TESTIMONY OF DAVID BRADDOCK, Ph.D.
COLORADO SENATE/HOUSE INTERIM COMMITTEE ON DEVELOPMENTAL DISABILITIES
JULY 18, 2007

Chairman Garcia, Co-Chairperson Boyd, I am pleased to have this opportunity today to testify before your Joint Committee on Developmental Disabilities. My name is David Braddock. I am the Coleman-Turner Chair and Professor in Psychiatry in the CU School of Medicine, Associate Vice-President of the University of Colorado System, and Executive Director of the Coleman Institute for Cognitive Disabilities. I have been involved in the field of developmental disabilities for almost 40 years. During my time in the field I have had the opportunity to work in various capacities in several states including Texas, Missouri, Illinois, Colorado and Washington, DC. I have testified in the legislatures of numerous states and before U.S. Congressional Committees on several occasions.

Many of the states in which I have testified have been at "turning points" in terms of their need to reframe and/or significantly expand resource commitments for developmental disabilities services. I believe Colorado is in such a position today. My testimony will describe the national context of developmental disabilities services in the states, identify certain strengths and weaknesses of the Colorado DD service system today, and summarize current challenges facing the State.

OUTLINE OF TESTIMONY

My testimony is organized into five parts:

I. **Historical perspectives on developmental disabilities**

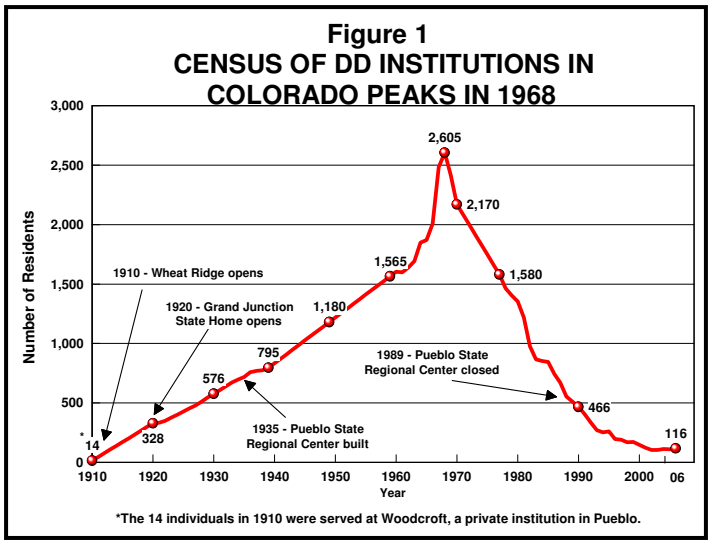
II. **Emergence of community programs**

III. **Colorado's limited "fiscal effort" for developmental disabilities**

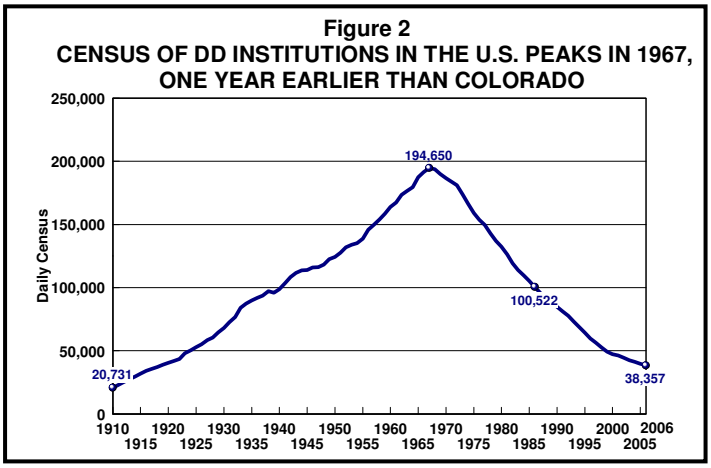
IV. **Factors influencing service demand**

V. **Innovation in emerging technology [Separate PowerPoint handout]**

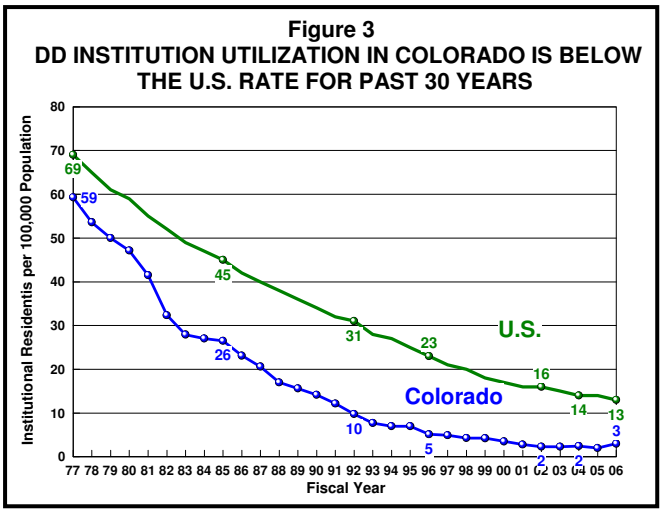
I. Historical Perspectives on Developmental Disabilities



The first state-operated institution for persons with developmental disabilities in Colorado (Wheat Ridge) was opened in 1910. Grand Junction opened in 1920 and Pueblo State Regional Center was completed in 1935. The census of these institutions peaked in 1968 at 2,805 persons, and declined virtually every year since then, although the census has recently leveled off. It was 116 persons in 2006 (***Figure 1***).



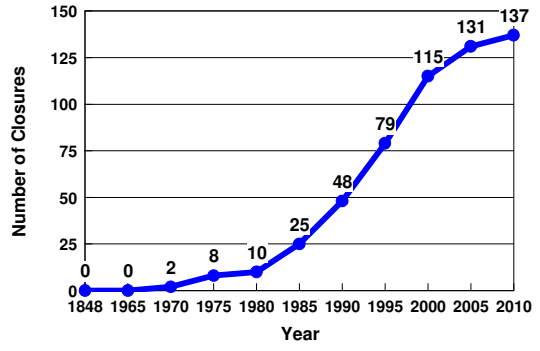
The census of residents in DD institutions peaked in the U.S. in 1967 at 194,650. This was one year before Colorado's peak was reached, and every year since 1967, the U.S. institutional census fell by approximately 3-6% per year. The census presently is estimated at 38,357 in 2006 (***Figure 2***).



The utilization rate of DD institutions in Colorado has consistently been below the U.S. rate, although recently, with the leveling off in the rate of decline of the Colorado DD census, the gap has begun to close slightly (***Figure 3***).

Ten states and the District of Columbia now operate without reliance on a state-operated DD institution. Recently, after leadership efforts were coordinated through an Indiana bipartisan "317 Commission" of legislators, agency staff, parents, and associations representing rehabilitation and DD service interests, the State of the Indiana became the largest state now operating its service system without reliance on a DD institution. We have identified 137 DD institutional closures in the U.S. since 1970 (***Figure 4***).

Figure 4
137 DD INSTITUTIONS HAVE/ WILL CLOSE SINCE 1970



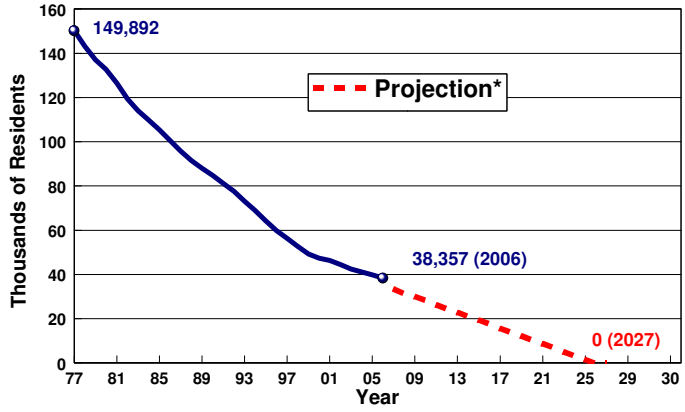
In 2006 ten states had fewer than 140 residents institutionalized in state-operated facilities for 16 or more individuals with DD. Colorado ranked 7th among these 10 states at 116 residents. Texas had the largest number of residents in state-operated institutions: nearly 5,000 persons in 2006. New Jersey and California each housed over 3,000 persons, and in Illinois there were over 2,700 (***Figure 5***).

Figure 5

SMALLEST INSTITUTIONAL CENSUS: 2006		LARGEST INSTITUTIONAL CENSUS: 2006	
1 Oregon	40	1 Texas	4,943
2 Montana	77	2 New Jersey	3,064
3 Nevada	79	3 California	3,025
4 Wyoming	88	4 Illinois	2,709
5 Idaho	90	5 Ohio	1,606
6 Delaware	99	6 New York	1,605
7 Colorado	116	7 North Carolina	1,605
8 Michigan	127	8 Virginia	1,452
9 Arizona	134	9 Louisiana	1,419
10 North Dakota	137	10 Pennsylvania	1,416
		11 Mississippi	1,377

Given the multi-decade decline in the DD institutional census coupled with the closure of so many such institutions, the question is often asked "will there always be state-operated institutions for people with DD in the U.S.?" Using simple projection techniques that include slower

Figure 6
WILL THERE ALWAYS BE STATE-OPERATED INSTITUTIONS? TRENDS SUGGEST NOT AFTER 2027

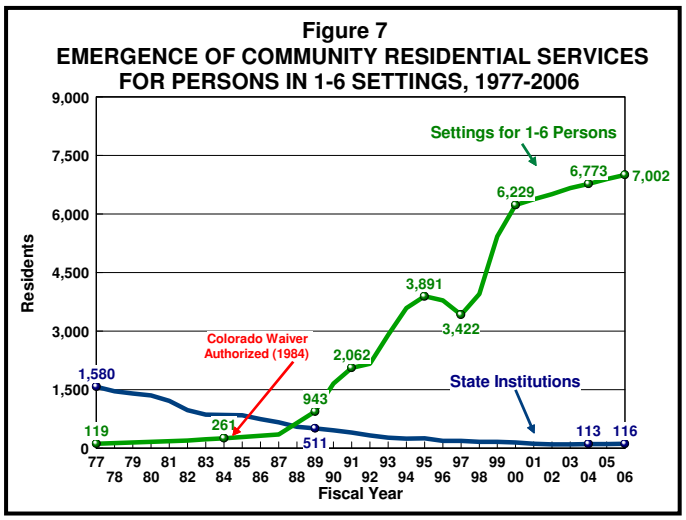


*Trend adjusted for slower deinstitutionalization in AR, GA, IL, IA, KY, LA, MS, MO, NV, TX, and VA.

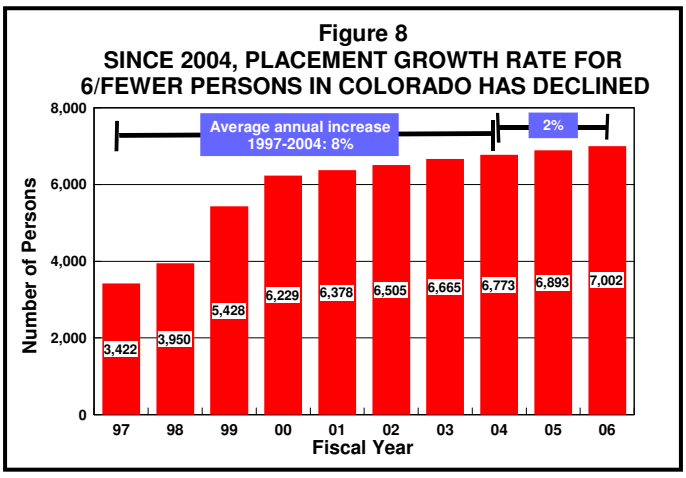
deinstitutionalization rates for the 11 primarily Southern states that have reduced their institutional populations more slowly than the rest of the country, current trends suggest that all U.S. institutions for people with DD would close by the year 2027 (***Figure 6***).

II. Emergence of Community Programs

The institutional model of services in our country and in other Western nations has been replaced in the past 30-40 years by the emergence of community programs with supported living, small group homes, and foster/host homes; supported employment; and family support. In the U.S., the Home and Community-Based Services Waiver (HCBS) has been the primary fiscal engine driving the growth of community service. The HCBS Waiver was authorized in the Omnibus Budget Reconciliation Act of 1981.



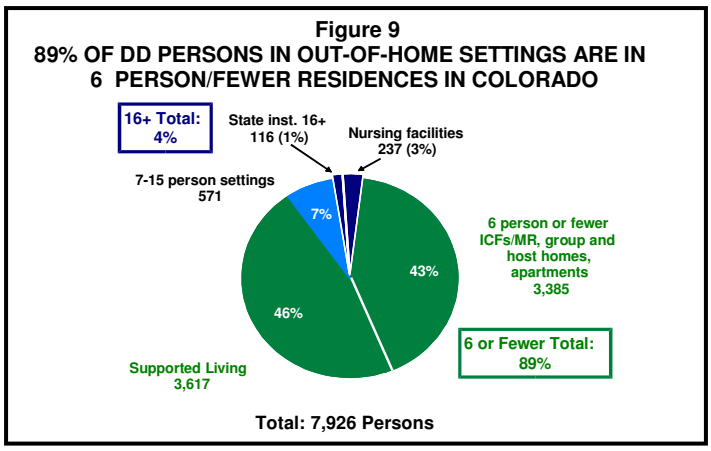
As the institutional model declined in Colorado over the past 40 years, small community-based settings for six or fewer persons grew rapidly—from 119 persons in such settings in 1977 to 7,002 persons in 2006. Persons with DD in state institutions declined from 1,580 to 116 (***Figure 7***).



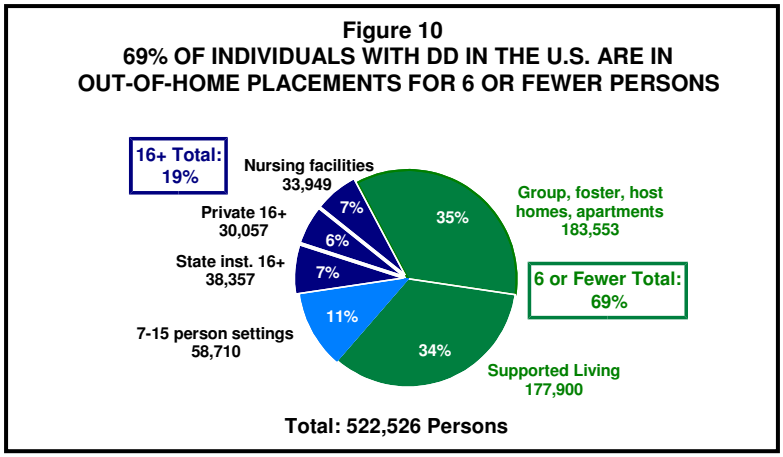
The growth rate of out-of-home placements for people with DD averaged 8% per year in Colorado between 1997-04, but it dropped to 2% annual growth during 2004-06 (***Figure 8***).

The U.S. rate declined too--from roughly 10% growth/year to 4%/year. The U.S. growth rate for

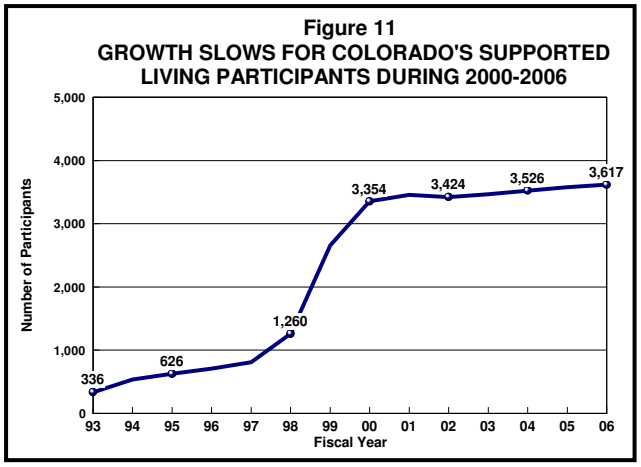
community residential settings has been significantly more robust than Colorado's, even as the Colorado general population's growth far exceeded the U.S. population's growth over the past decade.



In 2006, 89% of persons with DD in Colorado in supervised out-of-home placements were in settings for six or fewer persons. These settings included host homes, group homes, apartments, and supported living arrangements (***Figure 9***).

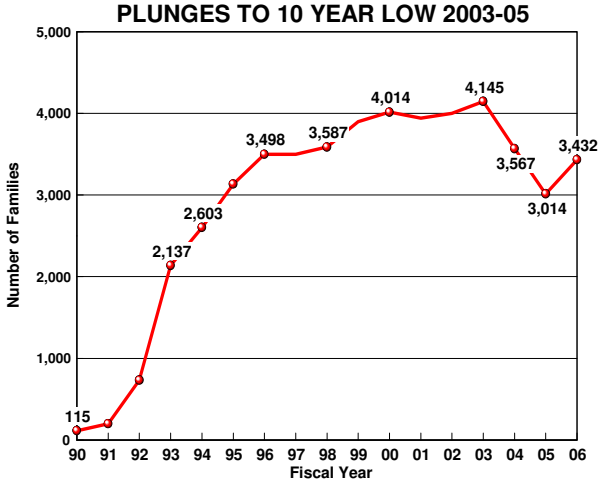


A substantially smaller percentage of persons with DD in the U.S. were in 6/fewer out-of-home community placements (69% vs. 89% in Colorado). Although many states utilize large settings such as nursing facilities, state institutions, private 16+ institutions and 7-15 person settings, the use of such settings in the U.S. is declining steadily (***Figure 10***).



The number of persons with DD receiving supported living services in Colorado has leveled off since the year 2000 (***Figure 11***). Principles of supported living include 1) choice (where to live, with whom and which lifestyle); 2) ownership by other than the service provider (i.e., the individual owns or rents, the family owns or holds

Figure 12
NUMBER OF FAMILIES SUPPORTED IN COLORADO PLUNGES TO 10 YEAR LOW 2003-05



the lease, or a housing cooperative owns the housing); and 3) individual support (focus on an individual's changing needs over time, and an individualized support plan or support contract).

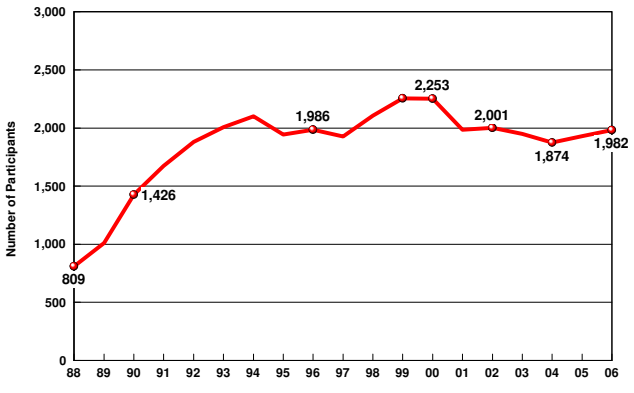
The number of families supported in Colorado has also declined significantly during 2003-06 (***Figure 12***). Family support includes respite; family counseling; architectural adaptation of the home; in-home training, education, and behavior management; sibling support programs; and purchase of specialized equipment. Colorado has yet to launch a cash subsidy family support program. Twenty-four states currently have cash subsidy programs (***Figure 13***). "Cash subsidy family support" includes payments or vouchers directly to families, and families determine what is purchased.

Figure 13
COLORADO HAS NO CASH SUBSIDY FAMILY SUPPORT PROGRAM--BUT 24 STATES DO

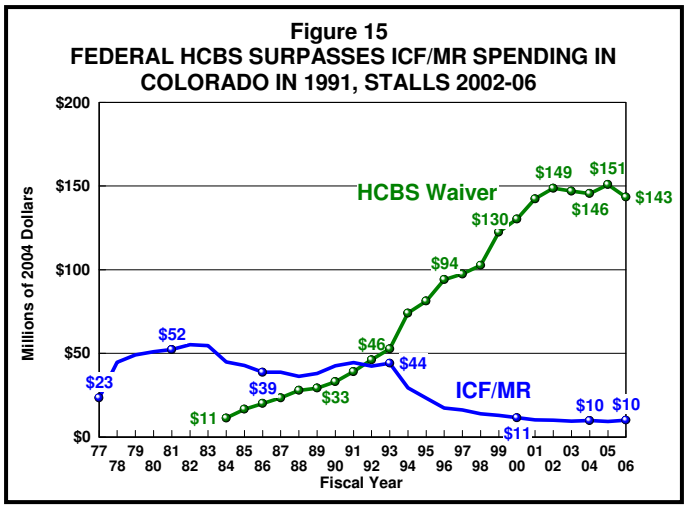
	State	Susbsidy Per Family
1	Illinois	$13,815
2	Minnesota	$5,709
3	Iowa	$4,712
4	North Dakota	$4,272
5	Nevada	$4,136
6	New Mexico	$3,468
7	Rhode Island	$3,299
8	Utah	$3,181
9	Alaska	$3,000
10	South Carolina	$2,809
11	Louisiana	$2,718
12	Michigan	$2,620
13	Kansas	$2,409
14	Oklahoma	$2,394
15	Florida	$2,255
16	Washington	$2,019
17	Tennessee	$1,932
18	Texas	$1,870
19	Delaware	$1,856
20	Arizona	$1,826
21	Arkansas	$1,555
22	New Jersey	$1,529
23	Maine	$1,101
24	Connecticut	$931
	U.S.	$3,050

	State	# Families
1	New Jersey	7,851
2	Michigan	6,722
3	Connecticut	3,525
4	Texas	2,674
5	Illinois	2,611
6	Washington	2,513
7	Minnesota	2,346
8	Oklahoma	2,077
9	Tennessee	2,018
10	Louisiana	1,705
11	Alaska	1,516
12	Kansas	1,418
13	South Carolina	1,151
14	Arizona	573
15	Maine	545
16	Nevada	454
17	Iowa	378
18	Florida	210
19	New Mexico	164
20	North Dakota	142
21	Delaware	126
22	Arkansas	92
23	Rhode Island	53
24	Utah	5
	U.S.	40,869

Figure 14
NUMBER OF SUPPORTED EMPLOYMENT WORKERS IN COLORADO IS AT A 10 YEAR LOW

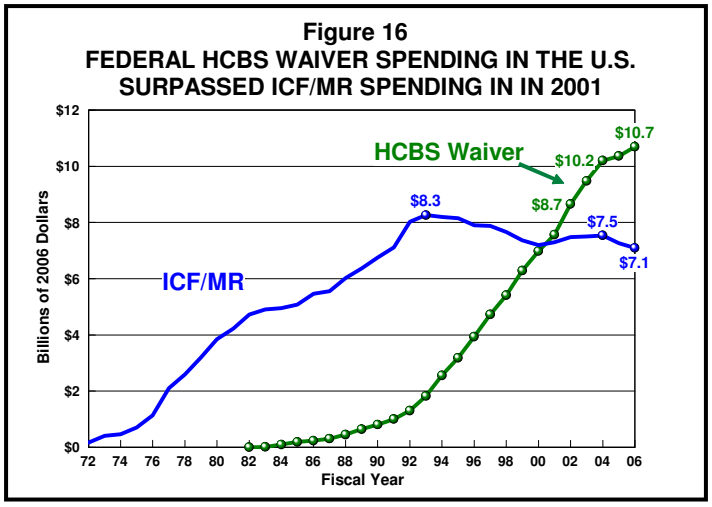


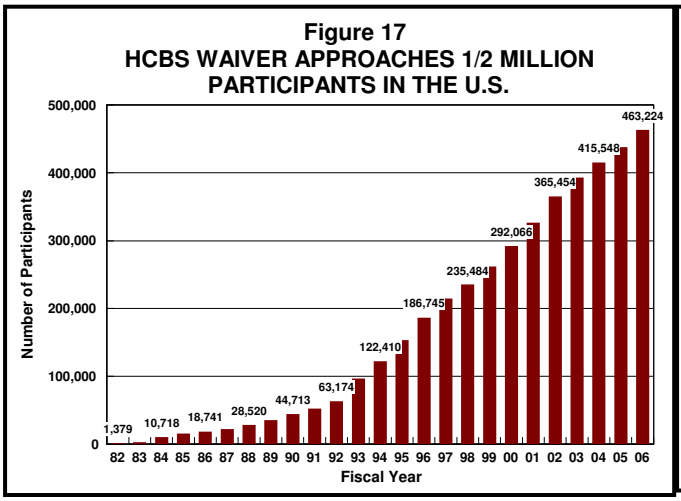
The number of supported employment workers with DD in Colorado is below the 1994 level, and the number of workers has declined steadily since 1999 (***Figure 14***). (The State was unable to provide us with spending data for 2006 on supported employment).

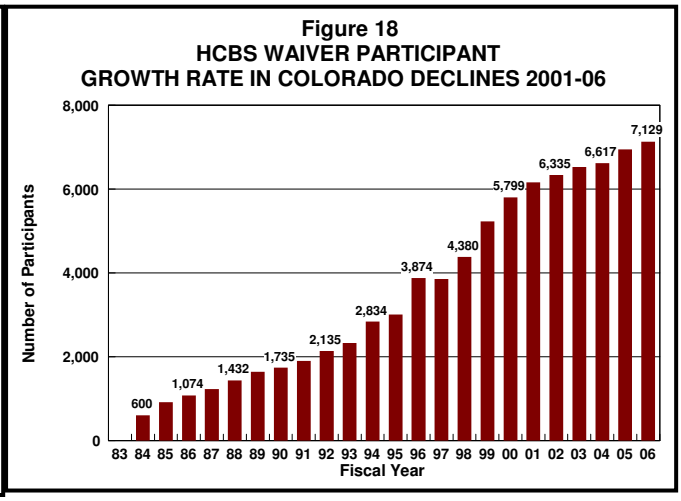


As previously noted, the HCBS Waiver has been an engine of community services growth in Colorado. Federal HCBS Waiver spending in Colorado surpassed ICF/MR spending in 1992, but growth stalled during 2002-06, as shown in ***Figure 15***).

In contrast, federal HCBS Waiver spending only surpassed ICF/MR spending at the national level in 2001, but it continues to grow quite rapidly on a national basis (***Figure 16***). Colorado has not used sufficient "matching" funds to draw down additional HCBS Waiver funding for community services, family support, and supported employment. The number of HCBS Waiver participants has grown twice as fast nationally (***Figure 17***) as it has in Colorado in recent years (***Figure 18***).







III. Colorado's Fiscal Commitment to DD Services and Supports is Limited

Colorado's fiscal effort for DD services (spending for DD services as a fraction of aggregate statewide personal income) has been significantly below the average U.S. state for 30 years and the gap is widening (***Figure 19***). Colorado ranked 46th in DD fiscal effort in 2006. Moreover, if we compare Colorado to states with roughly similar populations (4-7 million), the State ranks next to last out of 14 states within this population category. In fact, seven of these 14 states are spending ***50% more than Colorado*** in terms of fiscal effort: South Carolina, Tennessee, Indiana, Wisconsin, Massachusetts, Louisiana and Minnesota (***Figure 20***).

Figure 19
COLORADO DD FISCAL EFFORT IS SIGNIFICANTLY BELOW THE U.S. AVERAGE STATE--FOR 30 YEARS

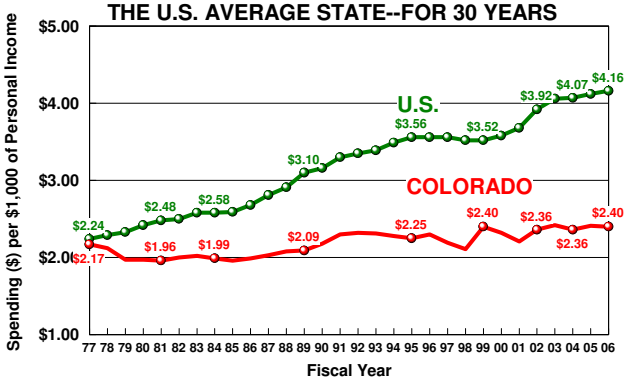
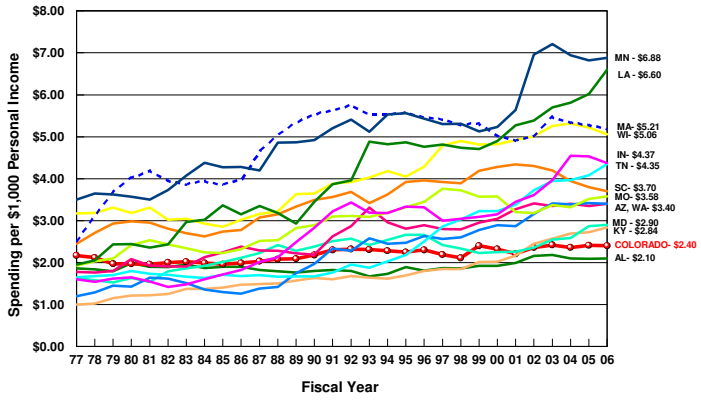
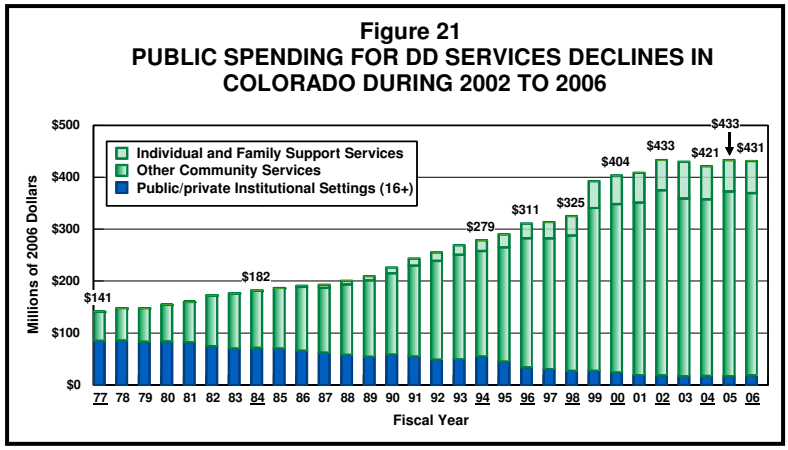


Figure 20
COLORADO NEXT TO LAST IN FISCAL EFFORT IN 14 STATES WITH 4 TO 7 MILLION POPULATION: 2006



When adjusting for the impact of inflation, Colorado spent $2 million more funds for DD services in 2002 than it did in 2006. As shown in ***Figure 21*** below, nearly all of

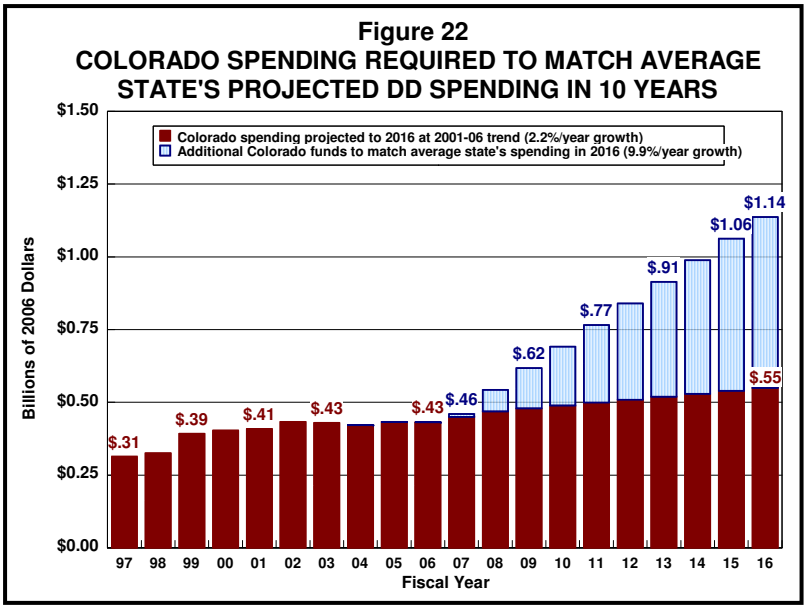
Figure 21
PUBLIC SPENDING FOR DD SERVICES DECLINES IN COLORADO DURING 2002 TO 2006



Colorado's funding was for community services, including supported living, group, foster/host homes, supported employment, and family support.

What would Colorado have to spend for DD services over the next 10 years to "catch up" to the average American state in terms of "fiscal effort?" The gap is significant. Colorado was 73% behind the average state in fiscal effort in 2006 ($2.40/$1,000 vs. $4.16/$1,000). A 9.9% increase in spending per year from 2007-2016 would be required to equalize Colorado's DD spending with projected figures for the average American state. Under present law, possibly one-half of these resources could be obtained from the federal HCBS Waiver program (Colorado's Medicaid federal medical assistance percentage, or FMAP rate, is 50%). ***Figure 22*** illustrates the projection of previous trends in spending in Colorado, an average increase of 2.2% per year, versus the 9.9% yearly increase required through 2016 to equalize Colorado with the projected U.S. average.

Figure 22
COLORADO SPENDING REQUIRED TO MATCH AVERAGE STATE'S PROJECTED DD SPENDING IN 10 YEARS



IV. Factors Influencing Demand for DD Services in Colorado and the U.S.

Demand for DD services is increasing. There are 1,107 persons awaiting services in Colorado under the Comprehensive Waiver and an additional 1,839 waiting under the Adult Supported Living Waiver. The aging of our society will also greatly influence demand for services. The number of Americans aged 65 years and older will double from 35 to 70 million persons between 2000 and 2030 (***Figure 23***).

Presently, an estimated 20% of Coloradans with DD, over 9,000 individuals, live at home with a caregiver aged 60 years or older (***Figure 24***).

Longevity is also increasing for people with intellectual disabilities, up from 59 years in the 1970's to over 66 years in the 1990s. Greater longevity requires extended services and supports. Seven years added to the adult life span requires 15-20% in additional supervised living arrangements and related supports.

Figure 23
GROWING NUMBERS OF AMERICANS AGED 65+ YEARS: 2000-2050

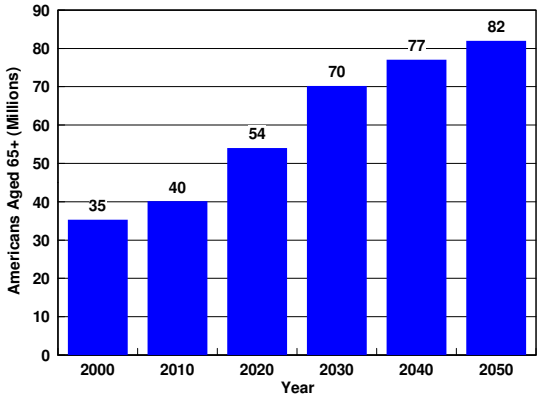
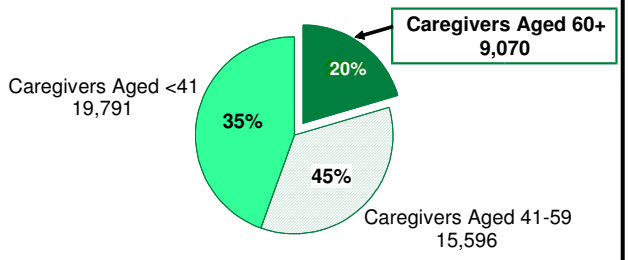


Figure 24
AN ESTIMATED 20% OF COLORADANS WITH DD LIVE AT HOME WITH AGING CAREGIVERS



Total Family Caregivers in 2006: 44,457

On a national basis there has also been extensive litigation on waiting lists, the U.S. Supreme Court's *Olmstead* decision, and Medicaid Access claims. Several of these cases have stimulated a significant expansion of services (***Figure 25***).

Figure 25
ROLE OF LITIGATION: STATES WITH ACTIVE/SETTLED CLASS ACTION CASES 2002-2007

Waiting List 25 States		*Olmstead* 12 States	Medicaid Access 17 States
(1) ALABAMA	(1) NEBRASKA	(3) ARKANSAS	(1) ARIZONA
(2) ALASKA	(3) NEW HAMPSHIRE	(2) CALIFORNIA	(1) ARKANSAS
(3) ARKANSAS	(3) NEW MEXICO	(2) CALIFORNIA	(3) CALIFORNIA
(3) COLORADO	(1) OHIO	(2)CONNECTICUT	(2) CALIFORNIA
(2) CONNECTICUT	(2) OREGON	(3) FLORIDA	(1) CALIFORNIA
(2) DELAWARE	(3) PENNSYLVANIA	(1) ILLINOIS	(2) CONNECTICUT
(2) FLORIDA	(2) TENNESSEE	(1) ILLINOIS	(1) ILLINOIS
(2) HAWAII	(2) TEXAS	(3) MARYLAND	(1) ILLINOIS
(2) ILLINOIS	(3) UTAH	(2) MASSACHUSETTS	(2) INDIANA
(2) KENTUCKY	(2) VIRGINIA	(2) MICHIGAN	(1) KANSAS
(2) MAINE	(1) WASHINGTON	(1) NEW JERSEY	(2) LOUISIANA
(2) MASSACHUSETTS	(2) WASHINGTON	(1) NEW JERSEY	(2) MAINE
(2) MONTANA	(2) WEST VIRGINIA	(1) NEW YORK	(1) MASSACHUSETTS
		(1) NEW YORK	(2) MINNESOTA
		(2) NEW YORK	(1) OHIO
		(2) OREGON	(3) OKLAHOMA
		(3) PENNSYLVANIA	(2) TENNESSEE
		(2) PENNSYLVANIA	(3) TEXAS
		(3) PENNSYLVANIA	(2) WISCONSIN

CASE STATUS CODE
(1) Active
(2) Settlement introduced/reached
(3) Case dismissed

Source: Smith (2007, January)

SUMMARY AND CONCLUSION

1. **COLORADO HAS COMMUNITY/FAMILY ORIENTED VALUES, BUT UNCOMMONLY LOW RESOURCE COMMITMENTS FOR DD, AND THUS GROWING, PENT-UP DEMAND FOR SERVICES/SUPPORTS;**
2. **COLORADO'S HCBS WAIVER FUNDING FELL 4% DURING 2002-06. THE AVERAGE STATE INCREASED SUCH SPENDING BY 24%;**
3. **AN ESTIMATED 9,000 FAMILIES IN COLORADO AGED 60+ CARE FOR FAMILY MEMBERS WITH DD;**
4. **OVER 3,000 PERSONS WITH ID/DD ARE ON WAITING LISTS;**
5. **COLORADO'S GENERAL POPULATION INCREASED BY 1.9% BETWEEN 2005 AND 2006 [*STATE POLICY REPORTS*, VOLUME 25, ISSUE 12, P. 6]. DURING 2002-06, COLORADO'S GENERAL POPULATION INCREASED BY 177,000 PERSONS. ROUGHLY 1,800 OF THESE INDIVIDUALS CAN BE EXPECTED TO HAVE INTELLECTUAL OR CLOSELY RELATED DEVELOPMENTAL DISABILITIES;**
6. **ADDRESSING THE LEVEL OF NEED IN COLORADO FOR DD SERVICES REQUIRES A MULTI-YEAR LEGISLATIVE/EXECUTIVE BRANCH/SERVICE PROVIDER PLAN AND COMMITMENT, AND SUBSTANTIALLY INCREASED RESOURCES, AS NOTED IN FIGURE 22;**
7. **I AM PROVIDING RECOMMENDATIONS ON EMERGING INNOVATIVE TECHNOLOGIES IN DEVELOPMENTAL DISABILITIES TO THE COMMITTEE TODAY IN A SEPARATE POWERPOINT DOCUMENT.**

I thank the Committee for the opportunity to testify today.