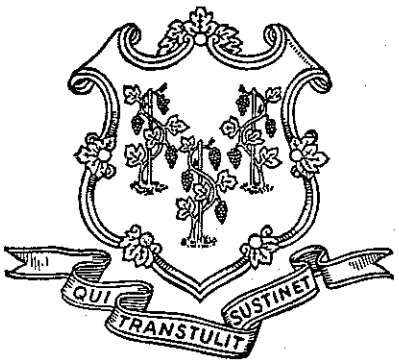
BIRTH TO THREE PROGRAM: EARLY INTERVENTION SERVICES

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 1995

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three members.

1995-1996 Committee Members

Senate
Eileen M. Daily
Co-chairman
Fred H. Lovegrove, Jr.
William H. Nickerson
Melodie Peters
Edith G. Prague
Stephen R. Somma

House
Ann P. Dandrow
Co-Chairman
Curtis Andrews, Jr.
Terry Concannon
Michael J. Jarjura
Brian E. Mattiello
Peter F. Villano

Committee Staff
Michael L. Nauer, Director
George W. McKee, Chief Analyst
L. Spencer Cain, Chief Analyst
Carrie E. Vibert, Chief Attorney
Catherine M. Conlin, Principal Analyst
Jill E. Jensen, Principal Analyst
Anne E. McAloon, Principal Analyst
Brian R. Beisel, Associate Analyst
Michelle Castillo, Associate Analyst
Maryellen Duffy, Associate Analyst
Renee La Mark Muir, Associate Analyst
Jacques S. Asselin, Analyst
Bonnine T. Klare, Executive Secretary

Staff for this Project
Maryellen Duffy
Neil Ayers, Graduate Fellow

STATE CAPITOL ROOM 506 HARTFORD, CT 06106 (203) 240-0300

BIRTH TO THREE PROGRAM: EARLY INTERVENTION SERVICES

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

DECEMBER 1995

TABLE OF CONTENTS

	EXECUTIVE SUMMARY	i
	INTRODUCTION	1
I.	OVERVIEW OF EARLY INTERVENTION SERVICES	3
II.	PROGRAM ORGANIZATION AND DESIGN	13
III.	DEMOGRAPHIC ANALYSIS OF THE B-3 POPULATION	19
IV.	PROGRAM RESOURCES AND EXPENDITURES	25
V.	POLICY IMPLEMENTATION	37
VI.	FINDINGS AND RECOMMENDATIONS	45

APPENDICES

A. Profile of Other States

B. Department of Education Response

C. Department of Mental Retardation Response

EXECUTIVE SUMMARY

One of the most devastating moments in the lives of parents is the discovery their child is developmentally delayed. The Birth to Three (B-3) Program has helped to alleviate some of the stress by providing families with early intervention services and offering parents information on how best to enhance their child's development. In three public hearings held by the Program Review and Investigations Committee, numerous families recounted the overwhelming value to them of the program. The testimony provided coincides with current research in the field that early intervention services promote a child's full development, have a positive effect on families, and provide critical support to parents. The strength of the program lies in the stories told by parents describing how the B-3 Program made a difference in their families' lives.

Part H of the Individuals with Disabilities Education Act (IDEA), enacted by Congress in 1986, provided states with funding to develop and implement a comprehensive statewide program of early intervention services for infants and toddlers, from birth up to three years old, with developmental disabilities. The program is considered an entitlement and participating states are required to design a statewide system that includes 14 program components and 17 mandated services reflecting a family-centered service approach.

Connecticut submitted its initial application for Part H funding in 1987 and full participation began with the passage of Public Act 93-383. The act named the state Department of Education (SDE) as the lead agency having jurisdiction over the general administration, supervision, and monitoring of the B-3 Program. Included in the act was a a stipulation that the program terminate June 30, 1996, unless reestablished by the General Assembly prior to that date.

The program design adopted in Connecticut, included a single point of entry for all referrals, an independent case management function, and a regional delivery system consisting of both public and private providers. To implement this structure, SDE contracted with the six Regional Educational Service Centers (RESC) in the state for the day-to-day operation of the B-3 Program. In addition, the Department of Mental Retardation receives a separate state appropriation to operate a program of early intervention. Children are referred by a RESC to DMR's "Early Connections Program" and DMR staff provide special instruction and some therapeutic services.

The Legislative Program Review and Investigations Committee authorized a study of the B-3 Program in June 1995. The study's primary focus was whether the current program design and delivery model being used in Connecticut allowed for the most cost-effective and equitable delivery of early intervention services. In addition, the committee examined if federal Medicaid dollars and private insurance were being accessed for delivered services.

The program review committee found the education department has developed a needlessly complex system of governance to administer the B-3 program, which includes 2 state agencies (SDE and DMR) and 11 regional entities (6 RESC grantees and 5 DMR regions). The decentralized design run by a lead agency that historically has not been involved in direct service delivery, has led to

deficiencies in program management, oversight, and cost. Although the utilization of services has been a major factor in escalating program costs, until recently cost control has not played a significant role in SDE's oversight of the program. Finally, the committee found an absence of any clear directives or quality assurance role on the part of the lead agency to guarantee equity, uniformity, and appropriateness of service delivery across all regions. The committee concluded the program needs a single coherent management structure.

In the public debate prior to the enactment of P.A. 93-383, policymakers expressed numerous concerns over the potential costs of the B-3 program and the source of funds to be used to pay for program services. The purpose of Part H funds is to maintain a structure to provide early intervention, not to provide the financial resources needed to deliver services. To cover most of the costs of service delivery, states are expected to assemble funding from a variety of sources including Medicaid, private insurance coverage, and state appropriations. Although 84 percent of referrals received by the program between January 1995 and May 1995 were covered by either private insurance or Medicaid, the committee found that neither Medicaid nor private insurance had been accessed. The primary reason for this, the committee found, was because of a lack of institutional expertise in the area of health insurance within the lead agency.

Recommendations

1. *Connecticut reauthorize legislation to maintain participation in Part H.*

2. *There shall be development of a mission that provides clarity to B-3 Program objectives. The mission shall define the tenets of a developmental program and the program's relationship to other services including:*

   - *medical services,*
   - *health services,*
   - *social services, and*
   - *instructional services;*

   The Interagency Coordinating Council, along with the lead agency, shall be involved in creating and promoting the vision and mission to ensure they are understood and accepted by employees, advocates, parents, and providers.

3. *The lead agency shall develop a long-range strategic plan. The lead agency shall provide an annual report detailing program and fiscal information including: number of children receiving services, the volume and intensity of services received, actual and projected per-child costs, provider capacity, comparisons of regional information, performance measures, and whether the measures are being met; and*

   The lead agency shall develop performance based outcome measures, including the treatment effectiveness of early intervention services, and report its findings to the committees of cognizance of the General Assembly.

4. *The authority to operate the Birth to Three Program be transferred from the state Department of Education to the Department of Mental Retardation. The Department of Mental Retardation shall become the lead agency for the program. The lead agency shall contract with private providers to deliver early intervention services to eligible children. The program design shall include a system to perform quality assurance, utilization review, cost containment, outcomes research, and performance evaluation. In addition, a uniform rate structure shall be used. Efforts should be made to encourage comprehensive community provider participation among contractors who may also conduct evaluations and perform service coordination.*

5. *The lead agency shall develop a data collection plan to obtain accurate, timely cost and programmatic data. The data collection plan should allow for a rational, planned approach to optimize the use of the data base for management and programmatic purposes. In addition, data systems should be randomly audited to verify the accuracy of the information.*

6. *The Department of Mental Retardation, as the lead agency, shall create an insurance reimbursement task force that includes the Department of Insurance, the Department of Social Services, the Department of Administrative Services Bureau of Collection Services, and representatives from the insurance industry. The task force shall define the scope and method of reimbursing services.*

7. *The lead agency shall develop a marketing plan. The plan should identify the targeted population, including the number and percent to be served. It should also measure provider capacity in each region to determine where there are shortages (geographically) and develop a plan to recruit providers.*

8. *The Interagency Coordinating Council shall assist in the development of service guidelines. The guidelines should provide a framework for the plan of services developed by the individualized family service plan team.*

9. *The lead agency shall develop uniform fiscal reporting standards to ensure financial information collected conforms to generally accepted accounting principles prescribed by the Government Accounting Standards Board.*

INTRODUCTION

The Birth to Three (B-3) Program provides early intervention services to infants and toddlers with developmental delays. The State Department of Education (SDE) is the lead agency for the program and receives state and federal funds for its administration. The department provides grants to six Regional Educational Service Centers (RESCs) that carry out the day-to-day program operations. Each RESC is a separate operating entity, with its own board of directors and management structure. In addition, the Department of Mental Retardation (DMR) and the Board of Education and Services for the Blind also receive separate state funds to provide direct service to eligible children referred by the service centers.

Scope. The Legislative Program Review and Investigations Committee voted to conduct a study of the Birth to Three Program in June 1995. The purpose of the study was to examine whether the current program design and delivery model being used in Connecticut allows for the most cost effective and equitable delivery of early intervention services. In addition, the committee was particularly interested in other available funding sources to pay for program services, such as Medicaid and private insurance, and if they were being accessed.

Methodology. A variety of sources and research methods were used in conducting the study of the B-3 program. The general literature on early intervention services was reviewed. Federal and state statutes, state budget documents, reports issued on the program by the administering agencies, and various cost data in three of the six RESCs were used. In addition, a phone survey was also conducted to obtain information on programs operating in other states.

Committee staff interviewed a number of individuals in the administering agencies, as well as parents, providers, physicians, researchers, and advocates. In addition, the program review committee held three public hearings in October 1995 to gather testimony on the Birth to Three Program.

Report format. This report contains six chapters. The first chapter provides a summary of the federal and state laws governing the program and discusses Connecticut's delivery system. Chapter II describes the organization of the program at the federal level and in Connecticut. This chapter also shows the intake process for children and families referred for services. Chapter III provides demographic information on the population served by the B-3 program. Chapter IV shows federal and state resources dedicated to the program's operation and provides a detailed examination of the costs associated with service delivery. Chapter V provides information on the department's effort to secure other funds to pay for early intervention services. In addition, policies recently adopted by the department affecting the program's administration, design, and delivery system are detailed. Chapter VI contains the program review committee's findings and recommendations. Appendix A profiles early intervention programs in other states.

It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies subject to a study with the opportunity to review and comment on the

recommendations prior to the publication of the final report. A copy of the Department of Education's response is contained in Appendix B, and the Department of Mental Retardation's response is contained in Appendix C.

CHAPTER I

OVERVIEW OF EARLY INTERVENTION SERVICES

Connecticut began providing early intervention services to infants and toddlers in the 1970s, however, services were fragmented and their availability limited. The program has changed considerably since then as a result of federal and state legislation aimed at improving the system's capacity to serve children with developmental delays. Connecticut's current system consists of a state and regional structure and a single point of entry through United Way of Connecticut's Infoline. The following three chapters provide descriptive information on the administration and operation of the B-3 program. The federal and state legislative directives are explained in this chapter, and the organization and design of the program is detailed in the following chapter.

Federal legislative history. Part H of the Individuals with Disabilities Education Act (IDEA), enacted by Congress in 1986, provided states with funding to develop and implement a comprehensive statewide program of early intervention services for infants and toddlers, from birth up to three years old, with developmental disabilities. Called the Program for Infants and Toddlers with Disabilities, the intent of the federal legislation was to provide states with financial assistance to develop and maintain a system that identifies children in need of services, and then delivers appropriate developmental interventions to them and their families. It is considered an entitlement program, and participating states are required to design a statewide system that includes 14 program components and 17 mandated services reflecting a family-centered service approach. Thus, if states choose to participate, certain mandated services must be made available to all eligible children and their families, and program expenditures cannot be limited through funding ceilings.

Eligibility for services under the program includes any child from birth to age three who is experiencing significant developmental delay in one or more of the following areas: (1) cognitive development; (2) physical development, including vision and hearing; (3) communications development; (4) social or emotional development; and (5) adaptive skills. Children are also eligible if they are diagnosed as having a physical or mental condition that has a high probability of resulting in a developmental delay. States are required to develop eligibility standards that include a definition of developmental delay.

In addition, states may choose, but are not required, to serve children considered at risk of developmental delay if services are not provided. Each state must adopt its own definition of "at risk" under the federal law. Factors in this category include known biological or environmental factors, such as a low birth-weight baby or lack of oxygen at birth, that can be identified as contributing to delays. There are 11 states that include "at-risk" populations in their eligibility criteria. Some other states do not serve "at-risk" children, but monitor their development and refer them for services if they later become eligible.

National research has documented the benefits of providing early intervention services to infants and toddlers. Studies have shown that when children are identified early there is a greater chance of eliminating or minimizing existing problems or preventing future problems through early intervention. Although more studies are needed that measure the benefits derived from providing early intervention services to children and their families, research indicates that providing services to eligible children encourages typical developmental patterns, prevents diagnosed conditions from becoming more disabling, and may improve the overall functioning of young children with developmental delays or are at risk of becoming disabled. In addition, services also have a positive effect on the child's family, providing support to parents and contributing to the quality of family life. Based on this, the federal legislation contained this concept and included the program goals of:

- minimizing the potential for developmental delay in infants and toddlers;
- reducing educational costs to society by reducing the need for special education services;
- lessening the likelihood of institutionalization for individuals with disabilities;
- enhancing a family's capacity to meet their child's needs; and
- enhancing state and local agency and service provider capacity to identify, evaluate, and meet needs of underserved populations.

Connecticut legislation. Connecticut submitted its initial application for Part H funding in 1987, and SDE assumed the role of lead agency for the purpose of planning for a statewide early intervention system. Full participation in Part H began with the passage of Public Act 93-383, which provided an entitlement to early intervention services for infants and toddlers meeting state-defined eligibility criteria. From October 1, 1993, through June 30, 1995, the program received more than 6,176 referrals and expended $43,442,176. The act also stipulated the program be terminated June 30, 1996, unless reauthorized by the General Assembly.

The act designated the state Department of Education as the lead agency having jurisdiction over the general administration, supervision, and monitoring of the Birth to Three Program. The act also established a 25-member Interagency Coordinating Council (ICC) to assist the lead agency in carrying out the program goals. The council, appointed by the governor, was intended to be the primary mechanism for developing an interagency, coordinated, statewide service system. The council was composed of parents, legislators, service providers, trainers, and 10 state agency designees.

In addition, the department is also responsible for coordinating B-3 services for children served by the Departments of Social Services, Public Health, Children and Families, and Mental Retardation, the Board of Education and Services for the Blind, the Commission on the Deaf and Hearing Impaired, and the Office of Protection and Advocacy for Persons with Disabilities. Coordination is accomplished through a formal interagency agreement, which defines the responsibilities of each agency and requires regularly scheduled meetings to discuss issues and initiatives in the Birth to Three Program.

Connecticut's organizational design. Although Part H requires tremendous cooperation among health, social service, and education agencies, most of the decisions regarding organizational structure and design of the program were left up to the discretion of the states. The key program elements adopted in Connecticut included: a single point of entry for all referrals through United Way of Connecticut's Infoline; an independent case management function, and a regional delivery system that uses both public and private providers. To implement this structure, SDE contracted with the six Regional Educational Service Centers in the state for the day-to-day operation of the Birth to Three Program. The program was statewide and fully operational by October 1, 1993.

Regional Educational Service Centers. Regional Educational Service Centers are statutory entities requiring approval by the State Board of Education. Each is made up of four or more local or regional boards of education and is created to cooperatively furnish services or programs. The board of each RESC is considered a public educational authority acting on behalf of the state of Connecticut, with powers to establish policy for the RESC, determine programs and services to be provided, employ staff, and prepare and expend a budget.

Each RESC established a Regional Family Service Coordination Center (RFSCC) to administer the B-3 program. Figure I-1 shows the regional boundaries of the six RESCs in Connecticut. RFSCC's are responsible for determining eligibility for services and employ service coordinators as the single point of contact for helping parents obtain services. In addition, the RFSCC's contract for direct services either with private providers or refer eligible families to other state agencies, such as the Department of Mental Retardation or the Board of Education and Services for the Blind, that operate direct service programs. The RFSCC's are funded through grants from the state Department of Education.

Department of Mental Retardation. The Department of Mental Retardation, through the operation of Unified School District #3, receives a separate state appropriation to operate a program of early intervention. The department's program is called "Early Connections" and DMR staff provide special instruction and some therapeutic services to children referred by an RFSCC. In addition, the department has several contracts with community providers. Since DMR has a limited number of staff providing direct services, some children receive services through DMR exclusively, some from DMR and private providers under contract to an RFSCC, and others solely through a RFSCC's contracted providers. On July 1, 1995, pursuant to Special Act 92-29, the department was reorganized from six to five regions to adhere to the designated uniform regions for state health and human services agencies (shown in Figure I-2 and I-3). The geographical boundaries of the uniform regions differ from those of the six RFSCCs.

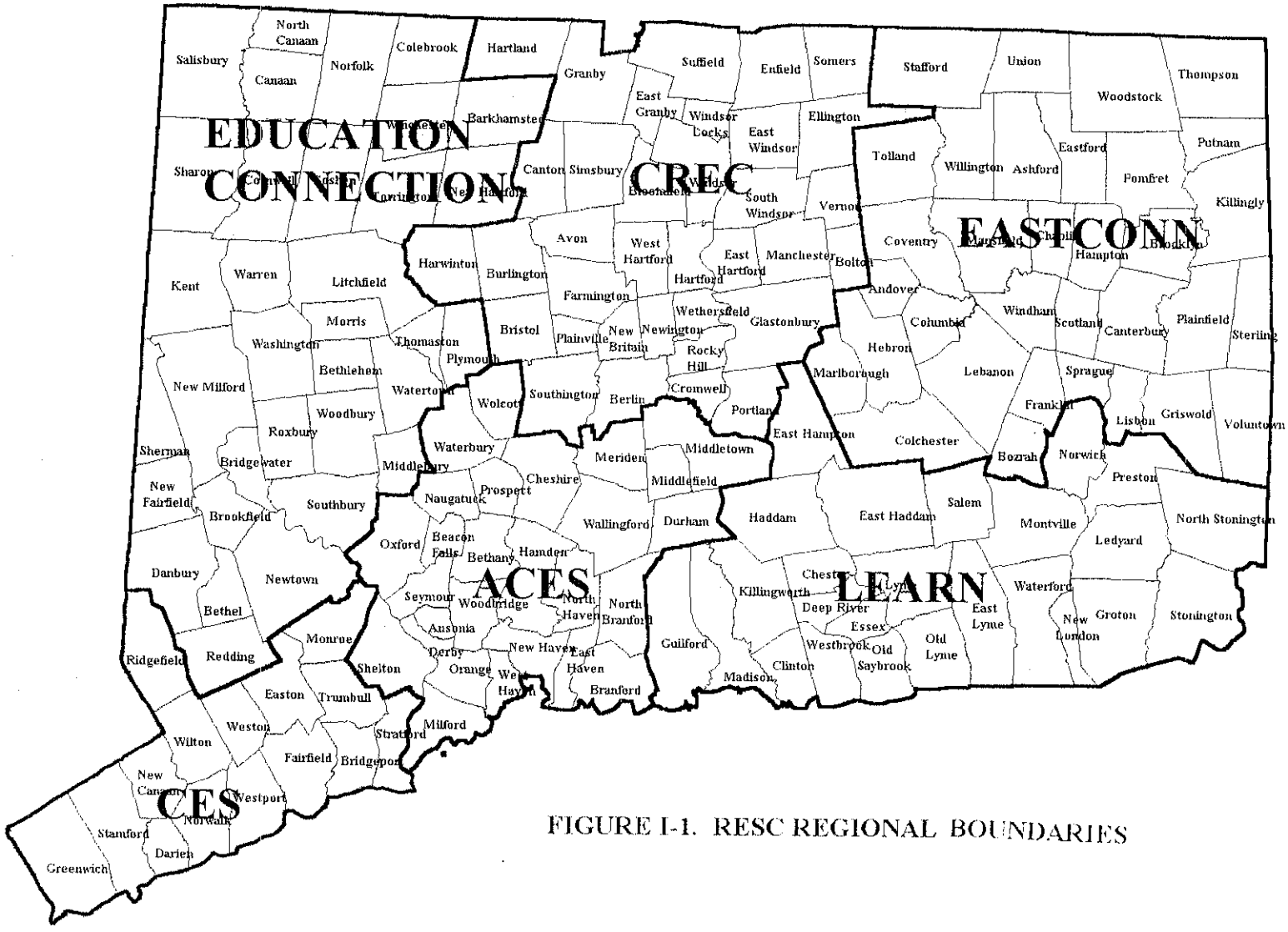


FIGURE I-1. RESC REGIONAL BOUNDARIES

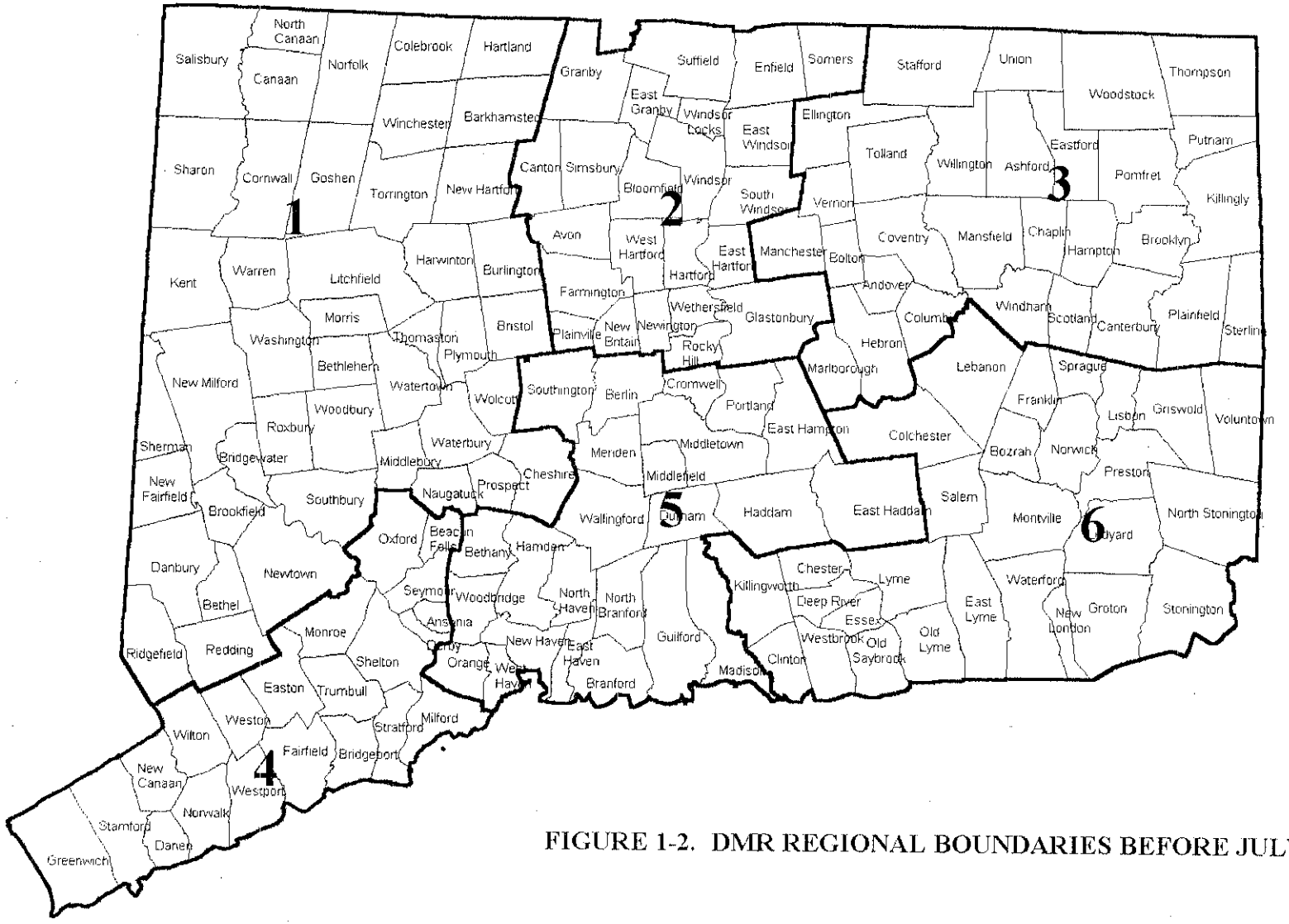


FIGURE 1-2. DMR REGIONAL BOUNDARIES BEFORE JULY 1, 1995.

FIGURE I-3. DMR REGIONAL BOUNDARIES AFTER JULY 1, 1995.

Uniform Regions

for State Health and Human Services Agencies

Federal Program Mandates

The legislative intent of Part H of IDEA was to provide a program that would not only provide early intervention services to a child, but would support and meet the needs of families. To accomplish this, Part H requires a family-centered approach that includes both services for the child and help to parents to enhance their child's development. The program was designed to recognize the family's role as decision-maker on behalf of their child in the early intervention process. In addition, federal regulation recommends that efforts be made to provide services in natural environments (home, day care centers, or other community settings) so as not to isolate a child from settings or activities with children of the same age who are not developmentally delayed.

Federal approval of a state's application to participate in Part H required it to have "a statewide system of coordinated, comprehensive, multidisciplinary, interagency programs providing appropriate early intervention services to all infants and toddlers and their families." To meet this definition, states had five years to implement several federal program requirements and ensure by the fifth year that all eligible children would be served. First, the law required the governor of each state to designate a lead agency responsible for planning and overseeing a comprehensive early intervention program. The governor was also required to appoint an Interagency Coordinating Council, consisting of parents, providers, legislators, and members of all involved state agencies, to advise and assist the lead agency in carrying out the goals of the program. In addition, states were required to offer 17 mandated services to children and their families. Finally, states were required to design a statewide system that included 14 federally designated program components.

Program components. Table I-1 classifies the 14 components into 4 broad areas: outreach and referral; eligibility determination and intake; service delivery; and program administration and oversight. The components provided a framework for states to use in the design of their program, and within these parameters, states were allowed to devise an administrative structure and service delivery system that best met their needs.

There are several requirements contained in the law including a public awareness program and a required "child-find," an identification system that includes a method for hospitals, physicians, parents, day care programs, and other providers to refer children for evaluation and assessment. There must also be a central directory for providing information on services, providers, and other groups. The law also requires that a system be established for compiling data on the number of eligible children, the number served, and the services provided.

Services. Table I-2 lists the 17 federally mandated services that must be made available in every state's program. Part H requires a family-centered service approach which is reflected in the authorized list of services. This approach encourages families to be integrally involved in determining their children's development programs. Federal law and regulation rely largely on the Individualized Family Service Plan (IFSP) process to determine what services are appropriate for a particular child and family.

TABLE I-1. MANDATED FEDERAL COMPONENTS OF PART H.	
Area	**Specific Part H Requirement**
Outreach and Referral	• a comprehensive child find and referral system • a public awareness program • a central directory of services, resources, research and demonstration projects
Eligibility Determination and Intake	• a state definition of developmentally delayed • timetables for providing service to all eligible individuals • timely and comprehensive multidisciplinary evaluation of the needs of the families and children
Service Delivery	• an individualized family service plan and case management services
Program Administration and Oversight	• a comprehensive system of personnel development • a single line of authority for the lead agency for carrying out: - general administration and supervision of programs; - identification and coordination of available resources; - assignment of financial responsibility to the appropriate agencies; - development of procedures to ensure that services are provided pending resolution of any disputes; - resolution of intra- and inter-agency disputes; and - entry into formal interagency agreements. • policy and procedures for contracting out for services • procedures for securing timely reimbursement of funds • procedural safeguards • policy and procedures for personnel standards • a system for compiling data on early intervention programs

The Program for Infants and Toddlers with Disabilities was not intended to be a medical insurance program. However, federal regulation requires that certain health services be included in the IFSP that would enable an infant or toddler to benefit from the other early intervention services provided. Included are such medical services as:

- clean intermittent catheterization, tracheotomy care, tube feeding, the changing of dressings or osteotomy collection bags, and other health services; and
- consultation by physicians and other service providers concerning children's special health care needs that need to be addressed to facilitate other early interventions services.

Specifically excluded services are those that are surgical or purely medical in nature, devices necessary to control or treat a medical condition, and medical health services such as immunizations.

TABLE I-2. MANDATED FEDERAL SERVICES.	
1. Assistive technology devices (Part H amended in 1991 to include)	10. Occupational therapy
2. Assistive technology services (Part H amended)	11. Physical therapy
3. Audiology	12. Psychological services
4. Communication services	13. Service Coordination
5. Family training, counseling, and home visits	14. Special instruction
6. Health services necessary to benefit from other early intervention services	15. Social work services
7. Medical services for diagnostic or evaluation purposes	16. Transportation necessary to receive intervention services
8. Nutrition services	17. Vision
9. Nursing services	

CHAPTER II

PROGRAM ORGANIZATION AND DESIGN

Federal organization. The U.S. Department of Education has jurisdiction over education of persons with developmental disabilities. Though its Office of Special Education Program (OSEP), the department distributes funds under Part H to help states carry out collaborative systems planning, policy development, and implementation of needed services for infants and toddlers with disabilities. In 1991, the federal statutes were amended to create the Federal Interagency Coordinating Council. This council, appointed by the secretary of education, is composed of representatives of federal agencies involved with children with disabilities, state agencies, state ICC chairs, and parents. The council advises and assists the secretary of education with regard to early intervention programs and ensures coordination and cooperation among the various federal agencies that deal with early intervention and preschool education programs.

Program history in Connecticut. In Connecticut, planning for the establishment of a statewide B-3 system began in 1980, many years before Part H was adopted. Initially, federal funds provided the impetus to create the Health/Education Collaborative system throughout the state. These collaboratives promoted early identification of special needs children and referred those families to whatever appropriate services existed. In May 1984, the Birth to Three Interagency Committee, comprised of representatives of state agencies, statewide organizations, parents, and public and non-public providers, was convened. The committee's charge was to study whether there should be a mandate to serve infants and toddlers with developmental disabilities, and it recommended creation of an interagency approach.

In response to these recommendations, the Commissioners' Steering Group was formed, led by the State Department of Education and comprised of eight other state agencies. In 1986, the group signed an interagency agreement to plan and implement a statewide interagency delivery system to provide services to children from birth to three years old with special needs. The steering group designed a demonstration project in 1987, called the Connecticut Birth to Three Interagency Service Coordination Center, which served as the pilot center for the system in place today. During FY 92, six service coordination centers were established and began accepting referrals, performing evaluations, and providing service coordination.

Connecticut submitted an application to the U.S. Department of Education in 1987 for funds that were made available through Part H of IDEA to establish the statewide system. The governor appointed a Birth to Three Council to act in an advisory capacity to the State Department of Education, the lead agency.

With the passage of Public Act 93-383 formally establishing Connecticut's participation in the Part H entitlement program, a statutory 25-member Interagency Coordinating Council was created. The council, appointed by the governor, was intended to be the primary mechanism for developing

an interagency, coordinated, statewide service system. The council was composed of parents, legislators, service providers, trainers, and 10 state agency designees. In addition, during 1994, local interagency coordinating councils were organized in regions to obtain suggestions from communities and coordinate service planning at the local level.

Lead agency. The state Department of Education as the lead agency, is responsible for coordinating and building collaboration between eight other state agencies that serve infants and toddlers and have overlapping responsibilities in programming, advocacy, or funding. Coordination is accomplished through a formal interagency agreement, which defines the responsibilities of each agency and holds regularly scheduled meetings to discuss issues and initiatives in the Birth to Three Program.

As described in Chapter I, the education department contracted with the six Regional Educational Service Centers in the state, which then established Regional Family Service Coordination Centers to administer the B-3 program. The contract, because of potential conflict of interest, prohibits any of the RESCs from operating a direct service program except under certain circumstances including: no other agency or institution is willing or able to administer a needed program; if unique regional needs require it; or if documented as the most cost effective alternative and approved by the education department. At this time, two of the six RESCs operate direct service programs.

The RFSCCs are responsible for the day-to-day operation of the program including:

- receiving referrals from Infoline, the single point of entry for the program;
- determining eligibility for services by conducting all assessments and evaluations;
- providing independent service coordination to families;
- contracting with private providers to deliver services;
- assisting in the transition of children into the local schools; and
- collecting data on the services provided and children served.

A major function of a RFSCC is to provide service coordination to children and their families. All families, whether eligible for services or not, are assigned a service coordinator as soon as a referral is received from Infoline. Specific responsibilities of coordinators, as defined under federal regulation, are:

- coordinating the performance of evaluations and assessments;
- facilitating and participating in the development, review, and evaluation of IFSPs (the plan of services for the eligible child and family) ;
- assisting families in identifying available service providers;
- coordinating and monitoring the delivery of available services;
- informing families of the availability of advocacy services;
- coordinating with medical and health providers; and
- assisting in the development of a transition plan to preschool services, if appropriate.

Current system design. Figure II-1 shows the early intervention system that operates in Connecticut. Connecticut has designed a highly decentralized system that emphasizes a regional structure of service delivery and an independent case management system, although neither is required under the federal law. The only centralized aspect is the single point of entry for all referrals to the program through an Infoline 1-800 number. A description of the intake process is presented below.

Outreach/Referral. Referrals through Infoline are received from multiple sources including parents, health care providers, hospitals, and day care providers. Infoline reviews calls, gathers referral information for children in need of developmental assessment, and forwards it to the geographically appropriate Regional Family Service Coordination Center.

Evaluation. Once a child is referred to an RFSCC, a service coordinator is assigned to the family. The service coordinator is responsible for contacting the parent(s) to schedule an evaluation to determine eligibility. In order to be determined eligible for services, children are evaluated in the five federally defined developmental areas (cognitive; physical, including vision and hearing; communications development; social or emotional development; and adaptive skills) and must exhibit:

- two standard deviations[1] below the mean in one area of development; or
- one and one-half (1.5) standard deviations below the mean in two areas of development.

If standardized instruments are not appropriate to use because of an infant's age or if a child requires significant adaptation to perform on a standardized instrument, the assessment process may use informed clinical opinion. Children from birth to age three who are diagnosed by a physician or an audiologist as having a physical or mental condition that has a high probability of resulting in developmental delay are automatically eligible for early intervention services. Established conditions include genetic disorders, chromosomal syndromes, major congenital syndromes and conditions, sensory impairments, conditions relating to significant fetal exposure to toxins, other physical conditions, atypical developmental patterns, and psychosocial conditions.

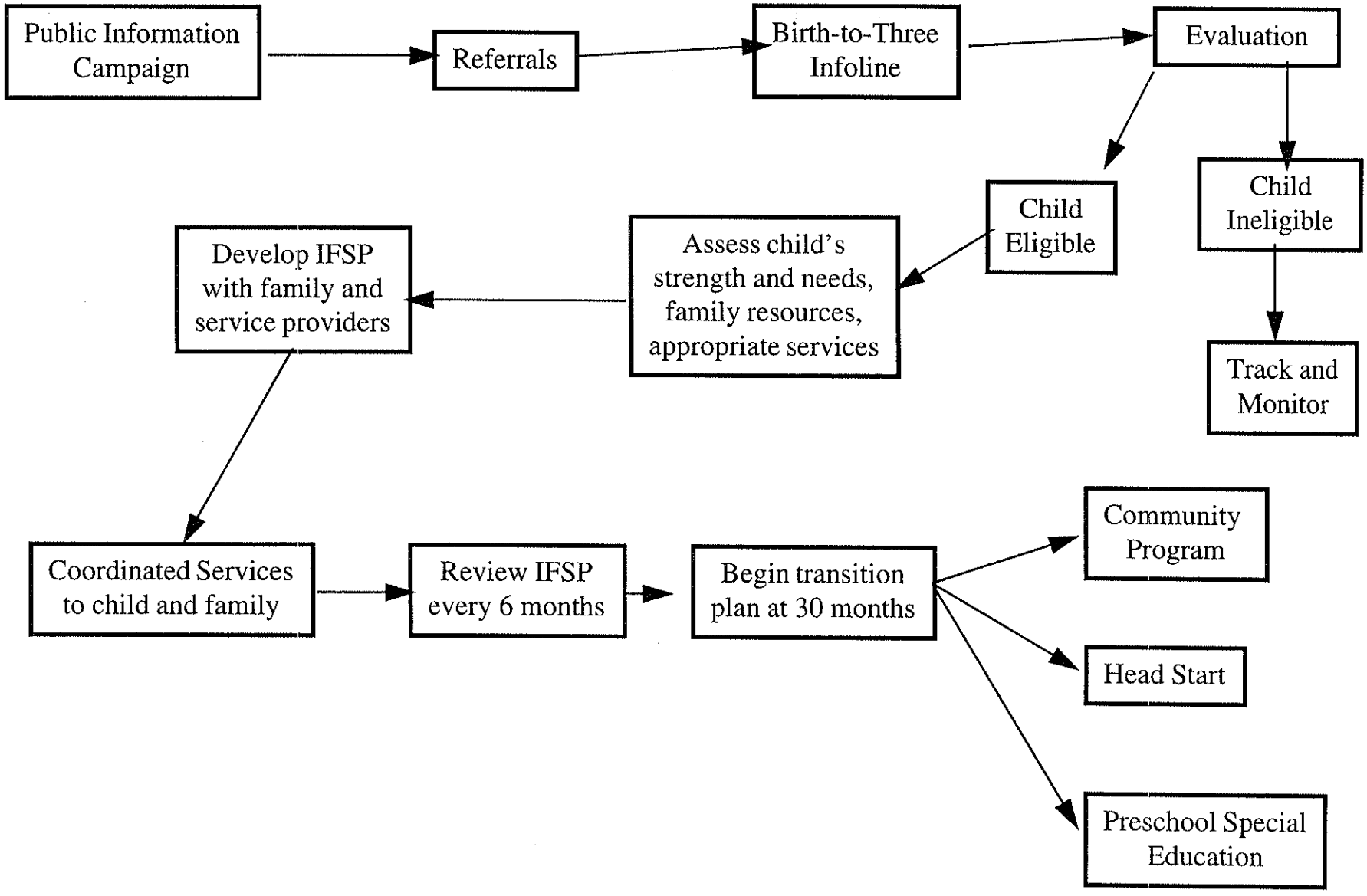
On August 1, 1995, the department began tracking and monitoring children evaluated and considered "at-risk" for developmental delay, but who are determined to be ineligible for services under the eligibility criteria. The purpose of tracking and monitoring is to help families monitor the development of their children and to have a formal re-referral mechanism for those children who might benefit from another evaluation. Tracking will be accomplished through questionnaires completed by parents in the areas of fine and gross motor skills, communication, adaptive skills, and personal and social development.

---

[1]One standard deviation is approximately two-thirds of the cases on either side of the mean.

FIGURE II-1. INTAKE PROCESS.

Connecticut Birth-to-Three System



Assessment. If eligible, a multidisciplinary assessment is performed to determine which services are appropriate. Federal law requires involvement of two or more disciplines or professions in identifying: the child's unique needs; the families' strengths and needs related to the child's development; and the nature and extent of early intervention services recommended to meet those needs. Evaluation and assessment may be performed at the same visit and is done either directly by RFSCC staff or through contracts with private providers.

Individualized Family Service Plan. Once eligibility is established and an assessment is performed, the service coordinator schedules an IFSP meeting. Typically included in this meeting are parents and other family members, advocates, service coordinators, and assessors. The law requires specific tasks be completed in the development of an IFSP. First, a plan must be in writing and include:

- a statement of the child's development status in each of the five developmental areas;
- a statement of the family's needs and resources related to the child's development, if the family agrees;
- a statement of the outcomes expected of the child's program, including criteria, procedures, and timelines for measuring progress;
- a statement of necessary early intervention services;
- a statement concerning the environment in which services shall be provided;
- a projected starting date and duration of services; and
- the steps necessary for transition to appropriate services when the child reaches age three.

After the IFSP is finalized, the service coordinator is responsible for scheduling and monitoring the services provided. In addition, other human or medical services may be identified for the child and family that are not provided under the Birth to Three Program. If this occurs, the service coordinator may need to assist the family in obtaining information to receive the necessary services. The IFSP may be revised as needed but must be reviewed every six months. A formal meeting must be held at least annually to evaluate the IFSP.

Transition from Birth to Three. Eligibility for early intervention under the Birth to Three Program ends when a child turns three years old. At least 90 days prior to a child's third birthday, an IFSP team transition meeting is convened to review a child's development status and evaluate a child's potential eligibility for Part B of IDEA, the preschool special education program for children ages three to five years old. Only a Planning and Placement Team (PPT) of a local or regional board of education can determine eligibility for preschool special education under Part B. If a child is determined eligible for Part B, the team prepares a transition plan and initiates the Individual Education Plan (IEP) process, which replaces the IFSP as the plan of service. To complete the transition, all records are transferred to the child's school district, and follow-up with local educators is conducted.

CHAPTER III

DEMOGRAPHIC ANALYSIS OF THE B-3 POPULATION

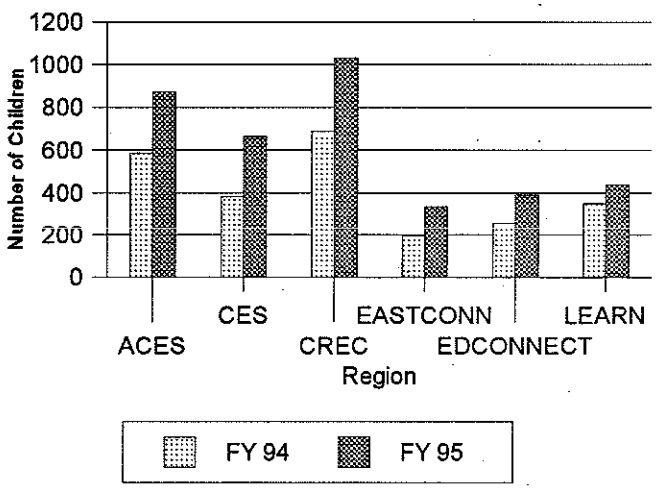
This chapter presents information on children referred to the Birth to Three Program. The program review committee examined referral, eligibility, and direct service delivery information statewide and by region. In addition, statistics on the operation of the Early Connections program are presented separately in order to provide an overview of the number of children served through DMR's program component.

Data Limitations. Federal mandates require states to systematically collect program data on the children it serves. The program review committee identified several limitations in the department's data reporting system. The system used by SDE was designed for federal reporting purposes and only provides a monthly snapshot of children receiving services. As a result, historical information is difficult to compile. In addition, children reaching the age of four are deleted from the system. Because of this, the program review committee was unable to determine the total number of children served by the program since October 1, 1993.

Program Statistics

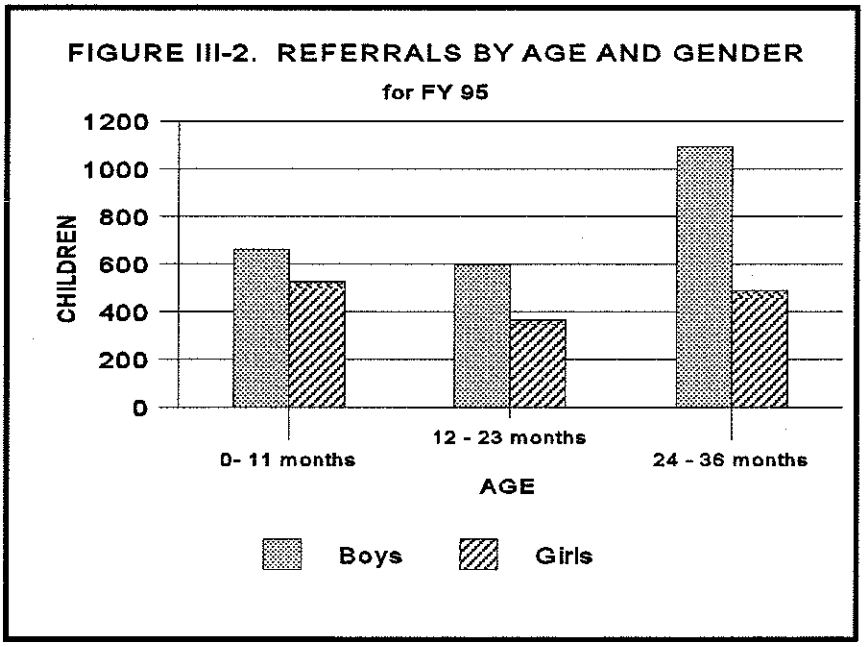
Referrals. Since the program began October 1, 1993, a total of 6,176 children have been referred to it. The program received 2,452 referrals in FY 94, and 3,724 in FY 95 (plus an additional 235 re-referrals and 85 transfers), representing a 52 percent increase. Figure III-1 shows the number of referrals received by each RFSCC for both years. The two regions receiving the greatest number of referrals were the Northcentral RFSCC (CREC), which received 1,032 referrals in FY 95, followed by the Southcentral RFSCC (ACES), which accounted for 23 percent (871) of the total number of referrals. The two smallest regions in the state are the Northwest (EDCONNECT), and Northeast (EASTCONN), which received 389 and 332 referrals, respectively in FY 95.

FIGURE III-1. REFERRALS BY RFSCC.
FY 94 and FY 95



Source: Infoline.

Information is also collected on age and gender of each referral, and this is shown in Figure III-2. In FY 95, boys accounted for 63 percent (2,346) of the referrals, and 37 percent (1,378) were girls. Figure IV-2 also shows that of the 3,724 children referred to the program, the largest group (42 percent) was between 24 and 36 months old.



When a referral is received at Infoline, information is collected on the reason. Table III-1 presents referral reasons by the child's age for FY 95. As shown, children between birth and 11 months old are most frequently referred based on concerns about physical development. During their second year, children are referred because of problems in communicating verbally or because of physical developmental concerns. In the third year of life, most referrals result from delays in the child's communication ability.

TABLE III-1. REASON FOR REFERRAL BY CHILD'S AGE FOR FY 95.

Reason for Referral	0-11 Months		12-23 Months		24-36 Months		Total	
Adaptive Delay	(16%)	244	(7%)	88	(3%)	69	(8%)	401
Cognitive Delay	(1%)	13	(1%)	18	(2%)	35	(1%)	66
Communication Delay	(3%)	50	(49%)	667	(69%)	1,387	(42%)	2,104
Established Condition	(17%)	266	(5%)	68	(2%)	39	(8%)	373
Other	(16%)	245	(4%)	62	(3%)	57	(7%)	364
Physical Delay	(46%)	716	(25%)	332	(8%)	160	(25%)	1,208
Social/Emotional Delay	(1%)	25	(9%)	116	(13%)	272	(8%)	413
Totals	(100%)	1,559	(100%)	1,351	(100%)	2,019	(100%)	4,929*

*This number is greater than total number of children referred for FY 95 (3,724) because of multiple reasons for referrals.
Source: Executive Summary, Birth to Three Infoline, July 1, 1994 to June 30, 1995.

Table III-1 also shows the most common referral reasons by developmental area. The greatest number of referrals overall (43 percent) are received because of suspected delays in communication. The next most frequent reason for referral is concern over physical delay. Together, these two areas account for 67 percent of the reasons cited.

Eligibility status. The program review committee, with data provided by Infoline, compared the eligibility status of all referrals received in FY 95. A referral was assigned to one of four categories: eligible, ineligible, undetermined, or pending. Referrals assigned to the undetermined category meant the children did not receive an evaluation. This occurred for a variety of reasons including parental refusal to participate, inability to locate the family, family moved out of the region, or child received transition services only. Pending meant children had been referred and were active in the system, but had not yet been determined eligible.

Table III-2 shows the eligibility status of each child by region. Of the 3,724 children referred to the program in FY 95, 57 percent (2,105) were actually determined eligible for services. The number of children found eligible for services compared to the number of children referred varied by region, from a low of 50 percent in the Southeast RFSCC (LEARN) to a high of 64 percent in the Southwest RFSCC (CES). Of the total number of children referred, only 19 percent were found ineligible for the program.

Table III-2. ELIGIBILITY STATUS OF ALL REFERRALS FOR FY 95.

RFSCC	Eligible	Ineligible	Undetermined	Pending	Total Referred
Southcentral (ACES)	476 (55%)	160 (18%)	124 (14%)	111 (13%)	871
Southwest (CES)	422 (64%)	84 (13%)	56 (8%)	101 (15%)	663
Northcentral (CREC)	542 (53%)	212 (21%)	129 (13%)	149 (14%)	1,032
Northeast (EASTCONN)	207 (62%)	49 (15%)	40 (12%)	36 (11%)	332
Southeast (LEARN)	220 (50%)	104 (24%)	48 (11%)	65 (15%)	437
Northwest (EDCONNECT)	238 (61%)	93 (24%)	27 (7%)	31 (8%)	389
TOTAL	2,105 (57%)	702 (19%)	424 (11%)	493 (13%)	3,724

Source: Executive Summary, Birth to Three Infoline, July 1, 1994 to June 30, 1995.

Table III-3 presents data only for those children who actually received evaluations and whose eligibility status was determined. When these numbers are compared to those shown in Table III-2, the percent of children eligible for services increases significantly. Of 2,807 children evaluated in FY 95, 75 percent were found eligible for services statewide, and 25 percent were ineligible. The percentage eligible varied by region -- from a low of 68 percent in the southeast region to a high of 83 percent in the Southwest region.

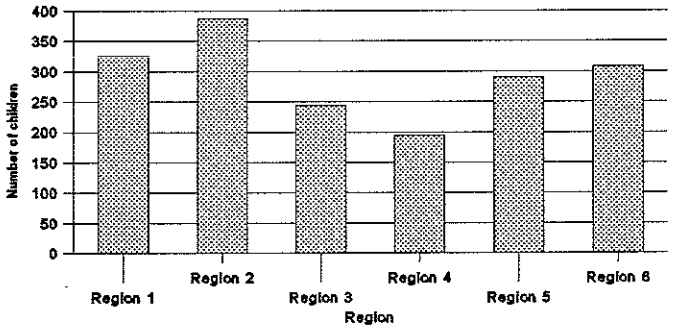
TABLE III-3. ELIGIBILITY STATUS OF CHILDREN EVALUATED FOR FY 95.		
RFSCC	Total Evaluated	% Eligible
Southcentral (ACES)	636	75%
Southwest (CES)	506	83%
Northcentral (CREC)	754	72%
Northeast (EASTCONN)	256	81%
Southeast (LEARN)	324	68%
Northwest (EDCONNECT)	331	72%
TOTAL	2,807	75%
Source: Infoline.		

Children served. A total of 3,966 infants and toddlers received services in FY 95. This figure includes children who were referred and received services in FY 94, and were carried over into FY 95. Also included in the totals are children who were served: exclusively by DMR's Early Connections program; solely through an RFSCC's contracted private providers; or dually served by both DMR's Early Connections program and an RFSCC's contracted providers. A breakdown of children served by region is provided in Table III-4. The three regions providing direct services to the greatest number of children are CREC, ACES, and CES, accounting for 65 percent of the total number of children.

TABLE III-4. NUMBER OF CHILDREN RECEIVING DIRECT SERVICES IN FY 95.		
Region	Number of children	Percent of Total Service
Southcentral (ACES)	832	21%
Southwest (CES)	625	16%
Northcentral (CREC)	1,123	28%
Northeast (EASTCONN)	466	12%
Southeast (LEARN)	385	10%
Northwest (EDCONNECT)	535	13%
Total	3,966	100%
Source: SDE database.		

DMR Early Connections. In FY 95, the Early Connections Program provided services to 1,748 infants and toddlers, about 44 percent of the total number of children receiving direct services in the Birth to Three Program. DMR had six regions prior to July 1, 1995, and the data presented for the program are based on that configuration. (Since July 1, 1995, the agency has been reorganized into 5 regions as a result of government reorganization of human and health service regions.) Figure III-3 presents the number of children served in each region. The largest region, in terms of the number of B-3 children, is Region 2. It is important to note that DMR's regional boundaries do not correspond to the geographical boundaries of the RFSCC's and therefore regional comparisons between the number of children served cannot be made. At any given point in time in FY 95, DMR served an average of 939 infants and toddlers.

FIGURE III-3. CHILDREN SERVED IN FY 95
by DMR's Early Connections



Source: DMR.

Services were delivered at home for 672 children and in group settings for 267 children. Table III-7 shows the average monthly number of children served in each region.

TABLE III-7. AVERAGE MONTHLY NUMBER OF CHILDREN SERVED IN DMR'S EARLY CONNECTIONS PROGRAM.			
Region	**Home Setting**	**Group Setting**	**Average Monthly Children Served**
Region 1	144	27	171
Region 2	4	70	234
Region 3	74	46	120
Region 4	59	27	86
Region 5	107	52	159
Region 6	124	45	9
Statewide Average	672	267	939
Source: DMR.			

CHAPTER IV

PROGRAM RESOURCES AND EXPENDITURES

This chapter gives information on federal and state dollars used to support the B-3 program. Information on total dollars expended and the source of funds is provided for SDE and DMR In addition, a comparison of the operations of the six RFSCCs and DMR's Early Connections Program by major expenditure category is provided. Finally, the costs associated with service delivery are presented at the end of this chapter.

Federal funds. Federal funds have been allocated to states over the last nine years to both develop and maintain early intervention systems. As of December 1995, all 50 states are receiving Part H funds and participate in the program. Each state receives a portion of Part H funds relative to its population of infants and toddlers. As of December 1, 1993, 150,783 children nationwide were served by the program.

Connecticut has received a total of $15,389,328 Part H funds since 1988. Seven years of funding amounting to $2,868,881 was used to plan for the program prior to its implementation on October 1, 1993. Table IV-1 shows the amount of funds received in Connecticut under Part H.

TABLE IV-1. PART H FUNDING HISTORY IN CONNECTICUT.

State FY	Part H Funds
FY 88	$537,964
FY 89	$739,037
FY 90	$795,940
FY 91	$0
FY 92	$795,940
FY 93	$914,070
FY 94	$2,329,754
FY 95	$2,426,424
FY 95	$2,754,255
FY 96	$4,095,944
Total	$15,389,328

Source: SDE.

State expenditures. Total expenditures on the Birth to Three Program, including the DMR's Early Connections Program, for FY 94 was $17,287,567, and for FY 95 was $26,154,609. In FY 95, General Fund monies accounted for 71 percent of total program expenditures and federal funds comprised the remaining 29 percent. Of the dollars expended by SDE in FY 95, $11,502,127 (64 percent) came from the General Fund, while federal funds accounted for 36 percent. In DMR, 85 percent of total expenditures were supported by the General Fund and 15 percent by federal funds. Table IV-2 shows program expenditures for FY 94 and FY 95 and the amount appropriated for FY 96.

TABLE IV-2. PROGRAM EXPENDITURES

Agency	FY 94	FY 95	% Change	FY 96 (approp.)	% Change
SDE	$ 9,195,166	$17,889,593	95%	$17,315,641	-3%
DMR	$ 8,092,401	$ 8,265,016	2%	$7,456,891	-10%
Total	$17,287,567	$26,154,609	51%	$24,772,532	-5%

Source: SDE and DMR expenditure reports.

Several reasons may have caused the large increase in the education department's program expenditures over the two-year period. First, since the program was begun in October 1, 1993, the FY 94 figures include only nine months of expenditures. In addition, the growth in the number of children served and the intensity of services provided in FY 95 would have a significant effect on program costs.

Overall, Table IV-2 shows that DMR's expenditures increased by only 2 percent from FY 94 to FY 95. Two reasons that account for DMR's lower growth rate include: services are provided within available appropriation (i.e., they are not an entitlement) and DMR had a well-established program prior to October 1, 1993, and therefore, program expenditures are more stable and predictable. In addition, the decrease in FY 96 is a result of a reduction in 17 staff positions in the Early Connections Program.

Table IV-3 and Table IV-4 separate SDE expenditures from those of DMR and provide a breakdown of federal and state resources. Table IV-3 does not include any federal funds passed through to DMR by SDE. In Table IV-3, program costs are broken down by funding source over a three-year period. It is important to note that contained within the FY 95 Part H funds of $5,676,622 is a $3,532,749 carryover of funds from prior year's grant awards. In addition, although there is a 3 percent decrease between the total expended for FY 95 and the appropriated amount for FY 96, program expenditures cannot be limited for FY 96 since the Birth to Three Program is an entitlement.

Table IV-4 shows the expenditures of DMR for the Early Connections program. The majority of DMR's program is funded by state dollars. In FY 96, federal funding under Chapter 1 was discontinued, but funds were reallocated and restored under Part H.

Table IV-3. SDE PROGRAM EXPENDITURES.				
Year	State	Federal Part H	Other Federal Funds*	Total
FY 94	$6,865,412	$2,329,754	0	$9,195,166
FY 95	$11,502,127	$5,676,622	$710,844	$17,889,593
FY 96 (approx.)	$11,366,000	$4,529,087	$1,420,554	$17,315,641

*FY 95 Includes $500,015 Federal IDEA, Part B funds and $210,829 from funds that were available under Chapter 1 of the Elementary and Secondary Education Act, but are no longer available.
FY 96 consists of $1,420,554 of Federal IDEA, Part B funds.
Source: SDE.

Table IV-4. DMR PROGRAM EXPENDITURES.					
Year	State funds	Federal Funds (Part H)	Federal Funds (Part B)	Federal Funds (Chapter 1*)	Total
FY 94	$7,017,110	$0	$705,716	$369,575	$8,092,401
FY 95	$7,031,728	$0	$876,429	$356,859	$8,265,016
FY 96	$6,396,491	$310,400	$750,000	$0	$7,456,891

*Chapter 1 of the Elementary and Secondary Education Act funds are no longer available.
Source: DMR.

SDE and RFSCC staffing. The Department of Education has five staff that support the Birth to Three Program. These positions are all federally funded. In FY 95, the RFSCCs employed 118 staff, with total salaries of $4,147,992, excluding fringe benefits. A breakdown of staff positions in the RFSCCs is shown in Table IV-5.

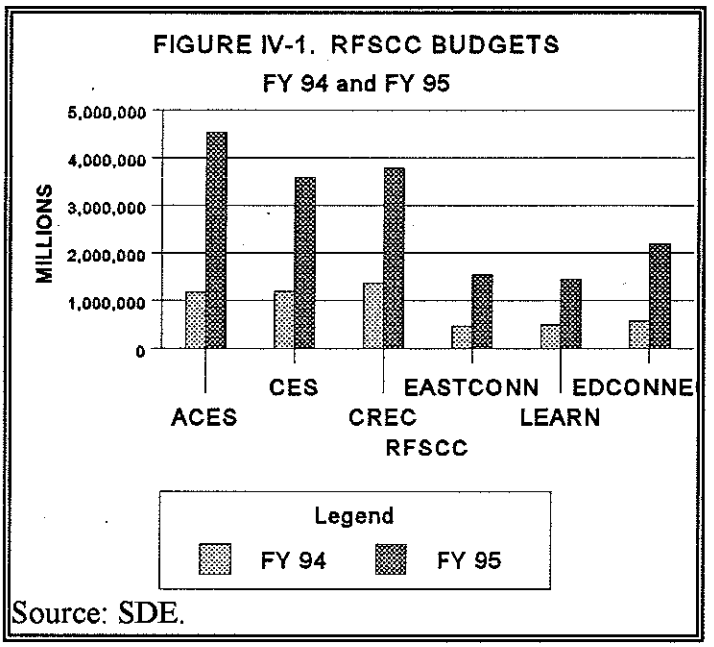
Table IV-5. FY 95 BIRTH TO THREE RFSCC STAFF.	
Staff	**Number in Position**
Directors	6
Service Coordinators	59
Evaluators/Assessors	26.5
Clerical	26
TOTAL	117.5
Source: SDE.	

DMR staffing. Table IV-6 shows the distribution of DMR staff for FY 95 and FY 96. In FY 95, there were 130 General Fund staff positions, with total salaries of $6,605,243, excluding fringes. Early childhood special education teachers, who provide direct services to eligible children, accounted for 73 percent of the staff and 75 percent of salaries. In addition, DMR employed 16.8 clinicians including speech pathologists, nurses, physical and occupational therapists, and a social worker.

TABLE IV-6. GENERAL FUND STAFF FOR THE EARLY CONNECTIONS PROGRAM.			
Staff	**FY 95**	**FY 96**	**Difference**
Central Office Administration*	3	2	1
Regional Administration	7	5	2
Teachers	95	81	14
Clinical	17	16	1
Support	8	8	0
Total	130	112	18
*scheduled to occur May 1996. Source: DMR.			

SDE and RFSCC expenditures. The program review committee examined the expenditures of the six RFSCCs over a two-year period. Since the program was not operational until October 1, 1993, expenditure data for FY 94 are based only on nine months of expenditures, but have been annualized for the purpose of this analysis. Total RFSCC expenditures grew from $5,278,295 in

FY 94 ($7,037,727 if annualized) to $17,075,576 in FY 95, an annualized increase of 143 percent. Figure IV-1 shows expenditure increases by RFSCC. All of the RFSCCs experienced significant growth, ranging from a 109 percent rise in expenditures (CREC) to a 188 percent increase (ACES), when annualized for FY 94. One explanation for the variation in expenditure increases may be the increase in the number of children served and/or the intensity of services provided, among the different regions.



Source: SDE.

The program review committee analyzed the program expenditures of SDE and the six RFSCCs for FY 95. Table IV-7 breaks down total expenditures by major category (administration, service coordination, evaluation and assessment, and direct service) for each RFSCC and SDE's administrative costs to oversee the program.

Administrative costs included salaries, rent and equipment, postage, copying costs, telephone, travel, supplies, and an indirect assessment of 4 percent provided for under the Statewide Cost Allocation Program. Service coordination is listed separately since it is an internal function within an RFSCC and involves both direct service and administrative activities. Expenditures for evaluation and assessment include all expenditures for these services, whether performed directly by RFSCC staff or by private providers. Employee fringe benefits ranged from 18 percent of total salaries in the Northwest RFSCC to 24 percent in the Southcentral RFSCC. Benefits accounted for $1,035,831 and are allocated based on salaries among the administration, service coordination, and evaluation and assessment categories. Direct services expenditures are privately provided early intervention services to families. Finally, the amount expended in each category is compared to total expenditures.

The table indicates notable variation among the RFSCCs in each of the four expenditure categories profiled. Administrative costs ranged from 12 percent of total expenditures in the South west RFSCC to 21 percent in the Southeast RFSCC. The statewide average was 15 percent, but increased to 19 percent when SDE administrative costs were also included.

Service coordination expenditures also fluctuated widely among the regions with a low of 10 percent of total expenditures in the Northwest RFSCC to 21 percent in the Southeast RFSCC. Only the Southcentral RFSCC was at or below the state average on percent of total budget spent on administration, service coordination, and evaluation and assessment.

TABLE IV-7. SDE & RFSCC EXPENDITURES FOR FY 95.					
RFSCC	Total Expenditures	Administration	Service Coordination	Evaluation & Assessment	Direct Services
Southcentral (ACES)	$4,533,428	$569,433 (13%)	$637,196 (14%)	$409,887 (9%)	$2,916,912 (64%)
Southwest (CES)	$3,584,513	$417,962 (12%)	$381,441 (11%)	$415,035 (12%)	$2,370,075 (66%)
Northcentral (CREC)	$3,790,263	$662,891 (18%)	$646,676 (17%)	$403,864 (11%)	$2,076,832 (55%)
Northeast (EASTCONN)	$1,533,395	$301,784 (20%)	$263,450 (17%)	$153,848 (10%)	$814,313 (53%)
Southeast (LEARN)	$1,448,808	$299,728 (21%)	$301,239 (21%)	$217,246 (15%)	$630,595 (44%)
Northwest (EDCONNECT)	$2,185,169	$333,073 (15%)	$213,213 (10%)	$242,761 (11%)	$1,396,122 (64%)
Subtotal	$17,075,576	$2,584,871 (15%)	$2,443,215 (14%)	$1,842,641 (11%)	$10,204,849 (60%)
SDE B-3 UNIT	$814,017	$814,017*	not applicable	not applicable	not applicable
Total	$17,889,593	$3,398,888 (19%)	11%	9%	57%

Includes fringe of: ACES 24.2%; CES 22.8%; CREC 23.1%; EASTCONN: 23.9%; LEARN 22.2%; and EDCONNECT 18.6%.
*SDE Administrative costs include fringe of $92,059.
Source: LPR&IC Analysis.

The variation among the six RFSCCs in percent of total expenditures consumed by direct service costs is most noteworthy. Three RFSCCs spent less than 60 percent of their total budgets on the provision of direct services to eligible children. In the Southeast RFSCC, expenditures on direct services accounted for only 44 percent of total expenditures. The Southwest RFSCC expended the greatest percentage (66 percent) of their total budget on direct services.

DMR expenditures. The program review committee examined DMR's expenditures for the Early Connections Program for FY 95 by major expenditure category (administrative, direct services and contractual services) for each region. Administrative expenses include salaries for central office, regional supervisory, and support staff and employee benefits for those staff calculated at the comptroller's FY 95 fringe rate of 39.25 percent. Direct services expenses include salaries and employee benefits (FY 95 fringe rate) for DMR early childhood special education teachers and clinical staff. Employee benefits accounted for $2,592,558 of total program costs. In addition, DMR has

20 contracts with private providers for therapeutic professional services (occupational therapy, physical therapy, and speech). DMR also funds day care group sites so children can be provided services in natural environments. Contract amounts shown in Table IV-8 are not actual expenditures but are for the face value of the contract.

Table IV-8 shows administrative expenditures account for a small portion (11 percent) of total expenditures. DMR expended 89 percent of program funds for direct services -- 76 percent provided directly by DMR staff and another 13 percent by contracted private providers. Thus, direct services expenditures account for a greater percentage of DMR's program expenditures than the RFSCCs.

TABLE IV-8. DMR EXPENDITURES FOR EARLY CONNECTIONS PROGRAM FOR FY 95.

Region	Total Expenditures	Administrative	Direct Services	Contracted Services
Region 1	$1,834,065	$271,664	$1,330,804	$231,597
Region 2	$2,297,325	$157,173	$1,853,697	$286,455
Region 3	$1,762,784	$203,759	$1,445,621	$113,404
Region 4	$1,172,090	$85,637	$810,782	$275,671
Region 5	$1,927,525	$91,209	$1,547,757	$288,559
Region 6	$1,515,074	$122,239	$1,233,854	$158,981
Subtotal	10,508,863	$931,681 (9%)	$8,222,515 (78%)	$1,354,667 (13%)
DMR C.O.	$257,790	$257,790	not applicable	not applicable
Total	$10,766,653	$1,189,471 (11%)	$8,222,515 (76%)	$1,354,667 (13%)

Source: LP&IC Analysis.

DMR Staff Reductions in FY 96

DMR's legislative appropriation for FY 96 and FY 97 required a reduction of 17 positions in the Early Connections Program. The department reduced its workforce from 130 positions to 113 in August 1995. The largest staff reductions occurred among early childhood special education teachers.

Table IV-9 reflects the total effect of the staff reductions for FY 96. A regional breakdown was not available. Employee benefits, calculated at the comptroller's FY 96 fringe rate of 40 percent of salary and wages, accounted for $2,403,013 and are allocated across the administrative and direct

services categories. The table shows direct services expenditures account for 76 percent of DMR expenditures in FY 96 and increase to 90 percent when services delivered by private providers under contract are included.

TABLE IV-9. DMR ESTIMATED EXPENDITURES FOR FY 96.			
Total DMR Expenditures*	Administrative	Direct Services	Contracted Services
$9,979,398	$1,055,327	$7,569,404	$1,354,667
*Includes fringe of $2,403,013			

Cost of Services

Program cost equation. Total service costs for a child are determined by three variables: 1) the amount and intensity of services used; 2) the cost of the services; and 3) the length of time a child is served. The program review committee attempted to determine an average cost per child for B-3 services, and then compare those costs between RFSCC expenditures and DMR's Early Connections Program for FY 95. However, there were serious data limitations, which prevented this analysis.

Children receiving services under the B-3 program can be served in three ways: 1) exclusively by an RFSCC's private providers; 2) exclusively by DMR's Early Connections Program; or 3) by both an RFSCC's private providers and DMR's program. The state Department of Education was unable to provide information on the number of children served in each of the three categories. To calculate average per-child costs, it is first necessary to determine the total cost and number of children in each category. Next, the volume and intensity of services for children dually served must be calculated so that costs can be allocated accordingly. For example, if an RFSCC provides a child with 25 percent of his or her total package of services, and DMR the other 75 percent, costs allocated between the two must reflect the difference in utilization.

Regional profile of privately provided direct service costs. The legislative program review committee attempted to develop a detailed cost analysis of B-3 services delivered by contracted private providers. However, the program review committee found a complete absence of comparable statewide automated cost data related to services on a per child basis for each RFSCC. Although the department intends to enhance the system's capacity in order to collect this information in the future, the data are not currently available. Some cost information is collected at the regional level but it has not been aggregated and analyzed. Further, only five of the regions have automated information and databases. Thus, the information captured varies from region to region, and cost comparisons among regions are difficult to calculate. Furthermore, data on children served by DMR, whether exclusively or in conjunction with private providers under contract to the RFSCC, are not aggregated and

compiled. DMR services to children significantly effect the total cost of the B-3 program, however, no information had been compiled on these services.

Table IV-10 illustrates the distribution of service costs in three RFSCCs for which data were available. It is important to note the table shows only average costs for privately provided services by the RFSCCs. DMR services are not included and would result in a higher average cost per child, if data were available. The committee found there were 379 children who were authorized to receive early intervention services in the Northwest RFSCC with an average cost per child of $5,533. In the Northcentral RFSCC, 787 children received privately provided direct services with an average per child cost of $2,618. Finally, in the Northeast RFSCC, 307 children received privately provided services at an average cost of $2,653.

TABLE IV-10. COST OF PRIVATELY PROVIDED SERVICES.

Cost Range	# of Children			Average Cost		
	North West RFSCC	North Central RFSCC	North East RFSCC	North West RFSCC	North Central RFSCC	North East RFSCC
Less than $1,000	75	295	139	$405	$432	$427
$1,000 to $2,500	84	227	72	$1,750	$1,653	$1,606
$2,500 to $5,000	83	156	55	$3,612	$3,474	$3,373
$5,000 to $10,000	75	76	29	$7,121	$6,898	$7,000
$10,000+	62	33	12	$17,597	$14,894	$20,916
Total	379	787	307	$5,533	$2,618	$2,653

Source: LPR&IC Analysis.

Table IV-10 also shows that a small percentage of the children account for a large proportion of total expenditures for services. In the Northwest RFSCC, 16 percent of the children had authorized costs in excess of $10,000 with an average of $17,597. The average cost per child, regardless of the cost range category was almost twice as much in the Northwest RFSCC as in the Northcentral. One reason for this is more children in the Northcentral RFSCC also receive services by DMR's Early Connections Program. Thus, because DMR does not service a large number of children in the Northwest RFSCC, the RFSCC has to directly fund more services for children, with the result a higher average cost per-child. However, the actual mix of services between DMR and each RFSCC is not known, and, therefore, the total package of services provided and average cost-per child cannot be calculated.

Table IV-11 shows the increase in average per-child costs as children remain in the B-3 system for the Northwest and Northcentral RFSCCs. It is important to note that data were available only for a 12-month period, however, children may have been receiving services for a much longer period of time. Also, higher costs may reflect that children who remain in the system for longer periods are more needy, and, therefore, receive more services because of more aggressive treatment methods.

TABLE IV-11. COST BY MONTHS OF SERVICE (FY 95).

Length of Time Receiving Services	Children		Average Cost	
	North West RFSCC	North Central RFSCC	North West RFSCC	North Central RFSCC
1 Month	39	117	$423	$237
2 Months	22	101	$1,239	$649
3 Months	27	98	$3,556	$1,059
4 Months	37	70	$2,497	$1,743
5 Months	33	53	$3,190	$1,736
6 Months	45	58	$4,402	$2,446
7 Months	53	50	$6,613	$3,211
8 Months	30	46	$10,383	$3,728
9 Months	25	52	$9,254	$4,201
10 Months	17	45	$10,360	$4,255
11 Months	26	32	$12,568	$4,896
12 Months	25	65	$8,466	$9,364

Source: LPR&IC Analysis.

The table does not include services provided by DMR, and, therefore, does not reflect the total cost of service on a per-child basis. Although the cumulative average cost of services increased as a child remained in the system, the costs did not increase by the same percent each month. The variation occurs because the number of children served each month and service utilization (volume and intensity of services) are not constant. The cost is also impacted by the length of time a child receives services. The education department has not developed adequate systems to measure the volume and intensity of services used though they obviously have a significant impact on the total cost of services provided.

Type and cost of service. The program review committee examined the costs of providing direct services through private providers to children enrolled in the Birth to Three Program statewide. It should be noted that these data include only the costs incurred from the private providers. The costs of service coordination, evaluation and assessment, services provided by the Department of Mental Retardation, program administration, and other related costs are not reflected. Total cost of direct services received from private providers statewide was $10,204,849. Four services -- speech therapy, physical therapy, occupational therapy, and special instruction accounted for $8,807,361, or 86 percent of all private provider direct service costs. The next highest service cost, assistive technology (selection or purchase of any item, piece of equipment, or product system that is used to increase, maintain, or improve the functional capabilities of children with disabilities) constituted only 3 percent each of the total cost. Table IV-12 lists the top six service costs.

TABLE IV-12. TOP SIX SERVICE COSTS STATEWIDE.

Service	Cost
Speech Therapy	$2,759,803
Physical Therapy	$2,317,747
Special Instruction	$2,101,022
Occupational Therapy	$1,628,789
Assistive Technology	$ 340,166
Family Training, Counseling	$ 333,030

Source: LPR&I analysis of provider database.

CHAPTER V

POLICY IMPLEMENTATION

A continued concern of the legislature since the Birth to Three Program's inception has been the use of state funds to pay for program costs and whether other available funding sources were being accessed by the education department. Information is presented in this chapter on health insurance coverage for families referred to the program. In addition, legislation passed over the last three sessions has focused on alternative funding sources to pay for B-3 services. Summaries of the legislation and studies required under it are provided. The chapter also contains a status report in terms of the department's effort to secure other funds to pay for early intervention services. Finally, newly established policies adopted by the education department are described at the end of this chapter.

Sources of Funding for the B-3 Program

While the federal government has provided states with funds under the Part H law to maintain a structure to provide early intervention, Part H funds have not supported states with the financial resources needed to deliver services. Instead, Part H funds are to be used by states to plan and coordinate existing programs, mobilize other financial resources, and fill gaps in services. To cover most of the costs of service delivery, however, states are expected to assemble funding from a variety of sources including Medicaid, private insurance coverage, and state appropriations. In addition, although early intervention services may not be denied based on income, and selected services must be provided at no cost to parents, states may use a sliding fee scale to obtain parental contributions for most direct services.

Legislation in Connecticut. In the public debate prior to the enactment of P.A. 93-383, policymakers expressed numerous concerns over the potential costs of the B-3 program and the source of funds to be used to pay for program services. Language contained in the act creating the B-3 program reflects these concerns, as does subsequent legislation adopted over the next two legislative sessions. Public acts adopted by lawmakers continued to stress the need to minimize the use of state dollars by strengthening mandates to access other funding sources including maximizing Medicaid and third-party payer reimbursement, and requiring parents to contribute to the cost of services on a sliding fee scale.

Health insurance coverage. The legislative program review committee found an overwhelming majority of potentially eligible children possessed insurance coverage. Although the Department of Education has only recently begun to collect insurance information from parents at intake, Infoline compiled data on health coverage for 1,450 referrals taken between January 1, 1995, and May 31, 1995. Table I-1 provides a breakdown of health coverage by type. Responses indicate that 84 percent of referrals were covered by either private insurance or Medicaid. Only 2 percent of respondents indicated they had no coverage.

At the present time, all early intervention services provided through the RFSCCs are still being paid for by state and federal Part H and Part B of IDEA resources with no Medicaid or private insurance participation. Even though the overwhelming majority of referrals indicated they either had private insurance or Medicaid coverage, the Department of Education has not yet been able to recover any reimbursement from these sources. DMR has recently begun to bill Medicaid, but has not accessed private health insurance.

TABLE. I-1. TYPE OF HEALTH COVERAGE FOR BIRTH TO THREE REFERRALS.	
Type of Health Coverage	**Number**
Private Insurance	677 (47%)
Medicaid	523 (36%)
Both Private and Medicaid	17 (1%)
No Coverage	24 (2%)
Unknown	209 (14%)
Source: Infoline for referrals from 1/1/95 through 5/31/95.	

Legislative History

Public Act 93-383. The initial act establishing the B-3 program identified Medicaid, private insurance, and parental income as three potential funding sources. Under the act, the commissioner of education was required to develop procedures to bill Medicaid and the commissioner of social services was given the authority to seek Medicaid reimbursement. The act also required the education commissioner to access other available funds for early intervention services and stated that funds appropriated to the lead agency not be used to satisfy a financial commitment for services which would have been paid by other public or private funds, with the exception of funds available under Part H (C.G.S. Sec. 10-91d(c)).

Public Act 93-383 also required an examination of other funding mechanisms by requiring the secretary of the Office of Policy and Management (OPM) to evaluate the cost effectiveness of requiring a sliding fee schedule for parental contributions for services and the commissioner of the insurance to evaluate using private insurance to pay for services. The results of these evaluations were reported to the education committee on February 1, 1994. Those studies are described below.

Required studies. The Department of Insurance's private insurance reimbursement study identified several issues related to receiving third party payments for B-3 services and developed a plan to make the state the payer of last resort. Although the report noted a serious lack of data, it

projected direct service expenditures (excluding developmental therapy) would exceed $8 million with $3 million potentially (37.5 percent of the total) reimbursable by private third-party payors for FY 95.

The study contained several recommendations aimed at controlling costs within the B-3 program and providing for administrative efficiency. The study cited the need to use Medicaid, private insurance, and a sliding fee schedule for parental contributions to offset program costs. Noting the inefficiency of using the state as a pass-through for insurance funds, it recommended a system requiring providers to bill insurers directly. Providers are experienced in collecting and maximizing insurance reimbursement. In addition, the study also identified a need to clarify the type and level of medical treatments covered under the program. Finally, it recommended establishment of service control mechanisms through strict utilization review.

Sliding fee scale for parental contributions. The Office of Policy and Management completed its study on a fee scale for parental contributions for B-3 services and recommended implementation by July 1, 1994. OPM estimated $1.5 million a year could be generated by imposing a sliding fee and argued that those who participate in paying for the cost of services are likely to more carefully evaluate the quality of the service provided. Another important consideration was that by providing services free, private health insurance payers could argue they have no legal obligation to pay since the insured are not at risk for payment.

Public Act 94-245. Following these studies, the 1994 legislature required the state Board of Education to adopt regulations by July 1, 1995, to recover insurance payments and to establish procedures for determining parent's liability. It gave the commissioner of education the right to claim insurance payments (with the parents' permission) and required the commissioner to establish a sliding scale of parental contributions for early intervention services and set criteria for it.

1995 legislation. With continued concern over escalating program costs, Governor John Rowland recommended several changes to the Birth to Three Program in the 1995 legislative session. The governor's budget proposed elimination of the state's participation in the federal Part H program and restructuring the state's delivery of services. This included the elimination of B-3 services as an entitlement and the Department of Mental Retardation's role in providing early intervention services, consolidation of the funding stream into the State Department of Education, and contracting for all direct services.

These recommendations were not adopted by the General Assembly. The legislature, however, passed P.A. 95-226 and P.A. 95-259, which addressed the costs of the program and ways to access other funding sources by requiring the commissioner of social services to seek Medicaid reimbursement for B-3 services. In addition, the Department of Education was required to implement procedures to bill parents' insurance carriers beginning July 1, 1995, but postponed by one year the deadline for the education commissioner to implement regulations concerning a sliding fee scale for parents. The legislation also required a review of any Individualized Family Service Plan (the plan of services for a child and their family) with estimated costs in excess of $10,000 during any 12-month period.

Establishment of Policies

The state Department of Education has redesigned elements of the early intervention system over the last six months in an effort to create more uniformity among the RFSCCs, contain program costs, and access other funding sources. As a result of the program changes, SDE most recently issued nine policy guidelines on November 14, 1995. Many of the changes will directly affect the operation of the program and the delivery of services. Other policies establish procedures to clarify the roles and responsibilities of all agencies involved in accessing public and private insurance. Although the policies establish standards for operation, decision-making authority primarily resides within the individual RFSCC. Each of the nine new policies are described briefly below.

Medicaid billing procedures. This guideline sets up a procedure to uniformly bill for early intervention services for children eligible for Medicaid. Each RFSCC must provide SDE with the necessary data to fulfill this requirement. SDE will input the data and forward it to the Department of Administrative Service's Bureau of Collection Services (BCS) which will be responsible for collecting the Medicaid reimbursement.

Procedures for accessing private health insurance. This guideline establishes a procedure to access private health insurance for children covered under health plans. Each RFSCC service coordinator is required to obtain a family's insurance information and contact the family's insurance company to determine if the services are covered. If a family's health insurance is provided through an health maintenance organization (HMO) network, the coordinator must determine if there are approved B-3 providers in that network. If there are no approved providers, the coordinator should ask the HMO how the provider can become a member of their network.

For reimbursement, the provider is required to submit the appropriate paperwork to the RFSCC. The RFSCC transfers the provider information to SDE and BCS. If there are questions related to the family's insurance policy, BCS is required to contact the parents directly for information or clarification, thus, having two agencies that must solicit information directly from parents.

Maximum unit rates for services. The department has established the maximum unit rate for developmental therapy, occupational therapy, physical therapy, and speech and language pathology for services delivered on a "fee for service" basis. Effective January 1, 1996, the maximum unit rate (one unit equals 15 minutes) is $20.00. The education department anticipates that, beginning July 1, 1996, rates for individual therapies will be further reduced by 5-10 percent in order to contain costs.

Guidelines for comprehensive early intervention programs. The department defines comprehensive early intervention programs as those programs with the ability to provide all early intervention services listed on each child's IFSP. To qualify, a

program must have 4 full-time staff members and a caseload of at least 60 children. This translates to a minimum caseload of at least 15 children per staff. In addition, the program must have the capacity to provide both home-based and center-based services in "natural environments" and demonstrate it provides a transdisciplinary approach to service delivery. Programs can also assume service coordination responsibilities as designated by the RFSCC. The policy requires the six RFSCCs to perform quality assurance including monitoring service delivery in accordance with IFSPs and ensuring cost effectiveness.

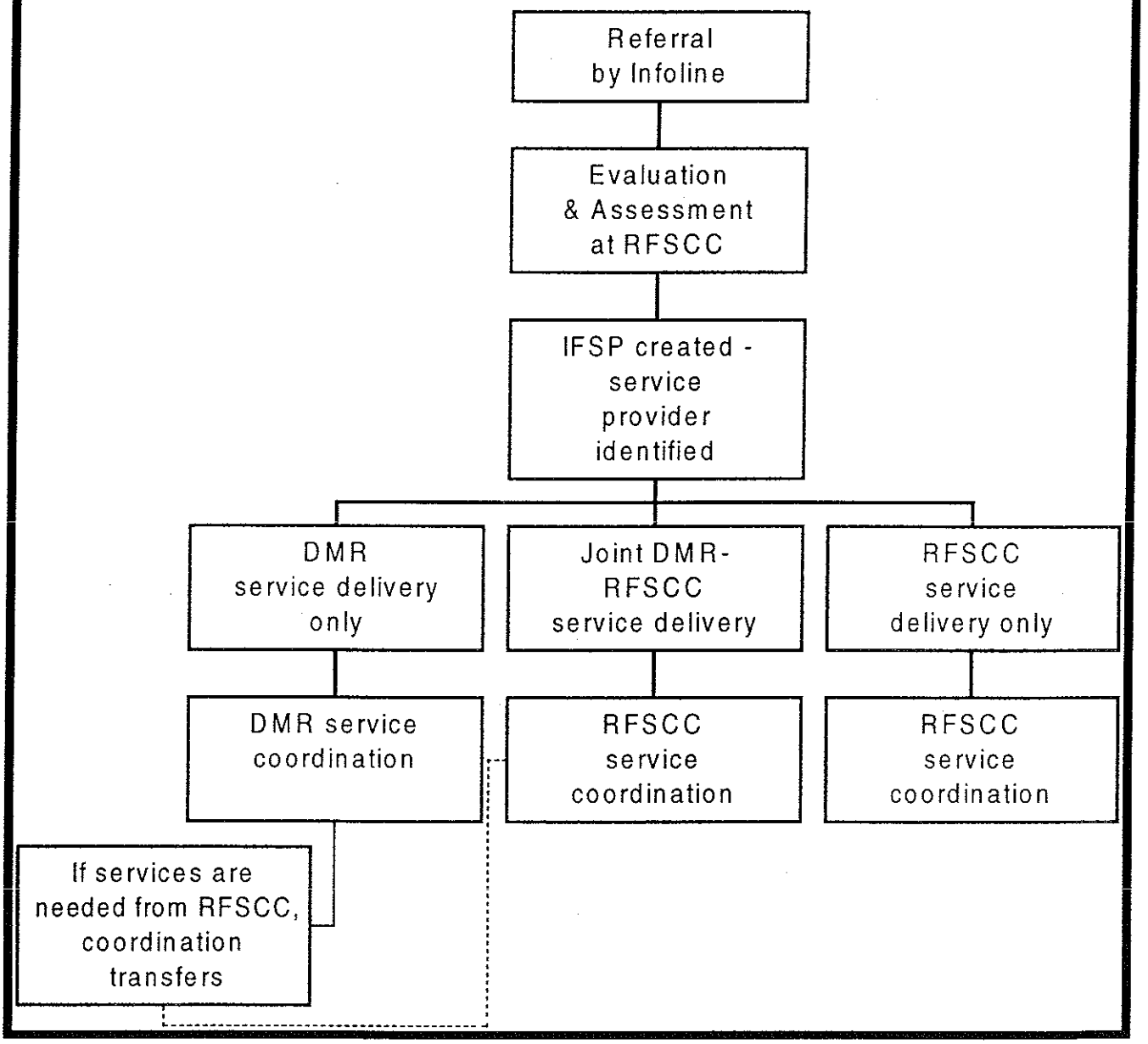
SDE technical assistance to RFSCCs/DMR. This policy outlines the types of technical assistance SDE will provide to the six RFSCCs and DMR. The policy also establishes SDEs oversight role in areas relating to the B-3 program.

Individual family service plan review. As required by Public Act 95-226, the department will review IFSPs over $10,000. The department has decided to review only those IFSPs developed after July 1, 1995, with projected costs of more than $10,000 during a 12-month period. Children with an IFSP before July 1 will not be subject to review, however, annual costs will be calculated so that information regarding the IFSP costs is available. The IFSP team makes the final decision regarding the service type, location, intensity, and frequency of early intervention services.

Transfer of service coordination responsibilities to DMR's early connection program. This policy provides clarity on who is responsible for billing for children who are exclusively served by DMR, or dually served by DMR and an RFSCC. As shown in Figure V-1, DMR will provide service coordination to children it serves exclusively and the RFSCCs will coordinate services for all other children (dually served and served exclusively by an RFSCC's contracted providers). However, the RFSCC will be still be responsible for all information entered into the B-3 system. Thus, DMR is required to still send all information on a child to a RFSCC. For Medicaid billing, DMR will be responsible for accessing Medicaid reimbursement for all children it serves through the BCS. If a child is dually served, DMR will bill private insurance only for the services it provides, and the RFSCC will bill for services it provides. BCS on behalf of DMR will be billing for both Medicaid and private insurance.

FIGURE V-1.

SERVICE COORDINATION



Permanent service record order. This policy sets up a permanent service record for each child in the RFSCC in which services are received. It is intended to create uniformity among the regions and requires documentation of activities.

Connecticut early intervention personnel standards. This policy identifies the requirements for personnel to practice within the B-3 program, including licensure and certification in each service approved. It also creates standards and defines the scope of practice for the use of paraprofessionals in early intervention.

Although the Department of Education should be commended for its effort over the last five months to develop oversight mechanisms, the program review committee believes the department's record needs to be examined in the overall context of its last nine years as lead agency. Several of the policies adopted by the department in November 1995 should have been instituted prior to the program's implementation in October 1993. In addition, many of the newly created policies actually will increase the program's complexity, particularly for health insurance reimbursement. Too many entities are involved in submitting information to multiple sources without any single oversight mechanism for the entire system.

Finally, the program review committee is concerned over the absence of uniform fiscal reporting standards. This type of policy is necessary to insure consistency among the RESCs where each has its own management structure and reporting standards. The committee repeatedly obtained financial information from SDE that had to be corrected by the department at a later date. Since the program is primarily funded by state dollars, the committee believes uniform reporting standards are needed to ensure the fiscal integrity of the program. **Therefore, the program review committee recommends:**

the lead agency shall develop uniform fiscal reporting standards to ensure financial information collected conforms to generally accepted accounting principles prescribed by the Government Accounting Standards Board.

CHAPTER VI

FINDINGS AND RECOMMENDATIONS

The federal legislation, Part H of IDEA, provided a framework for states to design their early intervention system. The law required states establish 14 program components and offer 17 mandated services to children and their families to ensure a comprehensive system. Because of the historical service pattern in the state, Connecticut designed a highly decentralized program. This decentralized design, run by a lead agency that has not been involved in direct service delivery, has led to deficiencies in program management, oversight, and cost. In addition, efforts to access Medicaid and third party reimbursement for early intervention services have been problematic because of a lack of institutional expertise in the area of health insurance within the lead agency.

In spite of the development of nine new policies by SDE, the program review committee believes the program still lacks accountability without a centralized organization, oversight, and single management structure. The goal of the recommendations presented in this study is to simplify the current program design, streamline the program's administration, and ensure fiscal and programmatic accountability. The recommendations cover six broad areas: public policy, administration, data management, insurance reimbursement, public awareness, and service delivery.

Public Policy

One of the most devastating moments in the lives of parents is the discovery their child is developmentally delayed. The Birth to Three Program has helped to alleviate some of the stress by providing families with early intervention services and offering parents information on how best to enhance their child's development. In three public hearings held by the Program Review and Investigations Committee, numerous families recounted the overwhelming value to them of the Birth to Three Program. The testimony provided coincides with current research in the field that early intervention services promote a child's full development, have a positive effect on families, and provide critical support to parents. The strength of the program lies in the stories told by parents describing how the Birth to Three Program made a difference in their families' lives.

While most would agree on the value of providing services to families, the scope and breadth of services and the state's responsibility to pay for them are debated. A major reason for passage of Part H was to provide incentive funding to states to encourage the development and maintenance of comprehensive service systems. Although the program has 14 mandated system components and 17 mandated services required by the federal law, it does not have to be overly burdensome. In fact, analysis by the program review committee shows that four services -- physical therapy, occupational therapy, speech therapy, and developmental therapy -- account for almost 90 percent of the direct service program costs.

Although better controls need to be placed on the program, Connecticut has received more than $15 million of Part H funds to establish an early intervention system. Participation in Part H has created adequate system capacity, allowing for all eligible children with developmental delays to be served. **Therefore, the program review committee recommends:**

Connecticut reauthorize legislation to maintain participation in Part H.

The program review committee found that the B-3 program lacks a clearly defined mission. One of the fundamental road blocks to implementing necessary changes in the program is that some groups believe the Birth to Three Program is primarily a medical program, some believe it is an educational program, and others believe it is a developmental program that provides both medical and educational interventions. Different philosophical approaches lead to fragmentation, poor collaboration, and false expectations of what the program should and can provide. This mission needs to be resolved to assure that everyone has the same expectations of the program and agrees on the attainable goals and objectives of early intervention. In addition, to strategically plan and perform subsequent program oversight, it is necessary for the lead agency to clarify the responsibility of the state in providing B-3 services. **The program review committee recommends:**

the development of a mission that provides clarity to B-3 Program objectives. The mission shall define the tenets of a developmental program and the program's relationship to other services including:

- **medical services,**
- **health services,**
- **social services, and**
- **instructional services;**

the Interagency Coordinating Council, along with the lead agency, shall be involved in creating and promoting the vision and mission to ensure they are understood and accepted by employees, advocates, parents, and providers.

Federal law requires the governor appoint an Interagency Coordinating Council to advise and assist the lead agency in carrying out the goals of the program. Connecticut's council has 25 members consisting of parents, legislators, providers, and members of all involved state agencies. Prior to passage of Public Act 93-383, the ICC actively assisted in the development of policies affecting the program's design and operations. However, there has been increasing frustration among council members that they no longer have input into the B-3 system. The council can play a vital role in developing and promoting a mission for the B-3 program, and it represents a variety of stakeholders in the system.

In addition to a lack of a mission statement, the program review committee found no evidence of long-term strategic planning. As a result, critical decisions are made without adequate information, on an ad hoc basis, and in reaction to criticism over program management. The committee believes

that change should occur in the context of long-range program goals with a coherent, structured, decision process. **Therefore the program committee recommends:**

> **the lead agency shall develop a long-range strategic plan. The lead agency shall provide an annual report detailing program and fiscal information including: number of children receiving services, the volume and intensity of services received, actual and projected per-child costs, provider capacity, comparisons of regional information, performance measures, and whether the measures are being met; and**
>
> **the lead agency shall develop performance based outcome measures, including the treatment effectiveness of early intervention services, and report its findings to the committees of cognizance of the General Assembly.**

Administration

Lack of clear leadership in the areas of planning, management, fiscal oversight, and evaluation of the service delivery system has placed the B-3 Program in jeopardy. As state resources become more and more scarce it is critical that other funding sources be identified and cost containment become a critical feature of the system. In fact, the failure of Connecticut to access both Medicaid and private insurance dollars has contributed to the feeling that program costs have grown out of control.

The program review committee found the B-3 program has not been managed well enough to ensure efficient uniform operations across all regions. Until recently, the costs of administering and providing services has not played a significant role in the department's implementation of the program. Although the department spends a considerable amount of its funds on purchasing services for clients, it has only recently begun to track the total costs of the services provided to each client, and this is in response to a legislative mandate passed in the 1995 session. Such information is critical if serious cost containment efforts are to be undertaken. Information on operational procedures such as the number of children served and volume of services provided, as well as the cost of services, are not collected or analyzed on a region by region basis. Finally, the committee found that no comparisons were being carried out among regions to ensure uniformity and equity among families receiving services.

The program review committee found the B-3 program has a needlessly complex system of governance to administer it, which includes 2 state agencies and 11 regional entities (6 RESC grantees and 5 DMR regions). Each RESC is a separate entity and without a centralized management structure. Therefore, it is difficult for the state to ensure consistency among their operations. Finally, there is an absence of any clear directives or quality assurance role on the part of the lead agency to guarantee equity, uniformity, and appropriateness of service delivery across all regions. This design

has made a program, with a small number of eligible children relative to other entitlement programs, inefficient and cumbersome to manage.

Although the program review committee recognizes the education department made serious efforts during this review to establish uniformity among the RFSCCs, the committee believes the department's record needs to be examined from the time the program became operational. Several of the policies adopted by the department in November 1995 should have been instituted prior to the program's implementation in October 1993. In addition, as discussed in Chapter V of this report, many of the newly created policies actually increase the program's complexity. In fact, in one policy, both DMR and the six RFSCCs are responsible for service coordination and accessing health insurance depending on if a child is exclusively served by an RFSCC, exclusively served by DMR, or dually served by both entities. This policy represents continued blurring of management accountability. Finally, the committee believes it is the underlying organizational design that has led to significant implementation problems, not merely the lack of administrative policies. **Therefore, the program review committee recommends:**

> **the authority to operate the Birth to Three Program be transferred from the state Department of Education to the Department of Mental Retardation. The Department of Mental Retardation shall become the lead agency for the program. The lead agency shall contract with private providers to deliver early intervention services to eligible children. The program design shall include a system to perform quality assurance, utilization review, cost containment, outcomes research, and performance evaluation. In addition, a uniform rate structure shall be used. Efforts should be made to encourage comprehensive community provider participation among contractors who may also conduct evaluations and perform service coordination.**

This program needs a single coherent management structure. DMR possesses a regional structure that reports directly to the central office of DMR. Furthermore, approximately 40 percent of children in the B-3 program are already served through the Early Connections Program, allowing for a smooth transition for many families. Moving the program would require DMR to enhance its current capacity by developing additional contracts with private providers. However, DMR is experienced in combining public and private services, and overseeing contractual relationships. DMR has systems in place to monitor utilization and costs, and access Medicaid and private health insurance.

Data Management

Federal mandates require states to systematically collect program data on the children it services. The program review committee found many limitations in the department's data reporting system. The system used by SDE was designed for federal reporting purposes and only provides a monthly snapshot of children receiving services. As a result, historical information is difficult to compile.

Another failure of the system is the lack of information on costs-per-child. Cost data have not been collected at the state level, and, therefore, only limited analysis of client costs could be performed. This lack of adequate cost data kept the state from establishing an acceptable Medicaid rate thus preventing Medicaid reimbursement.

The collection, compilation, and analysis of data are crucial to sound management, administrative, and operational decision-making. **Therefore, the program review committee recommends:**

> **the lead agency shall develop a data collection plan to obtain accurate and timely cost and programmatic data. The data collection plan should allow for a rational, planned approach to optimize the use of the database for management and programmatic purposes. In addition, data systems should be randomly audited to verify the accuracy of the information.**

Insurance Reimbursement

There is a need to carefully document all services provided children to obtain insurance reimbursement, whether public or private,. The department has encountered several difficulties in accessing both Medicaid and private third-party insurance. Although the Department of Insurance studied how best to access private insurance, as noted in Chapter V of this report, none of the recommendations were ever implemented. The program review committee found the education department and the RESCs have little experience with requirements of health insurance system. This lack of institutional expertise has contributed to the delays in accessing health insurance.

A stronger relationship with the Department of Insurance and major health insurers is needed to determine how best to provide for reimbursed coverage of early intervention services. In addition, as more people in the state are covered by health maintenance organizations, a system for ensuring coordination among B-3 providers and insurers networks of providers is needed. **The program review committee recommends:**

> **the Department of Mental Retardation, as the lead agency, create an insurance reimbursement task force that includes the Department of Insurance, the Department of Social Services, the Department of Administrative Services Bureau of Collection Services, and representatives from the insurance industry. The task force shall define the scope and method of reimbursing services.**

Public Awareness

In all human service programs, a large number of people eligible for services never enter the system. Part H requires that states make special efforts to reach populations who are typically underserved. It is necessary for states to create policies that distribute information to a wide network

of service providers, community leaders, clergy, and others who deal with families and young children so there is an awareness of the program.

Table VI-1 shows the number of children receiving direct services in FY 95. The total population of children birth to three years old is based on Department of Health statistics on live births in each town in Connecticut from 1991 to 1993, the latest year for which the department has complete data. These charts illustrate the differences in the percentage of children age 0 through 3 served in each RFSCC. The table shows a child is less likely to be identified and served in the urban RFSCCs -- ACES, CES, and CREC -- than in the rural RFSCCs. The highest percentage of children age 0 to 3 served is 5.5 percent at EASTCONN, in the least populated region in the state. Conversely, the area with the lowest percentage of children served, 2.2 percent, is CES, which includes Bridgeport, one of the most densely populated areas in the state.

TABLE VI-1. CHILD POPULATION SERVED BY RFSCC.

Area	Children 0-3 (1993)	Children Served in FY 95	Percentage Served
Southcentral (ACES)	37,435	832	2.2%
Southwest (CES)	30,094	625	2.1%
Northcentral (CREC)	39,938	1,123	2.8%
Northeast (EASTCONN)	8,542	466	5.5%
Southeast (LEARN)	13,381	385	2.9%
Northwest (EDCONNECT)	13,384	535	3.9%
TOTALS	142,774	3,966	2.8%

Source: SDE caseload statistics and DPH live birth statistics.

The department has conducted outreach through several professional organizations and provided handouts about the B-3 program at health fairs. A newsletter, called the Birth to Five Communicator, receives wide distribution among providers of early childhood services. In addition, flyers were mailed to about 7,000 family child care providers and also 60,000 AFDC recipients in October 1994. However, the program review committee found that little research is currently being conducted to evaluate whether underserved populations in urban communities are being reached.

A comprehensive program of public awareness is needed. **Therefore, the program review committee recommends:**

> **the lead agency develop a marketing plan. The plan should identify the targeted population including, the number and percent to be served. It should also measure provider capacity in each region to determine where there are shortages (geographically) and develop a plan to recruit providers.**

Delivery of Services

Several states have taken the lead in the implementation of guidelines that provide a framework for determining the appropriate scope and breadth of the services contained in the Individual Family Service Plan. The primary reason for the development of the guidelines is to contain the growth of Part H services by setting a clearer standard of the scope of services the state is responsible for providing under the program. Although all states must have available the 17 mandated services required under Part H, states have begun to set parameters on service intensity.

Under the federal law the plan of services (IFSP) must be developed based on a child and his or her family's unique needs. The law does not prohibit states from establishing a framework for making decisions within the IFSP team. States have had difficulty in developing guidelines because there is a lack of quality outcome data that indicates what the most appropriate level (volume and intensity) of services is, given the child's needs. However, in the absence of guidelines, children may receive inappropriate services. In addition, children with similar needs may not receive similar services because there is no reference point to ensure consistency and equity. **The program review committee recommends:**

> **the Interagency Coordinating Council shall assist in the development of service guidelines. Guidelines should provide a framework for the plan of services developed by the IFSP team.**

APPENDICES

APPENDIX A

Profile of Other States

Lead agency. All 50 states adhere to the Federal Part H requirements, but there is significant variation in how the programs have been implemented. The greatest factors that cause the differences among the programs seem to be the structure of early intervention systems that existed in the states prior to Part H, political commitment, and the size and demographics of the states.

Table A-1 shows the designated lead agency in each state as of 1995. Almost half of the states have designated either the state health or human services department as lead agency, or as exists in some states, a combined health and human services agency. In addition, some states do not have a separate department to provide services to persons with disabilities, but deliver those services through their health and human service agencies. Furthermore, 11 states have switched lead agency since 1991. Table A-2 shows six states have removed the education department as lead agency, and two states have renamed education from lead agency to co-lead agency.

The program review committee surveyed selected states to compare the structure, program, and administration of national early intervention programs. Table A-3 presents a profile of eight states and the way in which key program elements have been implemented. In addition, a brief narrative of these states is presented below.

Illinois. The State Board of Education, as lead agency, funds a staff position for each agency involved in the early intervention system. These people serve as permanent interagency liaisons to ensure that every agency's policies and positions are articulated. The Board of Education also has 10 full-time people to coordinate early intervention services with the medical community. All providers must be Medicaid certified, but Medicaid is billed through a central state billing office.

Maryland. All service coordination and delivery in Maryland is done at the local level and is a mix of public and private providers. Maryland has developed a "Frequency and Intensity of Services Guideline" to establish service parameters. These guidelines are based on a child's outcome goals rather than a prescriptive model based on a child's condition.

Massachusetts. Massachusetts has been operating an early intervention program since the 1970s, and, therefore, had a well established system that simply absorbed the Part H requirements. Program expenditures in FY 95 totaled about $50 million. Of that amount, $18 million was received from state appropriations, $13 million through Medicaid reimbursement, $8.5 million through Part H funds, and $8-10 million from third-party insurance. By law, the state is the payer of last resort.

TABLE A-1. STATE LEAD AGENCIES			
State	**Lead Agency**	**State**	**Lead Agency**
Alabama	Rehabilitation Services	Montana	Social and Rehabilitation Services/DD
Alaska	Health & Social Services	Nebraska	Education and Social Services (co-lead)
Arizona	Economic Security	Nevada	Human Resources
Arkansas	Human Services/Developmental Disabilities (DD)	New Hampshire	Health and Human Services
California	Developmental Services	New Jersey	Health
Colorado	Education	New Mexico	Health/DD
Connecticut	Education	New York	Health
Delaware	Heath and Social Services	North Carolina	Human Resources/MH-DD-Substance Abuse Services (SAS)
District of Columbia	Human Services	North Dakota	Human Services
Florida	Health & Rehabilitative Services	Ohio	Health
Georgia	Human Resources/Division of Health	Oklahoma	Education
Hawaii	Health	Oregon	Education
Idaho	Health & Welfare/DD	Pennsylvania	Public Welfare
Illinois	Education	Rhode Island	Health
Indiana	Family and Social Services	South Carolina	Health & Environmental Control
Iowa	Education	South Dakota	Education
Kansas	Health and Environment	Tennessee	Education
Kentucky	Human Resources/Mental Health-Mental Retardation	Texas	Interagency Council on Early Childhood Intervention
Louisiana	Education	Utah	Health
Maine	Education	Vermont	Education and Human Services (co-lead)
Maryland	Governor's Office of Children, Youth and Families	Virginia	MH/MR/SAS
Massachusetts	Public Health	Washington	Social & Health Services
Michigan	Education	West Virginia	Health & Human Services
Minnesota	Education	Wisconsin	Health & Social Services
Mississippi	Health	Wyoming	Health
Missouri	Education		

Source: Trohanis, P. Chapel Hill, NC: National Early Childhood Technical Assistance System .

TABLE A-II. LEAD AGENCIES CHANGES IN OTHER STATES.		
State	Lead Agency in 1991	Lead Agency in 1995
Alabama	Education and Rehabilitation Services (co-lead)	Rehabilitation Services
Delaware	Education	Health and Social Services
Florida	Education	Health & Rehabilitation Services
Indiana	Mental Health	Family and Social Services
Maine	Interdepartmental Committee	Education
Maryland (switched twice)	Governor's office to Education	Governor's office
Nebraska	Education	Education and Social Services (co-lead)
New Hampshire	Education	Health and Human Services
New Jersey	Education	Health
Rhode Island	Interagency Coordinating Council	Health
Vermont	Education	Education and Human Services (co-lead)
Source: National Early Childhood Technical Assistance System (NEC*TAS), Chapel Hill, N.C.		

Approximately 14,600 children were eligible for Massachusetts's early intervention program in FY 95. About 13,140 (90 percent) of the children were covered either under private health insurance plans or by Medicaid. Of the children who were insured, about 4,992 (38 percent) were covered by private insurance.

In January 1990, Massachusetts (General Law Section 47C.) mandated early intervention services be a benefit under insurance plans offered in the state. The law stated that insurers are liable for services up to $2,400 per year with a limit of $8,000 over three years. These limits were not tied to any inflationary index. However the state is currently negotiating with insurers to raise the per-year limit to $3,200. The current average cost per child is approximately $4,600 per year, based on a child receiving a full year of services.

Only those early intervention services that are medically necessary, including occupational, physical, and speech therapy, nursing care, and psychological counseling must be covered by a health policy. Services such as developmental therapy are not reimbursable under private insurance or Medicaid, however, the department is currently trying to obtain approval from the Health Care Financing Administration (HCFA) to bill Medicaid for this service.

Billing of private insurance and Medicaid is done directly by providers. A certified public accounting firm audits billing practices of private providers to ensure the service has been delivered and the fiscal integrity of system.

Minnesota. Minnesota has had a state mandate to provide early intervention services to all eligible children since 1987. The Part H requirements were grafted onto this existing program. Service coordination is done both publicly and privately, but almost all services are provided by public agencies. Public providers are used to ensure that all children in all regions of the state have access to the same services. Paraprofessionals are also widely used to ensure that services are available in all regions. There have been some efforts made to drop out of the federal program because many in the state feel the system that existed since 1987 was as good as the present system but without the burden of the added Part H requirements.

Rhode Island. Rhode Island has been very successful in accessing funding through Medicaid and private insurance. It has patterned its service definitions after Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) program to maximize reimbursement and has obtained a Section 1115(a) waiver. Rhode Island's policy with private insurance is that if a managed care network refers a child to early intervention, the company is then responsible for the costs. All costs are centrally billed.

South Carolina. South Carolina is faced with a shortage of private service providers. As a result, most children in the state's early intervention system receive services through public providers, and about 95 percent of the children receive services at home. South Carolina has made extensive use of paraprofessionals to make up for the lack of providers.

Virginia. Virginia's interagency coordinating council is composed of the heads of all participating agencies. In addition, each agency appoints a member to the Interagency Managing Team that meets as a once a month and subdivides into issue groups as necessary. This arrangement has facilitated interagency cooperation. Virginia uses a wide variety of public and private providers for both service coordination and delivery, basing this system on the programs existing prior to the implementation of Part H. Medicaid is billed by the service provider, with smaller providers forming consortiums for billing purposes.

Wisconsin. This program is run primarily at the county level. Although there are exceptions, many counties contract with the service providers for service coordination. Wisconsin recently made the early intervention program part of targeted case management, thus making all participating children eligible for Medicaid under a waiver. Responsibility for billing Medicaid varies among the counties.

Table A-3. OTHER STATE EARLY INTERVENTION PROGRAMS.

	ILLINOIS	MARYLAND	MASSA-CHUSETTS	MINNESOTA	RHODE ISLAND	SOUTH CAROLINA	VIRGINIA	WISCONSIN
LEAD AGENCY	EDUCATION	OFFICE OF CHILDREN, YOUTH & FAMILIES	PUBLIC HEALTH	EDUCATION	DEPARTMENT OF HEALTH	HEALTH AND ENVIR. CONTROL	MH/MR/SA SERVICES	HEALTH AND HUMAN SERVICES.
AT RISK SERVED?	YES, BUT NOT MANDATED	NO	YES	NO	NO, BUT SERVE MULTIESTABLISHED RISK	n/a	NO, BUT MANY ARE UNDER OTHER STATE PROGRAMS	NO
SERVICE PARAMETERS?	COVERED IN IFSP	GUIDELINES DEVELOPED	NO, BUT DEVELOPING A GUIDANCE DOCUMENT	NOT NEEDED, FEW PROBLEMS	NO PARAMETERS	DEVELOPING FRAMEWORK	TECHNICAL ASSISTANCE	NO FRAMEWORK
SERVICE COORDINATION	MOVING TO INDEPENDENT	PUBLIC AND PRIVATE; DONE AT LOCAL LEVEL	NOT INDEPENDENT - DONE AT LOCAL LEVEL	VARIES WIDELY; BOTH PUBLIC AND PRIVATE	APPOINTED LOCALLY TO FIT CLIENT	VARIES AT LOCAL LEVEL	DECENTRALIZED; PUBLIC AND PRIVATE	VARIES AT COUNTY LEVEL
PROGRAM ASSESSMENT?	INTERDISCIPLINARY EVALUATION	SYSTEMATIC QUALITY ASSURANCE WITH SITE VISITS	NOTHING SYSTEMATIC-SITE VISITS AND COMPLIANCE AUDITS	SEVERAL TYPES	QUARTERLY REVIEWS AND ANNUAL SITE VISITS	NONE	NONE	ONLY BUDGET REVIEW
PARA-PROFESSIONALS	USED UNDER SUPERVISION	n/a	USED UNDER SUPERVISION	USED EXTENSIVELY	YES	YES	FEW	YES
SERVICE DELIVERY	PUBLIC AND PRIVATE	PUBLIC AND PRIVATE	ALL PRIVATE	PUBLIC ONLY	ALL PRIVATE	PUBLIC AND PRIVATE	PUBLIC AND PRIVATE	VARIES AT COUNTY LEVEL
MEDICAID	BILLED THROUGH CENTRAL OFFICE	n/a	EXTENSIVELY USED, WITH 1115 WAIVER	USE TEFRA WAIVER	USE 1115 WAIVER AND EPSDT STANDARDS	BILL FOR 65%-75% OF CHILDREN	ALL PROVIDERS BILL	USE TARGETED CASE MANAGEMENT
PRIVATE INSURANCE	ACCESSED LOCALLY	n/a	EXTENSIVELY USED; BACKED BY LEGISLATION	YES	USED EXTENSIVELY	LIMITED	BILLED AT LOCAL LEVEL	NOT USUALLY BILLED
LOCUS OF PROGRAM	45 REGIONAL AREAS	23 COUNTIES AND BALTIMORE	LOCAL LEVEL	94 LOCAL AREAS	5 REGIONS	13 LOCAL REGIONS	40 REGIONAL AREAS	COUNTY
SLIDING FEE SCALE	YES	NO-BIRTH MANDATE STATE	NO	FOR SOME SERVICES ONLY	YES	NO	VARY AT LOCAL LEVELS	NO

APPENDIX B
DEPARTMENT OF EDUCATION RESPONSE

STATE OF CONNECTICUT

DEPARTMENT OF EDUCATION

February 8, 1996

Michael L. Nauer
Director
Legislative Program Review & Investigations Committee
State Capitol - Room 506
Hartford, Connecticut 06106-1591

Dear Mr. Nauer:

Thank you very much for the opportunity to provide an agency response to the Legislative Program Review and Investigations Committee final report on Birth-to-Three.

Obviously, we were pleased with the recommendation to continue this program, but we disagree with some of the characterizations of this agency's leadership of the program and the work of the six regional educational service centers. We have found it very hard to reconcile the staff briefing report of 9/27/95 with the staff findings and recommendations of 12/20/95. It is not so much the substance of the recommendations that we find troubling as it is the imbalance and incomplete commentary supporting those recommendations.

If the program is to continue - and that remains this agency's primary goal - we believe it is in part due to our successful initiation of a very difficult undertaking.

We were disappointed that the findings and recommendations failed to acknowledge the following:

1. the complexity of the SDE/DMR design as a model that was given to us by the legislature, with the requirement to serve as lead agency, but without control over approximately 40 percent of the state resources available;
2. the difficulties involved in initiating a new entitlement program in collaboration with many partners, under both state and federal legislation, and with widely disparate expectations of cost;
3. the results of the parent/family opinion survey (not conducted by this agency), which evidenced a very high level of satisfaction with the services received;
4. this agency's use of federal funds from 1987 to 1992 (prior to state legislation) to support DMR and a dozen other programs to provide direct service programs for hundreds of children and families, and to develop regional capacity for service;

Box 2219 • Hartford, Connecticut 06145
An Equal Opportunity Employer

5. the obvious and important link between the six regional educational service centers and local school district programs for children with disabilities who are ages 3 to 5;
6. the importance of (a) providing a range of programs and services designed to meet the needs of individual children; (b) the need to separate the evaluation/assessment, case management and direct services aspects of the program; and (c) the single point of entry concept;
7. the fact that the program operated within the state appropriations in 1993-94 and 1994-95, and in 1995-96 is projected to have a 4 percent deficiency, resulting from static state funding and a 35 percent increase in the active caseload - clearly the value of the cost-saving measures already underway was not given appropriate credit in the report;
8. the fact that the delays in accessing health insurance and parent fees were the statutory policy of the General Assembly, not the choice of this agency;
9. our success in accessing Medicaid in spite of extremely burdensome and changing federal requirements and a state policy of revenue maximazation (Medicaid is being billed retroactive to 1994);
10. the fact that the administrative cost comparisons betwen SDE/RESC and DMR compared a program charged with entry, evaluation, case management, referral, monitoring and transition out (SDE/RESC) to a direct service program (DMR);
11. the amount of staff work and collaboration from this agency, the RESCs and others, and the development of state regulations, procedures, standards and the data that does exist and was sufficient to prepare the first briefing report;
12. this agency's essential leadership and advocacy roles in drafting and securing the 1993 legislation; and
13. the successful delivery of services to more than 6,305 children and families in the initial 21 months of the program (10/1/93 - 6/30/95) and thousands more since that time.

None of the above is to deny the validity of the need to improve the long-term mission of the program, the databases, the cost controls, revenue enhancements, evaluation and public awareness; clearly none of our continuous efforts can be interpreted as satisfaction with the status quo.

Lastly, key items in your final report - the estimate of annual cost savings ($4M to $6M) to be realized by changing the lead agency and the projected insurance revenue and parental fees - do not appear supported by adequate investigation and documentation. (Please refer to the Governor's Budget Request of 2/7/95, prepared by the Office of Policy and Management.) The policy questions around insurance and parent fees remain unsettled and the future of Medicaid is uncertain. We have expressed to OPM, the Governor's Office and the leadership of the Education Committee grave doubts about your estimates.

Unfortunately, the budget proposals of 1995 and now your report may have created an appearance of competition between DMR and this department. Our view has always been that we were effective partners together -- with DMR serving the direct service needs of roughly one-third of the children. The designation of the lead agency is made by the Governor and the General Assembly, and it is this agency's intention to work cooperatively under the terms of

whatever policy decision is made. The interests of the children and families being served are our first concern.

As you may know, at the request of the Governor's Office, we have already begun working with DMR and OPM to ensure a successful transition, should the legislature approve Governor Rowland's budgetary and statutory proposals.

Our agency goal has always been the legislative continuation of this program. We believe it represents a significant investment in the lives of young children, with very positive long-term results.

Thank you.

Sincerely,

Theodore S. Sergi
Commissioner of Education

TSS:er

APPENDIX C
DEPARTMENT OF MENTAL RETARDATION RESPONSE

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL RETARDATION

DMR

JOHN G. ROWLAND
GOVERNOR

OFFICE OF THE
COMMISSIONER

February 5, 1996

Michael L. Nauer, Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Mr. Nauer,

Thank you for the opportunity to add our comments to the committee's report on the Birth to Three Program. Your staff did a thorough job in a very short period and should be commended.

After the committee adopted the report's recommendations on December 21, 1995, DMR was asked by the Office of Policy and Management to begin a planning process to implement the recommendations by July 1, 1996 (see attached letter dated January 17, 1996). Your report will be an excellent guide as we seek to redesign the administration of the program. Our efforts will be directed toward implementing the neccessary changes without disrupting the direct services that your report recognizes as invaluable to the families receiving them. It is a major undertaking, but our department is up for the challenge.

We endorse your recommendation to continue Connecticut's participation in Part H of the Individuals with Disabilities Education Act.

Sincerely,

Peter H O'Meara

Peter O'Meara
Commissioner

Phone: **Voice 418-6011** TDD 418-6079
460 Capitol Avenue • Hartford, Connecticut 06106
An Equal Opportunity Employer

STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

January 17, 1996

Hon. Peter O'Meara
Commissioner
Department of Mental Retardation
460 Capitol Avenue
Hartford, Connecticut 06134

Dear Commissioner O'Meara:

The December 20, 1995, Legislative Program Review and Investigations Committee report endorses the transfer of operational authority for the Birth to Three Program from the Department of Education to the Department of Mental Retardation (DMR). I am requesting that your agency begin to plan for a possible assumption of the program for SFY 1996-97.

The Program Review report recommends improved outreach, information management and program planning. The report notes that program design is too complex, costs are escalating and accurate data is virtually non-existent. It is imperative that attempts to control costs, simplify program design and pursue revenue not be delayed by a potential transfer. It is critical that private insurance be utilized to offset program expenditures. A copy of the 1994 study "Accessing Private Payment Sources" is enclosed for your review.

In addition to the guidance provided in the Program Review report, the following items should be considered:

- financially able families should contribute and allow access to appropriate private insurance;
- Medicaid reimbursement should be pursued;
- providers should exhaust all other sources of payment before state resources are used;
- utilization of direct services must be limited to what is necessary for a successful outcome;
- administrative costs must be reduced; and,
- lower cost direct care arrangements must be utilized.

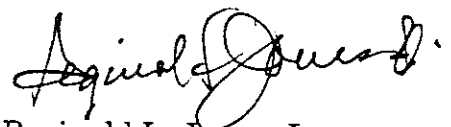
The Department of Mental Retardation must begin now to plan a transfer of the program that does not disrupt client services but does make the changes

Phone: (860) 418-6500 Fax: (860) 418-6490
450 Capitol Avenue-MS# 55SEC, P. O. Box 341441, Hartford, Connecticut 06134-1441

needed to curtail costs. The Department should begin drafting a "Request for Proposals" that establishes more stringent standards for program administrators. Regulations must be developed which incorporate the ideas put forth in the Program Review report with a general improvement in program efficiency. Issues of program effectiveness must be addressed and balanced with efforts to reduce costs and increase third party revenue.

The tasks are significant but designing a more efficient and client-focused service model will allow the state to continue operating this valuable program. My staff is willing to assist you as necessary.

Sincerely,



Reginald L. Jones, Jr.
Secretary

CC: Commissioner Theodore Sergi