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.

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, 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 is 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 where 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 DATA PROVIDED BY DDS, DCF, and DMHAS

Projected Cost Savings Workgroup
Fiscal Data Summary Template
DDS

Description of Data	Institutional Southbury Training School	Institutional Regional Data/State	Residential DDS Public	Residential DDS Private	Additional Considerations
Annual	$357,700.00	$361,350.00	$297,110.00	$136,371.00	Note: 2009 data prior to conversion of 17 public group homes. A portion of regional centers and Southberry health care is included for these costs - for the other two no portion of health care is included in these costs.
Daily	$980.00 per client	$990.00	$814.00	$373.62	
Average Daily Census	474.9	89	177	2698	

Projected Cost Savings Workgroup
Fiscal Data Summary Template
DMHAS

	Inpatient (Connecticut Valley Hospital)	MRO Group Home [2]	MH Supervised Apartments	MH Supportive Housing	MH Case Management	MH Outpatient
DMHAS Costs	$148,106,195	$9,621,036	$25,473,113	$7,825,347	$24,187,667	$21,761,722
Fringe Benefits	$60,685,314					
Comptroller Adjustment (Including SWCAP)	$24,693,982					
Actual Inpatient Cost	$233,485,491					
Inflation Amount	-$3,338,843					
Recovery amount	-$4,926,868					
Total	-$8,265,711					
Projected Total Costs For Next Year	$225,219,780					
Patient Days[1]	182,253	66,795	201,115	241,995	1,379,335	3,643,065
Per Diem	$1,236	$144.04	$126.66	$32.34	$17.54	$5.97

Note: 1. Patient days equals capacity * 365 for non-inpatient levels of care
2. Includes Medicaid FFS payments

Projected Cost Savings Workgroup Fiscal Data Summary Template DCF				
	Riverview FY 2009	Private Residential	Group Home	At Home Services
Average Census	66.0			
Total Days of Care	24,099			
Personal Services	$29,545,452			
Other Expenses	$3,715,116			
Workers' Compensation	$1,787,238			
Total Cost	$35,047,806			
Cost per day	$1,454.33			
Annualized	$530,829			
Fringe benefits (OSC)	$15,788,568			
Grand Total Cost	**$50,836,374**			
Total Cost per day	$2,109.48	$314.61	$570.37	$138.88
Annualized	$769,960	$113,592	$208,184	$50,691

FINDINGS AND RECOMMENDATIONS

1. The transition from institutional to community-based systems of care is a work in progress for Connecticut's health and human service 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/family seeking services; however, it is recognized that higher levels of care, including institutional, will always be needed as part of the service continuum.
3. The data indicates that private providers deliver community based services at a lower per diem rate than state institutional settings. Of note, other funding streams, both public and private, factor into supporting the necessary mix of community resources needed.
4. The Workgroup recommends that this effort be the impetus for a more standardized, comprehensive and integrated reporting system across state agencies. For example, the state could establish a statewide data warehouse for human services.
5. This initiative produced significant data from multiple state health and human service agencies. The lack of standardization of data collection and costing methodology prevented

the workgroup from performing a more in-depth analysis. The Workgroup recommends that additional in-depth data analysis be performed.

6. The Workgroup recommends that key fiscal staff in health and human service agencies meet regularly to address the recommendation and issues identified in #4 and #5 above.
7. A robust community based system of care that provides timely and accessible services across a broad continuum would offer the most cost effective health and human services system to Connecticut's children and adults.
8. 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.
9. Data trends across agencies point to the cost effectiveness of community based care vs. institutional care. 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 our-clients and providers across the continuum of care.

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

Please note, that the base data is from FY09 state issued Purchase of Service (POS) contracts for current services and for accounts that are not caseload driven. This projection assumes an inflation rate of 1.0% for FY10, 1.0% for FY11, 1.1% for FY12, 1.6% for FY13, and 1.9% for FY14. Caseload changes, contract term changes, or state policy changes could effect contract payments.

FY	Inflation	State Payments
FY09		$ 1,371,555,451
FY10	1.0%	$ 1,385,271,006
FY11	1.0%	$ 1,399,123,716
FY12	1.1%	$ 1,414,514,076
FY13	1.6%	$ 1,437,146,302
FY14	1.9%	$ 1,464,452,081

This projection is an informal estimate. Data analysis provided by Neil Ayers, Principal Budget Analyst, Office of Fiscal Analysis.