State of Connecticut

Commission on Nonprofit Health and Human Services

Date: December 30, 2010

To: The Honorable M. Jodi Rell, Governor

The Honorable Paul R. Doyle and Toni E. Walker
Co-Chairpersons of the Joint Standing Committee on Human Services

The Honorable Robert J. Kane and Lyle R. Gibbons
Ranking Members of the Joint Standing Committee on Human Services

The Honorable Toni Nathaniel Harp and John C. Geragosian
Co-Chairpersons of the Joint Standing Committee on Appropriations

The Honorable Dan Debicella 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: Preliminary Report of the Commission on Nonprofit Health and Human Services

We are pleased to submit, as required by Special Act 10-5, a preliminary report on the findings and recommendations of the Commission on Nonprofit Health and Human Services. According to Special Act 10-5, the Commission's Preliminary Report was to be submitted not later than January 1, 2011, with its final report due April 1, 2011.

The Commission held its first meeting on August 31, 2010 and monthly thereafter. It quickly became apparent that 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.

It was decided that the best approach to dealing with these complex issues would be a work group format. Throughout the next several months four groups gathered and analyzed data in the five areas the Commission was charged with looking at with an end goal of generating findings and recommendations for both this report and the final report. The four workgroups established are:

- 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 Costs (2010 - 2014)

Due to the volume of data and the time needed for analyzing the information only one of the work groups, Achieving Administrative Efficiencies, was able to conclude their work and provide a list of recommendations to the full Commission for their consideration for inclusion in this preliminary report.

The twenty-seven recommendations presented by the Commission in this preliminary report are therefore all from the Achieving Administrative Efficiencies workgroup and are presented by category. They were selected for inclusion in this report from a total of thirty-nine recommendations offered by the workgroup. The remaining twelve recommendations from this workgroup's list will be considered for inclusion in the Commission's final report along with recommendations from the other workgroups, following additional review by the Commission.

Each of the workgroups has provided a summary report of their work to date and those are included in their entirety in the Appendices.

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.

The report can be found on the link to the Nonprofit Health and Human Services Commission 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

Preliminary Report

as Required by

Special Act 10-5

December 30, 2010

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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 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.

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COMMISSION MEMBERS

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

Member	Appointing Authority
Robert Dakers, **Co-Chairman**, Executive Financial Officer, Office of Policy and Management	State of Connecticut Office of Policy & Management
Peter S. DeBiasi, **Co-Chairman**, President/CEO Access Community Action Agency	Senate President Pro Tempore, Donald Williams
Donna Grant, Executive Director, Thompson Ecumenical Empowerment Group	Senate President Pro Tempore, Donald Williams
Jessica Sacilowski	Senate President Pro Tempore , Donald Williams
Cindy Butterfield, Chief Fiscal Officer, Department of Children and Families	Commissioner of Children and Families
Joel R. Ide, Contracts Administrator Department of Correction	Commissioner of Correction
Peter H. O'Meara, Commissioner Department of Developmental Services	Commissioner of Developmental Services
Doreen DelBianco, Legislative Program Manager, Department of Mental Health and Addiction Services	Commissioner of Mental Health and Addiction Services
Michael J. Purcaro, MS, PT, Chief of Administration, Department of Public Health	Commissioner of Public Health
Claudette J. Beaulieu, Deputy Commissioner, Department of Social Services	Commissioner of Social Services
John Brooks, Director of Administration Court Support Services Division	Executive Director, Court Support Services Division
Steven A. Girelli, PhD, Vice-President, Education, Child Placement and Group Care, Klingberg Family Centers	Senate Chair of Appropriations, Toni N. Harp
Rep. Catherine Abercrombie	House Chair of Human Services, Toni E. Walker

COMMISSION MEMBERS

Member	Appointing Authority
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, Connecticut Department of Labor	Governor - M. Jodi Rell
Raymond J. Gorman, President Community Mental Health Affiliates, Inc.	Governor - M. Jodi Rell
James G. Palma, Jr.	Governor - M. Jodi Rell
Patrick J. Johnson, Jr.	Speaker of the House - Christopher G. Donovan
Cinda Cash, Executive Director The CT Women's Consortium	Senate Majority Leader - Martin Looney
Marcie Dimenstein, Director or Programs and Services Connection, Inc.	Senate Majority Leader - Martin Looney
David Pickus, Secretary Treasurer SEIU 1199NE	House Majority Leader - Denise W. Merrill
Maureen Price-Boreland, Executive Director Community Partners in Action	House Majority Leader - Denise W. Merrill
Lisa A. Mazzeo, LCSW, BCD	Minority Leader of the Senate - John McKinney
William J. Hass, Ph.D. President and CEO- FSW, Inc., CT	Minority Leader of the Senate - John McKinney
Daniel J. O'Connell, Ed.D, Chair, CT Non Profit Human Services Cabinet	Minority Leader of the House - Lawrence F. Cafero Jr.
Anne L. Ruwet, Chief Exective Officer CCARC, Inc.	Minority Leader of the House - Lawrence F. Cafero Jr.

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:

1. Listening/Learning using currently available data
2. Analyzing Data
3. 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 are:

1. Achieving Administrative Efficiencies
2. Cost Comparisons - Private and State Services
3. Private Provider Cost Increases, Nonprofit Agency Financial Condition, Sources of Revenue
4. 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 fourth 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 this report are to be considered by the Commission in the future.

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

Meeting Schedule 2011

- January 11, 2011
- February 8, 2011
- March 8, 2011

All meetings will be held from 10 - 11:30 am at a location to be determined

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.

Work Group 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 summary reports are included in this document's appendices beginning on page twenty-three.

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RECOMMENDATIONS

The twenty-seven recommendations presented by the Commission below are therefore all from the Achieving Administrative Efficiencies workgroup and are presented by category. They were selected for inclusion in this report from a total of thirty-nine recommendations offered by the Achieving Administrative Efficiencies workgroup. The remaining twelve recommendations will be considered for inclusion in the Commission's final report, following additional review by the Commission.

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.

Achieving Administrative Efficiencies

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 work group 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.

Identified with each set of recommendations are those actions that may be required to implement these recommend changes, whether it be a legislative change, regulatory change, policy directive or other change.

Contracting and Auditing

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:

1. Raise the dollar amount definition of a "capital expense" (e.g., from $5,000 to $25,000).
2. 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).
3. CT State POS agencies should collaborate to expedite Medicaid reimbursements.

☑ Legislative Change	❒ Regulatory Change	☑ Policy Directive	❒ Other

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.

Recommendation:

4. 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).

☑ Legislative Change	❒ Regulatory Change	☑ Policy Directive	❒ Other

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 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:

5. The legislature should eliminate nondiscrimination certification forms, which simply repeat language already included or referenced in all State POS contracts.
6. 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).
7. 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."
8. 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.
9. Upon creation of a Document Vault, each nonprofit contractor would be responsible for posting their own materials.
10. CT State POS agencies should adopt and use standard forms for collecting workforce and minority subcontractor data from POS contractors.
11. Electronic signatures should be permissible and accepted for contracts and financial reports.

☑ Legislative Change	❒ Regulatory Change	☑ Policy Directive	☑ Other–Exec Order

Reporting and Data

Finding:

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.

Recommendations:

1. State agencies, under the oversight of OPM and DOIT, should collaboratively develop a common reporting system that would satisfy the requirements for data reporting by private nonprofit providers.
2. 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.

3. Implementation of new data reporting "systems" should be spelled out in the POS contract language, including timing, data migration requirements and funding.

☑ Legislative Change	❒ Regulatory Change	☑ Policy Directive	❒ Other

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:

4. 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.
5. DOIT and AG together with representatives from nonprofit providers need to agree on the definition of which "devices" need to operate with encryption.
6. 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.

❒ Legislative Change	❒ Regulatory Change	☑ Policy Directive	❒ Other

State Licensing and Quality Assurance

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.

Recommendation:

1. 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.

❒ Legislative Change	☑ Regulatory Change	☑ Policy Directive	❒ Other

Finding:

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.

Recommendation:

2. The State of CT should appropriately fund new mandates.

❒ Legislative Change	❒ Regulatory Change	☑ Policy Directive	☑ Other-Exec Order

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.

Recommendation

1. 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.

❒ Legislative Change	❒ Regulatory Change	☑ Policy Directive	❒ Other

Adoption of Best Practices

Finding:

Below are several best practices used by one or more POS state agencies which have already been show to save time and money for consideration by other agencies.

Recommendations:

1. Encourage electronic payments, including electronic fund transfers.

2. Reduce the need for budget amendments, by not requiring them for slight (e.g., up to 5%) variances.
3. Where appropriate and allowable, use prospective payments after a one-year probationary period (for either new contractors or problematic contractors).
4. 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)
5. Encourage use of multi-year contracts and/or consolidate multiple contracts between one POS agency and one nonprofit provider.
6. 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.
7. 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)).

❒ Legislative Change ❒ Regulatory Change ☑ Policy Directive ❒ Other

Appendices

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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;

(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

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

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

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

Private Provider Cost Increases, Nonprofit Agency Financial Condition, 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 Haas
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 SUMMARIES

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:

1) Contracting and Auditing
2) Reporting and Data
3) State Licensing and Quality Assurance
4) 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 contact period to accommodate time for contact 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

WORKGROUP SUMMARIES

COST COMPARISONS - PRIVATE AND STATE SERVICES

Preliminary Report

Commission on Non-Profit Health and Human Services

Workgroup: Cost Comparisons - Private and State Services

Charge to the Commission and the Workgroup

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 calls for the Commission to issue a preliminary report of its findings and recommendations by January 1, 2011 and a final report by April 1, 2011.

Process

The Workgroup on Cost Comparisons – Private and State Services was created by the full commission and charged to address the portion of Section 1(f) of the Act requiring: "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.

Each workgroup is addressing a different section of the law's requirements in support of the Commission's objectives and this report fulfills the Cost Comparisons – Private and State Services portion of the Commission's objectives.

In pursuit of this objective, the Commission appointed co-chairs of the Workgroup and appointed Commission members to workgroups. In addition, co-chairs appointed two workgroup members each. The workgroup membership is as follows:

Workgroup Membership

1. Cinda Cash, Executive Director, The CT Women's Consortium (Chair)
2. Patrick Flaherty, Economist, CT Dept. of Labor (Chair)
3. John Noonan-OPM, Budget (Flaherty Choice)
4. Margaret Glinn-CT Dept. of Children & Families (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, Legislative Program Manager, CT Dtp. Of Mental Health & Addition Services
8. Peter O'Meara, Commissioner, Department of Developmental Services
9. Daniel O'Connell, Chair, Non-Profit Human Services Cabinet
10. Melodie Peters, First Vice President, AFT Connecticut

This workgroup met 5 times from October 2010 through December 2010. In determining how best to accomplish its goal with limited time and resources, the workgroup:

1. Decided to focus on attempting to compare wages and benefits for private union employees, private nonunion employees and state employees – instead of a comparison of all costs of services provided by a state agency with all of the costs of services provided by nonprofit providers of health and human services. Due to the availability of data (and the membership of the workgroup) wages of employees of DMHAS, DDS, and DCF were compared to those of the nonprofit providers under purchase of service contracts with those agencies. The scope of

the workgroup's work could not be broader at this time given the time and resources available.

2. At the first meeting, a list of occupations for particular attention was suggested:

- Mental Health Worker I
- Registered Nurse
- Case Manager
- Social Worker
- Psychiatrist
- Clinical Director

The workgroup accepted this list as a starting point. After initial research it was decided to focus on the Development Services Worker 1 (DWS-1) along with the Mental Health Worker 1 due to the large number of state employees in the DSW-1 position and the availability of aggregate data on the private providers under contract with Department of Developmental Services (DDS).

There was also a suggestion made at a meeting of the full Commission that IT and Human Resources positions also be examined.

3. Where possible, the workgroup collected and compared data on state and private wages and benefits for the stipulated job titles

The workgroup solicited and received data on state employees from state agency sources and the Comptroller's Office. The workgroup was also provided data on private employee wages and benefits from state agencies where possible and previously conducted private service provider compensation surveys.

The workgroup also collected job descriptions from a number of private providers and the job specifications for certain state positions.

FINDINGS

WAGES AND SALARIES OF SELECTED OCCUPATIONS:

Data on wages and salaries are contained in the attached table. Because the data comes from a variety of sources and may not be strictly comparable, we are not ready to make

recommendations at this time. Instead, we offer the following observation about the information we have collected.

Mental Health Assistant I (DMHAS) and Developmental Services Worker 1 (DDS) 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 positions in the private non-profit 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. Even in these categories, some of the positions may not be directly comparable. For example, the state runs an inpatient forensic hospital which is not replicated in the private sector.

Registered Nurses: Data from the Department of Labor did not show a significant difference in wages between the state and private sector. The workgroup concluded that the market for nurses was such that any employer wishing to hire and retain nurses must pay the market wage. Some nonprofits reported difficulty retaining nurses and that some left the private sector to work for the state due to better benefits available in state service. State agencies also reported difficulty recruiting nurses due to competition from general hospitals.

Case Managers: "Cost comparison" of this position may not be possible because the work related to this job title varies greatly within and between the state and nonprofit sectors. Job descriptions and educational and other requirements vary greatly despite the job title.

Social Worker: The Commission on Enhancing Agency Outcomes (CEAO) summary sheet showed a significant difference in salaries between state employed Child/Family Social Workers ($69,571) and those employed in the private sector ($47,709). Information from DCF confirmed a disparity. DCF's average FTE rate is $31.98 compared to $20.69 for DCF private providers (source: 2009 Single Cost Report).

Psychiatrists: Examination of data from the Department of Labor did not show significant disparity between state and private sector psychiatrists. The workgroup decided not to conduct a more detailed analysis of this position at this time.

Clinical Director: The workgroup was unable to identify comparable positions in the state and nonprofit sectors in this job category to facilitate a useful cost comparison.

IT workers: The wide variety of occupations in this category complicates a cost comparison. Data from the Department of Labor did not show a clear disparity in wages for IT occupations between the state and private sectors. A Summary Sheet

prepared for the Commission on Enhancing Agency Outcomes (CEAO) showed private sector employees in this category making either the same or more than their counterparts in state employment.

Human Resources: The workgroup was not able to identify comparable positions between the state and nonprofit sectors.

BENEFITS:

Data on benefits is summarized on attached table. Nonprofit provider cost data on benefits is for DDS only because DDS was able to aggregate data from provider's annual reports. For the state sector, the two largest expenditures are retirement and health insurance.

Retirement: State retirement expense includes a large "employer contribution" toward the unfunded liability so for comparison purposes it exaggerates the "cost" of current state employees. This contribution is a large majority of the state's retirement expense and those costs should be removed from a calculation of current costs. A rough estimate is that the cost of current retirement benefits for state employees is approximately 10% of payroll. Data provided by DDS show that the retirement expense for nonprofit providers under contract with DDS is approximately 3% of salary. The workgroup did not obtain comparable data for nonprofit providers under contract with other agencies. The workgroup was told by some nonprofit providers that many nonprofit providers are unable to provide this benefit at all.

Health insurance: While the gap is not as wide as with retirement, state costs for health insurance are higher than in the private sector. Nevertheless, nonprofits reported difficulty in funding premium increases that insurance companies have charged in recent years. Due to time constraints, the workgroup did not study the differences in benefits offered state employees vs. those in the private nonprofit sector but, due to the state's purchasing power, the assumption is that the difference in costs is due to the fact that state employees receive better benefits than those in the private nonprofit sector, not that the private nonprofits are able to provide the same benefits at a lower cost.

Conclusions: – For many occupations, both the state and the private sector pay wages determined in the labor market. However, for some positions there is evidence of a disparity between the wages paid by the state sector vs. those paid by the private nonprofit sector. This disparity seems greatest among some positions that provide direct care and services to clients in the DDS, DMHAS, and DCF systems.

Next Steps

Job Descriptions: Job descriptions were from several sources and were not always comparable. Positions with similar (or even the same) titles had significantly different education and experience requirements, suggesting that they were not, in fact, the same job. Workgroup plans further study of job descriptions/specifications to increase the value of the the cost comparison.

Health Benefits: Workgroup will attempt to compare benefits offered in addition to costs of benefits. Workgroup has discussed exploring potential cost savings for nonprofits through pooling.

Benefits in general: workgroup will attempt to explore the question of definitions of "part time" vs. "full time" for the state and nonprofit providers for the purposes of eligibility for benefits. Workgroup will attempt to analyze the prevalence of use of part-time workers by both state and nonprofit providers to determine whether a greater use of part time workers by nonprofit providers contributes to the benefits cost difference between state and nonprofit providers.

Cost Comparison Workgroup Wages and Benefits.xls — Wage and Salary Comparison — Wages and Salaries

State Title	Wage Rate	Salary	Data Source	Nonprofit Provider	Wage Rate	Salary	Data Source
Mental Health Assistant 1		$39,990 - $52,518	DMHAS				
	$21.35 - $28.75		CORE-CT	Direct Care Staff (DDS contract)			
				Community Living Arr.	$ 14.57	30,308	DDS review of Annual Reports
Developmental Services Worker 1		$35,449 - $48,127	DDS	CTH Supp	$ 13.73	28,567	DDS review of Annual Reports
	$19.44 - $26.35		CORE-CT	SL	$ 13.72	28,540	DDS review of Annual Reports
				Day Services	$ 14.30	29,744	DDS review of Annual Reports
				Total All Programs	$ 14.39	29,940	DDS review of Annual Reports
				Direct Care Staff (DDS contract)	$12.21 - $17.03 $14.48 per FTE		DDS 8 largest provders Annual Reports FY2009 Annual Report
Mental Health Assistant				HIV/AIDS Counselor/Outreach Worker		$38k - $42k	RNP
				Life Skills Facilitator		$32k - $36k	RNP
				Peer Counselor (Part-time)		$14k - $18k	RNP
Children Services Worker	$23.53 - $31.44		DCF	Child Care Worker	$12.73 - $19.41		SCAR
	$27.08 Average		DCF		$16.20 per FTE		2009 Single Cost Report
Clinical Social Worker	$31.98 to $43.21		CORE-CT				
	$31.98 DCF Avg		DCF	Social Worker	$16.08 - 25.91 $20.69 per FTE		SCAR 2009 Single Cost Report
Clinical Social Worker				Clinical Coordinator MATS		$50k - $60k	RNP
				Clinical Coordinator Co-occuring Residential		$50k - $60k	RNP
				Assistant Director MATS		$70k - $80k	RNP
DMHAS LCSW		$58,413 - 78,938	DMAS				
DS Case Manager or SW (Health Care Professional) -- N.B. LSCW not required	$30.49 - $41.28		CORE-CT				
Child/Family Social Worker		$ 69,571	CEAO	Child/Family Social Worker		47,709	CEAO
Community Clinician				Case Manager Prospect House		$30k - $35k	RNP
				Case Manager Psyciatric Services		$30k - $35k	RNP
				Case Manager Transitional/Supportive Housing		$30k - $35k	RNP
				Crisis Intervention Specialst		$30k - $35k	RNP
Developmental Services Case Manager		$55,696 - $75,416	DDS				
DMHAS Community Clinician		$50,737 - $68,842	DMHAS				
Rehabilitations Counselor				Rehabilitation Counselor Psyciatric Rehab.		$30k - $35k	RNP
Correctional Substance Abuse Counselor				Counsellor Horizons (Residential)		$32k - $37k	RNP
				Counsellor New Prospects (Residential)		$38k - $42k	RNP
				Counsellor Kinsella Treatment Center		$35k - $40k	RNP
				Counsellor Center for Human Services		$35k - $40k	RNP
Registered Nurse				RN Nusing Home Hiring Minimum	$26.55 - $31.39		NEHCEU, District 1199
				RN Nonprofit MH Agency Hiring Minimum	$21.05 - $24.07		NEHCEU, District 1199
				RN-Charge Nursing Home Hiring Minimum	$47.96		NEHCEU, District 1199
Registered Nurse		$ 70,623	CEAO			70,623	CEAO
DMHAS Nurse		$49,388 - 65,383	DMHAS				
Head Nurse (DDS or DMHAS)	$30.49 to $41.28		CORE-CT				
Clinical Nurse Coordinator	$30.49 to $41.28		CORE-CT				

Notes:

All source material is available on the workgroup's website http://www.ct.gov/opm/cwp/view.asp?a=3961&Q=466424

Workgroup did not obtain comparable data for all categories which why so many cells above are blank.

Workgroup does not suggest that all data are representative. For example, RNP is "Regional Network of Programs, Inc." RNP's salary range may be higher or lower that of other nonprofit providers.

CEAO is Commissoin on Enhancing Agency Outcomes Summary Sheet Handout-4/8/10

Benefit Type	State As % of Total Monetary Compensation	Source	Nonprofit Provider as % of Total Salary	Source
Social Security Expense	6.20%	CEAO Summary Sheet	6.99%	Annual reports submitted to DDS for FY2009
Medicare	1.45%	CEAO Summary Sheet		
Unemployment Expense	0.29%	CEAO Summary Sheet	0.94%	Annual reports submitted to DDS for FY2009
Workers Comp Expense			2.79%	Annual reports submitted to DDS for FY2009
Health & Other Insurance Expense	18.52%	CEAO Summary Sheet	11.58%	Annual reports submitted to DDS for FY2009
Retirement Expense	33.99%	CEAO Summary Sheet	2.97%	Annual reports submitted to DDS for FY2009
Other Benefit Expense			0.29%	Annual reports submitted to DDS for FY2009
Total Benefits	60.5%	CEAO Summary Sheet	25.6%	Annual reports submitted to DDS for FY2009
	DDS Employees as % of Salaries and Wages			
Group Life Insurance	0.12%	CORE-CT		
Medical Insurance	17.83%	CORE-CT		
Unemployment Compensation	0.29%	CORE-CT		
FICA	5.96%	CORE-CT		
Medicare	1.41%	CORE-CT		
SERS (retirement)	39.60%	CORE-CT		
Arp	0.0032%	CORE-CT		
Teachers Retirement System	0.0033%	CORE-CT		
Total	65.2%	CORE-CT		

Notes:
Private Social Security Expense includes Medicare
All private provider data above is average for providers under contract with DDS. Providers under contract with other state agencies may on average have higher or lower benefit costs.
State Retirement Expense and SERS include large (estimate 2/3 or more of payments shown above) for unfunded liabilities and our the result of past funding decisions not the current work of employees.

WORKGROUP SUMMARIES

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

Commission on Non-Profit Health and Human Services
Private Provider Cost Increases, Nonprofit Agency Financial Condition, and Sources of Revenue Workgroup

Preliminary Report
December 13, 2010

The Workgroup has been tasked with analyzing and developing a report in three separate areas of interest related to Special Act 10-5. The workgroup has developed a plan of action for executing the assigned areas of analysis and submitting a final report. The following represents the accomplishments to date and the Workgroup's plan for further action:

1. Private Providers Cost Increases

The workgroup has identified specific areas of concern related to cost increases. These expenditures include essential components of a nonprofit agency's budget, over which the agencies often have little or no 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. Commodities and services of particular concern are as follows:

a. Health Care and Benefits
b. Utilities: Lights, Gas, Heat
c. Insurance: Auto, Liability, and D & O
d. Maintenance of Technology - Requirements for Increased Data Collection and Additional Infrastructure
e. Gasoline
f. Vehicle Maintenance
g. Property Maintenance and Repairs
h. Wage Adjustments Below the CPI

The workgroup has determined that the most effective and accurate way to report on costs associated with these items is to research and assemble industry data for the State of Connecticut and the Northeast region of the country. There are too many variables to give a true indication of cost increases. For example, Health Care and Benefits have experienced significant increases over the past several years. To defray cost increases nonprofit agencies have reduced the benefits packages offered to their employees. This would result in a less than true cost comparison over several years. The Workgroup has requested information from the State Department of Public Utility Control, the Insurance Department, and Federal data sources. The workgroup will continue to research the data available, the variables that would impact the nonprofit providers and weigh the results against the nonprofit providers' budget at large.

The Workgroup is acknowledging the changing business climate and new requirements that are causing increased costs to private providers in the areas of billing, information system supports, and staff training. The Workgroup will further investigate the impact of these new requirements and explore possible solutions and recommendations.

2. Financial Condition of Agencies

The workgroup has researched and selected tools to produce a comprehensive view of the financial condition of the State's nonprofit providers. The workgroup is in the midst of creating a statistically accurate stratified sample of the 709 Health and Human Services providers. The workgroup will then proceed with the calculation of several financial ratios specific to nonprofits to test the financial fitness of the stratified sample group. The workgroup has selected the following ratios:

a. Liquid Funds Indicator
LFI = Total Net Assets - Restricted Net Assets - Fixed Assets / Average Monthly Expenses
b. Liquid Funds Amount
LFA = Dollar Value of Unrestricted New Assets - Net Fixed Assets + Mortgages and Other Notes Payable
c. Debt Ratio
DR = Average Total Debt / Average Total Assets

Based on the outcomes of these three ratios, the workgroup will decide if further analysis is warranted to get an accurate picture of the financial landscape of nonprofit providers in the State of Connecticut.

3. Sources of Revenue

The workgroup has decided to follow three separate tracks of analysis to provide a comprehensive picture of nonprofit revenue resources available in the past, the current revenue funding mix and what could possibly be available in the future. The workgroup will:

a. provide a State funding chart indicating increases in revenue that have been provided over the past 20 years.
b. calculate and application of a Revenue Ratio to the stratified sample group that will provide the percentage of revenue from various sources.
c. investigate possible alternative funding sources and the costs associated with pursuing those opportunities.
d. research trends in philanthropy.

The Workgroup notes that seeking alternative funding sources and pursuing Medicaid reimbursement may increase costs to both the providers and the State of Connecticut because of additional staffing to facilitate the billing, and the costs associated with new requirements.

The completion of these tasks will allow the workgroup to report potential challenges and opportunities facing the nonprofit providers regarding revenue.

After the completion of the Workgroup's action plan, the Workgroup will report on the findings and offer recommendations to be reviewed by the full Commission.

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PROJECTED COST SAVINGS WORKGROUP
INSTITUTIONAL VS. COMMUNITY BASED CARE
Commission on Nonprofit Health and Human Services

Preliminary Report
December 2010

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.

MEMBERSHIP

The Workgroup is 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 Choice)
Melanie Sparks – DOC (Purcaro Choice)	Heather Gates – (Kasdan Choice)
Claudette Beaulieu – DSS	Donna Grant
Lisa Mazzeo	David Pickus
Jessica Sacilowski	

In addition, Pete Gioa, Vice President and Economist of CBIA was invited by the Workgroup and agreed to serve in an advisory role. 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 and Nora Sinkfield, Administrative Assistant with the Connecticut Department of Public Health.

MEETINGS

To date, the Workgroup has held four (4) scheduled meetings. 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.

ACCOMPLISHMENTS

The Workgroup discussed setting manageable and attainable goals within the Commission's time frame. To this end, the Workgroup agreed to look at qualitative and cost variables from an institution vs. community perspective. Four health and human service areas were selected for comparison: mental health, substance abuse, supported living and primary healthcare. The Workgroup agreed to establish a common reporting platform/template for collecting and comparing the requested data across 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 agencies have through POS contracts with private providers. A copy of the summary reporting template distributed to the workgroup for completion is provided below.

PROJECTED COST SAVINGS WORKGROUP													
FISCAL DATA SUMMARY TEMPLATE													
Description of Data	Data											Source of Data	Additional Considerations
	Institution				Residential				NonResidential				
	Total	*Annual*	*Daily*		*Total*	*Annual*	*Daily*		*Total*	*Annual*	*Daily*		
Mental Health													
Substance Abuse													
Supported Living													
Healthcare													

To further enhance the data collection process, the Workgroup facilitated, with the Commission's approval, a meeting of fiscal officers from the state agencies referenced above. The Workgroup began analyzing the aggregate data as it became available. As a result and in the interest of ensuring the highest degree of comparability of data between state agencies that would result in the most relevant and meaningful recommendations to the Commission, the Workgroup decided to initially narrow its field of evaluation by prioritizing the collection and analysis of data to DMHAS, DCF and DDS. All other agency data collected will be subject to analysis following this initial evaluation. To standardize the collection of detailed back-up data for reporting purposes, a spreadsheet was discussed at the agency fiscal officers meeting. This

spreadsheet has been created and distributed to the above agencies for completion with a return date of no-later-than December 21, 2010. A copy of this spreadsheet is provided below.

PROJECTED COST SAVINGS WORKGROUP
DETAILED FISCAL DATA SPREADSHEET

	Private Hospital	Private Residential	Group Home	At Home Services
Average Census				
Total Days of Care				
Personal Services				
Admin				
Food Service				
Maintenance				
Clinical/ Medical				
Care and Custody				
Education				
Other Expenses				
Admin				
Food Service				
Maintenance				
Clinical/ Medical				
Care and Custody				
Education				
Workers' Compensation				
Total Cost				
Cost per day				
Annualized				
Fringe benefits (OSC)				
Grand Total Cost				
Total Cost per day				
Annualized				
Other Agency allocations				
Payments in Lieu of Taxes				
tuition Reimbursement				
Other Agency Equipment Depreciation				
Comptroller Adjustment				
SWCAP Total				
Equipment Depreciation				

Building Depreciation				
Central Office Allocation (less WC above)				
Bond Interest				
Payroll costs				
Other				
Adjustments (Dept ID corrections etc)				
Misc. Revenue				
Comptroller Adjustments to Costs				
Total Cost				
Comptroller Adjustments to Costs				
Comptrollers Actual In-patient Costs				
Prior period adj				
Adj Actual per Comptroller's				
Actual In-patient days				
Comptrollers rate for year				
Projected Costs				
Recovery amount (adj actual minus proj costs)				
Comptrollers Actual In-patient Costs				
Inflation Factor				
Inflation Amount				
Comptrollers Actual In-patient Costs				
Inflation Amount				
Recovery amount				
Projected Cost for the Next Year				
Actual In-patient days				
Per capita rate for the Next Year (Proj next year costs divided by current yr inpatient days)				

In addition, the Workgroup is compiling data provided by OPM and OFA to project costs associated with the provision of services by private providers under state health and human services programs.

NEXT STEPS

Receive and analyze spreadsheet data from state agencies, report on the findings and offer recommendations to be reviewed by the full Commission.