

**March 11, 2010**  
**Human Services Committee Public Hearing**  
**SB 282 and HB 5245**

**Alyssa Goduti, Vice President for Public Policy,  
Connecticut Community Providers Association (CCPA)**

Good afternoon. I am Alyssa Goduti, Vice President for Public Policy at the Connecticut Community Providers Association (CCPA). CCPA represents organizations that provide services and supports for people with disabilities and significant needs including children and adults with substance use disorders, mental illness, developmental, and physical disabilities.

Our members provide vital human services to hundreds of thousands of individuals across the state. We provide essential human services that keep people out of emergency rooms, hospitals, emergency shelters and prisons. Our work plays a critical role by serving as the safety net for many of our state's most vulnerable citizens.

**SB 282 – An Act Concerning Implementation of Attendance-Based Reimbursement System by the Department of Developmental Services**

We are grateful to the Committee for raising SB 282, An Act Concerning Implementation of an Attendance-Based Rate System by the Department of Developmental Services (DDS). We appreciate you taking action to address the many concerns raised in your Taskforce on Community-Based Human Services about this issue. You heard from parents, staff, providers and consumers about their many concerns with moving to an attendance-based reimbursement system for this population.

The DDS budget includes a nearly \$6M reduction to Employment Opportunities and Day Services. The budget proposes shifting those services into an attendance-based reimbursement system, which passes on those cuts directly to providers and disproportionately impacts providers who serve a more medically frail or behaviorally challenged population. The Legislature passed a bill in the September 2009 Special Session to require an Advisory Committee to Study the Reimbursement of Services under DDS, which was supposed to develop a plan for an attendance-based system reporting out by January 2011. We are incredibly concerned about the implementation of this major change on a very quick timetable, the administrative burden this new system places on providers, the financial impact this change has on provider and the implications for consumers and their families.

In 2007, DDS data showed that over 70% of community providers who contract with DDS were running deficits for the year. This proposal to implement attendance-based reimbursement further compromises their stability and has a negative impact on the people served by the system.

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- Under this new system, DDS will only reimburse providers the full cost of serving a client if that client attends the program at least 90% of the time.
  - a) Actual attendance rates, as reported in the DDS 2006 Consolidated Operating Report, reflect an average attendance of 81%, in 2007 the average rate was 84% and in 2008 the average attendance was 83%.
  - b) Data from the 2006 DDS Consolidated Operating Report shows an average attendance of 81% in Day Programs.
  - c) Most providers have attendance data in the low 80% range.
  - d) Implementing a 90% attendance factor is a deep and immediate cut to providers.
  - e) This new system creates a major challenge for agency administrators and fiscal staff who have to manage agency budgets and services without being able to anticipate their funding levels on a month to month basis.
  - f) Programs that serve elderly individuals or those with more complicated medical needs have significantly lower utilization rates.
  
- Basing the rates on 90% attendance is unreasonable given the medical, physical and personal needs of DDS consumers. This shift penalizes providers who serve consumers with generally lower attendance, typically older or more medically frail individuals. It creates a disincentive for providers to take on new consumers who are elderly or have significant health or behavior issues.
  
- In discussions with DDS about how to best manage vacancies, staff has recommended overbooking programs. We have serious objections to overbooking programs because:
  - a) Scheduling more consumers for programs than there are adequate staff to serve them puts client health and safety at risk.
  - b) It could also lead to staffing ratios that are not appropriate to meet licensing and quality assurance standards.
  
- This level of attendance-based reimbursement contradicts the philosophy of normalization for DDS consumers because it could discourage them from taking family vacations, traveling, and taking personal time off from their day or employment program. Under this model, providers will be placed in the unfortunate position of discouraging such valuable time off.
  
- Severe weather events, over which providers have no control, would also adversely impact attendance. Agencies rarely close, yet families and residential providers are often reluctant to transport day program participants to their sites base on weather predictions and road conditions. This new system forces providers to make the difficult decisions about keeping their agencies open for in hopes that clients may attend and help to mitigate their losses, or close completely and accept the loss of an entire day of funding.

We spent months last session trying to work on a reasonable compromise with DDS on this issue, with the help and leadership of the co-chairs of the Public Health Committee. We agreed that the best way to address this issue was through a Legislative Committee that would include key stakeholders – providers, family members, DDS staff in operations, information technology, fiscal and staff from DSS, OPM and the Governor’s Office. Together these stakeholders were to

study and pilot the proposed changes over the course of a year so that they could ultimately recommend a solution in January of 2011.

We were shocked and incredibly disappointed when we learned through a presentation by the Department in December of 2009 that, despite this Rate Study Legislation passed as part of the September 2009 Special Session, DDS would move forward to implement attendance-based reimbursement beginning February 2010. This effort undermines the intent of the legislation and the work taking place now in the Rate Study Committee. We urge you to support this bill and to encourage DDS to look at other ways of addressing funding cuts that are reasonable and sensitive to providers and consumers.

### **HB 5245 – An Act Establishing a Task Force to Study Privatization of Group Homes**

We support the concept of HB 5245 and encourage your committee to expand membership of this Taskforce to include members representing the community provider system.

Most services for people with disabilities are currently provided by the private sector. Community providers currently operate 778 of the 873 group homes licensed by DDS. DDS licensing reviews both settings and keeps statistics on plans of correction and other quality indicators. The quality data provided by DDS shows that community-based agencies provide high quality, cost effective services.

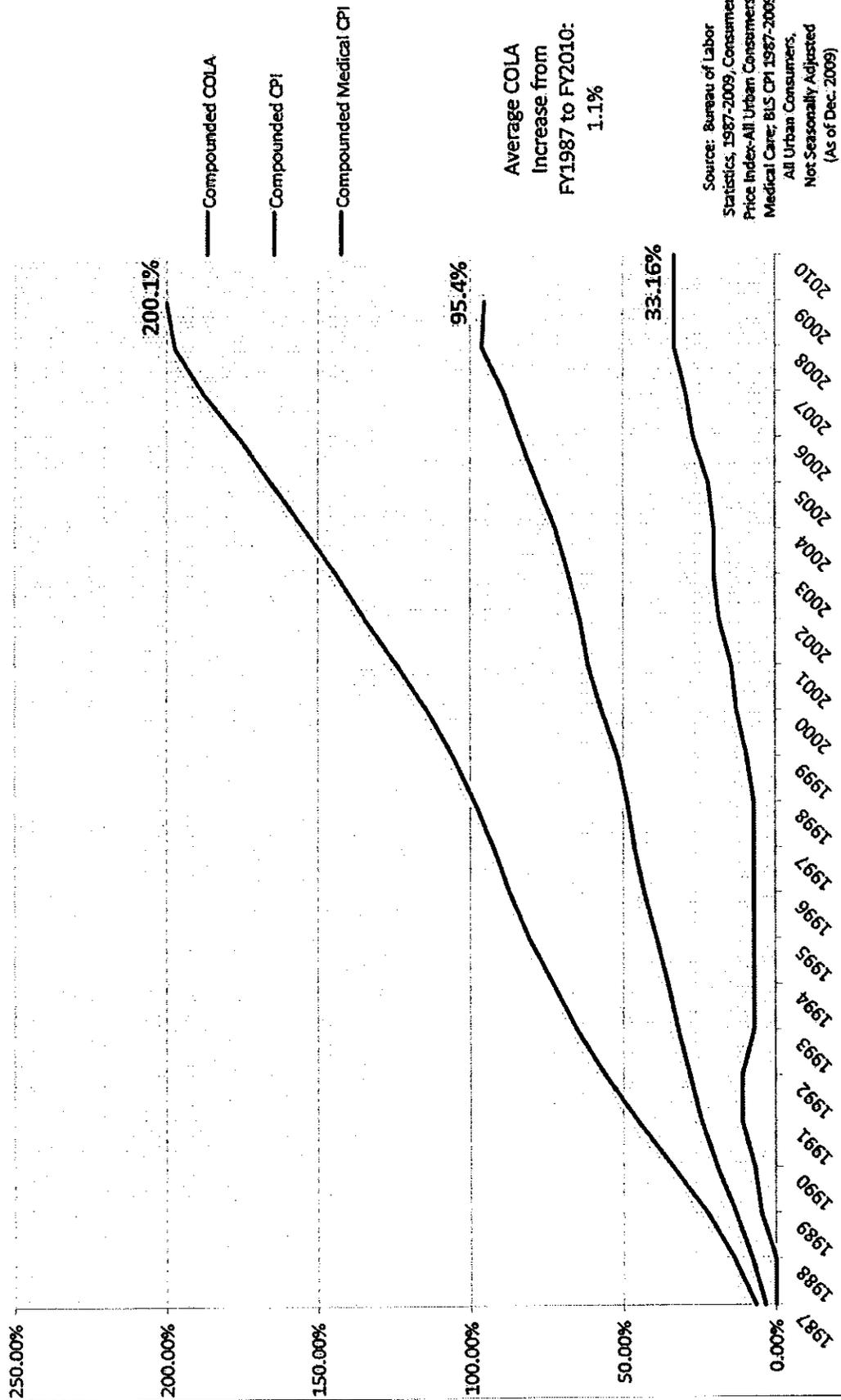
I've attached a chart of data comparing costs of community-based services versus those services provided by the state. Most other states play an oversight role while they depend on community providers to provide direct services. We encourage this Taskforce to look at models around the country as you do long-term strategic planning on how best to serve people with disabilities.

For more than 25 years, community providers have maintained high quality services despite being inadequately funded by the state, with increases that haven't come close to covering the costs of services. As the Medical Consumer Price Index has grown by over 201 %, the funding to cover costs of services for community providers has only increased 33%. That is an average funding increase of 1%, while staffing costs (wages and insurance) and the costs to run residential and clinical services (including food and fuel) have gone up exponentially. The current budget means three consecutive years with a zero (0%) percent increase in funding to cover the rising cost of services. That flat funding, coupled with recent rescissions and the deficit mitigation means cuts for community providers, for some up to 5 %.

As an industry, we are ready and willing to take on additional services. However, adequate funding must be provided to support those services in the community. We encourage this process to also examine a funding system that would support these services in a systematic and long-term way.

As you grapple with this historic fiscal crisis, we urge you to remember that community providers are a key part of the fiscal solution. We provide alternatives to more costly and restrictive systems of care including institutional care, emergency rooms, inpatient hospital stays and the Corrections and Judicial systems. With adequate funding we can continue to provide high quality health and human services in local communities in a cost effective and efficient way.

### Compounded COLA vs. Compounded CPI and Medical CPI FY1987-FY2010





**DDS FY 2006-2007**

Per Capita Costs for care in each State Region	In-Patient		Group Homes	
	Daily	Annual	Daily	Annual
West Region	\$763	\$278,495	\$670	\$244,550
North Region	\$920	\$335,800	\$782	\$285,430
South Region	\$1,169	\$426,685	\$807	\$294,555
Southbury Training School	\$952	\$347,480 (Not applicable)		
Average:	\$951	\$347,115	\$753	\$274,845

Source: November 8, 2007 Auditor's Report, Department of Developmental Services for the Fiscal Years ended June 30, 2005 and June 30, 2006 (Per Capita Costs for fiscal year ended 6/30/05, 6/30/06)

[http://www.cga.ct.gov/apa/pdf2007/DCF\\_81000\\_06.pdf](http://www.cga.ct.gov/apa/pdf2007/DCF_81000_06.pdf)  
<http://www.cga.ct.gov/apa/pdf2004/DMR%2041000-03.pdf>

**DMHAS FY 2005-2006**

Per Capita Costs for those in residence at:		
	Daily	Annual
Connecticut Valley Hospital	\$1,125	\$410,625
Connecticut Mental Health Center	\$1,339	\$488,735
Southwest Connecticut Mental Health System	\$1,499	\$547,135
Cedarcrest Hospital	\$1,179	\$430,335
Average:	\$1,286	\$469,208

Source: August 1, 2008 Auditor's Report, Department of Mental Health and Addiction Services for the Fiscal Years ended June 30, 2005 and 2006 (Per Capita Costs for fiscal year ended 6/30/05, 6/30/06).

[http://www.cga.ct.gov/apa/pdf2008/DMHAS\\_44010\\_06.pdf](http://www.cga.ct.gov/apa/pdf2008/DMHAS_44010_06.pdf)

**DCF FY 2008**

Per Capita Costs for Children in residence at:		
	Daily	Annual
Connecticut Juvenile Training School	\$1,192	\$435,080
Connecticut Children's Place	\$1,366	\$498,590
High Meadows Residential Treatment Center	\$1,903	\$512,095
Riverview Hospital for Children and Youth (FY08)	\$2,369	\$864,685
Average:	\$1,708	\$577,613

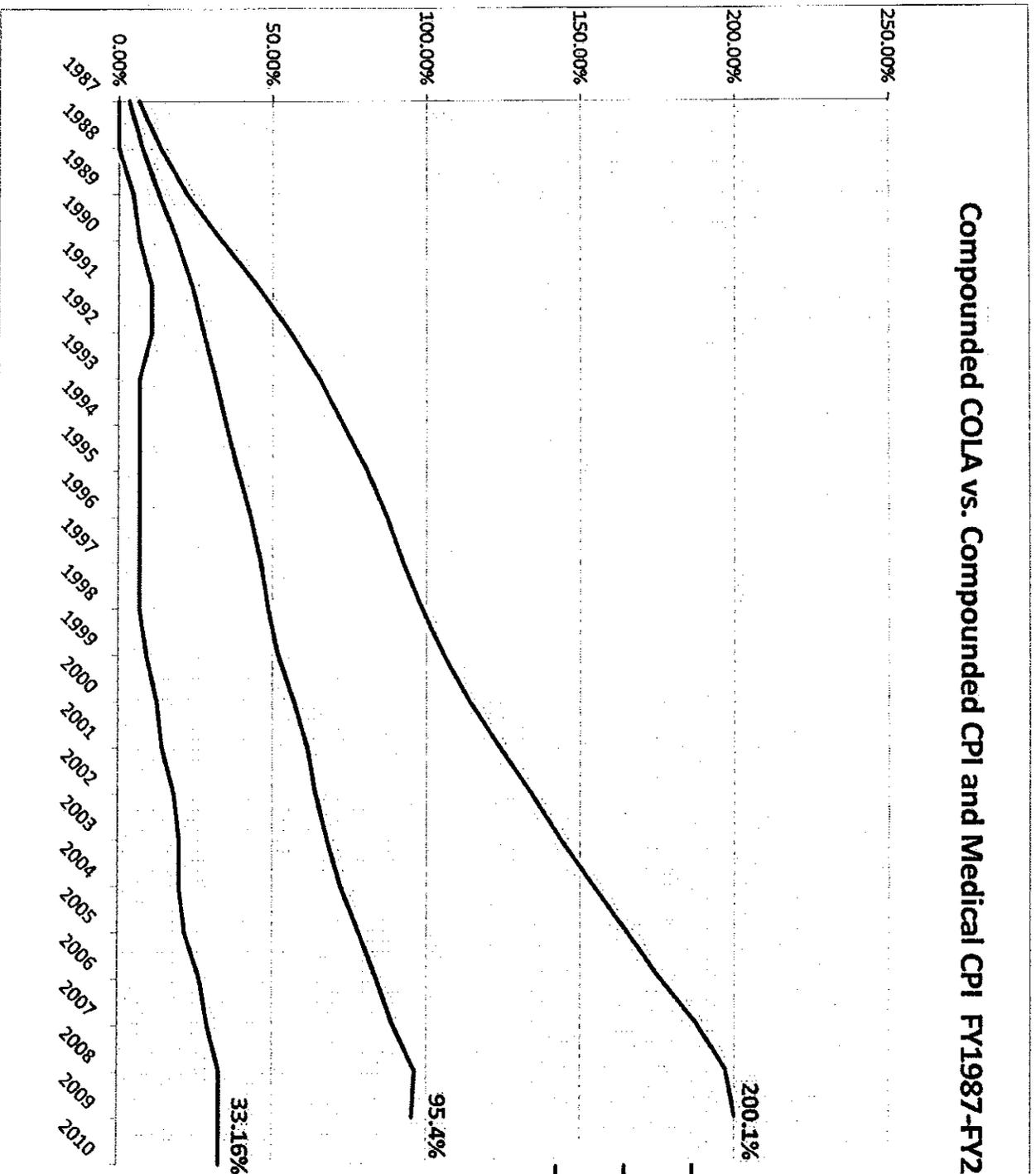
Source: Secretary Genuario's 10/20/08 testimony to Human Services and the Select Committee on Children, Joint Investigative Hearing on DCF, attachment-Operating Cost, OSC per capita and Annualized amounts from Office of State Comptroller.

[http://www.ccpa-inc.org/102008JointInvestigativeHearingDCF\\_SecGenuario](http://www.ccpa-inc.org/102008JointInvestigativeHearingDCF_SecGenuario)

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### Compounded COLA vs. Compounded CPI and Medical CPI FY1987-FY2010



Average COLA Increase from FY1987 to FY2010: 1.1%

Source: Bureau of Labor Statistics, 1987-2009, Consumer Price Index-All Urban Consumers Medical Care; BLS CPI 1987-2009 All Urban Consumers, Not Seasonally Adjusted (As of Dec. 2009)

# There is a better way: Cost-effective social services through nonprofit providers

by Pete Gioia  
CBIA Vice President and Economist



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The state of Connecticut administers hundreds of programs that provide much-needed and generally high quality services for many people with disabilities and special needs, including children, people with mental illness and intellectual disabilities, former inmates transitioning to society, people with addictions and others. These are people who probably wouldn't survive without some kind of lifeline or safety net, and state government is helping to fulfill its responsibility to care for them.

But these people, and Connecticut's taxpayers, deserve to have much-needed social services provided in a way that can be sustained as cost effectively as possible over time. With the state facing a steep budget deficit, it is critically important to explore every viable option.

Obviously, the state provides quality services for many of its clients. It is startling, however, how much more expensive state-run programs are, compared with the same or similar services provided by nonprofit organizations.

In Connecticut, state-employee caregivers are providing services at double the cost of comparable programs provided by people in nonprofit agencies.

How big is the discrepancy? Here are some examples, according to the latest data (2007) from the state Department of Developmental Services (DDS):

## Community living arrangements for disabled people

Annual rates, per client

	Nonprofit Providers	State programs
Average	\$87,221	\$238,624
Low	\$43,800	\$190,924
Median	\$99,278	\$240,228
High	\$158,77	\$250,193

## B. Day programs

Annual rates, per client

	Nonprofit providers	State employee provider
<b>Average</b>	<b>\$20,052</b>	<b>\$85,298</b>

As can be seen, average rates for community living arrangement are 2.7 times higher when provided by state employees vs. nonprofit provider services; worse, rates for day programs are 4.2 times more expensive when the state provides the services.

It's important to note that these nonprofit programs are vigorously monitored by the state agencies that have hired them. Nonprofit agencies would not be providing services under contract to the state if their quality was unacceptable.

What then is the advantage of high-cost state agencies providing these services? Wouldn't the state find exceptional savings for taxpayers if it were to make more use of reputable nonprofit social services providers?

Connecticut also continues to maintain institutional services at four regional facilities at very high rates--even though clients with similar disabilities and needs, who were deinstitutionalized years ago at the Mansfield Training School, are now being served at community-based programs.

Here are annual per-client costs, based on fiscal year 2009 annual interim rates:

**Nonprofit average: \$87,221**

Southbury Training School: \$347,480

West Regional Center: \$266,450

North Regional Center: \$268,275

South Regional Center: \$386,900

Again, these programs are costing far more than those being provided by community-based services.

Certainly, any kind of change with such vulnerable clients would need careful planning to make sure people's needs are met. However, these cost discrepancies are so clear and Connecticut's fiscal crisis so enormous that continuing to do business as usual is just fiscally unsound. The state should immediately investigate options to provide quality, lower-cost services.

Ultimately, it comes down to deciding whether we simply want to keep doing things in the same high-cost way, or choosing to make the very best use of taxpayers' dollars. People in Connecticut have already voted, saying in two recent Quinnipiac University Polls that they want state government to become smaller and more effective. This is an area in which the state could start making some significant progress.

