Job Descriptions** do not easily compare between the state and Private Non-Profit Providers. The Cost Comparison Workgroup settled on five (5) job titles and descriptions to review because some similarity between positions in each sector could be addressed. They are as follows:
 - Mental Health Assistant I (DMHAS)
 - Developmental Services Worker 1 (DDS)
 - Registered Nurses
 - Social Workers
 - Information Technology (IT) workers
- **Entry Level Positions**
 - a. The Committee found that there were similar job descriptions and duties within the Mental Health Assistant 1 (DMHAS) and the Developmental Services Worker 1 (DDS), both on the state side. As noted in this workgroup's Preliminary Report, "The payscale for MHA1 is \$21.35 to \$28.75 while for DSW1 is \$19.44 to \$26.35. These rates are significantly higher than comparable position in the private NonProfit sector. A survey by DDS of the annual reports of its eight largest providers showed a high wage rate (17.03)

that was below the minimum DSW1 rate.” That difference over one year based on a 40 work week amounts to a difference of \$8,986 – \$24,378 in wages. The information from DDS is based on the eight largest providers. If we assume that other medium to small agencies cannot pay what the larger agencies pay, the disparity would be even more significant.

- b. Comparison data from DDS and CCPA’s most recent Private Non-Profit salary survey on Group Home staff showed another significant wage disparity. The Developmental Services Worker 1 full time hourly average was \$25.41 compared to \$14.50 in the Nonprofit Sector. This disparity calculates a \$22,693 annual salary difference between the sectors using a 40-hour work week for 52 weeks.

➤ **Social Workers**

Data from the Commission on Enhancing Agency Outcomes (CEAO) showed a significant wage difference that on an annual basis amounted to almost a \$22,000 difference in annual salary.

➤ **Nurses and Information Technology**

With regard to both the Nursing and Information Technology staff, it was shown that each of those positions are “market driven” and each sector essentially has to pay market rates in order to employ necessary nursing and IT staff.

Benefits: The difference in benefit structure between the Private Non-Profit and State sectors is most apparent with regard to Pension, Retirement and Health Insurance.

➤ **Pension & Retirement**

Defined-benefit pensions are virtually non-existent in the non-profit sector. The ability of the State to provide pensions adds an element to the Wage and Benefit equation that produces a significant, incomparable imbalance between the two (2) sectors.

Cost of Retirement Benefits for State Employees and Retirees

According to the audit report dated November 15, 2010^{*}, as of June 30, 2010 there were 50,064 active members (current employees) and 41,782 retired members and beneficiaries in the Connecticut State Employees Retirement System. For FY2012, the normal annual required contribution will be \$296,567,797 or 9% of annual compensation, averaging 5,923.78 per active employee as of June 30, 2010.

This average includes employees in all “tiers” of the employee retirement system. Tier I employees (hired before July 1, 1984) contribute 2% of their salary. Tier II employees (hired between July 1, 1984 and June 30 1997) receive reduced benefits but do not have to make and contributions, and Tier IIA employees receive Tier II level benefits

^{*} Report of Cavanaugh Macdonald Consulting, LLC to the Office of the State Comptroller and the State Employee Retirement Commission, November 15, 2010.

also contribute 2% of their salaries. Just over half of current employees (26,136 of the 50,064) are in Tier IIA. Each tier also contains a significant number of employees in “Hazardous” groups. 6,185 of the current Tier IIA employees are in the hazardous category.

State normal cost contribution as percent of member payroll for Tier IIA Regular (nonhazardous) employees is 4.6% of member payroll. (Source: OLR 2010-R-0268)

While not a cost of *current* employment, a major cost of the state retirement system is the accrued liability. Again according to the audit report, payment toward this liability should be 22.06% of payroll or \$14,519 per current employee in order to reduce the liability to 0 by the year 2032. While these ratios are of interest and are used for budgeting purposes, they do not reflect the cost of a current employee. Should the number of state employees be reduced, the required total payment toward the accrued liability would be the same and so the ratio and cost per employee would rise.

- State Early Retirement Incentive Program:

The state offers a defined benefit plan with retirement benefits based on the average of the highest three years of salary and years of service. In the past, the state has used early-retirement mechanisms to reduce the high cost staffing levels although these have often added to the long-term costs of the state.

- No Nonprofit Early Retirement Incentive exists:

When the employees of a Nonprofit provider retire, they retire with whatever they have saved and there are no incentives or longevity or health care or other benefits. Some nonprofit agencies are not able to provide retirement funding at all.

Cost of Retirement Benefits for Private Nonprofit Providers

Based on annual reports submitted to DDS for FY 2009 retirement expense was \$25,633,191 or 2.97% of total salary of all providers.

The 2008 CT Nonprofit Employee Benefits Study does not have a section on retirement benefits.

Seven of the eight largest DDS providers responded to an informal survey regarding retirement benefits. Most reported no defined benefit plan at all. The two that did either require equal contribution from the employee or contributes 5% of annual salary. The others do make a defined contribution plan available although not all match any employee contributions. When some match is provided it is much less than dollar for dollar with the maximum employer contribution between 1% and 2.5% of employee salary.

➤ **Health Insurance:**

The state provides its employees with health benefits that provide a choice that is greater than private non-profits can provide. The benefits provided by the state to its employees carry a cost structure that is high per employee. Because of the size of its budget, the state has many options to respond to an increase in health care benefits and can often absorb these increases without harming direct services provided by the state.

Cost of Health Insurance Benefits for State Employees

State employees are eligible for a comprehensive set of health insurance benefits. As of September 31, 2010 the state had approximately 52,481 permanent full-time employees. In FY 2011, the state budgeted \$524.6 million to provide its employees with health insurance or approximately \$10,000 per permanent full-time employee. (OLR 2010-R-0479)

However, Appendix I of the Commission on Enhancing Agency Outcomes reported that the average state employee compensation for Health Insurance is \$12,173 or 18.52% of salary.

Data from CORE-CT show that medical insurance for DDS Employees is 17.83% of salaries and wages.

Note, this is the *average* cost to the state and does not include the employee premium share. Under the plans presently available, a single employee will pay \$495.30 annually for the least expensive policy (including dental). The most expensive family plan currently open costs the employee \$3,597.88 annually. (OLR 2010-R-0479).

Cost of Health Insurance Benefits for State Retirees

One significant cost to the state without a parallel in the private-nonprofit sector is the cost of retiree health insurance. According to the Office of Legislative Research (2010-R-0479) the state funds retiree health insurance on a “pay as you go” basis and the state budgeted \$595.3 million for FY11 for this expense. According to the same report there are 41,910 active retirees, so the annual cost to the state is \$14,204 per retiree. This figure includes retirees who participated in programs offering early retirement incentives.

Presumably in future years some of this cost will be partially offset by the employee retiree health insurance fund established as part of SEBAC 2009. Employees hired on or after July 1, 2009, and existing employees with less than five years of state service as of July 1, 2010 must contribute 3% of their pay to a retiree health insurance fund until they reach 10 years of service.

Cost of Health Insurance Benefits for Private Nonprofit Providers

Based on annual reports submitted to DDS for FY 2009 health and insurance expense was \$100,056,997 or 11.58% of total salary of all providers (this applies to DDS only).

The 2008 CT Nonprofit Employee Benefits Study reported that 92.7% of nonprofits provide group health insurance to employees and 74.4% provide dental coverage. According to this report, the average cost of all organization-paid fringe benefits was 25.3% of payroll including tuition assistance, counseling services, paid time off and applicable taxes such as Social Security.

Nonprofit providers have reported receiving regular and large increases in premium costs for the health insurance they provide their employees. When these increases occur, the providers have three options: reduce the level of benefits they provide their employees, reduce staffing levels and reduce service levels. There has been no increased state funding to cover these costs. Most state contracts, regulations, or licensure preclude service level changes without prior state approval.

Recommendations:

The workgroup endorses the principles that a healthy Private Non-Profit sector is vital to the citizens of Connecticut, particularly to the many families and individuals served by the Private Non-Profit providers. The Nonprofit Health and Human Service providers must be recognized as partners with the state in the provision of essential services to Connecticut's most vulnerable citizens. It is imperative that the State provide a system of adequate funding and support to ensure appropriate, high quality services by Private Non-profit providers now and in the future. This can only be achieved by working together in a true partnership.

Wages:

While the state's current fiscal situation may preclude immediate action, the state should commit to funding Private Non-Profit providers at a level that would allow the Private Non-Profit sector to raise the wages of its lowest paid workers and to implement a salary structure that would allow the Private Non-Profit sector to recruit and retain a qualified workforce.

Health Insurance

To attract and retain a qualified workforce and to ensure the health of its employees, the Private Non-Profit sector needs to provide comprehensive employee health benefits. The state's contracts, rate, and fee structure need to support this goal.

Retirement Benefits

Through its contracting procedures, the state should provide financial incentives to Non-Profit Providers to establish or enhance retirement benefit programs. Carefully structured retirement benefits could provide an incentive for employee longevity, reducing the costs and service discontinuity associated with staff turnover.

NOTE: Much of the data used in these discussions are attributed to the support of DDS. Other state agencies did not collect data in a fashion that could engage in good wage comparison discussion.

Workgroup Membership

Cinda Cash, Executive Director, The CT Women's Consortium (Chair)

Patrick Flaherty, Economist, CT Dept. of Labor (Chair)

John Noonan-OPM, Budget (Flaherty Choice)

Margaret Glinn-CT Dept. of Children & Families (Flaherty Choice)

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**PRIVATE PROVIDER COST INCREASES, NONPROFIT AGENCY FINANCIAL
CONDITION, SOURCES OF REVENUE**

Commission on Nonprofit Health and Human Services

**Private Provider Cost Increases, Nonprofit Agency Financial Condition and
Sources of Revenue Workgroup Report**

Committee Members:

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Introduction

The Commission on Nonprofit Health and Human Services assembled four workgroups to investigate various aspects and conditions impacting the Nonprofit Health and Human Services Providers, the State, and the delivery of services. The Private Provider Cost Increases, Nonprofit Agency Financial Condition and Sources of Revenue Workgroup was tasked with testing various financial conditions and evaluating the changing business environment. The following report represents the findings of the workgroup and recommendations based on those findings. We believe that a strong partnership between the State and the Nonprofit Providers is essential to the delivery of quality services to the citizens of our State. The recommendations offered in this report highlight remedies in areas of concern and opportunities to improve service delivery. The Workgroup appreciates the opportunity to work on such an important assignment and feels hopeful regarding the potential impact that implementation of the report's recommendations would have on improving the system.

Part 1

Task: To analyze nonprofit private provider cost increases that represent costs increases that exceed the CPI or represent a larger percentage of a provider's budget than would normally be attributed in the CPI calculation.

Method: Research was performed on industry and governmental information regarding inflationary increases.

Over the past several years there have been changes in the business environment faced by the Non-Profit Health and Human Services providers that have challenged the provider community to meet new mandates and inflationary increases for essential expenses that have far outpaced the normal inflationary increases and represent a larger percentage of the private provider budget than would normally be represented in a typical CPI calculation. These are the type of expenses a nonprofit agency has little ability to control. Although it may be within an agency's control to improve efficiencies or scale down the quality of a commodity or service, it would not be realistic to believe these expenditures could be eliminated.

In the case of several of these expenses there is industry data for the State of Connecticut and the Northeast region of the country that indicates the inflationary increases in those sectors. For the groups where the data are available we have looked at the period of time from 1999 to 2009 for comparison purposes. Some of the items are too narrow in scope because of the specialized nature of the service or mandates imposed by the State and Federal government through licensing and new legal provisions to be able to apply actual industry inflation figures. In those cases we have indicated the factors leading to inflationary increases over the normal CPI allocation.

a. Health Care Benefits Premiums

From the period of 1999 to 2009, health care benefits have increased by 135% in the State of Connecticut. With the COLAs the providers have received it is unlikely that the provider community has been able to sustain the same level health benefits the employees once had access to under the provider plans. There are cases where the providers still allow their employees access to the higher levels of health insurance but the premium cost to the employees has become so high they can't afford to take advantage of the provider's plan. There are a number of providers that have employees in the wage categories that make the employees eligible for inclusion in the Husky Plan. Provider employees that are utilizing the Husky Plan for the health benefits represent an unintended and undocumented additional cost to the State of Connecticut.

Source: The Burden of Health Insurance Premium Increases on American Families, Executive Office of the President of the United States

b. Electrical Utilities -

- CL & P from the year 2000 to 2010 has increased rates 90.1%
- UI from the year 2000 to 2010 has increased rates 87.3%

Due to the physical plant requirements of providers the CPI allotment doesn't entirely include these increases.

Source: State of Connecticut - Department of Utility Control

c. Motor Vehicle Expenses - Motor vehicle expenses, including general motor vehicle upkeep costs, and the cost of fuel and insurance increased by 77% during the period between 1999 and 2009. Providing transportation for clients is a higher percentage of operating expenses than the CPI would normally allow in its calculation.

Source: US General Services Administration

d. Insurance: Liability, and D & O - These are types of insurance that are specific to the provider community in many cases and premiums have increased beyond normal inflation. The increases by provider are too individual to document. This expense is not within the provider's control to economize.

e. Maintenance of Technology, Staff Training and Billing – Over the past several years there have been many new requirements for data collection, billing, data encryption, etc., coming from various sources. These are unfunded mandates and have been very expensive for the providers to managed and absorb. The outcome of unfunded mandates being passed to the providers is either a reduction in the quantity or quality of services being provided, or to have a detrimental impact on the private providers' financial position.

- f. Property Maintenance and Repairs - This expense is once again too individual in nature to attach a specific inflationary increase to the expense. Again this is an area where the private providers are very likely to have expenses that far exceed the CPI because of the nature of the business they engage in and the types of clients and services provided. Grants have not historically been given allowances for these types of expenses.
- g. Wage Adjustments Below the CPI - During the period from 1999 to 2009, Human Services contracts were increased by approximately 23.9%. The CPI increase from 1999 to 2009, has been 28.77%. As we look at expenses that represent a large portion of a private provider's budget and the requirement to absorb increases beyond the CPI, these factors are likely to impact the salary increases in a negative way causing private provider salary increases to not only not meet the CPI, but also not meet the State COLA percentage. Private provider employees that are in the lower paying positions and are not receiving regular increases that keep pace with inflation have historically had higher turnover rates. These employees are often represent the largest single group of the employees. High turnover rates increase costs in staff training, recruitment, and since this group often has the most direct contact with the clients, it negatively impacts the quality of service and client continuity.

Part 2

Financial Condition of Agencies

Task: To determine the financial condition of the State's Private Provider Community.

Method: The workgroup researched and selected tools to produce a comprehensive view of the financial condition of the State's non-profit providers. The workgroup selected a sample group of 101 from the 490 Health and Human Services providers with revenues over \$300,000 who receive State funds. The workgroup then proceeded with the calculation of various financial ratios specific to nonprofits to test the financial fitness of the sample group. The results from the sample group were then compared with the Urban Institute's National Study of Nonprofit-Government Contracts and Grants: Overview, from the National Study of Nonprofit-Government Contracting Survey Results (2009 Data), and found that the sample group and the Urban Institute's findings indicated similar results regarding the financial condition of the providers.

The Workgroup split the stratified sample group into three categories for analysis purposes. Group 1, as we will refer to it in our outcome analysis, is comprised of providers that had total revenue ranging from \$300,000 up to \$2,000,000, representing 31.68% of the total sample group or 32 agencies. Group 2 is comprised of providers with revenues from \$2,000,000 up to \$10,000,000, representing 36.64% of the total sample group or 37 agencies. Group 3 is the providers with total revenue over \$10,000,000 representing 31.68% of the entire sample group or 32 agencies. The decision to split the groups by these dollar values was made because large clusters of

vendors clustered at midpoints in each group and became more sparsely spaced towards the group break points.

The calculations were performed on the data taken from the in the private providers' audits, that were conducted by certified public accountants, and provided to the State of Connecticut, as per the State's contracting regulations. The audit period used was SFY 2009. The following are the outcomes of the financial ratio calculations:

The first group of ratios we tested was related to the liquidity of the Agencies and their immediate ability to meet expenses with the reserves on hand.

The first financial ratio we tested was the Defensive Interval (DI).

DI = Cash + Marketable Securities + Receivables / Average Monthly Expenses

This ratio score indicates how many months the organization could operate if no additional funds were received. The Defensive Interval includes all funds, including funds that are being held for restricted purposes and may not be able to be accessed for certain operating expenses.

Synopsis of Results: The results indicate that with the inclusion of all funds, the Group 1 and Group 2 providers are in a similar financial condition with roughly 25% of those tested not having sufficient assets to cover one month of expenses without receiving more funds. The Group 3 providers did score higher on this ratio with only 6.25% of the providers not having one month's worth of expenses available. Overall 19% of all providers did not meet the minimum of one month's of expenses on hand.

The second financial ratio tested against the sample group was the Liquid Fund Indicator.

Liquid Funds Indicator (LFI) = Total Net Assets - Restricted Net Assets - Fixed Assets/Average Monthly Expenses

The liquid funds indicator is similar to the defensive interval in its use but is more conservative in removing assets with restrictions on them from the calculation. It also determines the number of months of expenses that can be covered by existing assets. The benchmark for a favorable rating is a minimum of 1 month assets or a LFI score of 1 or more. This ratio has been used more often with non-profit providers because it does exclude restricted funds, that may not actually be available to cover operating expenses. Restricted funds are more common in the non-profit environment than in the private sector in general because of restrictions set by donors and by the provider's board.

Synopsis of Results: The vast majority of providers do not have an acceptable level of assets to cover one month of operating expenses. The results are somewhat effected because the audits were as of 6/30/2009 and the next quarter's allotment for State funding had yet to arrive. With that said, this would be the financial situation the

providers would find themselves in at the end of every quarter. Only 22.77% of the entire sample group had an acceptable ratio score of over 1.0. The smaller providers in Group 1 had a higher percentage of providers with acceptable scores. Groups 2 and 3 both had poor results. The difference between the DI and LFI results would indicate that Group 1 had fewer restricted funds than in Groups 2 and 3, changing the ranking of the Group results.

The third financial ratio we tested was the Liquid Funds Amount (LFA).

LFA= Dollar Value of Unrestricted New Assets - Net Fixed Assets + Mortgages and Other Notes Payable

The liquid funds amount is a common size value that quantifies the liquid unrestricted dollar amount that an organization has available to meet current obligations.

Synopsis of Results: This ratio is difficult to assess en masse with a sample group. To determine what is actually needed in liquid assets to be financially stable is highly individualize and based on the expenses of that particular provider. It is safe to assume that providers with a negative balance are experiencing serious financial difficulty and this represents 33.66% of the providers tested. With this ratio the providers in Group 1 seem to be in a better financial condition than the providers in Groups 2 and 3.

The fourth financial ratio tested was the Operating Reserve Ratio (OR):

OR= Operating Reserves/Annual Operating Expenses

Operating Reserves are the portion of the unrestricted net assets that are available for use in cases of emergency to sustain financial operations or in the case of an unanticipated event of significant unbudgeted increases in operating expenses or losses in operating expenses. An acceptable minimum OR score is 25%.

Synopsis of Results: Groups 1 and 2 both had over 50% of their providers not meeting the 25% target for operating reserves. Group 2 had over 70% of their providers not meeting the 25% reserve. These are poor results and indicate the providers experience chronic cash shortages. Organizations in this position can not engage in long range planning and opportunities, but rather are concerned with the current stability of the organization. This negatively impacts the service network.

The fifth financial ratio tested was the Savings Indicator.

Savings Indicator (SI) = Revenue - Expense/Total Expense

The savings indicator measures the increase or decrease in the ability of an organization to add to its net assets.

Synopsis of Results: According to a study conducted by the University of Wisconsin-Milwaukee, values greater than one indicate an increase in savings. The savings indicator is a simple way to determine if an organization is adding to or using up its net asset base.

There were no providers in the test group that achieved a score of 1 or higher. Using the interpretation of the indicator that scores over 0 actually indicate an ability to save, 50% of all the providers have scores of 0 or less. These results indicate that 50% of all of the providers in the sample are being forced to use their net asset base to remain viable. In both Groups 1 and 3, 53% of the providers had scores of 0 or below. In Group 2, 46% of the providers had scores of 0 or below.

Further research has discovered that this ratio can be defined in different ways. As indicated above the University of Wisconsin - Milwaukee has defined the ratio outcomes as scores below 1 indicate that the provider would not be able to save and would need to use their net base to remain viable. The following example uses this definition:

Revenue - Expense/Total Expense or $100-50/50=1$. This would indicate that a provider would need twice as much revenue as they have expenses to be able to save.

Guidestar offers the following definition for its use:

"The savings ratio reveals the rate of the nonprofit's savings in measuring the relationship between total annual savings and total expenses. Although the savings ratios is an important component of longevity, high ratios may indicate excessive savings.

The savings ratio should be considered in combination with the liquid funds indicator. If the nonprofit has low liquid funds, a higher savings ratio may be desirable."

To test the *Guidestar* definition, a combined analysis of both the Operating Reserves (OR) Ratio and the Savings Indicator (SI) was conducted for each provider group. The OR is being used for this analysis because there is a defined target of a score of 25% or more being a favorable rating. A second analysis was performed combining the Liquid Funds Indicator (LFI) and the Savings Indicator (SI).

Synopsis of Results: The majority of providers in 2009 were not in a financial position that would allow them to take advantage of new business opportunities. Since only one year was tested it is not known if 2009, represents a trend or just one year of poor performance. The majority of the providers did not have the liquid funds or the savings capability to adequately support a meaningful strategic plan or demonstrate an ability to take advantage of business opportunities. This means the State of Connecticut's private provider community is working too close to the margin to be able to change and grow with the business environment and this will negatively impact the State's ability to exploit revenue opportunities and changes to new proven service models.

The sixth financial ratio we tested was the Debt Ratio.

Debt Ratio (DR) = Average Total Debt/Average Total Assets

The Debt Ratio measures the proportion of assets provided by debt. High values indicate future liquidity problems or reduced capacity for future borrowing.

The higher ratios indicate the risk to potential lenders and would cause lenders to need to increase their rate of return to mitigate the risk. Historically high risk borrowers have to pay higher interest rates if they can borrow at all. Providers that have to pay high interest rates or cannot borrow, makes it difficult for them to compete and certainly changing their payer mix would be very difficult for them to sustain.

If the ratio is less than 0.5, most of the provider's assets are financed through equity. If the ratio is greater than 0.5, most of the company's assets are financed through debt. Organizations with high debt/asset ratios are said to be "highly leveraged," and have low liquidity. An organization with a high debt ratio (highly leveraged) would find it difficult to continue to operate if creditors started to demand repayment of debt.

Synopsis of Results: Overall slightly more than half of the providers tested had Debt Ratios over .5, making them less attractive for financing opportunities. Group 1 once again, scored slightly better than Groups 2 and 3. A high debt ratio coupled with not having a safe amount of operating reserves available would put a provider in a precarious financial position.

The seventh ratio we tested was the Current Ratio (CR).

CR = Current Assets/Current Liabilities

The current ratio is an indication of an agency's liquidity and ability to meet creditor's demands. If an agency's ratio is below 1 it will have difficulty meeting its short term obligations. A ratio of 2 is generally considered to be acceptable.

Synopsis of Results: The Group 1 provider's scores indicated that 40.63% would have difficulty meeting creditors demands, with nearly 75% of all the providers in Groups 2 and 3 having scores indicating they would have the same difficulty. Group 3 only had 12.5% providers that would have difficulty meeting short term obligations, while 25% of Group 1 and 37.03% of Group 2 would have difficulty meeting their short term obligations.

As indicated earlier in the report, the ratio results from the sample group were compared with the Urban Institute's National Study of Nonprofit-Government Contracts and Grants: Overview, from the National Study of Nonprofit-Government Contracting Survey Results (2009 Data), and it has been found that the sample group and the Urban Institute's findings indicate similar results regarding the financial condition of the providers.

The following are the findings of the Urban Institute’s National Study of Nonprofit-Government Contracting Survey Results (2009 Data) regarding the financial position of providers in the State of Connecticut:

CONNECTICUT

National Study of Nonprofit-Government Contracting
Survey Results (2009 Data)

NONPROFIT-GOVERNMENT CONTRACTS AND GRANTS: OVERVIEW

Human Service Nonprofits with Government Contracts/Grants^a

Number509

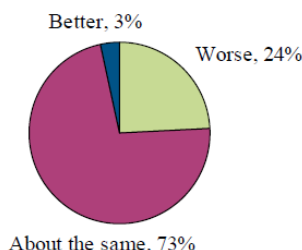
Types of Nonprofits with Government Contracts/Grants

Crime and legal-related . . . . .	.36%
Employment	< 1%
Food, agriculture, and nutrition . . . . .	.3%
Housing and shelter . . . . .	.14%
Public safety and disaster relief	< 1%
Youth development . . . . .	.2%
Human service: multipurpose . . . . .	.41%
Community and economic development . . . . .	.5%
<i>Total contracts/grants</i>	<i>100%</i>

Nonprofits with Government Contracts/Grants, by Level

Local government . . . . .	.76%
State government . . . . .	.86%
Federal government . . . . .	.79%

2009 Government Contracting Experience Compared to Prior Years



Number of Government Contracts/Grants per Nonprofit

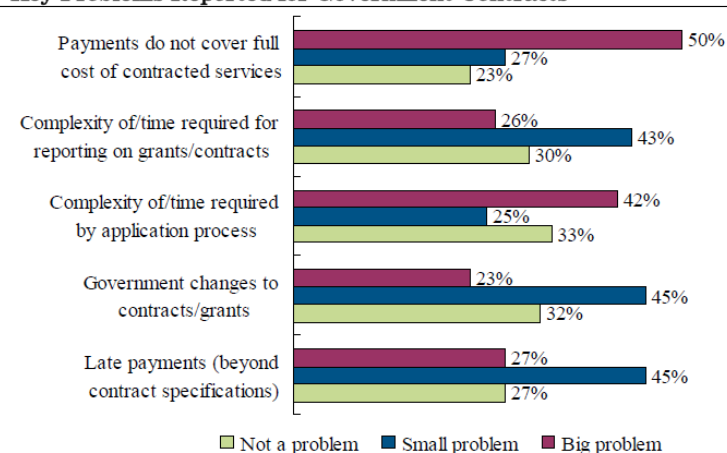
1 government contract/grant . . . . .	.21%
2–4 government contracts/grants . . . . .	.55%
5 or more government contracts/grants . . . . .	.24%

Total Nonprofit Government Contracts/Grants, by Level

Local government . . . . .	.1%
State government . . . . .	.96%
Federal government . . . . .	.4%

CONTRACTING PROBLEMS

Key Problems Reported for Government Contracts



State Ranking^b: Small and Big Problems

Payments do not cover full cost of contracted services	7
Complexity of/time required for reporting on grants/contracts	41
Complexity of/time required by application process	43
Government changes to contracts/grants	8
Late payments (beyond contract specifications)	3

1 = highest percentage of nonprofits with problems; 51 = lowest percentage of nonprofits with problems

CONTRACTING PROBLEMS (CONT'D)

Nonprofits with Late Payments from Government

Connecticut	43%
Nationwide	41%

Most Common Past Due Period for Government Contract/Grant Payments, by Level

Local government	.90 days or more
State government	.30 days
Federal government	n.r.

CONTRACT LIMITATIONS

Nonprofits Reporting Contract Limitations, by Type

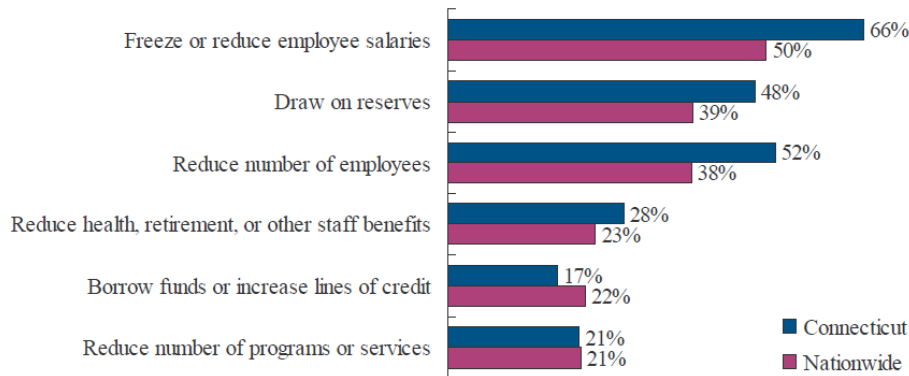
Require matching or sharing costs	.48%
Limit program administrative/overhead	.68%
Limit organization administrative/overhead	.75%

ACCOUNTABILITY AND REPORTING

Nonprofits That Report Outcomes or Give Feedback to the Government

Report results/outcomes of programs	.86%
Give feedback on contracting procedures	.41%

Actions Taken by Human Service Nonprofits in 2009



Source: The Urban Institute National Survey of Nonprofit-Government Contracting and Grants, 2010.

Notes: Percentages may not sum to 100 because of rounding. Full report available at <http://www.urban.org/url.cfm?ID=412159>.

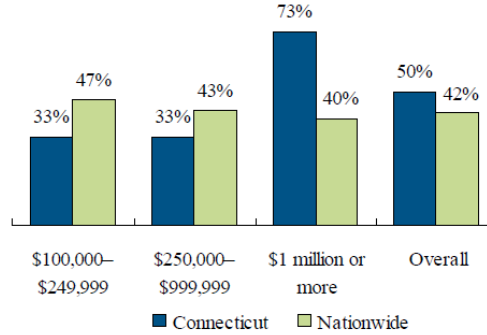
a. Number is based on a selected group of direct human service providers with budgets greater than \$100,000.

b. See appendix for more details on state rankings.

n.r. Data not reported or too few respondents answered the question.

RECESSION

Nonprofits with Deficits, by Expenditure Size



Connecticut Nonprofits Experiencing Declines in Revenue

Local government agencies	.35%
State government agencies	.44%
Federal government agencies	.35%
Individual donations	.61%
Private foundations	.43%
Corporate donations	.57%
Investment income	.71%

Ratio Analysis Conclusion:

The Workgroup's analysis, confirmed by the Urban Institute's report indicate that a large percentage of the Connecticut non-profit providers are in a financially precarious position, operating dangerously close to their margin and likely would not be able to maintain operations if they experienced unforeseen increases in expenses or a financially detrimental incident.

The difference between smaller and larger community based nonprofit providers, as it pertains to financial fragility, requires more careful analysis given the significant variables between organization's administrative costs, capital assets, fund development capacity, and ability to leverage debt.

Years of operating without adequate funding have had the impact of eroding the capability to provide services. Lack of adequate funding over time causes providers to forego strategic planning that would benefit the entire system in favor of attempting to maintain basic, current operations. The outcome will be more providers will fall into the financially "unhealthy" categories and will not be able to make the required changes and advances that the system needs to achieve to remain viable.

Part 3

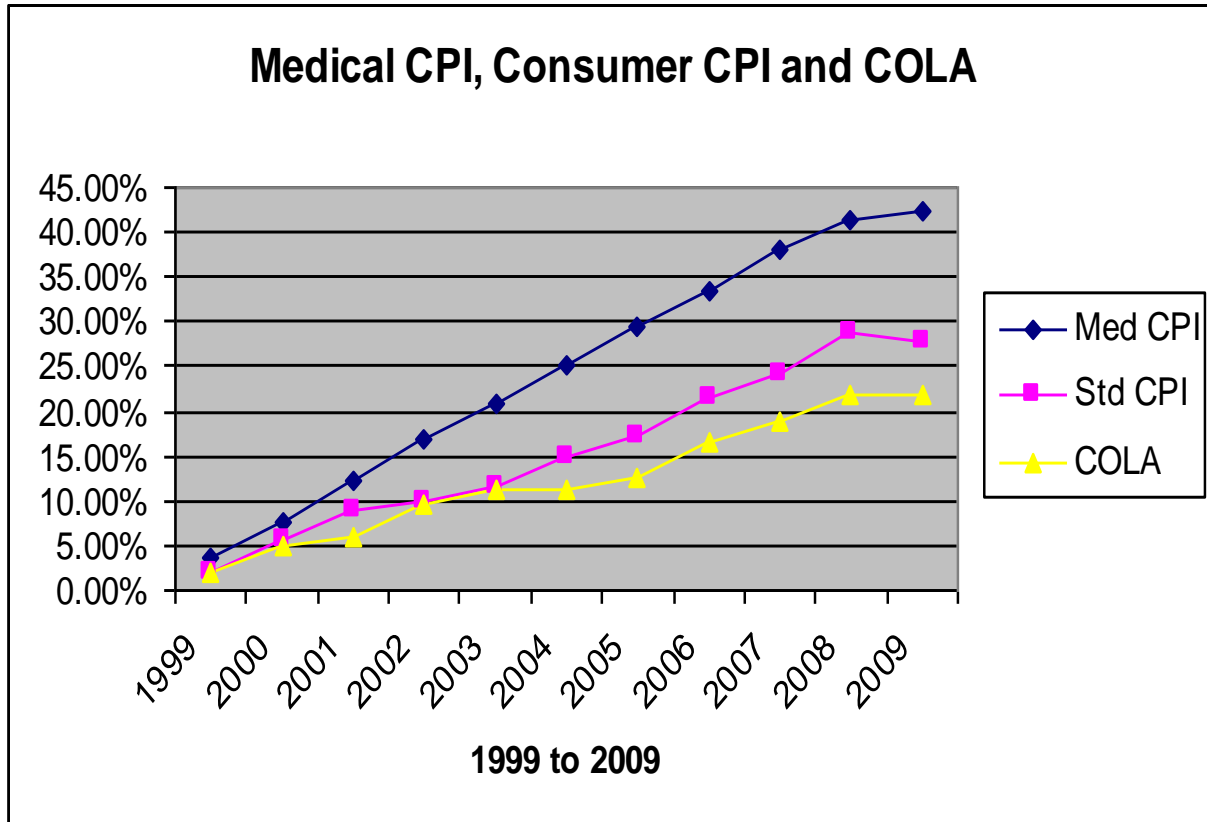
Sources of Revenue

Task: Explore the Nonprofit Providers current sources of revenue and potential future sources.

Method: Four separate tracks of analysis were employed to provide a comprehensive picture including a.) the State funding of the nonprofit community during the past decade, b.) the current revenue funding mix, c.) trends in philanthropy, and d.) possible future funding mixes.

A.) During the period of 1999 to 2009, the State of Connecticut has applied a cumulative total of 21.7% in increases, (also known as COLA increases) to the private provider grant funded programs. During that same of time, based on fiscal years, the CPI has increased by 27.7%. During this period of time there have been years where the State COLA did exceed the CPI for that year but because of a lack of keeping pace with the CPI in prior years, still resulted in the overall funding for each year being less than the CPI increase would have required. As has been indicated previously in the report, the Consumer Price index does not adequately represent the expenses of the Nonprofit Private Provider community. A more accurate indicator may be the Medical CPI that allocates increases to expenses that fall into a private provider's operations. The Medical CPI increased 42.2% during this same period of time. The

following is a comparison of the State COLA, the general consumer CPI against the Medical CPI:



Medical Consumer Price Index:

The Medical Consumer Price Index is one of the eight major spending groups that make up CPI. It is broken into two large categories; medical care services (MCS) and medical care commodities (MCC). MCS is the larger of the two, incorporating the costs of professional services, hospital and related services, and health insurance. MCC includes prescription/nonprescription drug costs and other medical supplies. Further details on the Medical Consumer Price Index are available at the [Bureau of Labor Statistics](#) website.

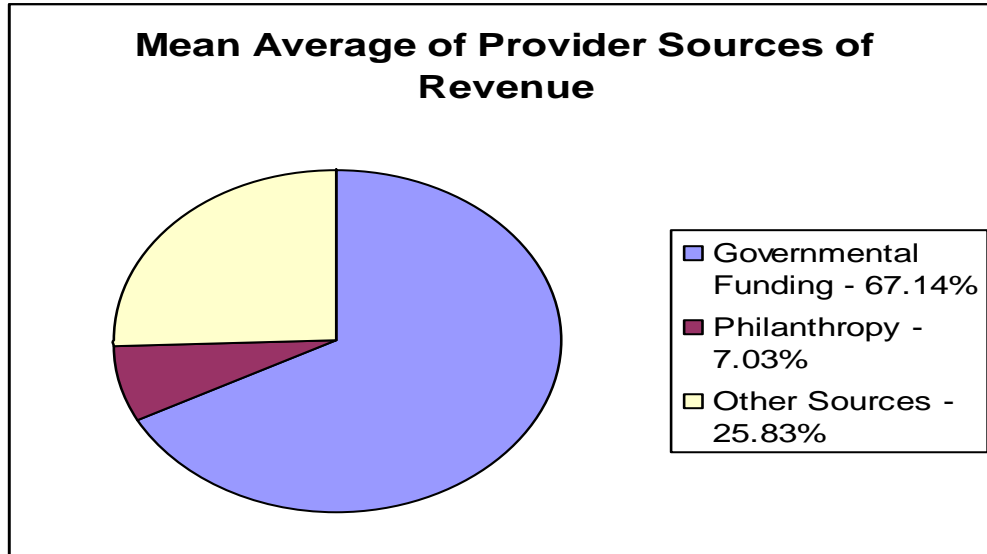
State COLAs

The following table indicates the COLA percentage increases in State contracts during the analysis period of 1999 to 2009.

State Fiscal Year	State COLA Increase
1999	2.1%
2000	3.0%
2001	1.0%
2002	3.5%
2003	1.5%
2004	0.0%
2005	1.6%
2006	4.0%
2007	2.0%
2008	3.0%
2009	0.0%

B.) The second part of the revenue analysis employed the use of the Revenue Ratio, providing information on the actual sources of revenues in the Private Providers community. These results will be represented by percentages by sources and grouped in the same manner as the Financial Fitness portion of the report, with Group 1 consisting of 32 providers with revenue between \$300,000 and below \$2,000,000 in revenue. Group 2 consists of providers with between \$2,000,000 and below \$10,000,000 of revenue consisting of 37 providers and Group 3 consists of 32 providers, with revenues over \$10,000,000.

Synopsis of Results: Group 1 had the highest percentage of Governmental Funding at 75.82%. The Group 2 and 3 had very similar levels of Governmental Funding 64.00% and 62.08% respectively. Another interesting similarity is that Groups 1 and 2 have the same exact percentage of funds coming from Philanthropy efforts at 9.5%, while Group 3 had a much lower percentage of funds from Philanthropy, with donated funds making up only 1.7% of their overall revenues.



C.) The Chronicle of Philanthropy reported on October 17, 2010, that donations had dropped 11% at the nation's biggest charities during this last year. This is the worst decline in two decades, with this year's decrease being four times as great as the next largest annual decrease that was recorded in 2001 at the rate of 2.8%.

It has been reported that there are many factors leading to these nationwide decreases including unemployment rates, the economy at large, the impact of tax laws, and stock market losses impacting both corporate and private donors.

Many donors are investors and have an investor mentality and if they begin to believe that the non-profits they have been supporting are no longer financially viable, their continued support becomes less likely.

Investors are acknowledging the need for donations to sustain operations now rather than to support innovation as they had in the past, although they are often unhappy with the need to subsidize State grants because of a lack of adequate inflation in grant funding to continue to provide services.

Locally, nonprofit providers that have merged with larger organizations have found that the merger often negatively impacts their community based image and the perception of local donors. The perception becomes that the organization is larger and not in need of the donations, and donors are no longer interested in making donations because of concerns that the funds will no longer be used in the local community.

D.) There is the possibility of changing the funding mix for services, and exploring more Medicaid reimbursed services. The following are opportunities and challenges that occur when switching the funding source from grant funding to Medicaid funding:

Opportunities:

1. The service being provided must be a medical model.
2. A rate of 50% reimbursement is available for the services being provided.
3. These types of services utilize evidence based practices with a proven outcome record.
4. Medicaid Waivers can be established to provide services outside of the State plan to a specific group and contain costs.

Challenges:

1. Changing to a medical model often requires the direct care provider have a higher level of credentials or licensing, which results in higher wages needing to be paid to the employees of the non-profits.
2. To be able to maintain the electronic records, reporting and billing requirements, expensive infrastructure changes need to be made by private providers. Reporting requirements include time studies, detailed cost reports and precise recording requirements within the client record. There is also an increased need for employee training.
3. Audits are performed on the providers by the Recovery Audit Contract (RAC) and on average require a reimbursement from providers of 15% to 20%, usually due to simple clerical errors or record omissions.
4. Interim rates are established, and then cost settled as a certified public expenditure.
5. Department of Administrative Services acts as the billing agent.
6. There is no reimbursement for the non medical aspects of the service including case management, travel time or other costs associated with client care that are required to provide the service but not the service itself, i.e., a prolonged intake process and meetings for a client returning to the State, etc..

The opportunity to receive reimbursement for provided services is a very attractive option but a cost benefit analysis should be performed before a decision to change a service model from grant funding to a medical model that would be applicable for reimbursement. The analysis needs to include all the new costs to the providers associated with the change, what parts of the service will no longer be funded but will still need to occur to be able to perform the service. These expenses should be weighed against the projected income from the reimbursement of expenditures. If reimbursements do not equal the additional costs and the potential grants necessary to

continue to provide the non reimbursable portions of the service, it might not be financially advantageous to pursue changing the funding mix.

Report Conclusions:

The Workgroup set out on this task with some impressions regarding the condition of nonprofit provider business environment. Many times during our analysis we found ourselves surprised by the results and concerned about the future of the service delivery network. We knew as we started our report that the State was under some of the most difficult economic and financial conditions that it had ever been presented with, making the services offered by the nonprofit community all that more important to the citizens of the State, but coupled with a lack of resources from the State to refresh and invest in the nonprofit community. The following recommendations are a balance between the two areas of concern, the need to keep this network of providers viable and the lack additional resources to support the network. We looked at how delivery of services, administrative mandates and the payer mix can impact a provider and the actual cost of services with the hope of removing non-value added activities. We looked at the combined costs of activities to both the State and the Nonprofits in service delivery. We believe that to some degree the two entities have been considered separately, instead of as partnership that must be considered as a whole. Consideration of how these recommendations might impact the entire system of care and all the costs associated with service delivery will lead us to wiser decision making and a better quality, more efficient service delivery system. Our goal is to have a true partnership with a vehicle to create a planned structure for the delivery of services and shared implementation of changes in the service environment.

Recommendations

1. We believe it is important to have data over a period of time. It is recommended that a retrospective calculation of financial ratios included in this report be conducted from 2007 to 2010, with the audits that are on hand at the OPM to determine if the results indicate trends. It is further recommended that the financial ratios be completed on an on-going basis so trends in the private providers' financial condition can be assessed over a period of time.
2. It is recommended that a special committee of providers and State officials, chaired by the Nonprofit Liaison to the Governor, be assembled to assess and report on financial trends and unforeseen expenses and analyze provider increases and fixed costs impacting the private providers' financial position and possible solutions.
3. It is recommended that when system wide technical requirements are imposed or expected of Nonprofit providers that the State takes a lead role in assisting providers

by investigating the options, initiating a bidding process to attempt to achieve savings and by providing technical assistance to providers. The current method results in a duplication of effort and costs and often results in providers having not acquired the required product. It also results in a system that makes communication with State agencies and other private providers inefficient which further burdens the system because of a lack of consistency amongst the State Agencies.

4. A cost benefit analysis should be conducted for all revenue producing initiatives including Medicaid services, waivers, and Private Non-Medical Institution. This analysis should be conducted with not only the State's costs being considered but also the costs to private providers. It is recommended that the State be cautious in its attempts to change the payer mix. If the new costs to the entire system, including both the State and the providers, are more than the State will receive in reimbursement it should be understood that this will not be a cost effective change for the State and may result in a need to continue to provide grant funding for non-reimbursable expenses. When providers do not have the investment dollars to establish the infrastructure necessary to successfully make the change in the payer mix, it results in audit findings and significant repayment of funds only further jeopardizing the providers' financial condition.

6. It is recommended that mechanisms be developed to compensate not for profit providers doing business with the state for necessary costs that occur outside the control of the provider. These necessary costs most commonly occur due to vacancies, admission delays, discharge delays, transfer delays, or unfunded continued occupancy (aka overstays).

7. It is recommended that a break-even analysis be done when changing service models and funding streams to determine if the funding model matches the program type and size and that the census requirements are realistic for the provider to remain financially viable.

Consideration should be given to the size of the program, turnover and average billable units of care. The best practices movement to smaller settings may make previous rate setting and funding models less effective and appropriate than the larger services they were created for decades ago.

Ratio Results Appendix:

Defensive Interval (DI)

DI scores for Group1:

N=32

Median: 3.08

Mean: 3.36

Percentage of Providers with Less than One Month in Reserves: 21.88%

DI scores for Group 2:

N=37

Median: 1.75

Mean: 2.50

Percentage of Providers with Less than One Month in Reserves: 27.03%

DI scores for Group 3:

N=32

Median: 1.91

Mean: 2.74

Percentage of Providers with Less than One Month in Reserves: 6.25%

Group 1, 2 and 3 Results:

N=101

Median: 1.49

Mean: 4.59

Standard Deviation: 2.68

Liquid Funds Indicator (LFI)

LFI Scores for Group 1

N=32

Median: -0.08157

Mean: 0.536865359

Percentage of Providers with Negative Scores: 48.38%

Percentage of Providers with Scores over 1.0: 41.94%

Percentage of Providers below an acceptable range: 58.06%

LFI Scores for Group 2

N=37

Median: -1.05154

Mean: -1.011010973

Percentage of Providers with Negative Scores: 62.16%

Percentage of Providers with Scores over 1.0: 21.62%

Percentage of Providers at or below an acceptable range: 78.38%

LFI Scores for Group 3

N=32

Median: -0.26933

Mean: 0.032160038

Percentage of Providers with Negative Scores: 68.75%

Percentage of Providers with Scores over 1.0: 6.25%

Percentage of Providers below an acceptable range: 93.75%

Group 1, 2 and 3 Results:

N=101

Median: -.84

Mean: .71

Standard Deviation: 4.42

Liquid Funds Amount (LFA)

LFA Scores for Group 1:

N=32

Median: \$78,386

Mean: \$136,122

Percentage of Providers with Negative Cash Balances: 22.58%

LFA Scores for Group 2:

N=37

Median: \$85,116

Mean: \$414,048

Percentage of Providers with Negative Cash Balances: 39.47%

LFA Scores for Group 3:

N=32

Median: \$464,443

Mean: \$3,850,644

Percentage of Providers with Negative Cash Balances: 37.50%

Operating Reserves Ratio (OR)

OR Scores for Group 1:

N=32

Median: 21.99%

Mean: 35.29%

Percentage of Providers with Scores of Less than 25%: 53.13%

OR Scores for Group 2:

N=37

Median: 18.62%

Mean: 34.93%

Percentage of Providers with Scores of Less than 25%: 56.76%

OR Scores for Group 3:

N=32

Median: 9.85%

Mean: 22.95%

Percentage of Providers with Scores of Less than 25%: 71.88%

Group 1, 2 and 3 Results:

N=101

Median: 12.27%

Mean: 31.25%

Standard Deviation: .4215

Savings Indicator (SI)

Savings Indicator Scores for Group 1:

N=32

Median: -0.0167

Mean: -0.039950702

Percentage of Providers with a Savings Indicator Score of 1 or Higher: 0%

Percentage of Providers with a Savings Indicator Score over 0 or Higher: 47%

Savings Indicator Scores for Group 2:

N=37

Median: -0.000587

Mean: -0.046403845

Percentage of Providers with a Savings Indicator Score of 1 or Higher: 0%

Percentage of Providers with a Savings Indicator Score over 0 or Higher: 54%

Savings Indicator Scores for Group 3:

N=32

Median: 0.002631

Mean: -0.018584777

Percentage of Providers with a Savings Indicator Score of 1 or Higher: 0%

Percentage of Providers with a Savings Indicator Score over 0 or Higher: 47%

Group 1, 2 and 3 Results:

N=101

Median: .00

Mean: -.011

Standard Deviation: .15573

Operating Reserves / Savings Indicator

Combination OR/SI

Group 1 had 17 out of 32 providers, or 53% of the providers, had the combination of an OR score below 25% and a SI score at or below .04.

Group 2 had 21 out of 37 providers, or 57% of the providers, had the combination of an OR score below 25% and a SI score at or below .07.

Group 3 had 23 out of 32 providers, or 72% of the providers, had the combination of an OR score below 25% and a SI score at or below .04.

Liquid Funds Indicator / Savings Indicator

Combination LFI/SI

Group 1 had 18 out of 32 providers, or 56% of the providers, had the combination of an LFI score below 1 and a negative SI score.

Group 2 had 28 out of 37 providers, or 75% of the providers, had the combination of an LFI score below 1 and a SI score of score at or below .04.

Group 3 had 29 out of 32 providers, or 90% of the providers, had the combination of an LFI score below 1 and a SI score at or below .07.

Debt Ratio

Debt Ratio Scores for Group 1:

N=32

Median: 0.35539

Mean: 0.53457309

Percentage of Providers with a Debt Ratio Score of .5 or Higher: 41.94%

Debt Ratio Scores for Group 2:

N=37

Median: 0.536668

Mean: 0.59004512

Percentage of Providers with a Debt Ratio Score of .5 or Higher: 55.26%

Debt Ratio Scores for Group 3:

N=32

Median: 0.598468

Mean: 0.62736829

Percentage of Providers with a Debt Ratio Score of .5 or Higher: 65.63%

Group 1, 2 and 3 Results:

N=101

Median: .54

Mean: .58

Standard Deviation: .388

Current Ratio

CR Scores for Group 1:

N=32

Median: 2.29

Mean: 9.29

Percentage of Providers with a Score Below 1: 25.00%

Percentage of Providers with a Score Below 2: 40.63%

CR Scores for Group 2:

N=37

Median: 1.32

Mean: 2.65

Percentage of Providers with a Score Below 1: 37.03%

Percentage of Providers with a Score Below 2: 75.68%:

CR Scores for Group 3:

N=32

Median: 1.48

Mean: 2.11

Percentage of Providers with a Score Below 1: 12.50%

Percentage of Providers with a Score Below 2: 75.00%:

Group 1, 2 and 3 Results:

N=101

Median: 1.49

Mean: 4.59

Standard Deviation: 13.7

Revenue Ratio

RR scores for Group 1:

N=32

Governmental Funding %: 75.82%

Philanthropy %: 9.5%

Other Sources %: 14.68%

RR scores for Group 2:

N=37

Governmental Funding %: 64.00%

Philanthropy %: 9.5%

Other Sources %: 26.5%

RR scores for Group 3:

N=32

Governmental Funding %: 62.08%

Philanthropy %: 1.7%

Other Sources %: 36.22%

Group 1, 2 and 3 Results:

Governmental Funding

N=101

Median: 76.15%

Mean: 67.14%

Group 1, 2 and 3 Results:

Philanthropy

N=101

Median: 1.15%

Mean: 7.03%



PROJECTED COST SAVINGS WORKGROUP

INSTITUTIONAL VS. COMMUNITY BASED CARE

Commission on Nonprofit Health and Human Services

Final Report

March 2011

OBJECTIVES

According to Special Act No. 10-5, the Commission shall analyze the funding provided to nonprofit providers of health and human services under purchase of service contracts. As part of this analysis, the Workgroup has been charged to provide the following:

- 1) a projection of cost savings that may be achieved by serving individuals who are recipients of benefits under health and human services programs in their communities rather than in institutions

- 2) The projected costs associated with the provision of services by private providers under health and human services programs through December 31, 2014. With respect to this second charge, the Workgroup was able to obtain projections done by the General Assembly's Office of Fiscal Analysis for the period up through 2014; however, this information involved an inflationary factor that applied to POS contracts for State budget projection purposes and did not reflect a deeper review of the actual costs for private providers moving forward. Additional time and resources would be needed to develop more detail projections of private provider costs.

MEMBERSHIP

The Workgroup was comprised of the following members appointed by the Commission Co-chairs and the Workgroup Co-chairs:

Barry Kasdan (Chair)	Michael Purcaro – DPH (Chair)
Pamela Fields – (Kasdan Choice)	Peter Mason – DDS (Purcaro)
Melanie Sparks – DOC (Purcaro)	Heather Gates – (Kasdan Choice)
Claudette Beaulieu – DSS	Donna Grant
Lisa Mazzeo	David Pickus
Jessica Sacilowski	

In addition, the Workgroup has also benefited from the participation of Terry Edelstein, President and CEO of Community Providers Association, Julia Wilcox, Senior Public Policy Specialist with the Connecticut Association of Nonprofits, Cindy Butterfield, Chief Financial Officer at the Department of Children and Families, Peter Gioa, Vice President and Economist of CBIA and Nora Sinkfield, Administrative Assistant with the Connecticut Department of Public Health.

OVERVIEW

The Projected Cost Savings Workgroup is pleased to submit its final report to the Commission on Nonprofit Health and Human Services. We acknowledge, with much appreciation, the time and effort from our committee members and those individuals who provided consultation and input, along with the many State department fiscal staff who labored over our challenging data requests. They responded to numerous questions and provided us with numerous revisions and up-dates. Special thanks to the Department of Public Health for providing ongoing administrative support that has made our work possible.

Historically, institutional care has provided a safe place for the provision of services to those whose disability or severity of illness required their removal from family and community and required a higher level of care. For some, long term or even lifetime confinement was deemed appropriate. Over time, advancements in treatment methodologies, expansion of community based services and psychopharmacological

advances have greatly reduced lengths of stay and even negated the need for institutionalization. Increasing numbers of individuals are now safely treated and served in their local communities; remaining with family, moving toward independent living, residing in group homes, attending school and maintaining a gainfully employed status. These developments are paralleled in the healthcare industry when we look at decreased lengths of stay for hospitalizations and increased utilization of ambulatory services.

The cost of institutional vs. community-based care was the focus of our work. To date, the Workgroup has held seven (7) scheduled meetings and two (2) scheduled conference calls. In addition, the Workgroup facilitated a meeting of state agency finance officers that was led by Cindy Butterfield, Chief Financial Officer at the Department of Children and Families, to discuss available data sources for collection, analysis and reporting purposes. Through these meetings, the Workgroup reviewed qualitative and cost variables from an institution vs. community perspective. The Workgroup established a common reporting platform/template for collecting and comparing the requested data across state agencies. This template included references to data sources and detailed back-up information to support any data reported. Aggregate cost data was requested from DMHAS, DCF, DDS, DPH, DOC, and DSS for both the state government and the non-profit sector through the grant information and fiscal reporting that the state agencies have through POS contracts with private providers.

The Workgroup concluded that the most useful and meaningful data to secure across various non-profit sectors would be generated by sampling cost data from DCF, DMHAS, and DDS. These agencies were requested to submit a comprehensive worksheet, which their fiscal staff assisted in developing. The data are summarized in the workgroup's template and is included in this report. In addition, the Workgroup requested that the remaining departments (DPH, DOC and DSS) provide their data on the summary template only.

The task of providing this data has been a challenge for the various reporting agencies because each Department collects and maintains their data differently. As a result, several factors contributed to lengthy and in-depth discussions to best understand how to gather and analyze this data. Some of these factors are important to mention and include:

- The need to clarify service sector data definitions across agencies in a meaningful way.
- The variability of standardization has made this task challenging; however, this has been an important “lessons learned” experience.
- Populations served and service needs are recognizably diverse and even unique in many sectors, therefore the comparability of data/costing between departments has limited use and was discouraged.
- The Workgroup concluded that a separate analysis of data within each state agency and how it related to institutional vs. community based care was most meaningful.
- The most challenging and time consuming task for the agencies was the aggregating of non-profit grant data for analysis and reporting in accordance with our template.

The Workgroup has gathered data in various forms from all of the reporting agencies. Not all departments were able to formulate their data into the template, thereby making the analysis challenging. State institutional cost data was more straight forward, whereas data from community non-profits was a significant challenge if departments were not already aggregating that data. Again, the lack of standardization of service definitions and levels of care for a diverse group of populations across departments was a major issue in understanding what we were asking for and then determining if a department had sufficient data to provide to the Workgroup.

While we encountered many challenges and obstacles, we were able to collect data to begin sampling the key issues that we were charged to explore. We stress the word “sampling” and do not present this report and its data as a definitive representation of all services and levels of care or funding streams that should be explored in doing a comprehensive data analysis that represents cost differences between state operated institutional care and community based services rendered by Connecticut’s non-profit agencies.

In addition, the Workgroup received data provided by the Office of Fiscal Analysis (OFA) to address our second objective which was to project costs associated with the provision of services by private providers under state health and human services POS for the fiscal years 2009-2014.

FISCAL ANALYSIS OF INSTITUTIONAL AND RESIDENTIAL SERVICES

Department of Developmental Services - Institutional Services		
Institution	Southbury Training School	Regional Center
Annual	\$357,000.00	\$361,350.00
Daily	\$980.00 per client	\$990.00
Average Daily Census	474.9	89
Level of Need	5.13	6.02
Included In This Data	<ul style="list-style-type: none"> • Health Care • Room and Board • Behavioral Health Services • Day Program/Day Services • DDS Costs: Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation Amount, Recovery Amount 	<ul style="list-style-type: none"> • Health Care • Room and Board • Behavioral Health Services • Day Program/Day Services • DDS Costs: Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation Amount, Recovery Amount

Department of Developmental Services - Residential Services		
Agency	Residential DDS Public	Residential DDS Private
Annual	\$297,110.00	\$136,371.00
Daily	\$814.00	\$373.62
Average Daily Census	177	2698
Level of Need	5.26	4.92
Included In This Data	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • DDS Costs: Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation Amount, Recovery Amount • 2009 Data prior to conversion of 17 public group homes • These do not include day programs • Non ICF 	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • No health care is included in these costs • DDS support to private sector • DDS Case Management • Provider Costs: Personal Services, Workers' Compensation, Employee Benefits, Non-reimbursable Costs, total non-salary costs and A&G • 2009 Data prior to conversion of 17 public group homes • These do not include day programs • Non ICF

Department of Mental Health and Addiction Services - Institutional Services	
Institution	Inpatient Connecticut Valley Hospital
Annual	\$451,140
Daily	\$1,236.00
Average Daily Census	499.3
Included In This Data	<ul style="list-style-type: none"> • Room and Board • Physical health care • Behavioral health services • Prescriptions • Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation • Transportation • Vocation Services

Department of Mental Health and Addiction Services Residential/Community Services					
Agency	MRO Group Home	MH Supervised Apartments	MH Supportive Housing	MH Case Management	MH Outpatient
Annual	\$52,274.60	\$46,230.90	\$11,804.10	\$6,402.10	\$2,179.05
Daily	\$144.04	\$126.66	\$32.34	\$17.54	\$5.97
Average Patient Days	183	551	663	3779	9981
Included In This Data	<ul style="list-style-type: none"> • Rent • Food • Includes Medicaid FFS payments • Provider Costs: Personal Services, Workers' Comp, Employee Benefits, Non-Reimbursable Costs, A&G 	<ul style="list-style-type: none"> • Case Mgmt. • Rent • Provider Costs: Personal Services, Workers' Comp, Employee Benefits, Non-Reimbursable Costs, and A&G 	<ul style="list-style-type: none"> • Case Mgmt. • Rent • Provider Costs: Personal Services, Workers' Comp, Employee Benefits, Non-Reimbursable Costs, and A&G 	<ul style="list-style-type: none"> • Client Support Money • Provider Costs: Personal Services, Workers' Comp, Employee Benefits, Non-Reimbursable Costs, and A&G 	<ul style="list-style-type: none"> • Provider Costs: Personal Services, Workers' Comp, Employee Benefits, Non-Reimbursable Costs, and A&G

Department of Children and Families - Institutional Services		
Institution	Riverview	Private Hospital
Annual	\$769,960	\$474,500
Daily	\$2,109.48	\$1,300.00
Average Daily Census	66.0	TBD
Level	5	4
Included In This Data	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Medical and Dental Services • Medication • Rehabilitation Therapy • Translation Services • Education / Academic and Vocational • All Care and Custody items including clothing, personal and hygiene supplies • DCF Costs: Fringe Benefits, Comptroller Adjustment (Including SWCAP), Inflation Amount, Recovery Amount 	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Rehabilitation Therapy

Department of Children and Families - Residential/Community Services				
Agency	Private Residential	Therapeutic Group Home	At Home Services	Out-Patient MH Services
Annual	\$113,592	\$208,184	\$50,691	\$687.78
Daily	\$314.61	\$570.37	\$138.88	N/A
Average Daily Census	409	267	Varies	15,800
Level	3	2	1	1
Included In This Data	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Rehabilitation Therapy 	<ul style="list-style-type: none"> • Room and Board • Behavioral Health Services • Rehabilitation Therapy 	<ul style="list-style-type: none"> • In home behavioral health services 	<ul style="list-style-type: none"> • Children placed at home, served at a DCF licensed clinic

FINDINGS

1. The transition from institutional to community-based care, with an appropriate balance of resources, is a work in progress for Connecticut’s health and human services agencies. This appears to be a strategic objective for all the state agencies submitting data.

2. A primary objective of our state and private providers is to provide the least restrictive level of care that is clinically indicated for every child, adult, and family seeking services; however, it is recognized that higher levels of care, including institutional, may always be needed as part of the service continuum.

3. The data indicates that where clinically appropriate community based services can be provided at a lower per diem rate than the more restrictive higher levels of care provided in an institutional setting. Of note, other funding streams, both public and private, factor into supporting the necessary mix of community resources needed.

RECOMMENDATIONS

1. The Workgroup recommends that Connecticut establish a statewide data warehouse for health and human services through a standardized, comprehensive and integrated reporting system across state agencies.
2. The Workgroup recommends that additional in-depth data analysis be performed to develop a standardized costing methodology.
3. The Workgroup recommends that key fiscal staff in state health and human service agencies meet regularly to address the recommendations identified in #1 and #2 above.
4. The Workgroup recommends that the state support a robust community based system of care that provides timely and accessible services across a broad continuum. Appropriate distribution of resources among community based services and institutions along this continuum of care would allow for a more effective service balance that would reduce institutional lengths of stay while providing community based services that can divert an increasing number of individuals from our hospitals and state institutions, where appropriate. This would offer the most cost effective health and human services system to Connecticut's children and adults.

CONCLUSION

In conclusion, data trends across agencies point to the cost effectiveness of community based care vs. institutional care. For the state to save money, there will need to be a plan-full phase-down of institutional beds as spending on community services grows. This trend needs to be embraced with the recognition that true cost savings can only be generated through a thoughtful and strategic planning process that recognizes and balances, with great care, both the risks and benefits that will impact clients and providers across the continuum of care.

As charged, the Workgroup was asked to develop cost projection associated with the provision of services by private providers under health and human service programs through December 31, 2014.

With respect to this second charge, the Workgroup was able to obtain projections done by the General Assembly's Office of Fiscal Analysis for the period up through 2014; however, this information involved an inflationary factor that applied to POS contracts for State budget projection purposes and did not reflect a deeper review of the actual costs for private providers moving forward. Additional time and resources would be needed to develop more detailed projections of private provider costs, that could also take into consideration data produced by this commission.