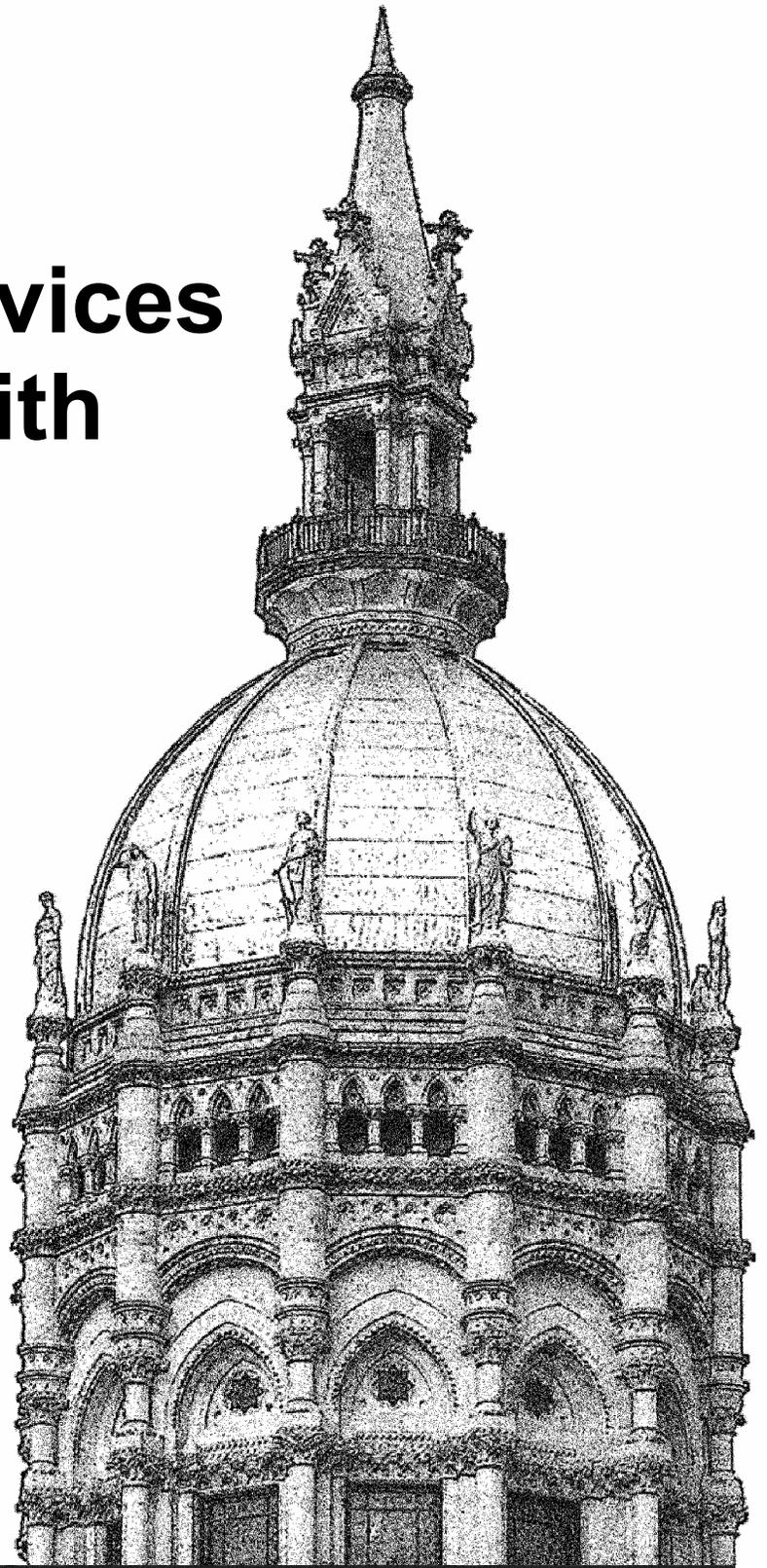


Provision of Selected Services for Clients with Intellectual Disabilities

January 2012



PRI

**Legislative Program Review and
Investigations Committee**

Connecticut General Assembly

**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

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Provision of Selected Services for
Clients with Intellectual Disabilities

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PROVISION OF SELECTED SERVICES FOR CLIENTS WITH INTELLECTUAL DISABILITIES

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Executive Summary

Provision of Selected Services for DDS Clients

In March 2011 the Legislative Program Review and Investigations Committee (PRI) voted to approve a study comparing the cost of providing public and private services (residential and day) to individuals with intellectual disabilities who are clients of the Department of Developmental Services (DDS) and receive 24-hour care in community or institutional settings.

Connecticut is one of 18 states that operate a dual system of public and private provision of residential services in the community. The department provides 24-hour residential services at the Southbury Training School (STS), and five of the eight regional centers; all of these are ICF/MR certified.¹ DDS also operates and staffs 70 community living arrangements (CLAs) or group homes in various towns throughout the state. The state also contracts with the private sector to operate another 800 group homes and 69 intermediate care facilities for intellectually disabled clients. Services delivered to clients in the ICF/MR facilities are based on a medical model and most comply with federal requirements regarding safety and sanitation, plan development, professional services, etc. Reimbursement under the Medicaid program is different based on whether services are delivered in an ICF/MR or a CLA.

Costs of services. The report examines the existing funding structure, the factors that affect costs, and how those differ among public and private service providers. Individual client acuity levels and how they impact the cost of care and/or the settings in which clients receive care are also discussed. The committee found the public delivery of residential services, even after controlling for client level of need (LON), is much more expensive than services delivered by private providers.

The study finds that, on average, it costs about 2.5 times more to take care of the clients with the same LON in a public CLA as a private one. Similarly among ICFs/MR, it costs 1.8 times more to provide public residential care for the same client mix as private ICFs/MR, and twice as much at Southbury given their costs and client mix. Because the individual costs per year differ so much between the two settings, the current dual system provision of care is very costly.

While the study found that direct care staffing resources did not vary among public and private settings on a staff-to-client ratio, it was difficult, for analysis purposes, to assign staff to a particular residential setting at Southbury and the regional centers because of the nature of the facilities. The study found that direct care staff in DDS residences is heavily comprised of part-

¹ Intermediate care facilities for people with mental retardation services (ICFsMR) are an optional (not mandatory) Medicaid benefit. Under a state's Medicaid plan, it allows states to receive federal matching funds for institutional services. Connecticut receives 50 percent reimbursement from the federal government for services provided. All beds at STS and the five regional centers are licensed and certified as ICF/MR and there is a small number of private ICFs/MR located in the community.

time workers, making up 40 percent of employees providing direct care at STS and regional centers, and 43 percent in public CLAs.

PRI found a substantial difference in the average hourly wage of direct care workers in DDS compared to those employed by private providers. The average hourly wage in the private sector is \$15.53 for a direct care worker, which is about one-third less than the average hourly wage (\$24.24) paid to the lowest classification of a DDS direct care worker. Other benefits are, for the most part, more generous in the public sector, with an annual monetary value of about \$40,000. Part-time DDS direct care workers are also eligible for state benefits, where private providers tend to be more restrictive in eligibility and benefits offered.

Moving Toward a Private System

Acknowledging the dual system is a costly one (as this report's analysis finds as well), the department has been implementing a policy of not accepting new admissions to any of its homes or facilities as a way to gradually reduce public residential services. In fact, as a result of the number of employees who left state service under the 2009 retirement incentive program (RIP), the state was able to convert 17 DDS-supported homes to private providers. Five additional such conversions are planned in the current budget, but have not yet been implemented.

Historical factors. Accelerating the shift to a solely private residential care system of care is complicated for several reasons. First, historical events have produced this bifurcated system. Until the 1980s, most of Connecticut's residents with intellectual disabilities who were in 24-hour care were located at either of the two state-run institutions, Mansfield or Southbury Training Schools. Both of these institutions were staffed by state employees that since the mid-1970s were allowed to collectively bargain and their employment was protected by labor agreements.

In 1978, the then-Connecticut Department of Mental Retardation was targeted in a federal class action suit, known as *CARC vs. Thorne*, in which the plaintiffs charged that care provided to residents at Mansfield violated their civil rights. The case was settled through a consent decree that ultimately resulted in the 1993 closing of Mansfield. This produced a rapid expansion in community group home placements for the Mansfield population. However, the employee labor agreements with the state required that the staff who had worked at Mansfield be placed in similar state employment within a limited geographic area. Consequently, there were transfers of staff to the regional centers but also a development of public group homes in the area for former Mansfield residents and staff.

While the Mansfield Training School closed, the other state institution, Southbury Training School, remains open. A 1986 federal consent decree required it to improve conditions for its residents, and it has been closed to new admissions since that year. A Southbury Planning Committee report was released in March 1994 by the DMR commissioner, calling for the closure of Southbury Training School within five years. Many legal disputes ensued and a Special Master was appointed by the federal courts to oversee the remedial plan. In 2006, the federal court found that the state had met all the requirements of the consent decree.

However, in June 2008 a federal court decision in another related case concluded that although the state had satisfied the consent decree requirements on improving care at Southbury, it had not done enough to provide residents with the information needed for them and their guardians to make informed and voluntary decisions about moving into community settings. In November 2010, the federal court issued an order for the implementation of a stipulated agreement which called for much more aggressive movement to provide individual assessments and present viable community alternatives based on those assessments to residents at Southbury, with the ultimate decision based on the best interests of the resident.

State collective bargaining agreements. But even as residents voluntarily relocate from Southbury, there is the complication of the staff employed there. Current labor agreement provisions prohibit layoffs as a result of contracting out, and also impose geographic limitations on transfers.² Further, as a result of the August 2011 agreement between SEBAC and the state, and concessions made by the state employee unions, there are broad no-layoff provisions now in force for four years.

As the department continues to consolidate and downsize its residential and day programs, thereby reducing the number of clients in those settings, and recognizing that department staffing reductions must come through attrition, the program review committee believes that DDS direct care staff could be redeployed to other capacities in the community. As a gradual transition to private services, DDS staff could provide services to individuals at home who are on the waiting list or by providing respite to families.

New rate-setting structure. Also facing the department are the more stringent requirements being placed on states in order to receive federal reimbursement. The Centers for Medicare and Medicaid Services (CMS) is emphasizing that only systems offering consumer choice in settings and a uniform rate-setting methodology will be reimbursed -- standards that Connecticut's system does not currently meet. The department will be transitioning to a new utilization rate-setting methodology for private CLA providers beginning in January 2012 and the intent is to match each client's level of need with appropriate funding. It is expected the transition will take 7.5 years, which will allow the time needed for the department to upgrade its information technology to implement and administer the new rate system. The relatively long phase-in period will also allow private providers to adjust to new rates gradually rather than experience sudden funding dips or increases.

In the meantime, the committee proposes that DDS establish a centralized utilization review process that would examine those cases where services exceed the funding guidelines in place for clients assessed at certain levels of need.

The report notes that the new rate setting system will apply only to private providers. The more inequitable differences in funding between public and private providers will continue as long as there is a dual system. In the interim, the committee recommends that DDS conduct a staffing assessment at the existing public residential programs using similar resource guidelines as employed when contracting in the private sector. DDS staffing patterns should be adjusted

² Articles 6 and 16 of the current contract between the State of Connecticut and New England Health Care Employees Union District 1199, in effect July 1, 2009 to June 30, 2012

based on client's level of need, and DDS staff redeployed as the system gradually transitions to a private provider framework for direct care.

Also supporting the private provider model for provision of residential services are the findings noted in the report on quality of care. Based on the lower number of deficiency citations in both private group homes and intermediate care facilities compared to the public settings, the committee finds that the quality is not lower in the private sector. Given the substantially lower costs for private residential care, the findings around quality bolster a move to a single private system of state-funded direct services.

In total, the committee makes 14 recommendations that would: accelerate the pace for phasing out DDS-operated services, except for a very small segment of the client population; apply the same provisions contained in the Southbury settlement agreement to residents currently living at the regional centers; establish a centralized utilization process for high-cost client services; and require DDS to consider certain factors when initiating or renewing contracts with private providers.

RECOMMENDATIONS

- 1. The Department of Developmental Services should evaluate all residents receiving 24-hour care at the five regional centers for possible placement in the community. Using the interdisciplinary team concept established by the Southbury Training School Consent Agreement, each team would exercise its professional judgment in recommending the “most integrated setting” appropriate to the needs of each regional center resident. For purposes of the agreement, the “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”**

For residents of Southbury and the regional centers, a rejection of a community placement should be revisited periodically. If the interdisciplinary team makes a recommendation for a community placement, which is rejected by the guardian, or family member, or client, the team should evaluate the resident's situation each year and present its recommendation for a family, guardian, or client decision.

- 2. The Department of Developmental Services should continue its phasing out of providing 24-hour residential care in any of its DDS settings, but that it accelerate its efforts through:**
 - Using DDS CLAs only for residential placements for clients from more restrictive public settings like Southbury or the regional centers, and as a transition phase only;**
 - DDS should not refill any direct care or direct service positions vacated through attrition in any of its residential or day programs; and**

- **DDS should conduct a staffing assessment at its residential locations in light of the 16 percent reduction in clients. For the clients still residing at DDS homes and facilities, DDS should use the LON assessment tool to determine the level of staffing needed (as it would in contracting for private placements). Where staffing levels are higher than comparable in the private sector, DDS should redeploy staff to serve clients on the residential care waiting list in their homes or to provide respite care, within labor contract provisions.**
 - **Ultimately, the only residential care that should be operated by DDS is to provide care for extremely hard-to-place clients and for those clients that the superior or federal (not probate) court directs into DDS care. This should involve about .5 percent of the 24-hour residential care population or 25 people.**
3. **DDS should reduce its overtime by at least 10 percent as recently required by the Office of Policy and Management, including through implementing those measures similar to those recommended by the Department of Children and Families in its overtime reduction report to OPM.**
 4. **In future contracts DDS has with private providers, the department should examine the salaries paid to direct care workers considering:**
 - **what they are paid relative to the agency's executive director's salary;**
 - **relative to wages needed for self sufficiency standards as calculated periodically by the Office of Workforce Competitiveness and the Office of Policy and Management and those that may be developed by the DDS Sustainability Subcommittee; and**
 - **income levels that qualify persons and families for eligibility for state Medicaid and other assistance.**
 5. **As a condition of future contracts with a private provider, the Department of Developmental Services should also ensure that the provider has complied with the requirements of cost reporting, including the submission of forms on the executive director's salary.**
 6. **The Department of Developmental Services should continue to phase out the provision of public day/work programs, with the overall goal to implement a single private delivery system for day/work services. The department should not refill any positions that are, or become, vacant in public programs, and shall redeploy existing staff to other direct services in the community as opportunities allow.**
-

- 7. Further, the Department of Developmental Services should conduct a staffing assessment of its current staffing levels for its public day programs, using the day/work LON scores in the private programs as a guide for level of resources needed, and redeploy staff resources over those levels to other services.**
- 8. As recommended for clients receiving 24-hour staffed residential services, the Department of Developmental Services should adopt a centralized utilization review process for clients exceeding the day/work program funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.**
- 9. Each client's Planning and Support Teams (PST) should review each client's day program relative to his/her LON. The objective for each client should be that he or she is participating in the most productive, meaningful work or day program in the most inclusive environment as possible. The client's PST should also be examining results of programs, such as day service options, that are geared to building skills to transition a client to a more competitive environment to ensure these outcomes are measured.**
- 10. The Department of Developmental Services should adopt a centralized utilization review process for clients exceeding the residential funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.**
- 11. The Department of Developmental Services should remind its case managers of the importance of keeping client automated records up to date.**
- 12. The Department of Development Services should randomly audit a sample of cases in its client demographic database to ensure client information is accurate.**
- 13. The results of quality inspections should be shared with all clients' Planning and Support Teams, which would include guardians and families. The results can be part of an education process about private community settings, and may help some clients' families reach a positive decision about moving from an institutional facility to the community.**

14. The Department of Developmental Services should ensure staff and client participation and involvement in the planning for the Integrated Care Organization model, especially as it pertains to dually eligible clients who are under 65. DDS should ensure that any health care delivery model reduces duplication, prioritizes preventive care, incorporates a data reporting system that easily tracks and reports on preventive care and screening clients have received, and can be used as part of a performance measurement and quality assurance system.

Introduction

Study Focus

In March 2011, the PRI committee voted to approve a study comparing the cost of providing public and private services (residential and day) to individuals with intellectual disabilities who are clients of the Department of Developmental Services (DDS) and receive 24-hour care in community or institutional settings. The committee completed its analysis in December 2011, and made recommendations to ensure a cost-effective, quality-driven system for Connecticut's citizens with intellectual disabilities receiving 24-hour residential care.

The Department of Developmental Services (DDS) operates, generally, under Title 17a, Chapter 319b of the Connecticut General Statutes. The department is responsible for the planning, development and administration of a complete, comprehensive, and integrated statewide program for persons with intellectual disabilities. The department offers an array of residential, day service, and family support programs.

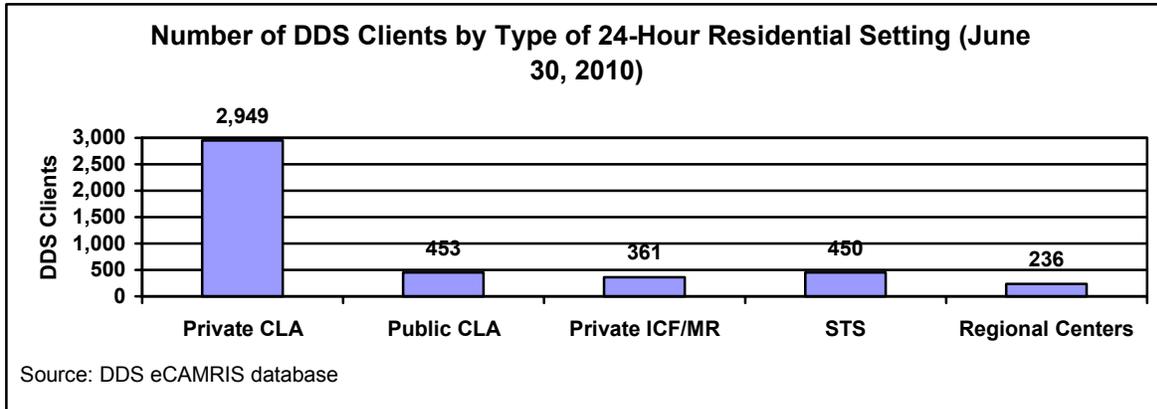
With General Fund expenditures of \$967.8 million and 3,657 staff in FY 10, DDS is one of the larger state agencies in Connecticut. During that same period, it provided either in-home or residential services to 15,448 DDS clients age three or older.

The department is organized into three geographical regions and administered out of what is called the Central Office in Hartford. The three geographical regions and headquarters of each are:

- North Region - East Hartford;
- South Region - Wallingford; and
- West Region – Waterbury.

Provision of residential care. The department operates eight regional centers, five of which provide 24-hour residential services to DDS clients. The West Region includes the Southbury Training School and operates three regional centers with 24-hour residential services; the North Region has one 24-hour residential regional center; and the South Region also has one 24-hour residential regional center. Residential services are also directly provided by DDS staff employed in community living arrangements (CLAs), or through contracts with private provider organizations throughout the state. On a day-to-day basis, the provision of 24-hour residential care, whether in private or public settings, and oversight and monitoring of the services, consume the greatest amount of department resources.

In Connecticut, there are several types of residential settings available to DDS clients who need 24-hour care. The figure below shows the setting for the 4,449 DDS clients receiving 24-hour residential services on June 30, 2010. This study focuses on the services provided to these clients and compares the costs in the various settings as well as examines the factors contributing to the costs.



Because of the complexity surrounding the operation of a public/private provider system that offers the same services, this report provides information and analysis on the existing funding structure, the factors that affect costs, and how those differ among public and private providers. In addition, because of the belief among some that public settings serve more difficult clients, and therefore have higher costs, client case-mix was accounted for when comparing costs of care in the four types of residential settings

Study Methodology

PRI committee staff reviewed federal and state law, national literature, and recent Connecticut-specific studies that examined the cost of client care and the rate structure used by DDS to reimburse private providers for residential and day services. Several interviews were conducted with state agency personnel in the Departments of Developmental Services, Social Services, Administrative Services, and Public Health. PRI staff also conducted site visits of Southbury Training School, Hartford Regional Center in Newington, and a DDS-operated group home. PRI staff attended meetings, presented information about the study, and responded to questions from two of the main nonprofit private provider advocacy groups – Connecticut Association of Nonprofit Providers and Connecticut Community Providers Association.

A major undertaking by committee staff was constructing a database that merged several databases from multiple agencies containing disparate client information, into a single database so that client characteristics and cost data could be analyzed. The table below shows the sources of that data used for the analysis in the body of this report.

Report Organization

This report is divided into seven chapters. Chapter I describes the rate-setting processes for the various types of DDS-supported programs and components. The chapter also summarizes the roles of state agencies involved in the various regulatory, administrative, or reimbursement aspects of the services and supports to DDS clients who receive 24-hour residential services. Chapter II provides a demographic profile of DDS clients in 24-hour residential settings and discusses the level of need (LON) assessment instrument used by DDS to assist with resource allocation for some clients.

Data for Cost Comparison of Selected Residential and Day Services			
<i>Category of Residence</i>	<i>Agency/Cost Category</i>	<i>Databases</i>	<i>Aspects</i>
Public CLAs	DDS costs/client residential and day programs DDS staffing	<ul style="list-style-type: none"> • eCAMRIS • DDS cost submissions to State Comptroller • DSS Medicaid • CORE-CT 	<ul style="list-style-type: none"> • DDS staff and costs • Client demographics and level of need • Individual client Medicaid costs
Public Regional Center ICFs/MR	DDS costs/clients residential and day	Same as above	Same as above
Private CLAs	DDS program/services residential and day DSS room and board	<ul style="list-style-type: none"> • DDS contracts • DSS Medicaid • DDS/DSS through contractor – Private Provider cost reports • DSS-contracted rate promulgation system • eCAMRIS 	<ul style="list-style-type: none"> • Private staffing and costs • Private room and board costs • Client demographics and level of need • Individual client Medicaid costs
Private ICF/MR	DDS day services costs DSS all residential costs	<ul style="list-style-type: none"> • DSS – through contractor – private ICF/MR cost reports • DSS Medicaid • DSS-contracted rate promulgation system 	Same as above
<i>All categories</i>	<i>Outcomes</i>	<i>Databases</i>	<i>Aspects</i>
By residence and day program	DDS DPH	<ul style="list-style-type: none"> • Licensing and Quality Assurance 	Adding quality measures to cost and client database
Source: PRI committee			

Chapter III profiles private providers that offer 24-hour residential care including the size of the provider (i.e., number of CLAs or ICFs/MR the provider operates). This chapter also provides some basic assessment of private provider revenue and financial stability.

Chapter IV examines residential care and costs of care by various components across the different settings and it identifies the key factors that contribute to the costs. This chapter also provides a detailed comparison of direct care staffing resources in the four types of settings and compares direct care wages and benefits of public employees and direct care workers employed by private providers. In addition, it examines some of the other staffing issues that contribute to costs, like overtime and worker compensation claims for DDS employees. Recommendations are made in this chapter to continue phasing out DDS-operated residential care, reduce department overtime, and require the review of DDS contracts with private providers to ensure that certain provisions are included.

Chapter V identifies clients by LON in all four types of residential settings, and compares the average cost per client while adjusting for level of need. This chapter also contains information on the type and costs of day programs for clients in 24-hour residential care and makes recommendations for the department to better assess those costs.

Chapter VI describes the rate-setting methodology the department will begin implementing in 2012, and provides analysis on the system-wide impact that will occur in funding private providers. Recommendations are also contained in this chapter.

Chapter VII compares quality among public and private providers and across the different types of residential settings. This chapter examines the number and types of licensing deficiency citations issued by DDS to private and public providers of service, as a proxy for quality of care provided. Recommendations are made to ensure inspection reports are available for review by clients, family members, and guardians.

The report also contains seven appendices. Appendix A contains a list of common acronyms from DDS, with definitions of acronyms used in this report.

Response from Agency

It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to a study with an opportunity to review and comment on the recommendations prior to publication for the final report. Appendix G contains the response from the Department of Developmental Services.

Rate Setting and Reimbursement

The 24-hour residential settings that are the subject of the PRI study encompass the following:

1. *Community Living Arrangements (CLAs)* – operated by both DDS and private providers. Clients live in either individual family-type group homes or apartments with 24-hour staffing.
2. *Private intermediate care facilities for the mentally retarded (ICFs/MR)*³ – considered "institutions" (4 or more beds) for people with mental retardation. Federal regulations specify that these institutions must provide "active treatment," as defined by the secretary of the federal Department of Health and Human Services, in order to receive Medicaid reimbursement.
3. *Regional Centers* – campus-type settings located in each region with 24-hour staffing and are certified ICFs/MR to receive Medicaid reimbursement.
4. *Southbury Training School (STS)* – individuals live in cottages of varying sizes in a campus setting with 24-hour staffing. STS is ICF/MR certified to receive Medicaid reimbursement.

Funding for services and supports to DDS clients who receive 24-hour residential services primarily comes from a combination of federal Medicaid and state funds. There are two separate reimbursement systems depending on the setting in which clients reside. Connecticut receives 50 percent federal reimbursement for DDS clients living in intermediate care facilities (ICFs/MR) as an optional service under the state's Medicaid plan. All Southbury Training School beds are certified as ICF/MR as well as all the beds at the DDS regional centers. In addition, there are 69 private ICFs/MR in the community.

As the single state Medicaid agency, the Department of Social Services (DSS), in conjunction with other state human service agencies including DDS, administers two home and community-based service (HCBS) waivers, which provide residential services and supports but do not reimburse for the room and board component. One waiver is known as the comprehensive waiver, which covers all of the clients in this study, allows for 24-hour residential supports, and is typically reserved for clients with significant needs. Room and board is paid separately by DSS and is offset by client contributions from any earnings, or from cash assistance a client may receive from federal or state programs like Supplemental Security Income (SSI), Social Security disability benefits and/or State Supplement for the Aged, Blind and Disabled.

³ Intermediate care facilities for people with mental retardation services (ICFs/MR) are an optional (not mandatory) Medicaid benefit. Under a state's Medicaid plan, the program allows states to receive federal matching funds for institutional services. Connecticut receives 50 percent reimbursement from the federal government for services provided. All beds at STS and the five regional centers are licensed and certified as ICF/MR, and there is a small number of private ICFs/MR located in the community.

Table I-1. Roles of Various Agencies and Contractors in Regulation and Reimbursement of DDS Residential Programs

<i>Agency</i>	<i>Rates/Costs</i>	<i>Licensing/Quality Assurance</i>	<i>Client Information</i>
Department of Developmental Services	<ul style="list-style-type: none"> Receives cost-reports from private providers for CLAs Sends cost reports to CJLC for audit of room and board costs to set prospective rates Administers contracts w/private providers and maintains contracting database 	<ul style="list-style-type: none"> Licenses public and private CLAs Conducts licensing inspections (see Section V) and maintains licensing inspection data Quality Service Review (QSR) database (separate from licensing) that will meet the CMS requirements 	<ul style="list-style-type: none"> Maintains e-CAMRIS, the DDS client information system – case managers responsible for updating information
Department of Social Services	<ul style="list-style-type: none"> Approves the rates for ICF/MR; the room and board rates for CLAs; and the Medicaid program “rates” for the CLAs Submits all allowable costs to CMS for Medicaid reimbursement to the state 	<ul style="list-style-type: none"> Approves certificate of need for any new ICFs/MR 	<ul style="list-style-type: none"> Maintains Eligibility Management System that contains data on Medicaid clients Provides income assistance checks to clients based on eligibility and monthly needs Through HP (the private contractor that handles Medicaid claims and payments for the State), maintains data warehouse and exchange that pays Medicaid providers and bills Medicaid
CJLC, LLC (private consultant w/DSS contract)	<ul style="list-style-type: none"> Develops full rate for private ICFs/MR based on prior year costs Develops room and board rate for private CLAs Maintains database on private providers’ cost reports Conducts desk audits of provider cost reports for room and board costs 	No role	No role
Office of State Comptroller (OSC)	<ul style="list-style-type: none"> DDS submits all cost information for regional centers, STS and group homes to OSC OSC annually establishes a maximum per diem “rate” by region that includes benefit costs and statewide cost allocation plan (SWCAP) OSC sends the rates to DAS which bills Medicaid and others (see below) Determines the benefit rate for state employees – added to the cost of public residential care – sends to DAS 	No role	No role
Department of Administrative Services	<ul style="list-style-type: none"> Merges costs per diem and attendance data for residential care into standard billing format Submits the bills monthly to HP for Medicaid Collects room and board payments from individual clients in DDS group homes 	No role	No role
Office of Policy and Management	<ul style="list-style-type: none"> Develops the standard purchase of service (POS) contract that DDS uses Develops the cost reporting standards for private providers Conducts single state audit 	No role	No role
Department of Public Health	No role	<ul style="list-style-type: none"> Certifies ICFs/MR (public and private) for CMS Conducts quality inspections of ICFs using federal standards Maintains database of ICF/MR for certification/monitoring 	<ul style="list-style-type: none"> Maintains client data for quality monitoring of ICFs/MR

Source: PRI staff analysis

There are various state agencies or contractors involved in the rate-setting, licensing, monitoring, or reimbursement processes for the residential services for the DDS clients in 24-hour care. Table I-1 indicates the roles of the various entities.

Intermediate care facilities (ICF/MR). The ICF/MR model was the first model to replace institutional care, and the first type to receive federal reimbursement, beginning in 1972. There are both public and private ICFs/MR, but all the state-operated facilities in Connecticut are located at a DDS campus, either at Southbury Training School or at one of the regional centers; there are none in the community. Sixty-nine private ICFs/MR are certified in Connecticut, operated by 14 different private providers. All of these facilities are in the community. Typically the homes have 4-6 beds, although one home has 10 beds. The regulation, licensing, and payment system for ICF/MR is different from the community living arrangements, which are the residential settings under the waiver program.

Community living arrangements (CLA). There are currently 731 private CLAs and 70 public CLAs. For clients in community living arrangements, the costs of most residential services are covered under the Medicaid comprehensive waiver for home and community-based services. As of December 2010, 3,247 enrollees in the waiver lived in CLAs. Table I-2 lists the services covered under the HCBS comprehensive waiver.

Table I-2. Comprehensive Waiver Covered Services
Adult Companion
Consultative Services (Behavior and Nutrition)
Family and Individual Consultation and Support (FICS)
Group Day Services
Health-care Coordination
Individualized Day Services
Individualized Home Supports (formerly Independent Habilitation or Supported Living)
Interpreter Services
Live-in Caregiver
Personal Emergency Systems (PERS)
Personal Support
Respite
Supported Employment Services
Specialized Medical/Adaptive Equipment
Transportation
Vehicle Adaptations
Assisted Living
Individual Directed Goals and Services
Residential Habilitation (CLA and CTH)
Source: DDS

Rate-Setting

Private ICFs/MR. It is important to note again that the only rates that are really “set” for any of the residential services are the private ICF/MR rate and the room and board rate for the private CLAs. Those are both established by the Department of Social Services, and are statutorily required to be based on “reasonable costs”. Unlike a utility rate, where a charge (e.g., per kilowatt hour) is the same for all customers and the difference in the bills to the consumer is

totally based on usage, the rates established by DSS vary considerably by provider and home, even before the utilization is calculated.

The ICF/MR rates are set prospectively for each facility and are based on the prior year's costs divided by the number of days the client received the service. However, in tight budget times, even if there have been increases in costs, the rates do not increase. In fact, there has not been an overall increase in rates for ICFs/MR since 2008. The per-client per-day rates in FY 10 ranged from \$279.44 to \$727.79, and the average was \$464.91.

Private CLAs. For CLAs, the “rates” and rate-setting is even less structured. One category of rates for CLAs set by DSS is the room and board rate. There have been no overall increases (other than for emergencies) since 2009. The FY 10 room and board rate range is very wide, from \$6.78 per client per day to \$96.49; the median is \$43.03 and the average is \$43.82.

However, the room and board is not the main contributor to costs; most of the costs for 24-hour residential care is for program services, or staffing. The vast majority of clients in private CLAs are Medicaid eligible, and therefore their residential services are reimbursable under the federal HCBS comprehensive waiver. Currently, one of the only financial considerations CMS uses for the waiver is that the service costs overall are no more than they would be in an institutional setting.

However, CMS is becoming more stringent in its regulations for reimbursing waiver program services, requiring that states: a) have a uniform rate-setting methodology for service models; b) pay only for services actually delivered; and c) offer waiver participants freedom of choice between service providers.

In preparation for the tightening reimbursement requirements, P.A. 09-3 (Section 57) established a DDS Legislative Rate Study Advisory Committee to examine the impact of the [CMS] proposed shift to attendance-based fee-for-service reimbursement for DDS-funded programs. That committee issued a report in January 2011⁴, and in response DDS is revamping its rate structure. The planned modifications and their impact are discussed in Chapter VI of this report.

Public Homes and ICFs/MR. While no real “rates” are established for public CLAs or ICFs/MR, DDS at the end of each year reports its costs to the Office of the State Comptroller (OSC). From that, the OSC calculates the per capita, per diem costs by region and those are sent to the Department of Administrative Services for billing. FY 09, FY 10 and FY 11 per capita per diem costs are shown in Table I-3. As the table shows, for most DDS facilities the per diem costs have increased – from 4.1 percent to 11.5 percent, while there have been minor decreases of less than 2 percent, in two settings.

⁴ The full report is available at DDS' website at: www.ct.gov/dds/lib/dds/opertions_center/rate/lac_final_report.pdf

Table I-3. DDS Public Per Diem Costs Established by Office of the State Comptroller				
<i>Facility</i>	<i>FY 09</i>	<i>FY 10</i>	<i>FY 11</i>	<i>FY 09 –FY 11 Change</i>
Southbury	\$997	\$972	\$987	1% decrease
West Regional Centers	\$737	\$788	\$779	5.6% increase
North Regional Centers	\$949	\$911	\$1,000	5.3% increase
South Regional Centers	\$1,221	\$1,223	\$1,362	11.5% increase
West Group Homes	\$710	\$789	\$792	11.5% increase
North Group Homes	\$800	\$785	\$833	4.1% increase
South Group Homes	\$857	\$815	\$844	1.5% decrease

Source: OSC transmittals to DAS

Reimbursement by Medicaid

The Department of Social Services, as the state’s Medicaid agency, bills the Centers for Medicare and Medicaid Services on a quarterly basis for allowable costs for services for clients in ICFs/MR and for clients under the comprehensive HCBS waiver. While the above costs per diem set by the OSC provides a cap or ceiling for public settings, a lower amount is set by DSS as allowable in its Medicaid reimbursement system.

One of the rate-setting study conclusions was that the future reimbursement of Medicaid services may be in question with the current state patchwork payment system. However, thus far the state continues to receive 50 percent reimbursement for the waived services billed by DSS, and DDS believes that as long as it taking steps to address the rate structure issues, state Medicaid waiver funding will not be in jeopardy. It is important to note that what is billed to Medicaid includes some of the costs for allowable services including employee benefits and allowable expenses for services provided by agencies through the statewide cost allocation plan (SWCAP, e.g., such services as the attorney general’s office review of contracts, DAS’ billing and collection services, and the like).

Residential costs. The costs of billed residential services to all DDS clients are 50 percent reimbursable by Medicaid, as long as the client is Medicaid-eligible. The costs, calculations, and the billing processes differ, as has been discussed throughout this report. The clients in ICFs/MR have the full cost of their care covered, including room and board, but the clients receive only a modest personal needs allowance each month. The clients in the CLA waiver homes are billed for room and board costs from their financial assistance or earnings, while Medicaid pays for half of the program (waiver services) costs.

The Department of Social Services bills Medicaid quarterly to receive the state federal reimbursement. PRI staff obtained from DSS Medicaid FY 10 billing information for all DDS clients in 24-hour residential settings, and Table I-4 includes a breakdown of the residential care costs (pre-reimbursement) by the four residential components.

Table I-4. Medicaid Billing for Residential Care FY 10.			
<i>Facility</i>	<i>Number of clients</i>	<i>Total billed to Medicaid</i>	<i>Average Medicaid billing per client</i>
Public ICFs/MR --includes Southbury and regional centers	684	\$215,245,809	\$314,687
Private ICF/MR	355	\$55,929,432	\$157,548
Public CLA	447	\$120,039,049	\$268,544
Private CLA	2,901	\$354,929,324	\$122,347
Total	4,387	\$747,143,614	\$170,309
Source: DSS Medicaid Data			

The figures in the table show the differences in what Medicaid is being billed in costs for residential services depending on the setting in which a DDS client is living. The cost of a public setting is on average about twice as much as a private facility or home. It is worth noting again that room and board costs are not a covered service for CLAs, only in the ICFs/MR. Therefore, the cost differential is even more dramatic, when the average cost per-client in a private ICF/MR is almost \$100,000 less than a public CLA, with room and board not included.

Other Medicaid costs. PRI had hoped to obtain all health care costs for the clients in the study so that committee staff could compare whether a type of setting might have had an impact on either the incidence or costs of the clients' other health care services. However, the data were not fully available to do that in any meaningful way. This is because the vast majority of DDS clients are dually eligible for both Medicare and Medicaid, and wherever a service is covered by Medicare, that program is billed first. Therefore, services like inpatient hospital stays, most prescription drugs, and many outpatient services are all covered Medicare services, and neither the incidence or costs of service is available.⁵

PRI staff was able to obtain Medicaid costs for the DDS clients in 24-hour care. In summary:

- total “other Medicaid reimbursement” was \$23.3 million;
- pharmacy costs was the largest single expenditure at \$7.85 million (this would be for drugs not covered under Medicare Part D);
- the next largest expenditures were for durable medical equipment at \$3.38 million, followed by home health agencies totaling \$2.93 million; and
- inpatient hospital stays had total expenditures of \$1.72 million for only 113 stays, demonstrating that most inpatient coverage for this population would be billed through Medicare, and not Medicaid

⁵ Under the 2010 federal Patient Protection and Affordable Care Act, CMS is moving toward more coordinated data systems, and Connecticut DSS has received a grant to further this effort at the state level, but currently the Medicare data are not available.

Chapter II

Client Demographics and Types of Residential and Day/Work Programs

DDS clients receiving 24-hour residential care can live in a variety of different settings as described in Chapter I. The program review committee obtained data from DDS that captures demographic and other information about clients who live in 24-hour residential care. The database contained information on 4,449 clients. This chapter provides a demographic snapshot of these clients as of June 30, 2010, and provides information on an assessment tool that assists in allocating resources based on a client’s level of need.

Client gender. Of the 4,449 clients in the DDS database, gender was identified for 4,445 clients. Almost 60 percent of the clients in 24-hour care are males. As Table II-1 shows, there were 1,847 females and 2,602 males among the three DDS regions. The West Region, which includes Southbury Training School, serves the greatest percentage of clients (39 percent) who receive 24-hour residential care.

Table II-1. Client Gender by Region (N=4,445)			
<i>Region</i>	<i>Female</i>	<i>Male</i>	<i>Total</i>
North	593	850	1,443
South	536	712	1,248
West	715	1039	1,754
Total	1,847	2,602	4,445
Region was not specified for 4 clients.			
Source: PRI staff analysis of DDS eCAMRIS database			

Client age. Table II-2 shows a breakout by age category of the DDS population included in the PRI study. Most of the individuals receiving 24-hour residential care fall either into the 45-64 age group or the 21-44 age group. Although the average life expectancy for individuals with intellectual disabilities is still lower than for the general U.S. population, there has been significant increase since the 1970s. As with the general population, health and medical needs will likely become more complex as clients with intellectual disabilities age and they will most likely need additional DDS services and supports.

Table II-2. DDS Clients Residing in 24-Hour Residential Settings (N=4,449)		
<i>Age Group</i>	<i>Number</i>	<i>Percent</i>
Age 0-20	106	2%
Age 21-44	1,386	31%
Age 45-64	2,331	53%
Age 65-74	443	10%
Age 75+	193	4%
Total	4,448	100%
Source: PRI staff analysis of DDS eCAMRIS database.		

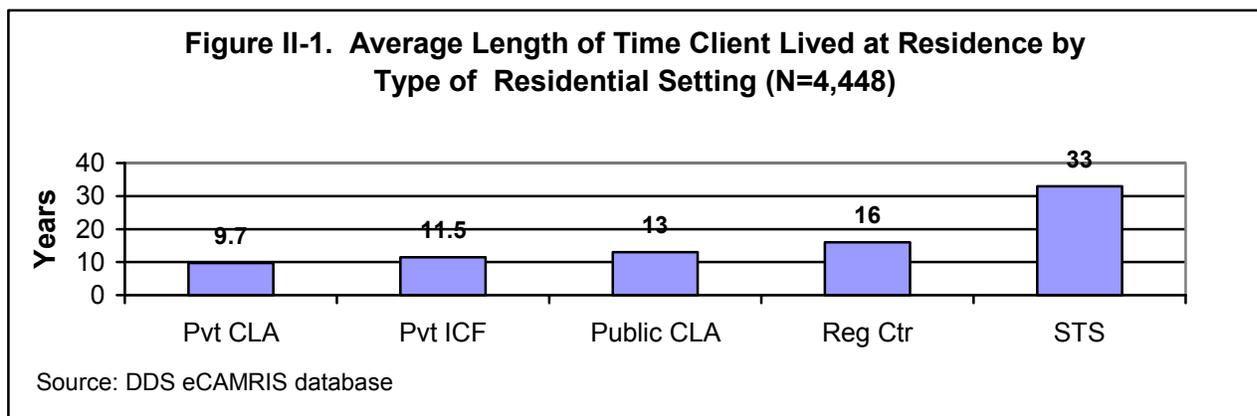
Clients by type of residence and region. Table II-3 shows the number of clients by type of residential setting and region. Seventy-four percent of clients reside in privately staffed CLAs or ICFs/MR, while the other quarter live in public CLAs, at STS, or in one of the five regional centers that provide 24-hour residential services. The North Region has the most clients

at publicly-staffed CLAs, perhaps influenced by the closing of Mansfield Training School in the early 1990s and the need to quickly develop housing capacity in the community, as well as to transfer staff who had been employed at the Mansfield facility. The fewest number of clients living in publicly-staffed CLAs are in the West Region. There are only three public CLAs in that region, and a larger number of clients reside either at STS or in one of its three regional centers.

<i>Type of Residence</i>	<i>North</i>	<i>South</i>	<i>West</i>	<i>Total</i>
Publicly-Staffed Settings				
CLA (N=70)	232	178	43	453
Regional Center (N=5)	59	31	146	236
STS	-	-	450	450
Subtotal	291	209	639	1,139
Privately-Staffed Settings				
CLA (N=731)	1046	962	937	2,945
ICF/MR (N=69)	106	77	178	361
Subtotal	1,152	1,039	1,115	3,306
Total – All Settings	1,443	1,248	1,754	4,445

Region was not specified for 4 clients.
Source: PRI staff analysis of DDS eCAMRIS database

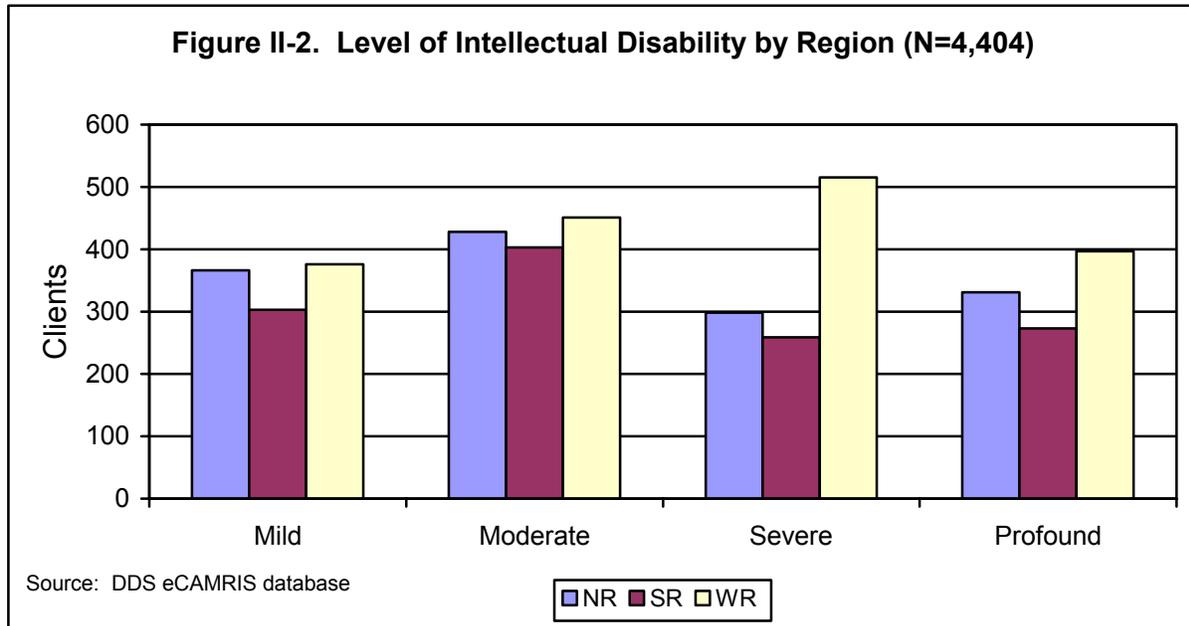
Length of time in residential setting. On average, the 4,448 clients receiving 24-hour residential care had resided at the facility or home for 13 years. Figure II-1 shows the average length of time that clients have lived at a specific type of residence. As the figure shows, the average number of years that clients have lived at STS is 33 years, followed by 16 years at a regional center.



Classification of intellectual disability. A person with an intellectual disability considered significantly subaverage based on general intelligence tests, and associated features, is eligible for DDS services. Intellectual disability levels are categorized by level of severity. The PRI committee examined the levels of intellectual disability among DDS clients in 24-hour residential care, and found the distribution was fairly even, with 1,048 people identified at a mild level, 1,238 moderate, 1,001 severe, and 1,072 profound. The remainder (45 individuals) did not have a specific identification but were eligible for DDS services for other reasons, such as they

were grandfathered in for services or had another condition, such as Prader-Willi syndrome, that makes individuals statutorily eligible for services.

Figure II-2 shows the number of clients in 24-hour residential care in each region by level of intellectual disability. The West Region had the greatest number of clients in 24-hour residential care among the three regions, and also the greatest percentage (88 percent) with a diagnosis of severe or profound intellectual disability. While it is not entirely clear why this region has such a high percentage, the most likely explanation is that the region has a greater percent of ICFs/MR— both private and public ICFs/MR typically care for more involved clients.



The committee also examined the level of intellectual disability among clients by the type of setting in which they resided. Table II-4 shows the total number of diagnosed clients in each setting and in the parentheses, the percent of clients *within* each type of setting with a severe or profound level. Of the 4,449 clients, 2,073 clients (47 percent) had a severe or profound intellectual disability. The North and South regional centers had the greatest percentage of clients diagnosed with either severe or profound intellectual disability (90 percent and 87 percent respectively), followed by STS.

<i>Region</i>	<i>Public CLA</i>	<i>Private CLA</i>	<i>Private ICF/MR</i>	<i>Regional Centers</i>	<i>STS</i>
North	232 (53%)	1,028 (37%)	106 (64%)	59 (90%)	-
South	178 (66%)	962 (37%)	77 (66%)	30 (40%)	-
West	43 (51%)	937 (32%)	178 (58%)	146 (87%)	450 (79%)
Total	453 (58%)	2,949 (35%)	361 (62%)	236 (72%)	450 (79%)

Source: PRI staff analysis of DDS eCAMRIS database

Level of Need Assessment for DDS Clients

Each client that receives DDS-funded services must have a level of need assessment. A client's DDS case manager uses a 15-page standardized assessment and screening tool, called the Connecticut Level of Need Assessment and Screening Tool (LON), to determine each client's level of need for supports and services. The LON tool examines a number of potential need areas including:

- health and medical;
- personal care activities;
- daily living activities;
- behavioral and mental health;
- safety;
- support for waking hours;
- overnight support;
- comprehension and understanding;
- communication;
- transportation;
- social life, recreation, and community activities; and
- unpaid caregiver support.

The LON, a web-based data application, generates a profile made up of a score in each of the areas cited above and produces two composite LON scores - one for residential services and the other for day/work services. Individual scores and the composite score range from "1" indicating a low level of need to "8" being the highest level of need. It is updated annually or upon a change in the client's life or situation. In 2009, administration of an annual LON assessment was discontinued for DDS clients residing in private ICFs/MR as part of budget reductions that eliminated public case managers for clients residing in this type of setting.

Funding caps. In 2006, DDS adopted separate funding guidelines for residential services (provided either in-home or out-of home) and for day/work programs. However the guidelines only apply to clients residing in private CLAs or attending private day/work programs. Furthermore, because the LON was introduced within the last five years, clients who had been receiving services prior to adoption of these funding guidelines did not have funding reallocated, regardless of their LON score. The guidelines are being used for new clients coming into the DDS system; transitioning from a home setting to a residential placement; moving from one residential placement to another; or because he or she has had a significant change in condition. For these clients, once an LON assessment is completed, the regional team uses the funding guidelines to assist in determining the resources needed to meet his or her needs. The funding guidelines for day/work programs are discussed separately later in the chapter.

Residential level of need range. The Department of Developmental Services first implemented the LON in 2006, in order to better link a client's health and safety needs to the financial services and supports that are needed. The results of a client's LON assist the regional

team responsible for determining the amount of resources that should be allocated for residential services and supports to corresponding funding limits based on level of need ranges: Minimum, Moderate, and Comprehensive (Table II-5).

Table II-5. Residential Level of Need: Services and Supports	
<i>Composite Score</i>	<i>Level of Need</i>
1 or 2	Minimum
3 or 4	Moderate
5, 6, or 7	Comprehensive
8	Allocation based on individual support needs
Source: DDS, <i>CT Level of Need and Screening Tool</i> , Powerpoint presentation, May 5, 2009, p. 6	

Residential funding guidelines. Table II-6 shows the LON score, need classification, and funding caps by approval authority. Sometimes the regional team resource allocation calculation shows an individual needs even greater services (due to intensive medical, physical and/or behavioral conditions and/or insufficient availability or natural supports are unavailable and a residential placement is needed) than the initial range (shown in the third column of Table II-6). In these cases, the regional team can only recommend higher funding up to a certain level (shown in the fourth column), even if the services and supports needed are higher.

Table II-6. FY 10 Funding Guidelines for Private Residential CLA Services and Supports				
<i>LON Score</i>	<i>Classification</i>	<i>Reg. Team Approval</i>	<i>Reg. Director Approval</i>	<i>Reg. Director Approval for CLA</i>
1-2	Minimum	\$27,000	\$33,000	N/A
3-4	Moderate	\$60,000	\$69,000	N/A
5-7	Comprehensive	\$93,000	\$98,000	\$139,000
8	Individual Program Budget	N/A	N/A	N/A
Funding caps do not include room and board costs.				
Source: DDS				

When the team recommends residential funding that exceeds its approval authority, a funding recommendation is forwarded to the regional director. He or she has three choices:

- the director can approve the regional team’s recommendation; or
- using discretion, if the client requires placement in a CLA and has comprehensive needs, the director can exceed the regional team’s recommendation slightly although the director’s authority is still limited (fifth column); or
- if the director believes the need exists, and the client’s health and safety would be jeopardized, the director can forward a recommendation to the regional Utilization Review Team at the regional office for approval of a higher funding level.

Utilization resource review (UR). Each DDS region has a utilization resource review committee made up of the region’s three assistant directors, the regional team manager, and the directors of clinical services, health services, and quality improvement. If a client’s health and safety needs

exceed the LON approved funding caps, a request for additional services and support may be submitted to the utilization review committee. The committee reviews all requests for intensive staffing in DDS funded, operated, or licensed services. If a client’s need for intensive staffing support is because of behavioral reasons and is expected to exceed six months, the request must be presented to a regional UR team.

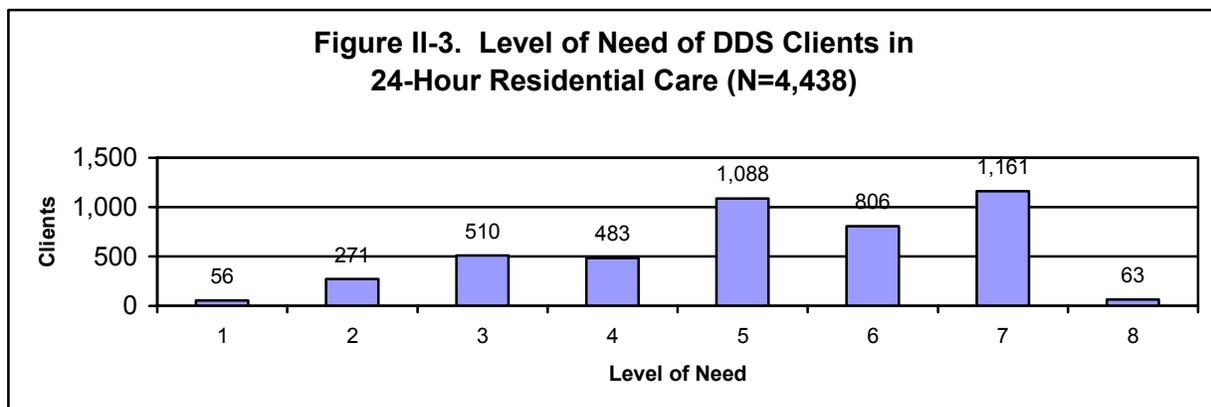
Date of last LON. The PRI committee examined the date in which clients had had their latest LON assessment by residential setting. Table II-7 shows that 86 percent of clients had their latest assessment in FY 10; 13 percent in FY 09; and 15 clients had an assessment in FY 08.

<i>Residential Setting</i>	<i>FY 08</i>	<i>FY 09</i>	<i>FY 10</i>	<i>Total</i>
Public CLA	0	13	440	453
Regional Centers	0	8	228	236
STS	1	44	405	450
Private CLA	10	188	2,741	2,939
Private ICF/MR	4	342	15	361
Total	15	595	3,829	4,439

Source: DDS eCAMRIS database

Level of need for DDS clients in 24-hour residential care. Figure II-3 shows the composite level of need score for residential services for the 4,438 clients with a completed assessment (“1” = least need; “8” = greatest need) as of June 30, 2010. As the figure shows, the most prevalent level of need is “7” accounting for 1,161 or slightly more than one-quarter of all clients. Furthermore, 69 percent of DDS clients in 24-hour residential placements had a level of need of “5” or higher for residential services, an indication that a comprehensive package of services will be needed to support the client and therefore, a significant commitment of financial resources required.

It is important to note that the levels of need shown in the figure are likely not indicative of the entire DDS client population. Individuals with lower levels of need may still be receiving services from DDS but are living with family or residing in supported living arrangements that do not require 24-hour residential services, and would not be reflected in the PRI study population.



In addition, it is possible that clients with lower LON scores included in the figure would not be living in 24-hour residential settings if those placements were made today. However, pre-institutionalization, the 24-hour institutional model was the preferred placement for most intellectually disabled clients who did not reside with their families. When deinstitutionalization occurred decades ago, clients were placed in CLAs, because that was the type of community model developed by the state.

Correlation between diagnosis and level of need. Table II-8 shows the level of need by client diagnosis. The committee also examined whether there is a relationship between the level of intellectual disability and the assessed level of need. Possible correlation can range from -1.0, showing a strong negative correlation to +1.0, showing a strong positive correlation. A strong correlation (either negative or positive) means there is a close relationship between the two measures analyzed, but the cause of that relationship is not identified. There was a correlation of .44, indicating a moderate correlation.

Table II-8. Number of Clients by LON and Level of Intellectual Disability (N=4,438)					
<i>Level of Need</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Profound</i>	<i>Total</i>
1	27	25	0	2	56
2	101	117	8	40	271
3	214	190	22	75	510
4	195	186	17	77	483
5	213	364	197	306	1,088
6	165	222	175	234	806
7	113	161	640	245	1,161
8	14	17	12	20	63
Total	1,042	1,282	1,071	999	4,438

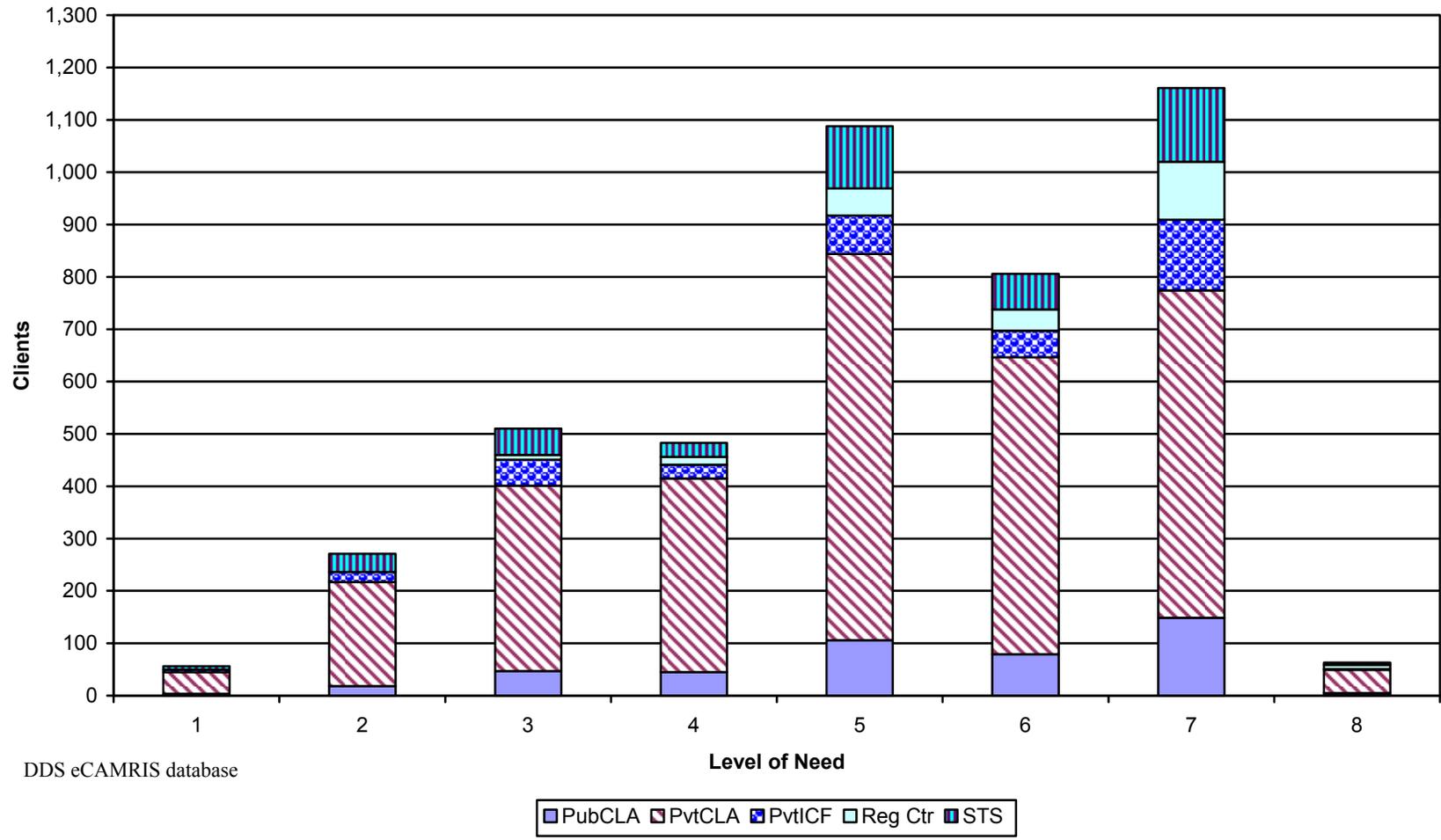
Source: PRI staff analysis of DDS eCAMRIS database

Level of need by provider type. Figure II-4 shows the level of client need by provider type. As shown in the figure, private CLAs is the largest provider category of residential services for all levels of need. Private CLAs serve 66 percent of all clients receiving residential care, and 62 percent of clients with LONs of 5 or higher. Even at the highest LON of 8, private CLAs serve 70 percent of DDS clients receiving 24-residential services who are assessed at that level.

The PRI committee also compared the proportion of clients with a residential level of need of 5 or higher to total clients within each type of residential setting (shown in Table II-9). The table shows most clients (90 percent) residing at a regional center have a LON of 5 or higher, followed by clients residing at public CLAs and STS.

Even at the highest levels of need (7 or 8), the regional centers serve the greatest number of such clients relative to the total number of clients living in that particular residential setting, and private ICFs/MR are the second most frequent provider (Table II-10). While private CLAs serve the largest number of clients with LONs of 7 or 8, the concentration of those high-LON clients is low relative to the number of private CLA beds, with less than 25 percent of the private CLA clients with a 7 or 8 LON.

Figure II-4. Type of Residential Setting by Level of Need



<i>Residential Setting</i>	<i>Number of Clients with LON of 5 or Greater</i>	<i>% of Total Clients in that Type of Residential Setting</i>
Private CLA	1,974	67%
Public CLA	339	75%
STS	332	74%
Private ICF/MR	261	72%
Regional Center	212	90%
Total	3,118	70% (of all DDS clients have LON ≥ 5)

Source: PRI staff analysis of DDS eCAMRIS database

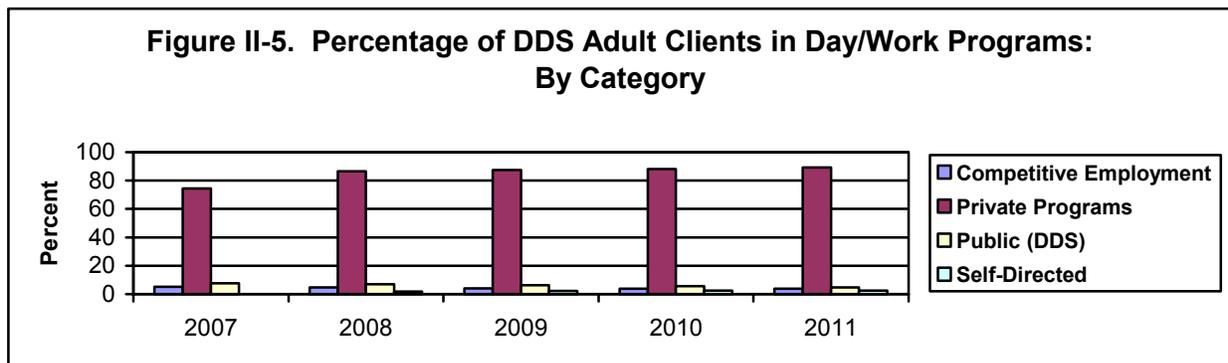
<i>Residential Setting</i>	<i>Number of Clients</i>	<i>% of Total Clients in that Type of Residence</i>
Private CLA	669	23%
Public CLA	154	34%
STS	145	32%
Private ICF/MR	137	38%
Regional Center	119	50%
Total	1,224	28% (of all DDS clients have LON ≥ 7)

Source: PRI staff analysis of DDS eCAMRIS database

Day/Work Programs for All DDS Clients

As with residential care, Connecticut has a dual provider system with day/work programs provided either directly by DDS or through contracts with private providers. Almost all of the DDS clients who received 24-hour residential services also received day/work program services in FY 10. In addition, many DDS clients that did not receive 24-hour residential services but lived at home with family or in supported living arrangements, also participated in day/work programs in FY 10.

Day/work program attendance trend. Overall, a large majority of DDS clients participate in day or work programs that are operated by private providers and the trend is increasing. Although this chapter provides information on the day/work programs for the clients who were the focus of the PRI study (i.e., receive 24-hour residential care), Figure II-5 shows there were 9,912 total DDS clients attending day/work programs and the trends in employment for all clients are shown.



The figure shows the percentage of participants in categories of day and work programs. As depicted, of the 9,912 clients receiving day/work services currently, almost 90 percent participate in privately operated programs, while fewer than 5 percent are in DDS programs. While difficult to detect on the graph, a trend that is of concern is that the percentage of clients who are competitively employed declined from 5.1 percent in 2007 to only 3.7 percent in 2011, perhaps a reflection of the job losses in this economic recession.⁶

Day/Work Programs for DDS Clients Also Receiving 24-hour Residential Services

For persons who receive 24-hour residential services, the PRI committee examined the day/work programs for 4,119 people for whom there was data on the specific type of day or work program they attended, and found the four most commonly used programs are:

- **Day support options** – provide supports to participants that lead to acquisition, improvement, and/or retention of skills and abilities to prepare a participant for work and/or community participation. *Of the 4,119 clients, 2,603 (63 percent) were in this type of program.*
- **Group supported employment** – a competitive employment situation in which a group of participants are working at a particular setting with some supervision and supports. Participants may be dispersed throughout the worksite among workers without disabilities; congregated as a group in one part of a worksite; or part of a mobile work crew. *Almost 29 percent of the clients (1,185) participated in this type of program.*
- **Sheltered workshop** – work is located at a segregated, supervised setting where the participant produces a good or performs a service under contract to third parties, and where the participant is paid a wage commensurate with workers who do not have a disability, and according to federal and state labor departments’ regulations. *This was the third most common day/work programs for clients in the PRI study – 178 (4 percent) of the 4,119 clients participated. (Eighty-six of the 178 participants (almost half) had LONs of 3 or below, suggesting that a segregated work environment might not be necessary, based on level of need.*
- **Local Education Authorities (LEAs)** – a small number of DDS clients who are in 24-hour residential care are under age 21, and the client’s local school district is responsible for their education or training program until they reach age 21. *Of the 4,119 clients, 153(4 percent) were within the LEA category for their day or training programs.*

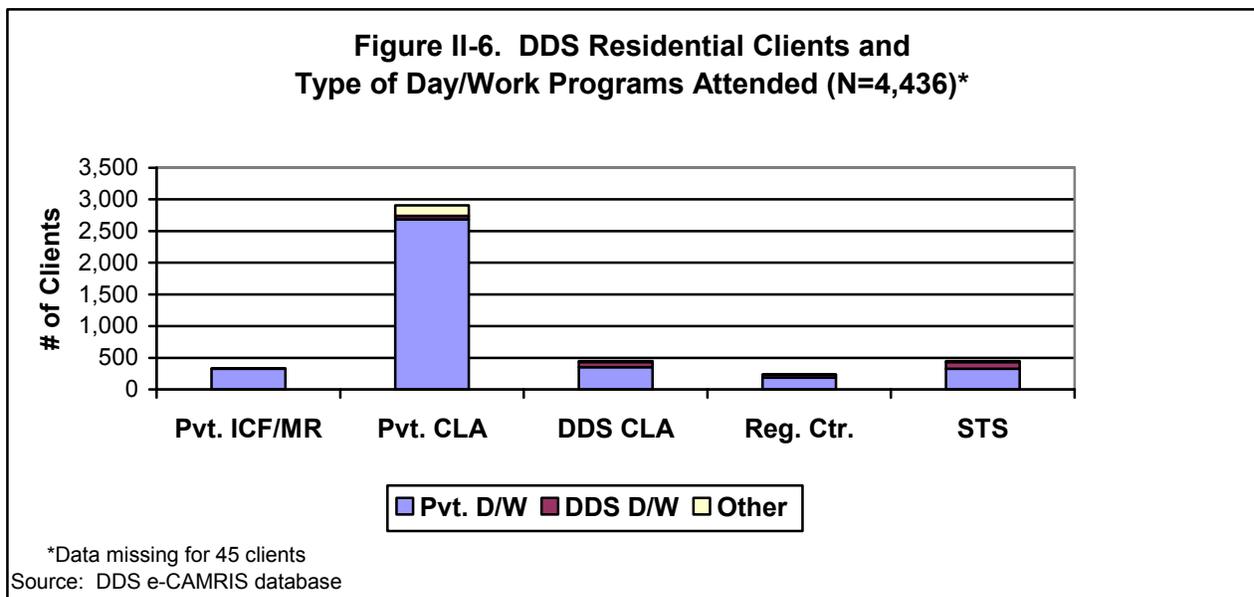
Type of day/work service provider. Figure II-6 shows, as of June 30, 2010, the majority of residential clients, regardless of the setting in which they resided, received their day/work

⁶ Competitive employment is defined as an individual who is employed and supervised directly by the employer and is paid prevailing wage. Minimal or no ongoing employment supports are provided through DDS.

program from private providers. For persons living in public DDS settings, about 84 percent of the 513 clients who lived in public CLAs attended private day/work programs, with about 16 percent attending public day/work/programs. Most (79 percent) of the 236 clients residing at regional centers also attended private day/work programs. Only at STS do a majority of persons living there also receive publicly-provided day/work services—from STS itself. About 25 percent of persons living at STS attend private day/work programs off campus.

For persons living in private residential settings, virtually all who participate in day/work programs attend privately-provided services. Less than two percent of persons living at private CLAs attended a public day/work program in FY 10.

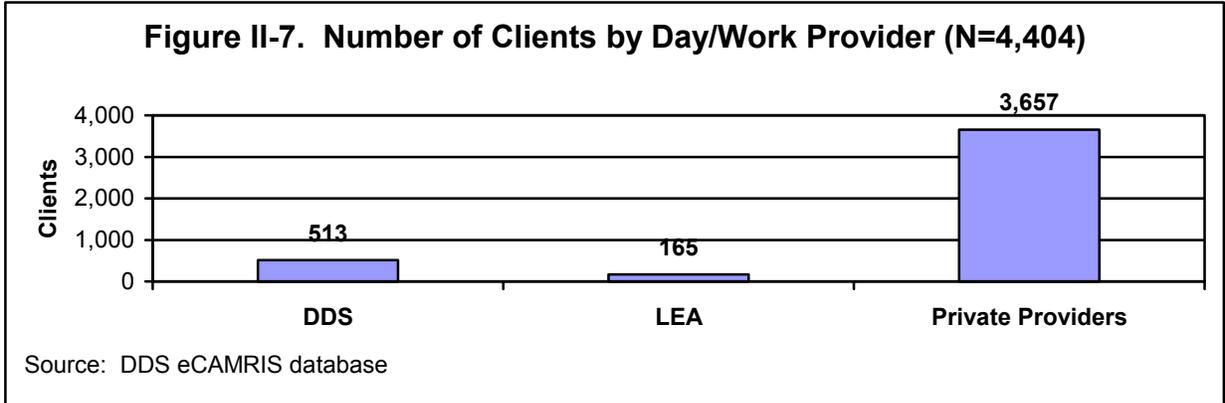
There were 68 clients across all residential settings who did not have a day/work program, either because they were retired or opted out for another reason.



Day/work service providers. There were 180 providers of day/work services to clients receiving 24-hour residential care. Of these:

- 119 were private providers;
- 61 were Local Education Authorities (LEAs), of which 58 were public school districts and 3 were regional education service centers; and
- DDS was the state public provider.

Figure II-7 shows the number of clients served by each type of day/work provider.



Day/work program funding caps. As noted above, a separate composite LON score is generated for clients related to his or her day/work program. There are separate funding guidelines for day/work programs based on the composite score or if the LON assessment generates a behavior score that is higher than the composite score. The recommended funding caps are shown in Table II-11 and range from \$11,286 for a LON score of “1” to \$28,215 for a LON score of “8.”

Table II-11. Funding Guidelines for Day/Work Programs.

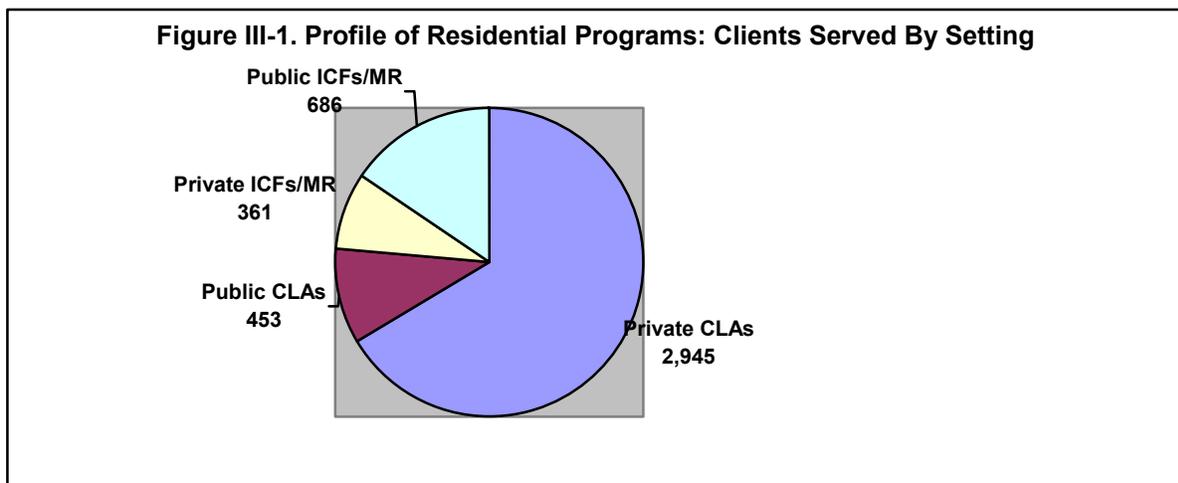
<i>LON Overall Day Score or Behavior Score (whichever is higher)</i>	<i>Recommended Maximum Based on 225 Days</i>
1	\$11,286
2	\$15,048
3	\$18,810
4	\$20,691
5	\$22,572
6	\$24,453
7	\$26,334
8	\$28,215

Source: DDS

Profile of Private Providers

Most residential programs for DDS clients in Connecticut are operated by private providers. The map on page 24 shows the number of 24-hour residential facilities (ICFs/MR and group homes) by region, and whether they are public or private. The public facilities are Southbury Training School and the five regional centers, which are all designated intermediate care facilities. There are only 70 public homes in the community, and none of them are designated as ICFs/MR. Community group homes are predominately operated by private providers -- about 800 homes are private, and 731 of the homes are CLAs, and 69 are larger ICFs/MR.

Figure III-1 shows the profile of community residential services by where the DDS clients are living. The figure shows that almost three-quarters of the 4,445 clients in 24-hour residential care are in private settings while just over 25 percent are either in public ICFs/MR or in a public CLA. Further, no public facility is accepting new residents, thus the private provision of residential services will only expand.



Private Providers. There are currently 79 different private providers operating residential programs. The majority (65) operate only community living arrangements (i.e., group homes), while 12 have both ICFs/MR and CLAs. Two providers operate just ICFs/MR.

There is a wide variation in the number of homes operated by the different providers, as shown in Table III-1. There are 12 very small providers, each operating only one residence. On the other hand there are 7 larger agencies operating more than 20 homes, including the state's largest private provider, Connecticut Institute for the Blind (CIB), which operates 78 homes. As the table indicates, 34 of the 79 providers (43 percent) operate five or fewer homes. At the other end of the provider network are 8 providers that operate 21 or more homes.

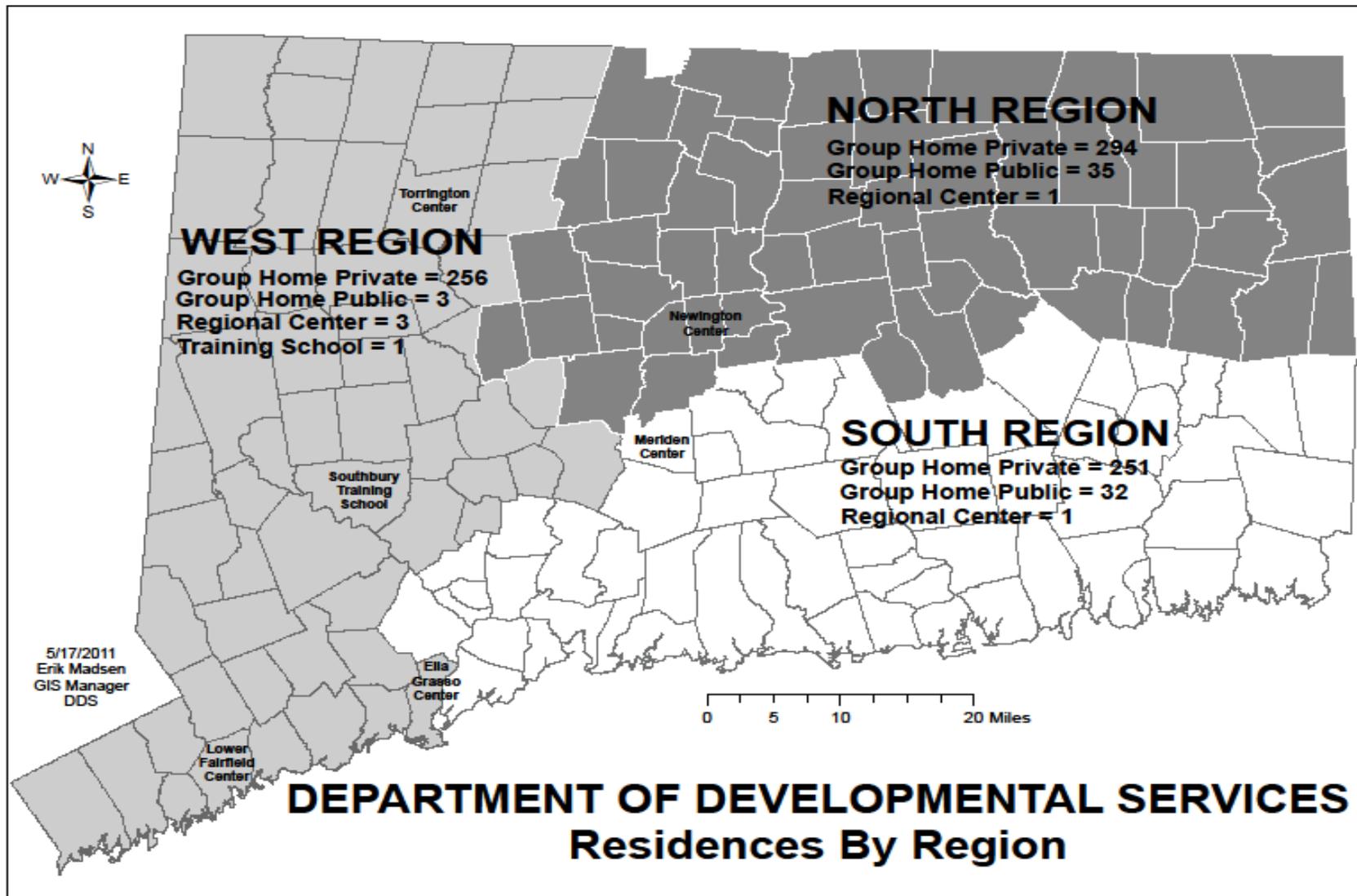


Table III-1. Categories of Private Providers by Number of Homes		
<i>Number of homes (ICFs/MR and CLAs)</i>	<i># of providers N=79</i>	<i># in each category unionized N=16</i>
One home	12	1
2-5	23	2
6-10	19	4
11-20	17	5
21-50	7	3
51+	1	1
Source: DDS and DSS data		

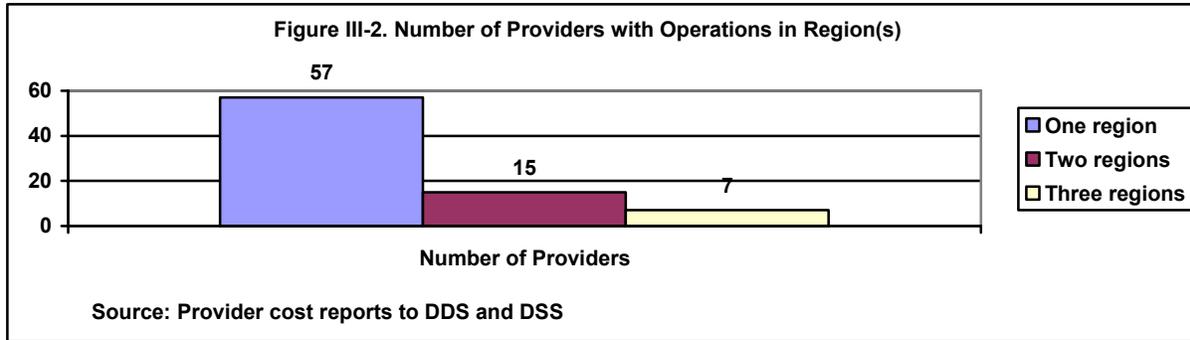
Private provider staffing. Residential programs of course require staffing whenever clients are at home. For some that is 24 hours, 7 days a week, while others may not require staffing during the day while clients are at work or another day program. Detailed analysis and comparison of staffing levels at the provider level and how those impact costs is provided in Chapter IV. However, in general terms the number of staff employed (regardless of the type of positions), varies dramatically – from fewer than 10 staff at a one-home provider – to more than 1,000 employees at Connecticut Institute for the Blind, the largest private provider.

Only 16 (or about 20 percent) of the private providers have unionized employees. However, because a greater number of larger providers are unionized (4 of the 8 providers with 21 or more homes), the percentage of unionized staff compared to all staff is likely to be much higher. Further information and analysis concerning unionization and the cost of care is contained in Chapter IV.

Organization and management location. The vast majority of private residential service providers are nonprofits – only 7 of the 79 operate as for-profit companies. Similarly, almost all – 72 of the 79 CLA providers – have their management located in Connecticut. Only seven have home offices located in other states – New York (1); Massachusetts (3); Pennsylvania (2); and New Jersey (1).

Many providers started as small organizations providing services locally in their communities, and many still operate like that. The graph below shows the number of providers that operate in one, two or all three regions. As the graph shows, more than 70 percent operate in only one of the three regions. Of course, with consolidation of regions over the years from six to the current three, it is more likely now that providers will operate in only one region. However, only seven providers have residential services in all three regions.

Revenue and profitability. Whether a for-profit or nonprofit, all providers must file an annual cost report for the prior state fiscal year on October 15 with both the Departments of Developmental Services and Social Services. (In times when state budgets permit, the data in the cost reports are used by a consultant under contract to establish rates – a full-service rate for ICFs/MR and the room and board rate for community living arrangements. In recent years, private providers have received no increase in either of these overall rates.)



The data contained in the cost reports is also used to assess how healthy a provider is financially. PRI staff used the data reported in the cost reports for 2009 and 2010 in the summary of profit and loss by provider; some of the results are reported in Table III-2 and III-3 below. The first table shows the profile of providers by revenue (total operating revenue), and the second table shows the net excess (profit) or deficiency (loss).

Table III-2 Profile of Private Residential Providers by Total Operating Revenue		
<i>Category of Revenue</i>	<i>Number of Providers (2009) N=79</i>	<i>Number of Providers (2010) N=79</i>
Less than \$1 million	6	5
\$1-\$5 million	24	24
\$5-\$10 million	21	22
\$10 -\$20 million	16	17
\$20-\$35 million	6	4
\$35-\$100 million	3	4
\$100 million +	3	3

Source: CJLC database with DDS cost report data, 2009 and 2010

As the first table shows, there are few providers on either end of the revenue spectrum, with only five providers in FY 10 with less than \$1 million in revenues and only three providers with \$100 million or greater in annual revenues. Forty-six providers, or 58 percent, have revenues in FY 10 that ranged from \$1 to \$10 million.

Table III-3. Profile of DDS Residential Providers by Net "Profit" or Loss		
<i>% profit/loss</i>	<i>Number of Providers (2009) N=79</i>	<i>Number of Providers (2010) N=79</i>
- 5% or greater (loss)	4	3
-1 to -5% (loss)	20	10
-0 to -1% loss	12	17
0 to 1% profit	23	19
1 to 5% profit	18	26
5% or greater profit	2	4

Source: CJLC database with DDS cost report data, 2009 and 2010

As Table III-3 indicates, in terms of financial stability, the most basic measure in the cost reports (operating revenues minus operating expenses) shows that most providers barely meet expenses, and in fact, 36 of the 79 providers (46 percent) showed an operating loss in FY 09. While the fiscal environment improved slightly in FY 10, still 30 of the 79 providers showed a loss in their cost reporting. This is a very gross measure of financial stability, and does not take

into account assets, reserves, or other factors that can influence a provider’s fiscal strength, but the measure does seem to show on an annual basis how tight the agencies’ budgets are.

Unlike nonprofit hospitals in Connecticut, which are annually assessed by the Office of Health Care Access (now part of DPH) for financial health using a variety of measures, nonprofit agencies providing human services are not regularly evaluated for this purpose. The Commission on Nonprofit Health and Human Services, in its March 2011 report, used a number of more complex financial tests that assessed all human service nonprofit agencies contracting with the state (not just DDS), and a more detailed discussion of these tests and findings are included in Appendix B. The commission concluded “that a large percentage of the Connecticut’s nonprofit providers are in a financially precarious position, operating dangerously close to their margin and likely would not be able to maintain operations if they experienced unforeseen increases in expenses or financially detrimental incident”.⁷

Executive salaries. One of the specific costs that must be itemized by each provider agency as part of the cost report is the salary of its Executive Director, if the salary exceeds \$100,000. Since 1991, the statutes limit the amount an executive director can be paid by state human service agencies as part of a grant or reimbursement for allowable costs. From 1991 to 2007, that allowable amount was \$75,000. In 2007, P.A. 07-238 increased the amount to \$100,000 (and was to increase with any cost-of-living adjustments provided in any state contracts with the agencies).

PRI staff reviewed the cost reports for 75 private CLA service providers on file at DDS, and the executive director salary results are shown in Table III-4 below. Forty of the providers (53%) included the form that is required if the director’s salary exceeded \$100,000 a year. In most of the cases, there were indications that the excess over the \$100,000 was being paid by fundraising or a source other than the State of Connecticut. In three cases where the salaries were substantially over the threshold, other states (e.g., New York) were paying the excess.

Table III-4. Private Provider (CLAs) Executive Director Salaries over \$100,000	
<i>Salary Category</i>	<i>Number of Providers (N=40)</i>
\$101,000 to \$110,000	12
\$111,000 to \$120,000	3
\$121,000 to \$140,000	8
\$141,000 to \$175,000	7
\$180,000 to \$200,000	5
\$201,000 and over	5
Source: FY 10 cost reports filed with DDS	

However, in several cases where there was no form filed, the agencies had large amounts paid for “management fees”. Committee staff inquired of DDS and the private contractor for rate promulgation whether this type of cost reporting is allowed or not. While apparently there is no prohibition of reporting the costs this way, and the management fees are not an “allowable” cost

⁷ Commission on Nonprofit Health and Human Services (S.A. 10-5) March 31, 2011. p. 83

for ultimate Medicaid reimbursement, it does appear to circumvent the statutory requirement for transparent reporting of an agency's executive director's salary.

The salaries overall appear to be reasonable in Connecticut. However with the New York Times articles⁸ published earlier in 2011 on exorbitant executive directors' salaries in agencies under contract with the developmental services agency in that state, efforts should be made to ensure that providers comply with the statutorily required reporting of salaries. The committee makes a recommendation to implement this in Chapter IV.

⁸ *Reaping Millions in Nonprofit Care for the Disabled*, New York Times, August 2, 2011.

Residential Care Resources and Cost Components

This chapter examines the resources allocated to residential care services in the various settings, both those operated by DDS and those in the private sector. The chapter also analyzes the compensation and benefit levels that are paid to direct care workers in the public and private sectors, based on FY 10 staffing and compensation data. The chapter additionally examines some of the contributors to higher staffing costs for DDS, such as overtime and workers' compensation, and recent trends in the component areas.

The chapter presents overall trends in the number of clients in the various residential care settings, the funding levels since FY 07, and the per client cost trends over that time. The chapter also examines the components that make up costs and compares them on a percentage basis among the various settings. While much of the analysis focuses on variation between the DDS-operated facilities and those in the private sector, there are substantial differences in costs among just the private providers, and this chapter discusses those as well.

Direct Care Staffing

A large part of the costs of residential care is the *direct care* staffing. The job classification and titles vary depending on provider, but include aides, developmental service workers, and nurses or nurse aides directly providing care or assistance to clients with their activities of daily living. For analysis and comparison of resource level and allocation, program review staff used only direct care staff assigned to a specific residential setting, and did not include any indirect care staff (e.g., therapists, nurses) with responsibilities at a regional level or assigned to multiple residential settings.

It is important to note that the numbers of homes or units may vary by setting in each analysis and may be different than other sections in the report for different reasons. This is because, for example, not all providers had costs or data in a particular field of a cost report, and in some cases the residential provider number did not match or could not be located in both staffing and client data sets. Only settings with both staffing and client data were included.

This chapter first compares the average direct care staffing levels (not the cost) in the various residential settings – public and private CLAs, and public and private ICFs/MR, and Southbury Training School – using several measures:

- total number of staff in that setting – taken from CORE-CT assigned staff to location as of July 2010;
- total number of clients living in that setting – according to the DDS e-Camris data, as of June 30, 2010 (not the number of certified beds);
- average number of full-time equivalent (FTE) staff by home or ICF/MR; and

- average direct staff-to-client ratio by home or ICF/MR (total number of direct care staff in that type of setting divided by the total number of clients)/

The results of the comparisons are contained in Table IV-1. Since private providers submit their staffing data on an FTE basis in the filed cost reports, PRI staff calculated FTEs for public settings for comparative purposes.⁹ The table results indicate that when the staffing per residential unit is measured, there are more per-unit numbers of staff assigned to the public settings --- Southbury Training School (19.2), followed by the regional centers (12.9) and the public CLAs (11.8). However, those public units also care for a greater number of clients per setting, an average of 11.3 clients in a cottage at Southbury, followed by 6.9 clients in a cottage at a regional center. The public CLAs also have more clients – 5.8 per home – than either of the private settings – ICFs/MR (5.0) or CLAs (4.4).

<i>Type of Residence</i>	<i>Total # of FTEs</i>	<i>Average Number of Staff per Home/Cottage</i>	<i>Total # of Clients</i>	<i>Average Number of Clients per Home</i>	<i>Average Direct Care Staff-to-Client Ratio</i>
Public ICFs Regional Centers N+ 5 Centers 28 units	427.2	12.9	227	6.9	1.9 to 1
Private ICFs/MR N=69	713.6	10.3	359	5.2	2.0 to 1
Public CLAs N=70	828.2	11.8	410	5.8	2.0 to 1
Private CLAs N= 647	5,788	8.9	2,830	4.4	2.0 to 1
Southbury Training School N=1 facility = 40 Units	768	19.2	450	11.3	1.7 to 1

Source: PRI staff analysis of staffing from DDS and DSS cost reports; client data from DDS e-Camris

Thus, when an average *direct care* staff-to-client ratio is calculated for all settings, the public and private facilities are much closer. In fact, as the table shows, the regional centers and STS appear to have somewhat lower resources than the other settings. What must be kept in mind, however, is that, because of the nature of the setting at regional centers and Southbury, the distinction between staffing residences and the overall facility is more blurred, and the assignment of direct care staff more fluid than it is at an individual group home. For example, at an individual CLA, there may be an LPN (or part of an FTE LPN) assigned to the home, while at Southbury Training School, there are 172.48 LPN full-time equivalents that are considered direct care, but they are not assigned to individual cottages or units. Thus, if *just* the number of LPNs were added to the number of direct care staff assigned to all residents in all the cottages at Southbury, the staff to client ratio would be about 2.1, similar to the other settings shown in Table IV-1.

Part-time staff. A component of the staffing data that was readily available in public (DDS) settings, but not in the private, was the number of part-time workers. The direct care staffing in DDS residences is heavily made up of part-time workers; thus while FTEs are one

⁹ Because DDS direct care staffing are on a 35-hour work week and most private provider staff are on 37.5 or 40 hours per week, there will be a greater number of FTEs in the public sector needed to cover the 24-hour scheduling.

measure, there are actually many more *people* working in those settings than the FTE numbers would imply. For example, in the public ICFs/MR there were 427 FTEs, but 302 persons employed full time and another 202 employed part time, translating to 504 persons employed (40 percent part time). Similarly, in the public CLAs, the FTE count was 828, but the number of people employed was actually 1,047 – 592 were full time, and 455 (43 percent) were part-time. While the heavy reliance on part-time staff may assist with coverage of hours and scheduling (PRI was unable to obtain part-time numbers for the private homes), it may add expense because of the generous benefits for state workers.¹⁰

Staffing Resources by Client Level of Need

The resource information in Table IV-1 above presented analysis of direct care staffing based on the number of clients only. PRI also examined the staffing resources allocated by client level of need, and those are shown in Table IV-2 below.

- *Average client LON score by residential setting:* Using this measure, the highest average client LON occurs at the regional center ICFs/MR, while the lowest average LON is at private CLA. Interestingly, clients in public CLAs have an average LON score of 5.42, the second-highest LON of the five settings, higher than Southbury, private ICFs/MR, or CLAs.

<i>Type of Residence</i>	<i>Average Client LON</i>	<i>Average Direct Care FTEs by setting</i>	<i>Number of Clients per-home/cottage</i>
Public ICFs Regional Centers N= 5 facilities, 28 units	6.08	12.9	6.9
Private ICFs/MR N=69	5.36	10.3	5.2
Public CLAs N=71	5.42	11.8	5.8
Private CLAs N= 647	5.03	8.9	4.4
Southbury Training School N=1 facility, 40 Units	5.24	19.2	11.3
Sources of data: Client data from e-CAMRIS, staffing data from cost reports and CORE-CT			

- *Average FTE by setting:* Comparing the average client LON with the average staff per home shows that the staffing at STS is greater than all the other settings, including the public ICFs/MR (which has the highest average client LON). However, STS has more clients per home or cottage (11.3). It is worth noting again that this analysis includes only direct care staff assigned to a particular home or cottage, and does not include those that work at a facility or in region generally.

¹⁰ The annual value of benefits for the average state employee is slightly less than \$40,000, or about 60 percent of the average state employee’s salary, according to the Office of the State Comptroller. However, for part-time workers, still eligible for benefits, the value of the benefits may exceed the monetary compensation.

Comparison of Salary Levels

The number of staff or ratio of staff-to-clients is one component of costs. The other important factor, of course, is staff compensation levels. PRI staff examined salary levels by category of workers in the private and public sector and by setting, and the analysis is presented below. Because of the great number of part-time workers in the public sector, and the tendency that this would have to artificially lessen the average annual salary, PRI staff used hourly wages for all comparisons. (For private CLAs, the annualized salaries were divided by 1,950 hours, or 37.5 hours per week.) For the public sector, the actual number of workers in that classification is given, regardless of assignment or location. Similar numbers were not available for the private providers, thus only the number of providers with salary data for direct care workers by home is provided. The analysis is presented in Table IV-3.

Table IV-3. Direct Care Staffing Salaries Comparison			
<i>Department of Developmental Services</i>			
<i>Type of Provider</i>	<i>Class or Category of Direct Care Worker</i>	<i>Average Hourly wage</i>	<i>Range</i>
DDS	Developmental Services Worker 1 N=1,331	\$24.24	\$19.34-\$26.35
DDS	Developmental Services Worker 2 N=820	\$27.79	\$21.35-\$28.75
DDS	Developmental Services Specialist N=13	\$39.11	\$29.09-\$43.21
DDS	Lead Developmental Services Worker N=183	\$31.14	\$27.47-\$31.44
DDS	Supervising Developmental Services Worker N=161	\$33.93	\$29.25-\$34.39
DDS	Licensed Practical Nurse N=200	\$28.25	\$22.95-\$31.44
<i>Private Providers</i>			
Private CLAs	Direct Care workers N=659 homes	\$15.53	\$8.24-\$27.14
Private ICFs/MR	Direct care aides/workers N=64 homes	\$15.16	\$12.32-\$30.39
Private ICFs/MR	Licensed practical nurse N=14 homes	\$24.86	\$21.22-\$31.05
Source: PRI staff analysis of staffing and client data from DDS and DSS cost reports			

As the table shows, there is a remarkable difference in the average hourly wage of direct care workers in DDS compared to those employed by private providers. For the private CLAs, the average hourly wage (\$15.53) is about one-third less than the lowest classification of direct care worker wage (\$24.24) within DDS. Private providers that operate ICFs pay an almost identical hourly wage (\$15.16) as the private CLAs, again substantially below the DDS workers.

Only in the LPN category does the hourly wage gap shrink to less than \$4.00 an hour separating the DDS LPN from the lower-paid LPN at the private ICF/MR. While the range for the LPN class is similar in both the private and public sector, the average is higher in DDS, which may be due to length of service or that wages increase more quickly within the class at DDS.

Another element regarding compensation is that as a single employer, DDS wages do not range that much in any given classification; for most about \$7.00 an hour separates the top and the bottom of the class. The exception is the developmental services specialist class (which includes only 13 employees), with about a \$14 per-hour wage range. This contrasts with the private providers where the range for direct care staff and LPNs can be from \$10 to \$20 an hour. However, there are many providers in each category as noted in Chapter III, with different levels of direct care, and unlike DDS salaries, private provider wages can be different in various parts of the state.

While the compensation level for a certain class in public service may not have a wide range, in general, longer-term public employees have more promotional opportunities to move to a higher classification level, and a higher wage, compared to private provider employees. The data to analyze length of time employed, as well as time in class, are available for the public sector but not for the private providers.

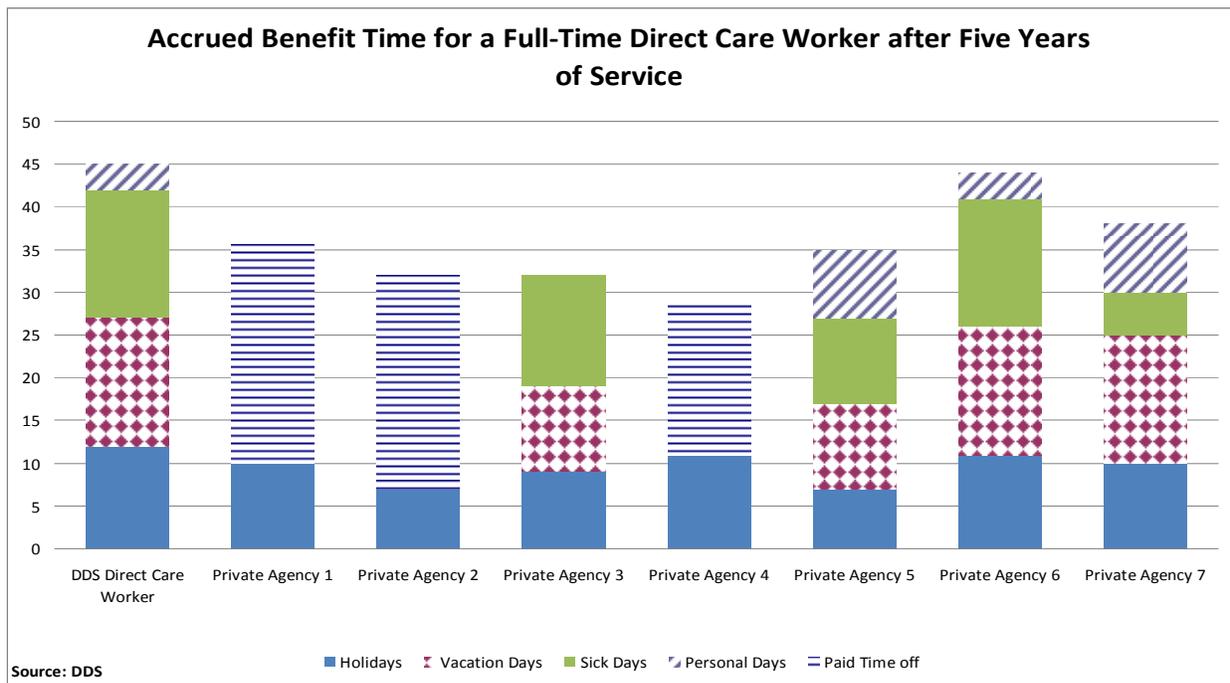
Benefits

The salary comparison shows that, even based on monetary compensation alone, there is a huge gap between the private and public sector employees who care for DDS clients. In addition to wages, there is also a substantial difference in benefit costs between DDS and its contracted private providers. As was noted earlier, the Office of the State Comptroller calculates the costs of state employees' benefits (health insurance, FICA, and retirement) at almost \$40,000 or about 60 percent of the average state employee's wage. This is a somewhat higher percentage in DDS, perhaps because of the prevalence of part-time workers who are still eligible for full benefits, as discussed earlier. Further, all employee benefit costs borne by the State of Connecticut include a significant portion to cover the unfunded liability of health and retirement costs of state retirees, which may not be considered a "benefit" to the individual employee, but is still a cost to the employer.

The same cost information DDS developed for per diem rates in FY 10 shows that the provider benefit costs for private CLAs was about \$51.4 million, which accounted for about 27 percent of the overall \$191.5 million in private provider direct care salaries. The dramatic difference in benefit costs and percentage is due to several reasons, but primarily private providers are more restrictive about an employee's eligibility for benefits, especially for costly health care. Often, only employees considered full time are eligible for health care that covers dependents and family, and even individual coverage may be limited to those who work more than half-time. As mentioned previously, DDS part-time employees are eligible for benefits, including health care.

In addition to broader eligibility standards, few employers offer the generous health care benefits the State of Connecticut does. Nationally, health care premiums for family coverage have more than doubled from 2000 to 2010, and those premiums nationwide average \$13,770. In Connecticut, the average premium for family coverage approaches \$15,000. Thus, many employees in the private sector must pay high deductibles, and/or more in premiums and co-pays, which keeps the benefit more affordable for the employer, or in some cases, the ability to offer it at all.

Other benefits. Benefits such as holidays and sick time can certainly make employment at one agency more desirable than another. While not additional expenses *per se*, they can add to costs if overtime or additional per diem costs must be used to cover for the use of the paid time off. The graph below, prepared for the Commission on Nonprofit Health and Human Services (S.A. 10-5) in early 2011, shows that DDS workers enjoy a greater number of days off after five years of service (45). However, there is not the great discrepancy in time off between DDS employees and private provider workers that there is in other areas, and the way the days can be used in DDS appears more limited. For example, 15 days for DDS workers are for sick use, while in private agency 1 and 2, the majority of days are unspecified paid days off.



Other Costs

Overtime hours and costs. It is important to note that the wages paid in the private provider homes are annualized for cost reporting and include overtime and any longevity payments or bonuses. This is not the case for DDS salaries, which do not include overtime or longevity; those costs would be in addition to the straight time wages for that classification.

DDS provided its overtime hours for the past few years and a summary is presented in Table IV-4 below. The department has gradually been bringing the number of hours of overtime down – a more than 20 percent reduction, from a high of almost 1.5 million in FY 08 to slightly less than 1.2 million in FY 11.

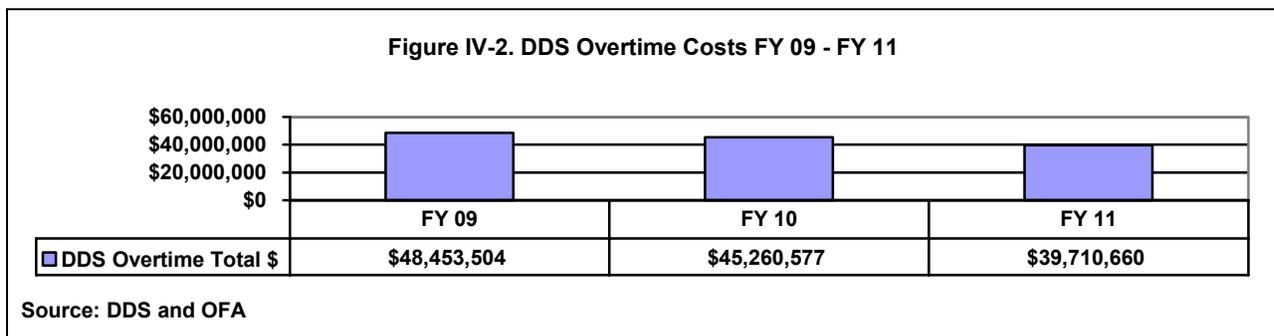
However, to put the reduction in overtime in context, PRI staff measured the trends in staffing and workload that might affect overtime. As a proxy for workload, PRI staff used the number of clients in DDS residential settings. This client number was compared with the

number of full- and part-time staff in the department (without central office) in June of each the past four years and the results are shown in the table below. While the overtime hours have decreased about 21 percent over the five year period, clients in DDS residential facilities have decreased by almost 39 percent.

At the same time, DDS staffing has decreased – but less than 7 percent in full-time staff and just over 1 percent in part-time staff. Thus, given that DDS has a decreasing number of clients in its own residential settings, and that it now provides care for less than one-quarter of all the clients in 24-hour care, the overtime hours remain high. In fact, if translated to regular working hours (conservatively 40 hours per week *52 weeks=2080 hours) the number of overtime hours equates to 558 full-time staff.

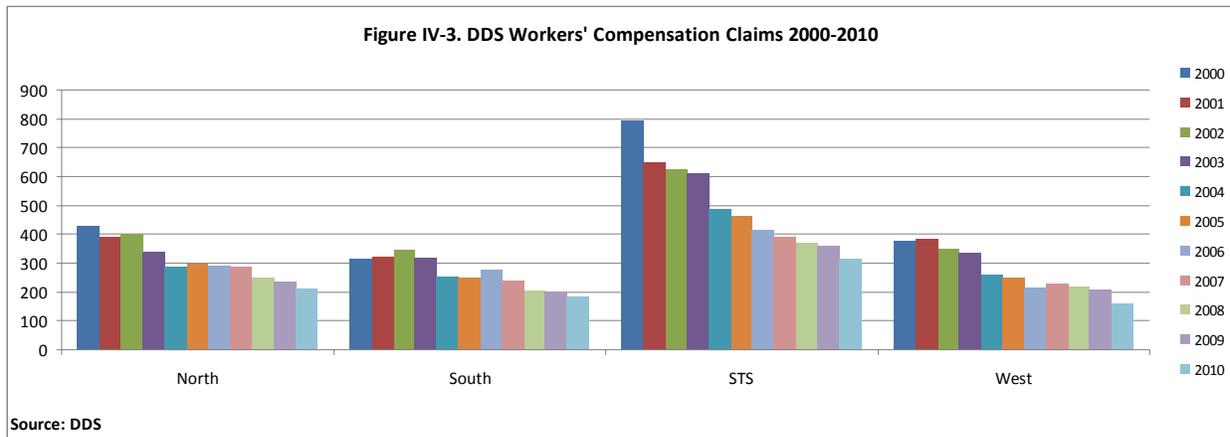
Table IV-4. DDS Overtime Hours, Clients and Staffing: FY 07-FY 11						
<i>Year</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>	<i>FY 10</i>	<i>FY 11</i>	<i>% Decrease FY 07-FY 11</i>
OT hours	1,472,992	1,478,078	1,371,737	1,361,899	1,161,622	(21.1%)
Clients in DDS residences	1,744	1,309	1,260	1,139	1,064	(38.9%)
Staffing Full-time	3,716	3,744	3,741	3,457	3,457	(6.9%)
Staffing Part-time	1,172	1,191	1,194	1,159	1,158	(1.2%)
Sources of Data: DDS and OFA for overtime data. DDS MIR reports June 2007-June 2011 for client and staffing data; PRI staff analysis						

Similarly, the DDS overtime costs are decreasing as Figure IV-2 shows, and have declined about 18 percent over the past two years. However, in FY 10, the overtime costs for the department totaled \$45 million, or almost 15 percent of the \$272.5 million in DDS personal services expenditures. Overtime costs are reported by regions and at Southbury, and not by individual homes, while the costs of direct care overtime is not separated from other staff costs of operating facilities – like cooks, custodians, maintainers and the like. However, regardless of how the overtime is accounted, the overall costs added another \$33.26 per hour on average in FY 10 (total \$ amount/total hours) to the cost of care for clients receiving services from DDS staff.

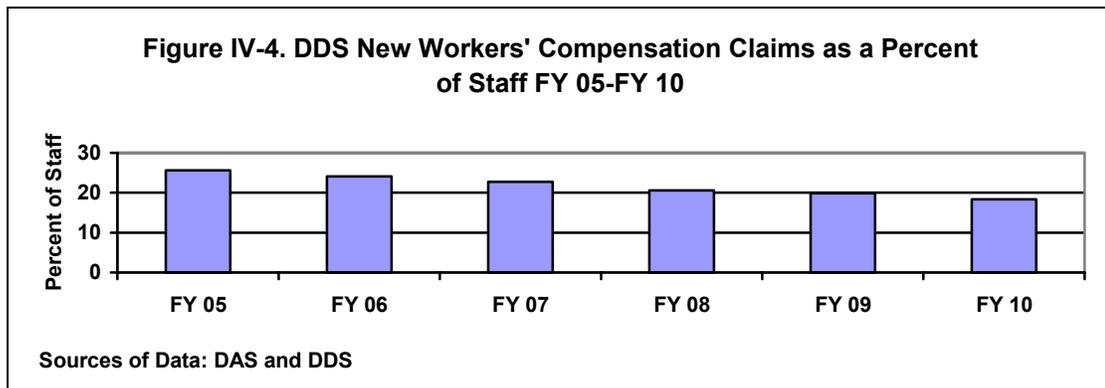


Workers’ compensation costs. There are a number of reasons why overtime occurs, often to cover for regularly scheduled staff who are out for one reason or another, including those out on workers’ compensation. Workers’ compensation is a long-standing issue in DDS, as it is in many agencies that provide direct care or health services to clients. Figure IV-3 depicts the number of DDS workers’ compensation claims by region and at Southbury from 2000 to

2010. Overall, the trend in the number of claims has been decreasing and in fact the number of new claims in FY 10 (872) is less than half the 1,918 claims filed in 2000.

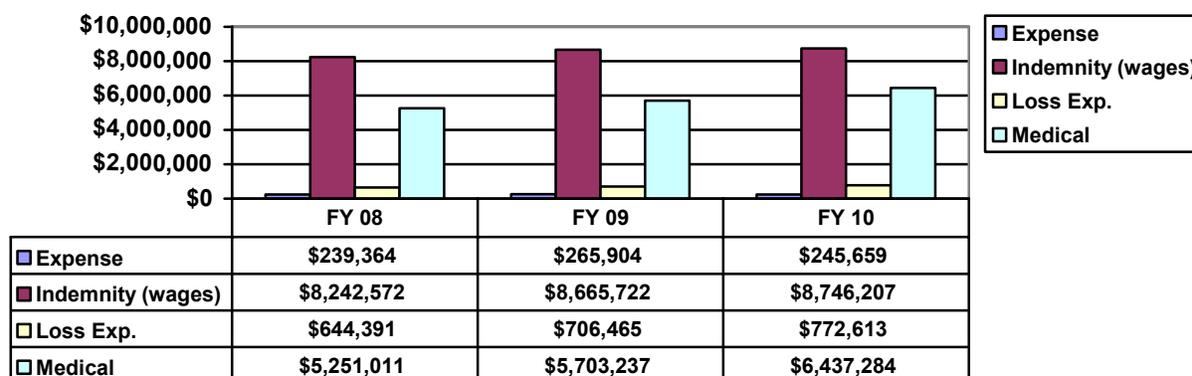


The number of claims as a percentage of the DDS workforce has been declining as well. PRI staff examined this ratio for the FY 05 to FY 10 period and the results are depicted in Figure IV-4. However, while new claims may have declined overall and as a percentage of staff, the costs continue to increase, as shown in Figure IV-5. This is partially due to the nature of workers' compensation claims where the costs of claims can continue beyond the year the claim is filed, expenses can result from an old claim, and wages and medical costs continue to rise even if claim numbers decline.



Workers' compensation claim costs for DDS in FY 10 totaled \$16.2 million, about 15 percent of the state's \$110 million workers compensation costs, according to the DAS annual report on workers' compensation. (Only the Department of Correction was higher at 30 percent.) DDS workers' compensation costs are depicted in Figure IV-5.

Figure IV-5. DDS Workers' Compensation Costs FY 08 - FY 10



Source of Data: DAS

Trends in Residential Care by Setting

The above analysis focused on individual cost components, especially those contributing to costs in DDS. The following analysis examines trends in overall and per-diem funding among the public and private delivery system, and explains the shift in residential support for clients from public to private settings over the last four years. It also discusses the factors that contribute to the cost of care, and compares them among the different residential settings.

The next portion of this chapter also describes current efforts to offer residents at Southbury Training School (STS) the opportunity to live in a community living arrangement. The contents of the settlement agreement entered into by the state regarding STS residents are described and the committee recommends a similar process be used for clients who reside at DDS regional centers.

The committee staff also examined the components that drive costs in private CLAs and present analysis on the factors that influence costs the most. Based on the overall analysis, the PRI committee made several findings and proposed several recommendations, which are presented at the end of this chapter.

Overall Funding

Supporting DDS clients in 24-hour residential care is expensive. In FY 07, all costs for private and public residential care were \$781.8 million and in FY 10 the costs had increased to approximately \$807.5 million, a 3.3 percent increase. However, the FY 10 amount was actually a decrease of about \$10 million over the FY 09 amount, largely due to the retirement incentive program (RIP) offered to state employees.

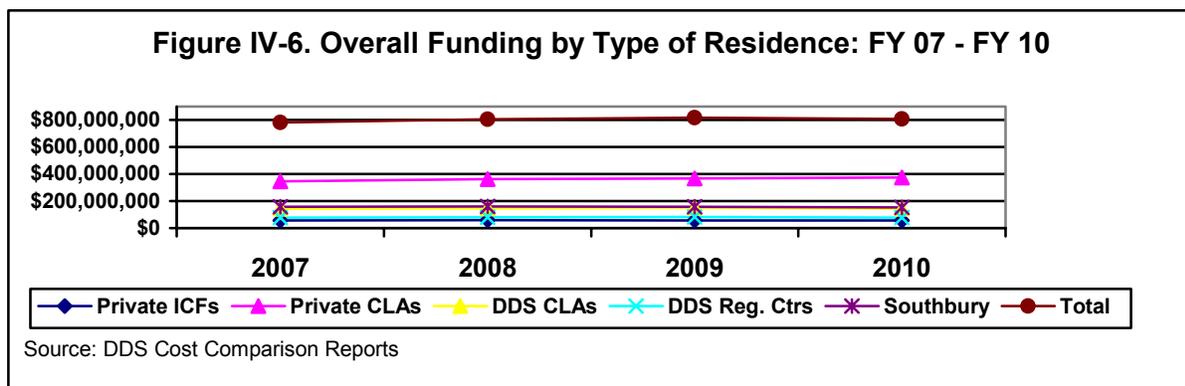
Table IV-5 provides the funding totals to each of the five residential settings over the four years examined. As shown, private CLAs receive the largest amounts – in FY 07 \$345.5 million

– which grew to about \$373.9 million in FY 10 (an 8.2 percent increase). At the same time funding to three of the settings remained essentially flat, and Southbury’s funding declined by almost three percent.

<i>Facility Type</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>	<i>FY 10</i>	<i>% Ch FY 07-10</i>
Private ICFs	\$56,459,276	\$58,572,746	\$57,295,063	\$57,280,049	1.4%
Private CLAs	\$345,454,088	\$362,734,922	\$367,927,518	\$373,857,195	8.2%
DDS CLAs	\$144,345,890	\$145,646,863	\$151,743,447	\$144,740,807	0.1%
DDS Regional Ctrs	\$77,676,820	\$79,094,726	\$83,380,995	\$78,134,956	0.6%
Southbury	\$157,852,710	\$160,823,878	\$157,469,510	\$153,433,679	-2.7%
Total	\$781,788,784	\$806,873,135	\$817,816,533	\$807,744,686	3.3%

Source: DDS Cost Comparison Reports

As Table IV-5 also shows, FY 10 funding for the three public settings declined over FY 09 levels. This decrease was largely due to reductions in staffing resulting from the state’s 2009 retirement incentive program, which allowed for the conversion of 17 public CLAs to private homes, and further downsizing of Southbury and regional centers. (See further discussion of Southbury and regional centers later in this section.) Figure IV-6 shows the four-year trends in overall funding, as well as the trends in financial resources for the various 24-hour residential settings that are the focus of the PRI study.



Residential Population Trends

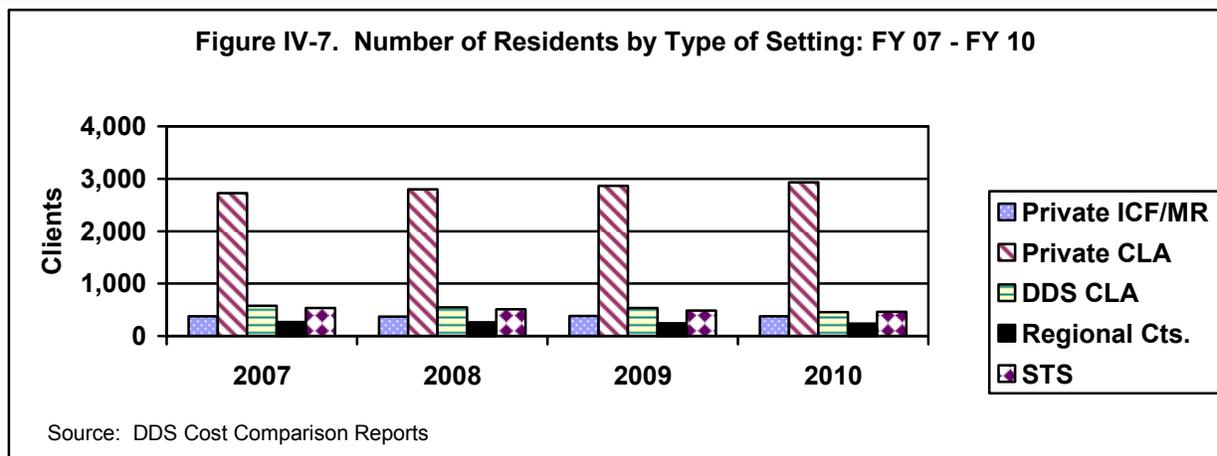
Examining funding trends alone, without also looking at changes in residential populations in the various settings, can be misleading. As Table IV-6 and Figure IV-7 below indicate, there is a disconnect between the funding and population trends. While the number of people in 24-hour residential care remained virtually unchanged over the period (less than 1 percent), many clients’ residential settings changed. For example, while the funding to DDS public CLAs was relatively flat over the period, the residents served in that setting declined by more than 21 percent.

This finding verifies the claim that private providers make that they have been flat-funded over the past few years, as any increase in overall funding has been offset by serving an

increasing number of clients. At the same time, in the three types of DDS public settings, the population has declined by 223 residents (16 percent), while the funding has remained virtually unchanged. (The numbers of clients were taken from DDS Annual Cost Comparison Reports; they may vary somewhat from numbers from other sources such as e-CAMRIS or DDS' Management Information Reports.)

<i>Residential Setting</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>	<i>FY 10</i>	<i>% Change</i>
Private ICFs	379	368	381	378	-0.2
Private CLAs	2,726	2,799	2,863	2,932	7.5
DDS CLAs	575	549	537	453	-21.2
DDS Regional Centers	265	260	240	236	-10.9
Southbury	536	510	487	464	-13.4
Total	4,481	4,486	4,508	4,463	-0.40

Source: DDS Cost Comparison Reports, FY 07-FY 10

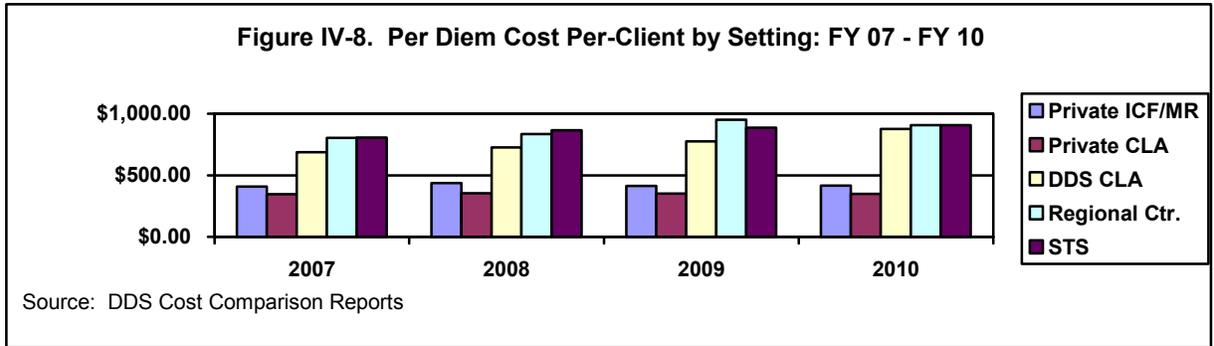


Per Diem Cost Trends

The reduction in the number of clients served in DDS-operated residential programs has resulted in an ever-increasing per diem cost for each resident there, illustrated by Table IV-7 and Figure IV-8. While the costs, or more accurately what is paid, to serve a client in public residential settings has increased by as much as 27 percent in three years, the privately run CLAs and ICFs have received very little funding increases for each client's residential care.

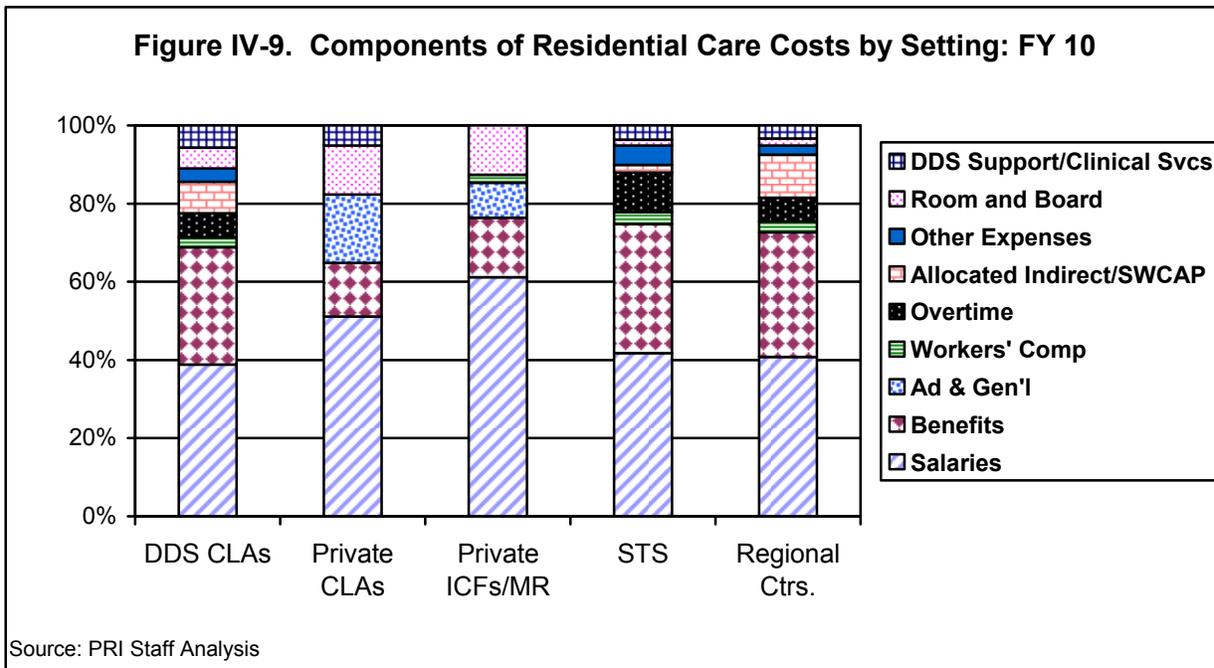
<i>Residential Setting</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>	<i>FY 10</i>	<i>% Change</i>
Private ICFs	\$408.13	\$436.37	\$412.41	\$415.46	1.8
Private CLAs	\$347.19	\$355.02	\$352.04	\$349.31	0.6
DDS CLAs	\$687.77	\$726.84	\$774.18	\$875.39	27.3
DDS ICFs	\$803.07	\$833.45	\$951.84	\$907.07	13.0
Southbury	\$806.85	\$864.80	\$886.79	\$905.96	12.3

Source: DDS Cost Comparison Reports



Cost Components

PRI staff also examined how much various components contribute to the overall costs among the various settings. The analysis is illustrated in Figure IV-9. While all cost components are not categorized and labeled the same for each type of residence, the committee staff portrays the various elements by a percentage of overall costs among types of facilities. It is important to note that this does not compare overall dollar amounts in total or by category, but rather only the portion each component contributes to the overall costs.



Providing residential care is labor intensive, and most of the costs are for staffing and employees benefits. The figure above shows salaries and wages make up almost 80 percent of the cost of care in every setting, except private CLAs (which may be due to some employee benefits costs being accounted for under administrative and general expenses).

One of the most obvious differences is the percentage of costs that goes toward employee benefits in the private versus the public sector. For example, the portion of funding for employee

benefits is about 14 percent in the private CLAs, while it is double that, 30 percent, in public CLAs. As discussed in the briefing, one of the biggest contributors to the cost of benefits is health care, and the state's employee health benefits on the whole are more generous and more costly than the private sector.

However, there is anecdotal information that certain low-paid direct care staff who work for private providers may indeed qualify for state medical assistance, so there may be hidden costs shifted to the public sector. PRI staff obtained a list of the 100 employers in the state with the highest number of employees on HUSKY (family Medicaid). While none of the private provider agencies under contract with DDS was on the top-100 list, it may be that they do not have that many employees, and is not a confirmation that no employees of these private agencies are eligible for Medicaid, or other assistance.

Workers' compensation. A similar portion of costs was for workers' compensation payments in the private ICF and the DDS-operated settings. (PRI staff was not able to isolate the workers' compensation costs for private CLAs as the electronically available cost reports do not capture that separately.) For the ICFs, 2 percent of the overall costs were for workers' compensation insurance payments, while DDS' workers' compensation (the state is self-insured) payments to workers averaged 2.7 percent of overall costs. Again, the total amounts paid are substantially different, but the portion that workers' compensation makes up of the total amount is similar.

Room and board costs. Another great variation is the portion of the total costs that goes to room and board. In the private sector residences it was 7.5 percent in the ICFs and 12.6 percent in CLAs, while room and board contributes to about 5 percent of the costs in any of the three public settings.

A couple of reasons explain this variation. The private provider agencies must delineate and submit all their costs to DSS in order to have their rates approved and their costs to be paid. The ICFs' room and board costs are part of their bundled rate, but the costs are reported to DSS for the rates. For the private CLAs, room and board rates are approved and paid separately by DSS.

On the other hand, DDS does not have its room and board costs reviewed, as no "rates" are set for public residential settings. DDS calculates an average regional room and board cost for the CLAs it operates and sends those to the Department of Administrative Services. Those amounts are billed to clients and some or all of the amounts are offset against wages earned in their day/work program and/or federal or state assistance checks. The DDS room and board costs at Southbury and the regional centers are not calculated discretely or submitted for review, but are instead absorbed into the overall facility expenses. Clients here (and in private ICFs/MR) are allowed to keep a \$60.00 per month personal needs allowance; all other assistance or wages goes to room and board.

Secondly, some parts of the room and board costs may indeed be higher in the private residential program, because the state as an entity is treated differently. For example, many private providers – 406 of the 712 private CLAs and 49 of the 69 private ICFs – paid local property tax in FY 10. State properties, on the other hand, incur payment in lieu of taxes

(PILOT), which, for most facilities, is 45 percent of what the tax would have been. Another reason is likely that there has been no recent purchase of public CLAs or ICFs in many years.

Overtime. Another large difference is the overtime component. Private providers do not account for overtime separately; it is built into staffing costs as part of the rate. Therefore, PRI was not able to separate out the portion of private labor costs for overtime. Because DDS does not have a prospective rate set for residential care as do the private providers, there is not the same incentive to keep overtime costs down. DDS overtime is decreasing, as discussed previously in this chapter, but not proportionate to the declining number of clients in DDS residential and day settings.

The portion that overtime contributes to the costs in the public sector residences ranged from 6.1 percent at the regional centers to 10 percent at Southbury. In FY 10, overtime costs were more than \$15.5 million for Southbury alone or an additional 24 percent to the personnel costs there. On a per-client basis, overtime costs at Southbury account for about \$94 per day.

According to DDS staff, some of the overtime at STS and the regional centers is due to regulations requiring licensed nursing staff to administer medication in any facility with 16 or more people. Thus, nursing staff must be on duty 24/7 at the DDS facilities, while at the private homes and smaller DDS CLAs, trained non-licensed staff may administer medication, substantially reducing the need for nursing staff. Further, the 35-hour work week in collective bargaining agreements for DDS direct care and nursing staff increases the need for use of overtime for scheduling.

Other overtime may well be used by staff in order to elevate salaries prior to retirement, as the Hartford Courant reports was occurring in some state agencies¹¹. In response to those newspaper articles and other criticism of overtime in state agencies, the governor, in August 2011, called for a thorough review of the use and need of overtime pay stating that “we have got to be more mindful of overtime . . . as well as the reaction of taxpayers to it, as well as the impact over a long period of time on our pensions.” In October, the Office of Policy and Management (OPM) prepared reports of overtime in FY 11 in 47 state agencies, which totaled more than \$200 million; DDS was the third-highest. The Secretary of OPM then required certain state agencies to submit plans on how overtime could be reduced by 10 percent. PRI obtained the submitted proposals and references them in the recommendations later in this chapter.

DDS-Operated Public Institutions

Southbury Training School. According to the DDS June 2011 Management Information Report, 429 people live at Southbury, 97 fewer people (18 percent) than lived there just four years ago. Admissions to the facility were stopped by federal court order in 1986 amid concerns of the U.S. Department of Justice over the care and conditions for residents.¹² In 1997, the Connecticut General Assembly statutorily prohibited the DDS commissioner from accepting new admissions. At the same time, the federal court appointed a Special Master to find out why the state’s efforts were showing poor results in improving conditions. In 1998, a remedial plan was established in a consent decree with specific outcomes and criteria to be met as conditions

¹¹ Hartford Courant, Articles by John Lender, June 22, 2011, August 23, 2011, and October 2, 2011.

¹² United States v. Connecticut, 931 F. Supp. 974 (D Conn. 1986)

for compliance. The federal court found in 2006 that the state had met all requirements of the consent decree.

Following years of litigation, a federal judge issued a decision in June 2008 on a related case, concluding that although the state had satisfied the consent decree requirements it had not done enough to relocate Southbury residents voluntarily into the community.¹³ Hearings to determine the next steps were scheduled in 2010 and on November 18, 2010, United States District Court Judge Ellen Bree Burns signed an order approving the settlement agreement in the 1994 class action *Messier v. Southbury Training School (STS)*. The agreement, negotiated by the parties, which includes The Arc of Connecticut as a plaintiff and the Department of Developmental Services (DDS) as a defendant, was filed with the U.S. District Court on July 12, 2010.

The order requires the state to evaluate all residents of the Southbury Training School for possible placement in the community. DDS must train and establish interdisciplinary teams, who are required to use professional judgment in recommending the “most integrated setting” appropriate to each individual’s needs for each STS class member. For purposes of the agreement, the “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”¹⁴

The implementation of the settlement agreement supports community transition for any STS resident who wishes to move, but does not direct the closure of STS. The judge’s ruling and the settlement agreement affirm that ultimately it is up to the residents and guardians, as applicable, to make an informed decision if a resident is to move from STS. This includes providing guardians and STS residents with “exposure to community-based alternates to assure that informed choices are made” and discussions about the “most integrated setting” and the community services and supports that will be needed for a client to transition and live successfully in the community. In addition, the agreement calls for the appointment of a remedial expert, mutually selected by both parties, “to facilitate and monitor implementation of the benchmarks, to have a primary role in dispute resolution, and to serve a ‘gatekeeper function’ related to any future necessity of court involvement or intervention.”

DDS Regional Centers. Southbury Training School is not the only state-operated institution for persons with intellectual disabilities. As of June 2011, five regional centers still provide 24-hour residential care to 227 clients. The North Region has one regional center with 57 clients; the South Region also has one center with 26 clients; and the West region has three centers with 144 clients.

The average cost of care at the five regional centers (\$907.07 per diem) was even higher than at STS (\$905.96) in FY 10. Further, the quality at regional centers was found deficient in a number of areas in FY 10 (see Chapter VI). The PRI committee concludes that the state should offer the residents at the regional centers the same opportunities that STS residents are being provided through the settlement agreement to live in private community settings.

¹³ *Messier v. Southbury Training School*, 562 F. Supp. 2d 294 (D. Conn. 2008).

¹⁴ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

Therefore, the PRI committee recommends that:

The Department of Developmental Services should evaluate all residents receiving 24-hour care at the five regional centers for possible placement in the community. Using the interdisciplinary team concept established by the Southbury Training School Consent Agreement, each team would exercise its professional judgment in recommending the “most integrated setting” appropriate to the needs of each regional center resident. For purposes of the agreement, the “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”¹⁵

For residents of Southbury and the regional centers, a rejection of a community placement should be revisited periodically. If the interdisciplinary team makes a recommendation for a community placement, which is rejected by the guardian, family member, or client, the team should evaluate the resident’s situation each year and present its recommendation for a family, guardian, or client decision.

While the ultimate goal should be to close the regional centers and Southbury, the PRI committee believes that vigorous implementation of the Southbury settlement and expansion of its provisions to clients at the regional centers is a better and less expensive way to achieve this than to recommend closure of any facility by a certain date. In the judge’s written approval of the Southbury settlement agree, she notes that “To date, the litigation has been especially costly. If the settlement had not been reached, the costs [of the litigation] would only escalate. . . . Moreover, in the absence of settlement, it is likely that appeals would be taken from the court’s remedial orders, and this would further delay relief to the class members and would increase costs substantially.”

DDS has already signed contracts for two privately operated community living arrangements for eight Southbury residents – three women in one CLA and the other for five men. DDS reviewed 10 responses to one RFP and seven to the other in selecting the two providers. In addition, the department has found placements for 10 Southbury residents through vacancies at existing CLAs, and is trying to locate three more openings for clients who have expressed interest. DDS is also moving ahead with plans to reopen one DDS-operated CLA in Hamden in the late spring of 2012, as a home for another five Southbury residents.

The department has also been active in bringing providers in to meet with Southbury residents, and their guardians and families. The provider community has responded, and given the number of bids to the RFPs for the two CLA contracts, PRI concludes that if the funding were available, there is interest and capacity in the private system to provide services to all but a few clients at Southbury and the regional centers.¹⁶ Furthermore, according to DDS staff, there has been a greater willingness on behalf of Southbury clients (and their families or guardians) to

¹⁵ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

¹⁶ In some instances, DDS as an agency may be required to provide direct services through court orders or stipulated settlements. An example is the McCoy consent decree – in 1992 U.S. district court directed [then DMR] that specific measures for care and treatment of two plaintiffs that might have been so costly and intensive a private provider may not have been able to comply.

consider community settings as cottages are closed and clients must relocate elsewhere on campus.

Provision of Private Residential Services

As noted above, 75 percent of the clients in 24-hour residential settings live in private homes. DDS contracts with private provider agencies through a purchase of service (POS) agreement to provide services for a number of clients in a particular group home (or CLA). While the largest difference in costs is between the public and the private sectors, there were also major variations in costs among private providers, even for services provided to clients with the same level of need.

To better assess the contributors to cost variation in the private sector, PRI staff combined and analyzed data from several sources: licensing inspection results; direct care staffing per home; and client, costs and home elements. The contributing factors were examined using three different cost structures – 1) total costs including all program and room and board expenses; 2) program costs alone; and 3) just room and board costs. The analysis below discusses the factors and variations among the three.

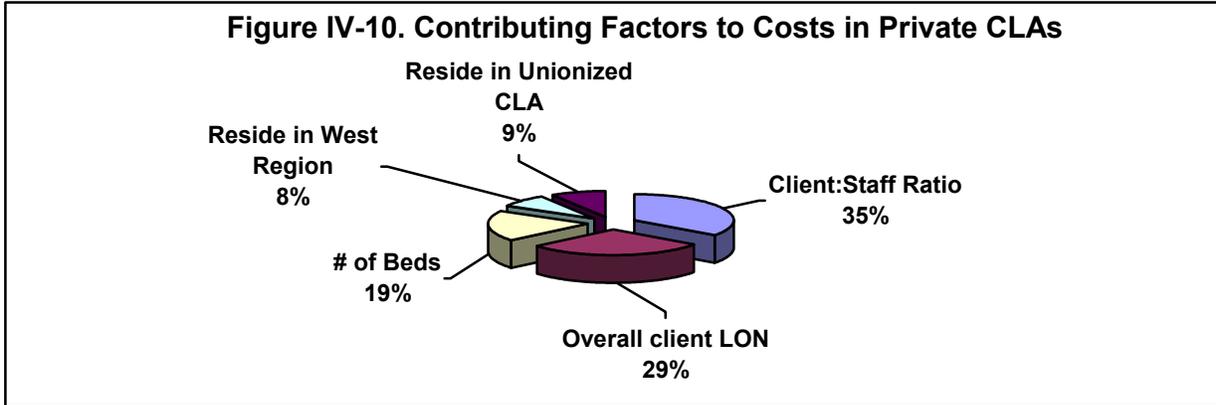
Total Costs for Clients in 24-hour Private Residential Care

PRI staff combined all costs including those for residential services; day and work programs; one-time client funding allotments; and room and board expenses. Using statistical analyses to determine which potential factors are the best predictors of total costs per client, the following were found to be associated with *higher* total client costs in private homes:

- higher staff to client ratios – higher costs were found for clients living in private CLAs with more staff relative to the number of residents
- higher level of need (LON) scores¹⁷ – clients who had higher overall residential LON scores (using the assessment tool that measures a client’s need and assigns a numeric score from lowest (1) to highest(8) – also had higher client costs
- fewer beds in the home – as the number of beds in the CLA got smaller, the costs per client became greater
- living in the Western DDS Region – clients in CLAs in the Western DDS region had relatively higher costs than clients residing in the Northern and Southern regions
- living in a unionized CLA – the cost for clients living in unionized private CLAs was higher than the cost for clients living in non-unionized private CLAs (\$150,396 vs. \$134,429)

Although all of the above factors are statistically significant, Figure I-5 shows the relative contribution of each to predicting cost. In predicting the cost for a particular client, for example, client-to-staff ratio has a much stronger influence than regional location of the CLA.

¹⁷ Almost all clients have a level of need assessment using a standardized instrument to determine each client’s LON. Each client has a separate residential score based on outcomes of the assessment. DDS has issued funding guidelines based on LON scores, which are described more fully in Chapter II and V.



Contrasting clients with relatively higher and lower total costs. To further illustrate factors driving the total costs for clients living in private CLAs, the clients with the highest costs (top 10 percent) were contrasted with clients having the lowest costs (bottom 10 percent). As shown in Table IV-8, the 290 clients with the highest costs are three times as likely to be living in a unionized home. Not surprisingly, the highest-cost clients also live in CLAs that have more staff and fewer beds. There are twice as many staff per client for those residing in CLAs with the highest costs. However, the more intensive staffing pattern is associated with a significantly greater overall LON. Higher total costs for clients living in private CLAs were also associated with more recently opened homes, younger clients, and fewer deficiencies found in the most recent DDS licensing inspection.

Table IV-8. Comparing Characteristics of Clients and CLAs -- High vs. Low Costs

<i>Factor</i>	<i>Clients with Highest Costs (above \$201,030)</i>	<i>Clients with Lowest Costs (below \$88,226)</i>
Live in a unionized CLA	41%	14%
Average # of beds in CLA	3.8	5.2
FTE direct care staff in CLA	7.8	5.3
Average # of staff per client (ratio)	2.9	1.4
Overall residential LON (per home)	6.2	3.6
Average # of years CLA open	13	19
Average client age	39	48
Average # of deficiencies per home	5.5	7.3

Source: PRI staff analysis

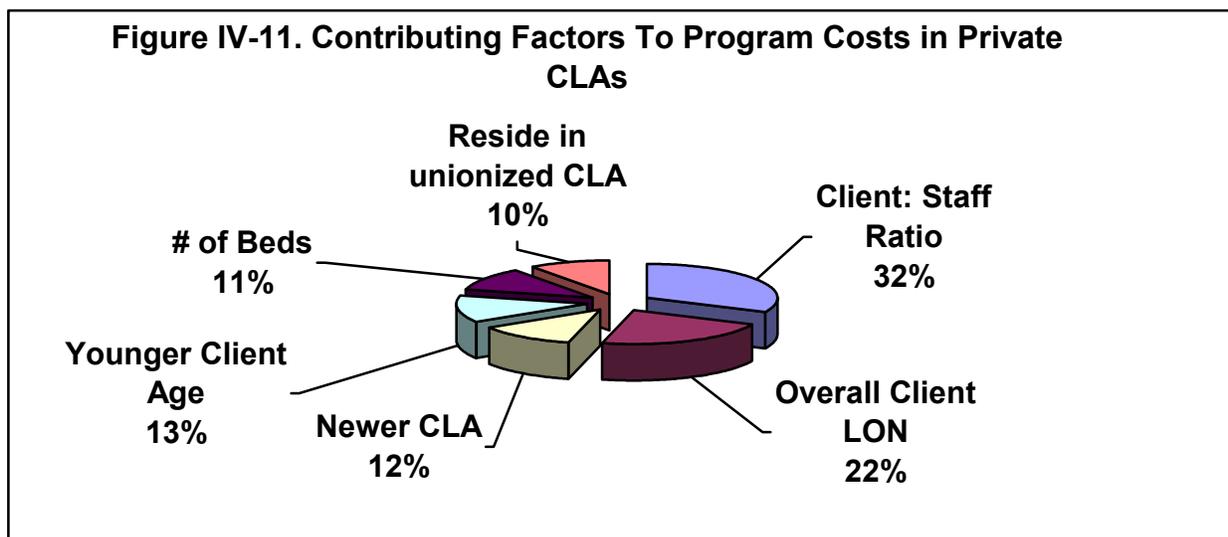
At its September meeting and hearing on the study, the committee questioned whether there may be too many private providers operating in Connecticut. Although PRI staff attempted to compare the number of providers with those in neighboring states, the data for comparison were not readily available. Absent that comparative data, one of the factors examined for this analysis was the number of homes a provider has, which is a proxy for size of provider. If a smaller or a larger size of provider were a cost factor it might indicate that smaller ones are more inefficient and contribute to higher costs, or conversely that large providers dominate that market and charge higher costs. However, the number of homes (i.e., size of provider) was found not to be a factor in costs. Further, DDS indicates that CMS requirements mandate that any qualified provider be allowed to serve clients under the waiver program, and thus DDS cannot limit the number of providers who offer services.

Factors Associated with Higher Client DDS Annual Program Services Costs

PRI staff examined only those costs that are paid for by DDS for staffing and program supports for the residential component. It does not include the client's day/work program costs or room and board expenses. Several potential factors were also examined that may contribute to predicting the program services costs for clients living in private CLAs. Program services costs covered by DDS include the direct care staffing component, indirect care from therapists and other clinicians visiting the home, but would not include room and board expenses. Using statistical analyses to determine which factors are most associated with program services costs, the following were found to be associated with higher costs:

- higher staff to client ratios – higher DDS program services costs were found for clients living in private CLAs with more staff relative to the number of residents
- higher level of need scores – clients with higher overall (residential) LONs had higher DDS home services costs
- newer CLAs – higher DDS program services costs were more likely for newer CLAs
- younger clients – higher DDS program services costs were associated with younger clients
- fewer beds in the home – as the number of beds in the CLA got smaller, the DDS home services cost tended to get larger
- living in a unionized CLA – the DDS program services cost for clients living in unionized private CLAs was higher than the cost for clients living in non-unionized private CLAs (\$113,728 vs. \$98,731)

Figure IV-11 shows the relative contribution of each of these factors in predicting the DDS program services cost for a client living in a private CLA.



Contrasting clients with relatively higher and lower DDS program services costs. To further illustrate factors driving the DDS home services cost for clients living in private CLAs, the clients with the highest costs (top 10 percent) were contrasted with the clients with the lowest costs (bottom 10 percent). As shown in Table IV-9, the 289 clients with the highest costs are more than five times as likely to be living in a unionized home. The clients with the higher costs

are also living in CLAs that have more staff and fewer beds. This configuration contributes to the higher costs. There are twice as many staff per client for those residing in the CLAs with the highest DDS program services costs. The more intensive staffing pattern is associated with a significantly greater overall LON. Another factor, not shown in the graph but associated with higher program service costs for clients in private CLAs, is fewer deficiencies found in the most recent DDS licensing inspection.

Table IV-9. Comparison of Factors Contributing to High vs. Low Costs of Direct Care		
Factor	<i>Clients with Highest DDS Home Services Cost (above \$154,067)</i>	<i>Clients with Lowest DDS Home Services Cost (below \$60,169)</i>
Live in a unionized CLA	40%	7%
Average # of beds in CLA	3.7	5.1
FTE direct care staff in CLA	7.6	4.8
Average # of staff per client (ratio)	2.8	1.3
Overall residential LON	6.0	3.6
Average # of years CLA open	12	19
Average client age	39	51
Average # of deficiencies	5.6	7.5
Source: PRI staff analysis		

Factors Associated with Higher Client DSS Annual Room and Board Costs

Staff also examined factors using only the room and board cost component. The room and board costs do not make up a large portion of the private CLAs' overall costs; about 12 percent as shown previously in Figure IV-9. In comparison to the total client costs and DDS program services costs, fewer factors appear to predict the DSS annual room and board costs for clients living in private CLAs. As might be expected, the most salient predictors are the total number of beds in the CLA and the region within which the home is located.

Regional cost differences. For illustrative purposes, the clients with the highest DSS annual room and board costs (top 10 percent of the 2,742 clients for which this information was known) were contrasted with the clients with the lowest costs (bottom 10 percent). Not surprisingly, clients who had the highest annual room and board costs live in CLAs with fewer beds (3.7 beds vs. 5.4 beds). Figure IV-12 shows the average annual room and board cost for each of the three DDS regions. As might be expected, the West Region (which includes Fairfield County) has higher room and board costs, which includes housing costs and property taxes.

The major costs for caring for clients in private CLAs in each of the DDS regions are shown in Table IV-10. As discussed, the program services makes up most of the costs. While the average annual DSS room and board costs are higher for clients in the West Region, the DDS program services costs are lower than those found in the North and South Regions, contributing to an overall total cost that is not significantly different across the three regions.

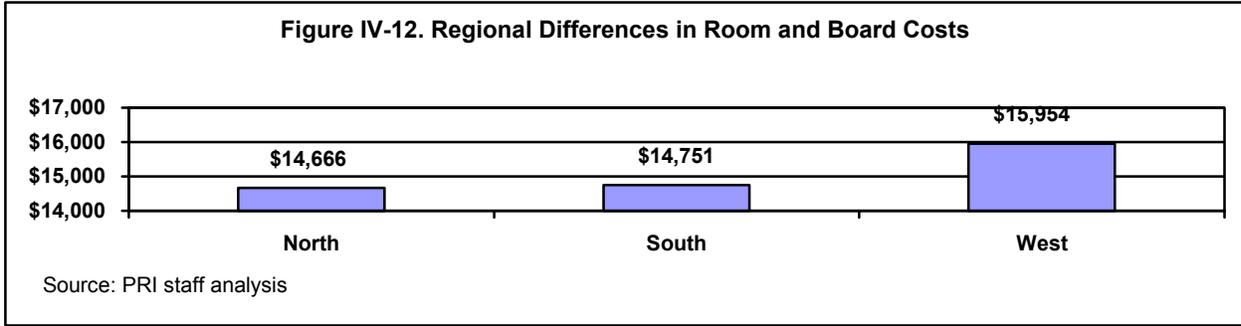


Table IV-10. Overall Per-Client Cost Differences Among Regions

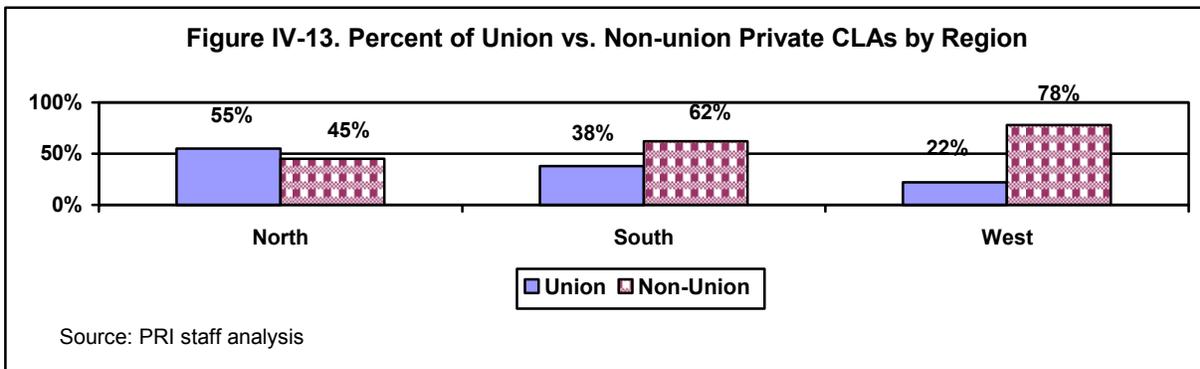
<i>Components</i>	<i>North (n=983)</i>	<i>South (n=924)</i>	<i>West (n=834)</i>	<i>Total (N=2,741)</i>
DDS program services costs	\$105,569	\$101,291	\$99,764	\$102,361
DSS room and board costs	\$14,666	\$14,751	\$15,954	\$15,087
Total costs ^a	\$141,698	\$140,558	\$139,375	\$140,607

^aThere are additional costs, such as one-time payments, that are not shown in this table.

Source: PRI staff analysis

Unionization Differences

Only 16 percent of private providers statewide have unionized employees. However, because the larger agencies tend to have unionized employees, 36 percent of the private CLAs have unionized staff. CLAs with unionized staff were more likely to be found in the North Region and less likely in the West Region (Figure IV-13). Also, unionized CLAs were more likely to: care for clients with higher overall level-of-need residential scores (5.5 vs. 4.8 average overall residential LON); and have fewer deficiencies found at DDS licensure site visits (4.6 vs. 7.0).



Wait List for Services

In addition to the inequities in the costs for services for clients who are receiving care, a perhaps greater inequity is the fact that so many people receive little in the way of DDS services at all. Services provided by the Department of Developmental Services are not an entitlement and availability of services to individuals who meet the eligibility criteria and want services is reliant on the appropriation that DDS receives from the legislature. With limited funds, DDS

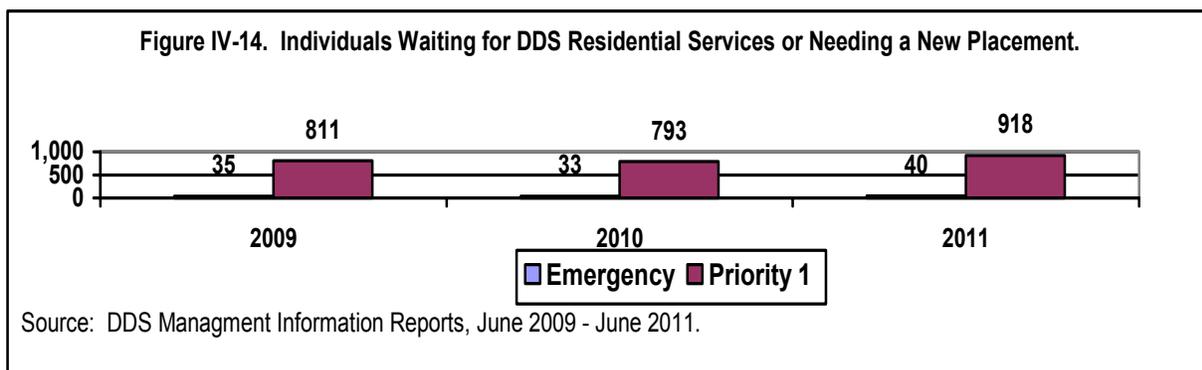
maintains wait and planning lists based on a priority ranking system to guide allocation decisions and determine who receives services.

In October 2001, the Association for Retarded Citizens of Connecticut (ARC/Connecticut) filed a federal lawsuit on behalf of individuals waiting for residential supports and/or day services from the then Department of Mental Retardation and the Department of Social Services. The suit alleged among other things that the agencies' failure to provide services with reasonable promptness to all persons eligible under Connecticut's Home and Community Based Services waivers (HCBS) was a violation of Medicaid law. The class action lawsuit included over 1,000 individuals on the wait list that existed at that time. The parties negotiated and eventually agreed to a five-year settlement agreement (FYs 2005 – 2009), which was reviewed by the Attorney General's Office and approved by the General Assembly during the 2004 legislative session.

The wait list assigns priority based on serving individuals with the greatest service needs first. It includes individuals at home with relatives who receive no services from DDS, as well as individuals that are in a DDS residential setting but need to move to another residential placement. It also includes individuals who had an emergency or required residential supports within one year (Priority 1 status). In addition, there is a planning list for individuals with non-emergency needs and likely will not need services for at least a year.

PRI reviewed the growth in the number of individuals waiting for services on just the wait list (not the planning list) to examine if the wait list had grown since the end of the wait list initiative. Figure IV-14 shows in June 2009, at the end of the five-year settlement agreement, there were 846 individuals on the wait list. Of these, about half (482) lived at home with no support and 21 were considered needing an emergency placement, while the other half were receiving support from DDS but needed a new placement. By June 2011, there were 958 individuals waiting for DDS services. Of these, 549 people had no DDS supports and 25 were considered an emergency.

Thus, the number on the waitlist – individuals living at home receiving no DDS services or support, and those waiting for a new placement – increased 13 percent over the two-year period. The recent growth is more dramatic considering that in 2009 there had been a decrease of 113 from the prior year, while by June 2011 there were an additional 132 individuals on the wait list.



RESIDENTIAL CARE AND COSTS: FINDINGS AND RECOMMENDATIONS

Based on the analysis provided in this chapter the PRI committee finds:

- *DDS receives about half the total funding for 24-hour residential care, yet it serves only about 25 percent of the clients in 24-hour care.*
- *Private CLA providers have received slightly more in overall funding since 2007 (8.5 percent in three years), but these agencies have been serving more clients,, so their funding per client has remained flat.*
- *DDS has higher direct care FTE counts per residential setting than either of the private CLAs or ICFs/MR, contributing to the large differences in costs.*
- *Many of the staff positions at Southbury are not allocated to a particular residential setting. For example, there are 172.48 LPN staff for the 450 Southbury residents, one for every 2.6 clients.*
- *Despite the higher FTE count in the public residential settings, there is significant use of overtime. In FY 10, DDS overtime costs were \$45.3 million, including \$15 million at Southbury.*
- *Salaries are considerably lower in the private sector for direct care workers. The average hourly wage for direct care aides in private CLAs were \$15.53, about one-third less than the lowest classification of direct care DDS worker at \$24.24 per hour.*
- *Workers' compensation costs for all of DDS in FY 10 were \$16.2 million or about 15 percent of the state's workers' compensation costs overall. About half of that amount (\$8.7 million) was for lost wages. As a component of overall costs, workers' compensation costs for DDS facilities are about 2.7 percent of the total costs of care, a similar percentage as in private ICFs.*
- *Some of the component costs of care may be higher in the private sector (e.g., property costs, taxes and other room and board expenses), while some costs in DDS may be absorbed in the larger state budget.*
- *During this period of downsizing the public sector delivery of services to a private one, the per diem costs of serving the clients who remain in the public settings is likely to remain high. This is because DDS cannot lay off staff due to both the 2011 SEBAC agreement and restrictions on layoffs and transfers in labor agreements the State has with its collective bargaining units.*

- *However, DDS staff numbers are decreasing through normal attrition. Since July 2011, 37 permanent developmental service worker positions and six supervisor positions at DDS residential care locations were vacated through retirements and resignations. Another seven instructors and three school teachers at public day programs (not including DDS Early Connections Program) terminated from state service. Those positions have not been refilled.*
- *DDS is already moving toward a largely private-driven residential system – in FY 10 there were 223 fewer clients in DDS public residential care than in FY 07, a decrease of 16 percent in three years. DDS has had a policy of no new placements to its residential settings for a number of years, with the objective of replacing the dual system with an almost entirely private provider system. The department converted 17 homes from public to private in FY 10, and is currently eliminating another 5 programs in the current budget cycle.*
- *The number of persons on the DDS waitlist for residential services has increased to almost 550 people, an increase of 13 percent in the last two years alone.*
- *Individual client costs in the public sector are not calculated because there is no rate-setting for services in DDS facilities or homes. Instead, the department submits overall average per diem cost reports to the Office of the State Comptroller and the Department of Administrative Services. Even under the new rate-setting system discussed in the Chapter VI, rates will apply only to private providers and not to the DDS settings.*
- *The state requires that forms be filed if an executive director is paid \$100,000 or more. Fifty-three percent (40) of the cost reports contained forms indicating executive directors of private provider agencies were paid more than \$100,000, with 10 earning in excess of \$180,000. In most cases, there was indication that the amounts in excess of \$100,000 were from a source other than the State of Connecticut. However, in several cases where there was no form filed, the agencies had large amounts of “management fees”, perhaps circumventing the required reporting on executive director salaries.*

The program review committee concludes that the ultimate policy objective should be to replace the current dual system of DDS and private providers offering direct care with a single private provider framework for the provision of direct care in the community.

Based on that policy objective, **the Legislative Program Review and Investigations Committee recommends the following:**

The Department of Developmental Services should continue its phasing out of providing 24-hour residential care in any of its DDS settings, but that it accelerate its efforts through:

- **Using DDS CLAs only for residential placements for clients from more restrictive public settings like Southbury or the regional centers, and as a transition phase only;**
- **DDS should not refill any direct care or direct service positions vacated through attrition in any of its residential or day programs; and**
- **DDS should conduct a staffing assessment at its residential locations in light of the 16 percent reduction in clients. For the clients still residing at DDS homes and facilities, DDS should use the LON assessment tool to determine the level of staffing needed (as it would in contracting for private placements). Where staffing levels are higher than comparable in the private sector, DDS should redeploy staff to serve clients on the residential care waiting list in their homes or to provide respite care, within labor contract provisions.**
- **Ultimately, the only residential care that should be operated by DDS is to provide care for extremely hard-to-place clients and for those clients that the superior or federal (not probate) court directs into DDS care. This should involve about .5 percent of the 24-hour residential care population or 25 people.**

DDS should reduce its overtime by at least 10 percent as recently required by the Office of Policy and Management, including through implementing those measures similar to those recommended by the Department of Children and Families in its overtime reduction report to OPM (see Appendix C).

In future contracts DDS has with private providers, the department should examine the salaries paid to direct care workers considering:

- **what they are paid relative to the agency's executive director's salary;**
- **relative to wages needed for self sufficiency standards as calculated periodically by the Office of Workforce Competitiveness and the Office of Policy and Management and those that may be developed by the DDS Sustainability Subcommittee; and**
- **income levels that qualify persons and families for eligibility for state Medicaid and other assistance.**

As a condition of future contracts with a private provider, the Department of Developmental Services should also ensure that the provider has complied with the requirements of cost reporting, including the submission of forms on the executive director's salary.

While DDS should not interfere with the marketplace and dictate what private providers pay their workers, as the funding agency, DDS has some responsibility to ensure that the contracted amounts are not being spent disproportionately on executive or administrative costs.

The program review committee recognizes that the current dual system for providing residential care needs to be replaced – the current one is too costly and inequitable, and serves too few people. However, the transition to a new delivery system may take a number of years, as the current SEBAC agreement has a four-year, general no-layoff provision for state unionized workers. In addition, the state's collectively bargained labor contracts contain restrictions for layoffs as a result of privatizing services, with limited ability for state agencies to transfer staff. Thus, the parameters for downsizing are fairly narrow.

However, the department appears to be committed to downsizing as it continues to observe a no-new-admission policy to its public programs, and closes public programs and converts others to private. If it does not refill any current or future vacant positions in direct care and redeploys staff to serve clients on the waitlist as a transition, it will hasten the move to an almost entirely private system for the provision of direct services. When this occurs, it will lessen the most serious of the inequities in staffing and costs, those between the public and private sector.

Further, as will be discussed in Chapter VI, DDS is embarking on a rate restructuring in the private sector that may take a number of years. This will alleviate many of the inequities found in the current system. However, it is important to keep in mind that much of the inequities in the system have built up over many years and will take time to address and correct.

Cost of Care for DDS Clients in 24-Hour Residential Settings

The annual average cost per DDS client for 24-hour residential services differs significantly, depending on whether a client resides in a private or public CLA or an ICF/MR, as well as other factors. Most agree that a client case mix, or level of need score (discussed in Chapter II), has an influence on cost. Some believe that the public sector serves more clients with higher levels of need, and therefore this raises its costs. Many other factors could also influence cost, such as whether a home is unionized, staff wages, and number of beds within a home. Other factors and their impact on costs, besides client LON, are discussed throughout this report.

The program review committee examined client demographic and cost data, including levels of need across the four types of 24-hour residential settings, and presents analysis to determine whether the high cost of client care in public settings is because they provide services to clients who have higher needs. The cost of providing day/work programs to clients receiving 24-hour residential care is also discussed in this chapter.

The settings reviewed include:

- private CLAs;
- public CLAs;
- private ICFs/MR; and
- public ICFs/MR (STS and the five regional centers).

It is important to note that detailed cost data on a client-level basis exists only for clients receiving care in private CLAs and private ICFs/MR. The cost of care provided in public settings (public CLAs, the five regional centers, and STS) is available from DDS only on an overall average cost-per-client basis by type of residential setting. There are no detailed public client-specific cost data available.

Methodology for developing cost estimates for clients living in private CLAs. The Department of Developmental Services enters into contracts with private providers prospectively to provide residential services and supports. In FY 10, DDS had contracts with private providers for 2,875 clients residing in 24-hour private CLAs. For each client in a private CLA, DDS has an established monthly cost based on the contracted amounts for services for that individual. The department annualizes these costs by estimating the number of days it expects the client to receive residential services and supports. The other residential component is the room and board rate. It is separately calculated prospectively by the Department of Social Services and it is set on a per-home, not per-client, basis.

To develop comprehensive per-client cost estimates for each private CLA, PRI staff merged the prospective DDS contracted costs with an average room and board cost per-client based on the number of clients residing in each private CLA as of June 30, 2010. These two calculations together, along with any state funds for temporary supplemental services a client

may receive, were then merged in order to obtain an estimated cost per-client in private CLAs for FY 10.¹⁸ Finally, the projected cost per-client data were combined with client demographic information and LON score, provided by DDS, in order to derive an overall profile for clients residing in private CLAs.

Private CLA cost data. Table V-1 shows minimum, maximum, and average contracted per-client residential costs for FY 10, along with projected total client costs, by funding streams. As the table shows, the most expensive costs are for the residential services and supports provided by DDS, ranging from a minimum of \$8,604 for one client to a maximum of almost \$500,000 annually for another.

Table V-1. Projected Annual Cost-per-Client (FY 10) and Total Cost				
Funding Agency	Minimum	Maximum	Average	Total
DDS Contracted Services and Supports (N=2,875)	\$8,604	\$497,640	\$104,444	\$300,275,069
DDS Supplemental Funds (N=282)	\$75	\$187,954	\$14,301	\$4,032,825
DSS Room and Board (N=2,833)	\$2,475	\$35,219	\$15,512	\$41,039,825
Total	\$17,656	\$525,059	\$120,120	\$345,347,744
Source: PRI staff developed database from DDS eCAMRIS, DDS contracted rates, DDS supplemental funds database, and DSS room and board database. No day program costs are included in the calculations above.				

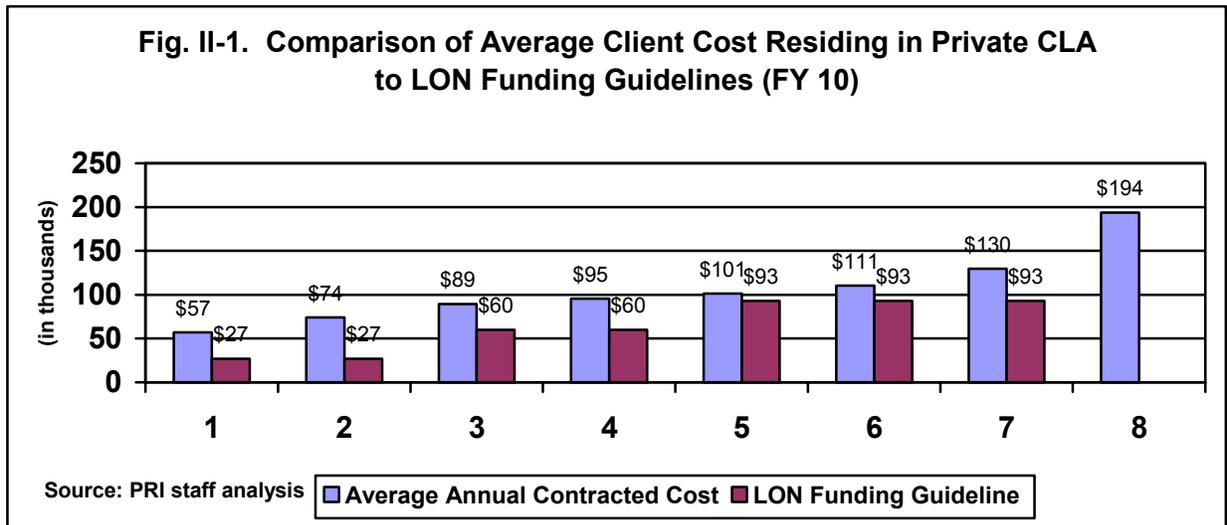
The PRI committee also examined DDS contracted per-client costs for residential services and supports, temporary supplemental funds, and DSS room and board rates, based on each client’s level of need assessment score for FY 10. Table V-2 shows average costs ranged from almost \$70,000 to provide 24-hour residential services to the 40 clients that were assessed with a “1” level of need, to slightly more than \$209,000 for clients with a level of need of “8.” The range in costs-per-client was great with a minimum of \$17,656 for a client with level of need of “1”, to a maximum of \$525,059 for a client with an “8” level of need.

The PRI committee examined the average contracted residential services and supports and temporary funds per-client costs at each LON, and compared them to the funding guidelines that guide the LON assessment process. The DSS room and board costs and any day program costs were excluded from the analysis since the LON funding guidelines are only for the residential services and supports needed by the client. Figure V-1 shows, in all cases, the average cost per client exceeds the maximum amount that a regional team can approve for services and supports until its authority is exceeded and the regional director or the regional UR team must make the decision about resource allocation. There are no funding maximums for clients who have a LON score of “8;” rather, an individual budget is developed by the regional Utilization Review Team.

¹⁸ State supplemental payments for temporary services and supports are state funds that DDS allocates for clients experiencing a temporary change in condition. Any services provided are expected to be temporary and DDS does not expect the payments will be annualized as part of a clients year-to-year expenses. There were 292 clients that received funding from DDS in FY 10 with a total amount of \$4,078,253.

<i>Level of Need (Residential)</i>	<i># of clients</i>	<i>Min.</i>	<i>Max</i>	<i>Average</i>	<i>Total Cost</i>
1	40	\$17,656	\$111,433	\$68,994	\$2,759,757
2	194	\$27,696	\$222,481	\$86,749	\$16,829,296
3	347	\$29,712	\$247,220	\$102,781	\$35,665,094
4	360	\$39,177	\$261,062	\$109,237	\$39,325,187
5	722	\$26,552	\$369,600	\$115,348	\$83,281,465
6	562	\$57,000	\$308,337	\$125,438	\$70,496,283
7	608	\$60,409	\$389,540	\$145,074	\$88,204,761
8	42	69,732	\$525,059	\$209,188	\$8,785,900
Total	2,875			\$120,121	\$345,347,743

Costs do not include any day programs received by the client.
Source: PRI staff developed database from DDS eCAMRIS, DDS contracts database, and DSS room and board database.



Public versus private CLAs average cost per client. The Department of Developmental Services (along with other human service agencies with 24-hour public residential care facilities) submits its costs to the Office of the State Comptroller so that a per diem “rate” or cost can be billed to Medicaid and other payers for those clients in DDS facilities and homes. (See Chapter I for a description of the process.)

From those cost submissions, the Department of Developmental Services each year develops a report that compares per diem client costs, annual costs per person, average level of need scores, and the number of people served across public and private DDS residential settings. Table V-3 compares the DDS average cost-per-client between public and private CLAs. To keep consistent with the costs included in the private contracted data previously presented, PRI staff deducted costs of case management and SWCAP and therefore, they are excluded from the

annual and per diem cost-per-person served and total costs.¹⁹ For public CLAs, PRI staff used the average costs-per-client calculated by DDS in its 2010 Cost Comparison Report since no client-specific data are available for DDS clients residing in publicly operated placements. Thus, just based on overall averages and not adjusting for LON, it cost about two and half times as much for residential services in a public DDS-run CLA as it does in a private group home.

Table V-3. DDS Comparison of Per Client Cost		
<i>Measures</i>	<i>Public CLA</i>	<i>Private CLA</i>
Annual cost per person served	\$313,553	\$124,981
Per Diem cost	\$859.05	\$342,41
Average LON	5.4	5.04
People served	453	2,932
Total cost	\$142,039,483	\$366,444,350
Source: DDS FY 10 Cost Comparison Report		

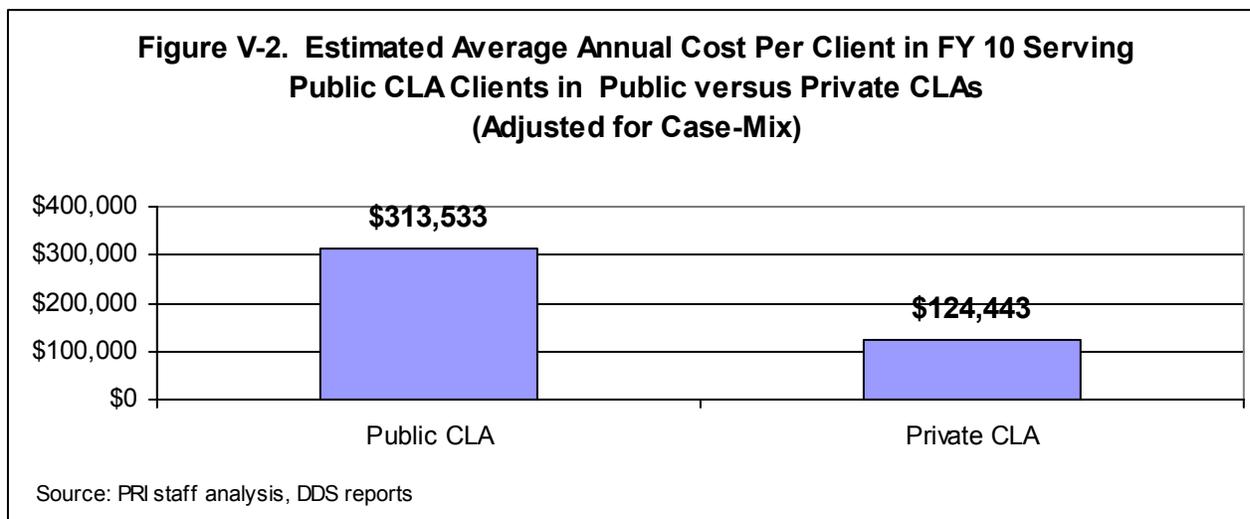
Comparisons based on client level of need. In general, a higher level of need score is associated with an overall higher cost for services, hence the development of funding guidelines based on LON. By making sure that the level of need profile is the same for the groups being compared, any cost differences found cannot be attributed to different levels of need across the two groups (i.e., the more costly group is not more costly because the clients have a higher level of need).

To compare annual average per-client costs adjusted for LONs, between private and public providers, a weighted average was employed to statistically maintain the same level of need across the four settings (i.e., public CLAs; private CLAs, public ICFs/MR; and private ICFs/MR). By doing this, PRI staff could estimate how much it would have cost private providers to serve the identical case-mix of clients that lived in public CLAs, at the regional centers, or at STS during FY 10. The methodology to compare the cost of care in private CLAs to public CLAs, given the same client case mix by using LON scores:

- calculated the average cost-per-client in private CLAs within each level of need (excluding day program);
- identified the percent of clients living in public CLAs at each LON relative to the total clients in public CLAs;
- multiplied the average annual cost-per-client in private CLAs by the weighted level of need average within public CLAs for each level of need; and
- summed the weighted calculation and divided by 100 to estimate the average annual cost-per-client for private providers to serve the clients that were living in public CLAs in FY 10.

¹⁹ Statewide Cost Allocation Plan (SWCAP) is a per capita per diem cost for publicly supported settings (STS, the regional centers, public CLAs, and public supported living arrangements) and includes an allocation of central state agency administrative support for DDS programs and services. SWCAP calculates the cost of central agency services (i.e., administrative support) furnished by, but not billed to, other state agencies like DDS.

Figure V-2 shows that it would have cost 2.5 times less for private CLAs to care for clients with the same client case mix that was at the public CLAs in FY 10. The average annual cost-per-client in a public CLA is \$313,533 compared to \$124,443 at a private CLA – a difference of more than \$189,090 in average annual cost per-client.



Private ICFs/MR. The Department of Developmental Services Cost Comparison Report also compares private and public ICFs/MR by per diem client costs, annual costs per person, average level of need scores, and the number of people served across the various DDS residential settings. Table V-4 compares the DDS average cost-per-client between private and public ICFs/MR. To keep consistent with the costs presented for public and private CLAs, case management, SWCAP, and day program costs are excluded from the total, annual and per diem cost-per-person served for the public ICFs/MR. Thus, just based on overall averages, without adjusting for LON, it cost twice as much to provide residential services to clients living at a regional center or STS than it did for clients residing in private ICFs/MR.

<i>Measures</i>	<i>PRI Private ICF/MR</i>	<i>Regional Centers</i>	<i>STS</i>
Annual cost per person served	\$151,641.13	\$325,835	\$321,983
Per diem cost	415.46	\$892.70	\$882.15
Average LON	5.34	6.08	5.24
People served	378	236	464
Total cost	\$57,280,049	\$76,897,036	\$149,400,049

Source: DDS Cost Comparisons Fiscal Year 10, which excludes the cost of day programs for all three settings and adjusted by PRI staff by excluding case management and SWCAP.

PRI comparison. Because PRI data for private ICFs/MR were based on a prospective rate, the results of the PRI analysis differs slightly than those contained in the DDS Cost Comparison Report for FY 10, which uses cost reported data reported at the end of the fiscal year. In addition, private ICFs/MR are reimbursed differently than private CLAs because they operate under a different Medicaid reimbursement system. As such, a single bundled rate is prospectively established for private ICFs/MR by the Department of Social Services and it is

considered a bundled rate because it includes residential services and supports, and room and board, as well as day program services.

Furthermore, private ICFs/MR can either operate their own day programs or negotiate with other providers to provide the day program for clients living in their facilities. Unlike the DDS analysis contained in the Cost Comparison Report, PRI staff were unable to determine what portion of each private ICFs/MR rate that was allocated for day services, and therefore, the per-client rates in the PRI staff analysis include day costs, while the public ICFs/MR do not include day program costs.

Table V-5 shows the DSS-established prospective bundled rate for FY 10 on an annualized per-client basis by LON. The average annual prospective rate for a client residing in a private ICF/MR was \$168,786.

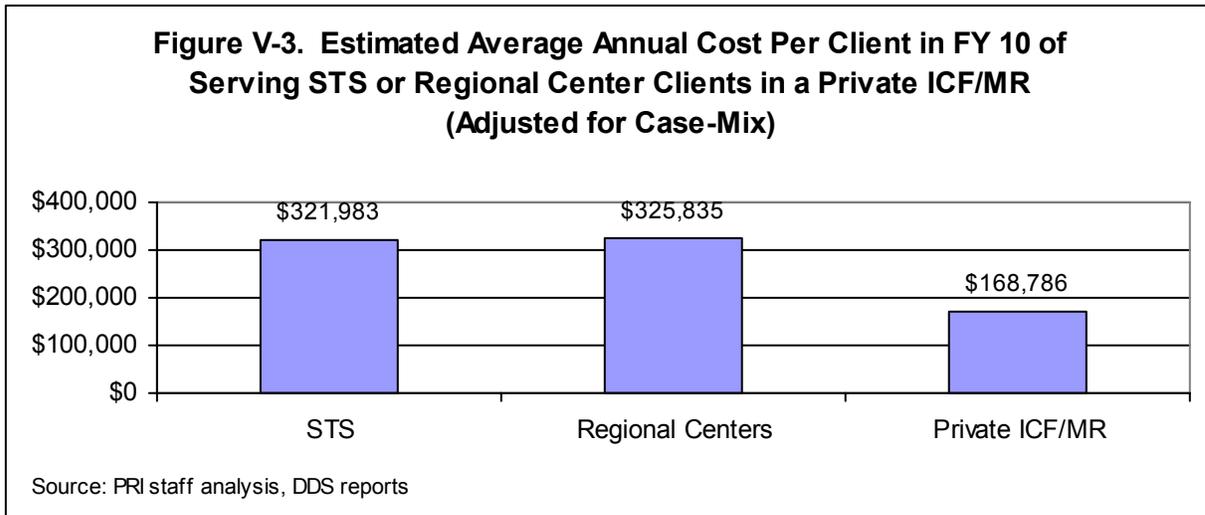
Table V-5. DSS FY 10 Annual Per-Client Rate for Private ICF/MR by Level of Need (N=347)*					
<i>Level of Need (Residential)</i>	<i># of clients</i>	<i>Min.</i>	<i>Max</i>	<i>Average</i>	<i>Total Cost</i>
1	5	\$101,996	\$160,421	\$115,417	\$577,087
2	19	\$101,996	\$234,246	\$135,016	\$2,565,301
3	49	\$101,996	\$234,246	\$146,440	\$7,175,541
4	26	\$109,471	\$234,246	\$155,862	\$4,052,404
5	71	\$109,471	\$265,643	\$168,388	\$11,955,562
6	49	\$117,968	\$275,843	\$170,531	\$8,356,011
7	127	\$117,968	\$275,843	\$186,764	\$23,719,076
8	1	\$167,648	\$167,648	\$167,648	\$167,648
Total	347			\$168,786	\$58,568,630

*No cost data for 14 clients
 Costs *include* day program costs for clients in private ICF/MR
 Source: Department of Social Services

Applying the same methodology used to compare private CLAs to public CLAs, PRI staff also compared average annual cost-per-person residing at private ICFs/MR by LON and weighted it by the level of need for clients in public ICFs/MR. Since data were available for public CLAs only based on an average cost, and DDS data does not include day program costs for public ICF/MR residents, and PRI staff were unable to exclude day programs from the available data for private ICF/MR, costs are overstated for clients in private ICFs/MR. However, even given this caveat, the average private ICF/MR cost per client is much less, as shown in Figure V-3. PRI staff found, for clients in public ICFs/MR, given the same client residential level of need:

- the average annual cost-per client at regional centers is \$325,835, which is at least 1.8 times more than it would have been to serve the same clients at private ICFs/MR (and would even be higher if day programs were included in the calculation for clients living in regional centers as they are for clients in private ICFs/MR); and

- the average annual cost-per-client at STS was \$321,983, almost double the cost of treatment at a private ICF/MR (and would even be higher if day programs were included in the calculation for clients living at STS as they are for clients in private ICFs/MR).



Cost of Day/Work Programs

Cost guidelines. In 2006, DDS adopted funding guidelines for residential and day/work services delivered by private providers based on a client’s level of need (LON). (Both residential and day/work funding thresholds are discussed in more detail in the next chapter.) Because the LON was introduced within the last five years, clients who had been receiving services prior to adoption of these funding guidelines did not have funding reallocated, regardless of their LON score.

Level of need. As noted above, each client who receives DDS-funded services must have a level of need assessment. The assessment generates a profile and produces two composite LON scores - one for residential services and the other for day services. Most individual scores and the composite score range from “1” indicating a low level of need to “8” being the highest level of need. It is updated annually or upon a change in the client’s life or situation.

Currently, the funding guidelines are being used for new clients coming into the DDS system, transitioning from a home setting to a residential placement, moving from one residential placement to another, or experiencing significant changes in condition. For these clients, once an LON assessment is completed, the regional team uses the funding guidelines to assist in determining the needed resources. Table V-6 shows the FY 10 day/work funding guidelines by LON. Further detail on the use of DDS funding guidelines in transitioning to a new rate-setting methodology is discussed in Chapter VI.

Table V-6. Funding Guidelines for Day Programs.		
<i>LON Day/Work Score or Behavior Score (whichever is higher)</i>	<i>Level of Need</i>	<i>Recommended Maximum Based on 225 Days</i>
1	Minimum	\$11,286
2	Minimum	\$15,048
3	Moderate	\$18,810
4	Moderate	\$20,691
5	Comprehensive	\$22,572
6	Comprehensive	\$24,453
7	Comprehensive	\$26,334
8	Individual Budget	\$28,215

Source: DDS

Data limitations. The Department of Developmental Services provided PRI staff with client-level cost data for 3,278 (90 percent) of the 3,657 clients receiving 24-hour residential services and attending private day/work programs. The data missing from the DDS database was for 328 clients who reside in private ICFs/MR, due to the way ICF/MR rates work. (Because the rate paid for ICFs/MR is all-inclusive, it is the responsibility of the private ICF/MR to negotiate and pay for day/work program services directly with the day/work provider.) In addition, although the data indicated that these clients had a private day/work program, there was no cost information for 53 clients in private CLAs, or 6 clients living in a public CLA.

On the public side, for STS and regional center residents also receiving their day/work program at the school, only overall average day/work costs could be calculated. For clients attending other DDS-staffed public day/work programs, the costs are accounted for similar to costs for clients in public residential settings – an average cost is calculated for the region and not on a per-client basis.

In addition, although DDS does produce an annual cost report that breaks out day/work program costs by public or private provider, the report does not allow any further breakdowns by residential status that would be beneficial for this study. For example, although DDS calculates client per diem day/work program costs by private providers, these costs are based on all DDS clients that receive day/work services, not just those in 24-hour residential care. Per diem costs are also calculated for clients attending publicly staffed day/work programs which are provided in the three DDS regions, but again, those include costs for all DDS clients, not just those in 24-hour residential care.

Overall average private day/work costs. Table V-7 shows the overall average cost per client for a private day/work program was about \$24,000, with a minimum and maximum range of \$1,453 to \$134,750 for clients with part-or full-time day per week program. Total day/work program contracted costs for these clients for FY 10 was \$78,468,836.

Table V-7. Private Day/Work Program Costs for Select DDS Clients (N=3,278)	
Mean	\$23,938
Range	\$1,453 - \$134,750
Total Costs	\$78,468,836

Source: PRI staff analysis of DDS databases

Average private day/work costs by LON. Table V-8 shows that, as one might expect, the average costs increase as the level of need score rises. The most dramatic growth in average costs is when clients have a LON score of “8,” with an average cost of \$44,329. The table also shows the cost range at each level of need. The minimum cost range includes clients that receive day/work services on a part-time basis. The highest maximum cost for a day/work program was \$134,750 for one client with a LON score of “8.”

Table V-8. Private Day/Work Program Cost Measures by Client Level of Need.				
<i>Score</i>	<i>Level of Need</i>	<i>No. of Clients</i>	<i>Average Cost</i>	<i>Cost Range</i>
1	Minimum	50	\$14,099	\$1,452 - \$37,287
2	Minimum	251	\$16,825	\$1,452 - \$57,202
3	Moderate	400	\$19,103	\$2,906 - \$23,439
4	Moderate	367	\$21,412	\$1,819 - \$68,643
5	Comprehensive	809	\$23,229	\$1,819 - \$92,573
6	Comprehensive	596	\$25,083	\$2,807 - \$133,301
7	Comprehensive	747	\$29,086	\$4,129 - \$132,426
8	Individual Program Budget	58	\$44,329	\$23,288 - \$134,750
Total		3,278	\$23,938	\$1,452 - \$134,750

Source: PRI staff analysis of DDS databases

Average private day/work costs by residential setting. PRI staff examined the average cost of private day/work services by the type of residential setting the client resided in and the average LON score for that setting (shown in Table V-9). Clients who lived at Southbury Training School, but who participate in private day/work programs, on average, had the lowest day/work program costs at \$22,554, while clients living at regional centers but attending private day/work programs had the highest average cost at slightly more than \$27,000 and had the highest average LON scores of the four settings.

Table V-9. Average Cost of Private Day/Work Program by Client’s Residential Setting and LON			
<i>Residential Setting</i>	<i>Clients Attending Private Program</i>	<i>Average LON</i>	<i>Average Cost</i>
Private CLA	2,639	4.96	\$23,746
Public CLA	351	5.17	\$24,249
Regional Center	178	5.99	\$27,161
STS	108	5.05	\$22,554

Source: PRI staff analysis of DDS databases

Clients at Public and Private Day/Work Programs by LON

PRI staff also examined the level of need score for clients being served by public day/work programs and specifically examined those with a comprehensive level of need (LON score of 5 or more). As Table V-10 shows, almost 75 percent of clients served by public day/work programs had a level of need score of “5” or higher (indicating a comprehensive level of need), while 68 percent of clients served in private day/work programs had comprehensive needs. In terms of numbers though, private providers actually serve more clients who score “5”

or higher on the level of need assessment – 2,210 clients attending private day/work programs versus 345 attending public programs.

<i>Score</i>	<i>Level of Need</i>	<i># of Clients in Public Program</i>	<i># of Clients in Private Program</i>
1	Minimum	12	58
2	Minimum	36	268
3	Moderate	53	456
4	Moderate	34	389
5	Comprehensive	125	880
6	Comprehensive	77	664
7	Comprehensive	136	880
8	Individual program budget	7	62
Total		513	3,657
*Additional 153 clients served by LEA, 68 clients did not have a day/work program (refused, retired, etc.) and information was missing for 45 clients. Source: DDS e-Camris database			

Cost Comparison Between Private and STS Day/Work Programs

The only cost comparisons between public and private day/work programs that PRI staff could perform were for clients receiving services at STS and only on an average, not specific, client-level cost basis. The reason for this is that DDS calculates the average cost of day/work programs at STS separately in its cost comparison reports. In the DDS FY 10 Cost Comparison report, the average cost of providing publicly staffed day/work programs to the 326 STS residents who stayed on campus was \$37,202 annually, 68 percent higher than the average cost of privately staffed programs attended by STS residents. Given that the average LON score was 5.23 at STS and 5.05 for the 108 STS residents served by private programs, PRI staff finds clients with similar levels of need are served by both providers, but providing services through public programs is costlier. **Therefore, the PRI committee recommends:**

The Department of Developmental Services should continue to phase out the provision of public day/work programs, with the overall goal to implement a single private delivery system for day/work services. The department should not refill any positions that are, or become, vacant in public programs, and shall redeploy existing staff to other direct services in the community as opportunities allow.

Further, the Department of Developmental Services should conduct a staffing assessment of its current staffing levels for its public day programs, using the day/work LON scores in the private programs as a guide for level of resources needed, and redeploy staff resources over those levels to other services.

As recommended for clients receiving 24-hour staffed residential services, the Department of Developmental Services should adopt a centralized utilization

review process for clients exceeding the day/work program funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.

Given the four-year no-layoff provisions in the 2011 State Employees Bargaining Agent Coalition (SEBAC) agreement, DDS is limited to downsizing most of its staff based on attrition. Recognizing this, PRI staff does not believe terminating all public programs by a specific date can be accomplished. However, DDS should continue and even accelerate its consolidation and downsizing of public programs, and wherever possible redeploy staff to serve clients in the community awaiting day/work programs, provide additional respite to families, or to support those on the waiting list waiting for a residential placement. This would not be a substitution for private services, but a productive use of staff as the state transitions to a single private provider service delivery system.

Day/Work Program Plan Review

Each client residing in a public or private CLA and enrolled in the HCBS waiver has an individual plan that guides the services and supports provided by the department. The plan is reassessed annually or if a client experiences a significant change in condition. A client's case manager is responsible for coordinating the team members, known as the Planning and Support Team (PST), who assist in the development of the plan, and may include direct care staff, health providers, clinicians, and family members or a client's guardian. However, as noted earlier, PRI staff identified almost half of the clients in the study who were employed in sheltered environments had LONs of 3 or less. While there may be other reasons why these clients need to be in a segregated day or work setting, the PRI committee believes a more rigorous assessment by the PST should be conducted to ensure a client's best interests are being served.

Also, DDS should determine why the percentage of clients competitively employed is declining. Competitive employment has never had a high percentage of participants – 5.4 percent at its highest, and as noted, the economic recession likely contributed to job losses. However, according to statistics in DDS Management Information Reports (issued at least annually), the number of clients who are competitively employed has decreased from 502 in 2007 to 371 in 2011, a drop of 26 percent. **The PRI committee recommends:**

Each client's Planning and Support Teams (PST) should review each client's day program relative to his/her LON. The objective for each client should be that he or she is participating in the most productive, meaningful work or day program in the most inclusive environment as possible. The client's PST should also be examining results of programs, such as day service options, that are geared to building skills to transition a client to a more competitive environment to ensure these outcomes are measured.

Cost of Care and New Rate Structure

The Department of Developmental Services will be transitioning to a new rate-setting structure for all DDS clients who are enrolled in the Home and Community Based waiver programs, and receive residential care and/or day/work services from a private provider. This chapter describes the reasons why and how the department will implement the new rate system. Funding levels for clients served by private providers in FY 10 are also examined and compared to DDS-promulgated residential and day/work funding guidelines based on clients' levels of need (LON), which are the basis for the new rate system scheduled for implementation in January 2012.

Transition to New Rate System for DDS Waiver Clients

The Centers for Medicare and Medicaid (CMS) is requiring states to adopt fair and equitable rate-setting systems in order for states to qualify for Medicaid reimbursement (known as federal financial participation ((FFP)). In response to new guidelines published by CMS, the department will begin transitioning to a new rate system for clients enrolled in the Medicaid Home and Community Based waiver program. The methodology for the new system will link funding for services and supports for **all** clients in private settings to already DDS-developed level of need funding guidelines for both private residential and day/work providers.

While the department's funding guidelines were first developed in 2006 and have been through several revisions, they currently apply to only a minority of clients: new clients coming into the DDS system; transitioning from a home setting to a residential placement; moving from one resident placement to another; or because he or she has had a significant change in condition. Thus, funding for most of the clients in private settings has not been subject to the department's guidelines. That will have to change to meet the CMS provisions.

States must address three areas in order to be in compliance with federal CMS requirements:

- have uniform rate-setting methodology for each mode of service;
- pay only for services actually delivered (i.e., attendance-based rates); and
- afford service recipients freedom of choice between service providers.

Attendance-based rate provision. The department has already begun implementing the attendance provisions for all clients who are in day/work programs that are reimbursed under the Home and Community-Based waiver. This will address the second CMS requirement for rates, that payments be made only for services actually delivered. In February 2010, DDS imposed a requirement for 90 percent attendance at private day/work programs, with financial hold-backs if attendance fell below that level.

Testimony was given regarding the 90 percent attendance requirement at the PRI public hearing in September 2011. In follow-up interviews with PRI staff, DDS indicated that there had

been no industry standard or prior studies on which to base the 90 percent threshold, but that it was believed achievable since most providers had attendance levels above that. Further, 10 holidays and 25 other out-of-program days are excluded from the attendance requirements.

However, providers express dissatisfaction that attendance factors apply to the programs operated by private agencies but not the DDS-operated programs. While DDS has been downsizing its public programs, as long as there is a dual system with different rules applying to the two sectors there will be inequities.

Legislative Rate Study Advisory Committee. Informal workgroups were established within DDS in 2005 to discuss needed rate changes in response to the new CMS guidelines, and some changes to the funding structure were made and applied, but mostly to new clients. Recognizing that a more comprehensive restructuring was necessary, the DDS Legislative Rate Study Advisory Committee was created in 2009, under Section 57 of Public Act 09-3 (September Special Session). The committee was composed of bi-partisan legislative members, members from the executive branch, and representatives from provider and advocacy groups. The committee was charged with studying the impact on private providers of moving from a point of service contract rate-setting system to an attendance-based, fee-for-service reimbursement model.

Rate committee findings. The committee issued its final report in January 2011. The committee found that DDS:

- has employed several different methods of funding services and supports which has led to unequal funding among DDS private providers for the same service based on historical reasons;
- did not have a utilization-based funding system in place to meet CMS requirements; and
- did not have information technology systems in place to manage to support documentation of the CMS requirements to the federal government.

Further, the rate committee found the DDS-developed level of need (LON) assessment tool was a valid instrument to measure client LON, if used correctly.

As a result of these findings, the rate committee concluded that Connecticut's existing reimbursement systems was not meeting any of the CMS requirements and therefore, the state may risk losing FFP.

Rate committee recommendations. In its report, the committee recommended that beginning in July 2011, there be a five-year transition period to phase in a LON-based funding methodology for privately operated day/work programs. The attendance provision is already being implemented.

For residential services, the report recommended the process begin the following year, July 2012, and transition over five years. In addition, the committee also recommended:

- a waiver workgroup be created to focus on key issues identified in its report;
-

- transition plans be developed and include provisions to increase funding for underfunded providers;
- waiver rates be tied to an inflation index;
- information technology systems be upgraded to provide a comprehensive database for private and public sector services and costs; and
- funding appropriations recognize the existing rate disparity and reallocate funds to the private sector through attrition in the public sector.

Department implementation of transition process. The department recognizes the need to change the funding structure but believes the timeframe established by the rate committee may be too ambitious and has established a more prolonged schedule. The two timeframes are shown in Table VI-1.

Table VI-1. Comparative Timeframes for Implementing New Rate Structure		
<i>Type of Service</i>	<i>Legislative Rate Study Advisory Committee Recommendations</i>	<i>DDS Plan</i>
Residential Service	<ul style="list-style-type: none"> ○ Begin Transition July 2012 ○ Phase in over 5 years 	<ul style="list-style-type: none"> ○ Begin Transition January 2013 ○ Phase in over 7.5 years
Day/Work Programs	<ul style="list-style-type: none"> ○ Begin Transition July 2011 ○ Phase in over 5 years 	<ul style="list-style-type: none"> ○ Begin Transition January 2012 ○ Begin July 2013 for providers at \$250,000 or less ○ Phase in over 7.5 years – two phases: <ul style="list-style-type: none"> ○ those at 8% or greater from guidelines begin January 2012 ○ those within 8 percent begin July 2013
Sources: DDS and Rate Study Committee Report		

The department believes the extended period is needed to allow providers to adjust to funding changes under the new rate-setting methodology. The department has recently informed the private provider community of the delayed implementation. In the interim, the DDS commissioner appointed a group of DDS staff, provider representatives, and the nonprofit liaison to the governor to formulate a transition plan. Two subcommittees were established under this group: a Transition and Implementation Subcommittee to develop policies, procedures and processes during the transition; and a Sustainability Subcommittee to determine a sustainable wage and benefit package for DDS providers and to evaluate the impact of indexing the package to an inflation index.

Transition process. The department intends to use a two-step process to phase in providers with the new day/work rates during the transition period. The intent is to begin the transition for agencies that provide day/work programs and are farthest from the need-based rates (greater than 8 percent above or below the rate) in January 2012, with incremental adjustments each year until funding is in alignment with the LON funding guidelines. Providers whose funding is within 8 percent will not begin the transition until July 2013. Based on DDS calculations:

- 30 percent of day/work service providers are more than 8 percent below the LON rates;
- 54 percent of these providers are within 8 percent of the LON rates; and
- 16 percent of these providers are more than 8 percent over the LON rates.

According to DDS, the two reasons for implementing the LON rate methodology in two phases are to allow the department to work with providers that have the greatest discrepancy (both above and below) in rates first. It also offers an opportunity for continued discussion and analysis around the issue of sustainable wage and benefit levels over the next two-year budget cycle.

The same process will be used for providers that begin the transition process July 1, 2013 (i.e., providers that are within 8 percent of the LON-based rates). The date to complete the transition is the same, June 30, 2019.

Transition planning. Each provider will work with the regional staff in the primary region the provider offers services to develop a transition plan. The plan is required to contain funding and LON information for people currently served and the transition amounts for each year. It will be updated on an annual basis to account for any changes to individual level of need scores or the case-mix of clients receiving services from the provider.

DDS-Developed Level of Need Funding Guidelines

There are two sets of DDS funding guidelines based on level of need scores – one for residential services and supports and the other for day/work programs. Funding for private providers serving DDS clients will be based on the funding guidelines, with providers that operate day/work programs beginning the transition on January 1, 2012 and residential providers on January 1, 2013 (as described above).

Residential funding guidelines. Table VI-2 provides the LON score, need classification, and current funding caps by approval authority. Sometimes the regional team resource allocation calculation shows an individual needs even greater services than the initial range (shown in the third column of the table). This could be due to intensive medical, physical and/or behavioral conditions and/or insufficient availability, or natural supports are unavailable and a residential placement is needed. In these cases, the regional team can only recommend higher funding up to a certain level (shown in the fourth column), even if the services and supports needed are higher.

Table VI-2. FY 10 Funding Guidelines for Residential Services and Supports				
<i>LON Score</i>	<i>Level of Need</i>	<i>Reg. Team Approval</i>	<i>Reg. Director Approval</i>	<i>Reg. Director Approval for CLA</i>
1-2	Minimum	\$27,000	\$33,000	N/A
3-4	Moderate	\$60,000	\$69,000	N/A
5-7	Comprehensive	\$93,000	\$98,000	\$139,000
8	Individual Program Budget	N/A	N/A	N/A
Funding caps do not include room and board costs.				
Source: DDS				

When the team recommends funding beyond its approval authority, a funding recommendation is forwarded to the regional director. He or she has three choices:

- the director can approve the regional team’s recommendation; or
- using discretion, if the client requires placement in a CLA and has comprehensive needs, the director can exceed the regional team’s recommendation slightly although the director’s authority is still limited (fifth column); or
- if the director believes the need exists, (i.e., without the additional funding, the client’s health and safety would be jeopardized), the director can forward a recommendation to the regional Utilization Review Team at the regional office for approval of a higher funding level.

Utilization resource review (UR). Each DDS region has a utilization resource review committee made up of the region’s three assistant directors, the regional team manager, and the directors of clinical services, health services, and quality improvement. If a client’s health and safety needs exceed the LON approved funding caps, a request for additional services and support may be submitted to the utilization review committee. The committee reviews all requests for intensive staffing in DDS-funded, operated, or licensed services. If a client’s need for intensive staffing support is because of behavioral reasons and is expected to exceed six months, the request must be presented to a regional UR team.

Residential funding comparison to LON funding guidelines. The PRI committee examined contracted costs in FY 10 for clients residing in private CLAs to determine the relationship between the funding guidelines and actual contracted funding for the year. Table VI-3 shows, by LON score, information on 2,836 clients who resided in private CLAs and for whom cost data were available for FY 10. The table below shows the maximum funding threshold before a regional utilization review team must approve the excess expenditure, the number of clients within the LON score, the number exceeding the funding threshold, and the percent that exceeds the threshold. It is important to note that these thresholds are only for DDS residential services and supports and do not include a client’s day/work program, DSS-calculated room and board costs, or any one-time funding received by the client.

<i>LON Score</i>	<i>Classification</i>	<i>Reg. Director Approval Threshold</i>	<i>Total Clients with Cost Data</i>	<i># over Threshold</i>	<i>Percent Over Threshold</i>
1-2	Minimum	\$33,000	237	222	96%
3-4	Moderate	\$69,000	707	476	67%
5-7	Comprehensive	\$139,000	1,892	392	21%
8	Individual Program Budget	n/a	n/a	n/a	n/a

Source: PRI staff analysis of DDS databases

The PRI committee found that almost half of all clients in 24-hour private CLAs, for which there were data, exceed the residential funding thresholds. Further, almost all clients with a LON score of “1” or “2” are over the funding threshold although in terms of numbers, clients

with moderate or comprehensive needs make up the majority of those exceeding the limits. As noted previously, clients who have a LON score of “8” have individual program budgets determined by the regional team and residential funding guidelines for these clients have not been promulgated by DDS since their needs are unique.

Similar to the DDS-staff analysis for day/work programs discussed above, PRI staff calculated the number of clients that are 10 percent over or under the funding guideline thresholds in FY 10, as well as within 10 percent of the funding threshold (shown in Table VI-4). The range in funding is shown and is grouped by whether clients have a minimum, moderate, or comprehensive level of need. This table is important because it is an indication of the extensive systemic adjustments providers will have to make in order to bring them into alignment with the DDS residential funding guidelines.

Table VI-4. Maximum Residential Funding Guidelines based on Level of Need						
<i>LON Score</i>	<i>Funding Guideline</i>	<i>Total Clients</i>	<i>More than 10 percent below threshold</i>	<i>Within 10 percent of threshold</i>	<i>More than 10 percent over threshold</i>	<i>Range</i>
1-2	\$33,000	237	11 clients (i.e. below \$29,700)	8 clients (between \$29,700 – \$36,300)	218 (over \$36,300)	\$8,604 - \$204,576
3-4	\$69,000	707	133 (i.e. below \$62,100)	146 (between \$62,100 - \$75,900)	428 (Over \$75,900)	\$29,712 - \$247,692
5-7	\$139,000	1,892	1,318 (i.e., below \$125,100)	341 (between \$125,100 – 152,900)	233 Over \$152,900	\$25,464 - \$369,600
8	Individual Program Budget	44	n/a	n/a	n/a	n/a
LON 1-2: no data available for 6 clients LON 3-4: no data available for 12 clients LON 5, 6, or 7: no data available for 33 clients Source: PRI staff analysis of DDS databases						

Day/work funding comparison to LON funding guidelines. Using the FY 10 contract data, PRI staff identified 3,278 clients receiving 24-hour residential services who were served by private day/work providers. Table VI-5 compares the recommended maximum day/work thresholds for each level of need to the actual contracted day/work cost. The table shows that the day/work funding thresholds exceeded the recommended maximum funding guideline for 48 percent of clients living in 24-hour residential settings. The highest percent of clients with funding over the maximum occurred with clients who had a level of need score of “1” (70 percent of the 50 clients) and a level of “8” (81 percent of clients), although high percents over the threshold occurred in all LON ranges.

Impact on private providers. Based on the analysis in this chapter it is expected that the results of the new rate system will have significant consequences for some private providers of both residential and day/work programs. In response to the funding changes, some providers will have to reduce expenses, or add additional participants without an increase in funding. Given the tremendous variation and substantial deviation from the funding thresholds, it will

probably take the full seven and a half year transition period for all clients' funding authorization to match the LON-based allocation. Therefore, the PRI committee finds:

The Department of Developmental Services should implement its phase-in schedule for residential and day/work programs. This gradual transition to the new rates will help absorb any funding shocks to individual providers.

Table VI-5. Number and Percent of Clients Exceeding Day/Work Program Cost Threshold					
LON Score	Classification	Recommended Maximum	Total Clients with Cost Data	Number over Threshold	Percent Over Threshold
1	Minimum	\$11,286	50	35	70%
2	Minimum	\$15,048	251	142	57%
3	Moderate	\$18,810	400	178	45%
4	Moderate	\$20,691	367	164	45%
5	Comprehensive	\$22,572	809	380	47%
6	Comprehensive	\$24,453	596	260	44%
7	Comprehensive	\$26,334	747	374	50%
8	-	\$28,215	58	47	81%
Total			3,278	1,580	48%

Source: PRI staff analysis of DDS databases

As recommended in Chapter IV for clients receiving 24-hour staffed residential services and exceeding the day/work funding thresholds, in the interim, PRI also recommends that a more stringent utilization review process be developed for residential programs as follows:

The Department of Developmental Services should adopt a centralized utilization review process for clients exceeding the residential funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.

Upgrading Information Technology Systems and Ensuring Accurate Client Data

The Department of Developmental Services information technology systems are inadequate and in need of upgrades, and there needs to be more emphasis on consistency in data entry and in keeping data current. As noted in the report produced by the DDS Legislative Rate Study Advisory Committee, DDS does not have the “information technology systems in place to effectively manage the documentation and system requirements to meet waiver assurances,” as required by CMS. The current Medicaid waiver regulations require providers to document the delivery of services in the type, scope, duration and frequency outlined in the Individual Plan. To accomplish this, the rate study committee recommended that IT systems be upgraded to provide a comprehensive database for private and public sector services and costs.

This will be a significant undertaking. As an indication, to arrive at the total costs of care for clients served by DDS, PRI staff combined cost and client information from several different sources, both within DDS and from data maintained by the Department of Social Services and the Department of Public Health. Even within the Department of Developmental Services, client information was spread across four different databases.

DDS is currently preparing an Advance Planning Document (APD) application to the Centers for Medicare and Medicaid requesting funding to develop the data applications of a Medicaid management information system (MMIS) needed to meet the waiver requirements. If the application is approved, DDS will receive up to 90 percent federal reimbursement for all IT development costs and 75 percent for federal reimbursement for ongoing system maintenance. Setting up the new IT system will be a complex and multi-year effort, and must dovetail with the Department of Social Services' activities, since it is the lead Medicaid agency. Ultimately, the new system will assist in capturing budget allocations at the individual level, which can then be tied to other individual demographic data.

The PRI committee finds the implementation of a new IT system that merges client demographics with individual cost data is vital to the department in order to manage client costs more efficiently, identify outliers, and determine the reasons for this. However, the committee finds the accuracy of the information, particularly in the database that contains client demographic information, questionable.

For example, the database indicated there were 49 clients who had lived at their residences for 66 years, but when PRI staff examined the ages of these clients, only 11 of them were 66 years old or older and therefore were not able to have lived at their residences that long. Similarly, there were 41 clients residing at STS that according to the database had been admitted after admissions to the school were closed in 1986. Since a client's case manager is the individual responsible for inputting demographic information, PRI staff believes there should be some kind of quality check performed to ensure that client data is accurate and up-to-date. **Therefore, the PRI committee recommends:**

The Department of Developmental Services should remind its case managers of the importance of keeping client automated records up to date.

The Department of Development Services should randomly audit a sample of cases in its client demographic database to ensure client information is accurate.

An audit of this database could be conducted simply, with a list of five percent of clients in each region with demographic information attached generated by the central office and sent to each the regional office. Each region could conduct a quick review, correct any inaccurate information and report the number and percent of clients with incorrect information back to the central office. If the number of clients with inaccurate information exceeds a certain percentage, the central office could determine if a more widespread audit is needed.

Another area where there appeared to be inconsistency in reporting by DDS was in CORE-CT, the state's automated personnel system, from which PRI staff obtained some of the DDS staffing information. For one region, locations for position classes were assigned by

generic office (e.g., West Region, administration building) while another region inputted the position class location by program within the region (e.g. South Region, Early Connections). This made it difficult to compare staffing levels and assignment by region. Since the CORE-CT system is the state's only personnel system from which to obtain and analyze staffing information, it is important that data be entered with some degree of consistency.

Quality Assurance

Of course, quality of care should not be compromised in order to reduce costs. To ensure quality standards are met, all 24-hour residential care homes and facilities are regulated. However, the way in which residences are licensed, inspected, and monitored varies depending on the type of facility. If the facility is an intermediate care facility (ICF/MR) it is certified by the federal Centers for Medicare and Medicaid (CMS), under federal regulations.²⁰ These regulations are similar to those that apply to nursing homes. The inspection and monitoring is carried out by the state Department of Public Health, the agency designated by CMS to oversee ICFs/MR and nursing homes in Connecticut. The certification of ICFs/MR is necessary in order for the state to receive federal reimbursement for the costs of care for the residents who live there.

If the residence is a community living arrangement, the Department of Developmental Services (DDS) inspects, licenses, and monitors these homes using department regulations. The regulations were adopted in 1992, as the move to community residential placements and away from institutions was beginning. Residential services in community living arrangements (CLAs) in Connecticut are eligible for Medicaid reimbursement through the comprehensive waiver program 1915(c) as long as the residents are Medicaid eligible. While CMS does not require that the home be licensed per se, CMS does require that standards of health and safety be maintained.

CMS is currently revising its quality requirements and the standards and measures a state must report on in order to participate in the waiver program. Many of the measures are client-based and revolve around client choice and satisfaction. DDS has received a grant to design and build a data system and adapt its data collection efforts in order to comply with these new quality service review (QSR) directives. Thus, these quality review measures were not comprehensively available for program review staff to assess and analyze.

Focus on CLA Licensing Inspections

Because the QSR measures are still unavailable, program review staff sought other standards that might be used to evaluate quality of care. In discussions with agency staff, advocates, and others, there does not appear to be consensus around a set of quality measures that one could easily use to rate or assess quality. Therefore, program review staff focused primarily on the number and areas of deficiencies found in licensing and certification inspections and, to the extent possible, the provision of preventative health and dental care to clients with intellectual disabilities in 24-hour residential settings.

Quality assurance for CLAs. An initial inspection is required before a community living arrangement can be licensed. Licensing inspections are required prior to licensure, six and 12 months after the initial licensure, and at least biennially thereafter. While licenses are renewed

²⁰ The federal Centers for Medicare and Medicaid are proposing a modification in regulations to change the name to Intermediate Care Facilities for Intellectually Disabled. This should take effect early in 2012.

annually, inspections are only required at least every two years. If an inspection indicates deficiencies or problems exist, a “revisit” or follow-up inspection may be done. Annual inspections are conducted if a home or provider needs increased monitoring. Also, even if a full licensing inspection is not conducted annually, quality service reviews are performed of all CLAs during the interim year.²¹

The Quality Assurance Division maintains a database that includes information on each inspection, and data from that database for FY 10 were used for this analysis. While DDS also “licenses” private ICF/MRs, the ultimate regulation tied to reimbursement lies with DPH, and thus the analysis of the inspection results of those facilities is provided separately later in this section.

Inspections in FY 10. In FY 10, DDS conducted 542 licensing visits to 477 homes – 443 CLAs (93%) and 34 ICF/MRs (7%). Table VII-1 shows a profile of the inspections of the 443 CLAs that were conducted during that year. As the table shows, three-quarters of the inspections were standard, but more than 20 percent were “revisits”. While over 90 percent of the inspections were conducted of private CLAs, a similar percentage of both private and public was inspected during FY 10 – about 60 percent of the 70 public homes, and 56 percent of the 731 private CLAs.

Table VII-1. CLA Inspections During FY 10 N=443		
<i>Type of Review</i>		
	<i>Number</i>	<i>Percent</i>
Standard	338	76%
Revisit	93	21%
Other	12	3%
TOTAL	443	
Agency Type		
Public N= 70	42	9%
Private N=731	401	91%
TOTAL	443	
Licensing Period		
Annual	37	8%
Biennial	398	90%
Other	8	2%
TOTAL	443	
Announced/Unannounced Visit		
Announced	344	78%
Unannounced	99	22%
TOTAL	443	
Source: DDS licensing data		

Table VII-1 also shows whether the visits were announced or not; most of the inspections (78%) are announced. Inspectors need access to the house and client and staffing records, and therefore typically schedule in advance so that someone will be at the CLA to provide that access. (CLAs are unlike nursing homes and other facilities where staff and residents are always there.)

²¹ Quality service reviews (QSRs) include interviews of at least one consumer and support staff, as well as observation and review of safety checklist and other home documentation.

Deficiencies. When an inspection is conducted, inspectors are looking at whether the home complies with the regulations; citations are given by section of the regulations if the home is found to be non-compliant.

Table VII-2 below shows the categories the regulations cover, from health services, (which include medication administration, whether the client’s medical needs are being met to whether the client has had a recent dental check-up) to financial records (which would include whether the clients’ finances appear in order). The table shows the number of CLAs with deficiencies in each category cited for all 504 CLA licensure visits (including revisits) in FY 10. Sixty-four percent of the inspections resulted in a finding of a deficiency in the health services area, while over half had a physical requirement deficiency (e.g., adequate living space, phone and laundry access, water temperature, etc.). More than 42 percent had a citation around emergency planning (from fire drills to whether plans on how to evacuate clients in a timely fashion existed). Overall, an average of six deficiencies was found at each home inspected.

Table VII-2. Deficiencies for CLA Licensure Visits in FY 10 (N=504)		
<i>At Least 1 Deficiency within the Category</i>	<i>Number of CLAs with Deficiencies by Category</i>	<i>% of CLA Visited with that Deficiency</i>
Health services	320	64%
Physical requirements	290	58%
Habilitative services	243	48%
Emergency planning	214	42%
Staff development	196	39%
Special protections	174	35%
Financial records	105	21%
Plans of correction	76	15%
Policies and procedures	43	8%
Annual license renewal	29	6%
Individual records	29	6%
Initial application	6	1%
Licensure	1	<1%
TOTAL SITE VISITS	504	
Average # of deficiencies per CLA	6	

Source: DDS licensing data.

Table VII-3 below categorizes deficiencies by size of the provider (i.e., number of homes the provider has). Given that six was the average number of deficiencies per home, PRI examined the types of providers that had a much greater than average number of deficiencies per home, and identified several factors. All but four private providers had at least one home inspected during FY 10. Of the 26 private providers that had 8 or more citations per home, fully half (13) had 5 or fewer homes. Further all six providers with the greatest number of deficiencies (13+) had five or fewer homes. This may be because very small providers are not as familiar with the regulations and how to comply. There also may be a more relaxed attitude given that these providers serve fewer clients. However, DDS, the largest single provider in the

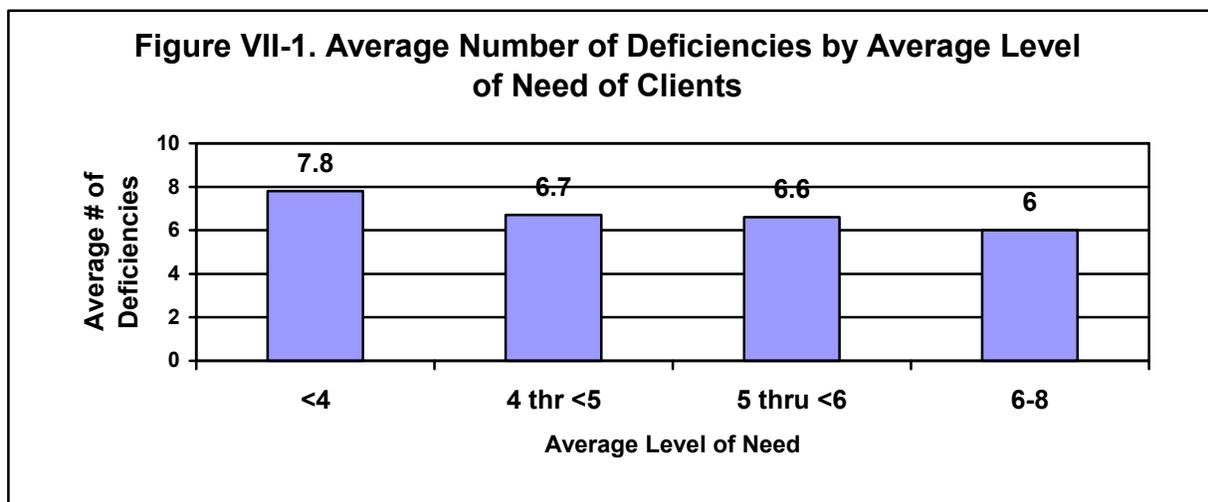
state, and one that should be very familiar with the regulations, was cited with high deficiencies. In each of the three regions, DDS CLAs had greater than the average number of deficiencies per home.

Table VII-3. Number of Deficiencies by Size of Providers –FY 10								
Category of Providers by Number of Homes	Number of Deficiencies							
	0	.45-2.99	3 to 3.99	4 to 5.99	6 to 7.99	8 to 9.99	10 to 12.99	13 +
One home (N= 8)		1		1	1	2	2	1
2-5 (N= 22)	2		2	4	6	2	1	5
6-10 (N=18)		1	3	5	1	6	2	
11-20 (N=16)		2	3	3	5	1	2	
21-50 (N=8)		1	3	2	1		2	
51+ (N=1)				1				
Total Private	2	5	11	16	14	11	9	6
Public DDS Regions (N=3) (51+ homes)						2	1	

Source: DDS licensing inspection data FY 10

Level of Need in the CLA

PRI also analyzed the inspection data to determine whether the average level of need in a group home had a bearing on the number of deficiencies found. Interestingly, as Figure VII-1 shows, the average number of deficiencies identified in a CLA actually decreased as the overall level of need (averaged for residents in the home) increased. This may suggest that as the average LON increases, there are more staffing and other resources available for clients, and concomitantly, compliance with the regulations.



Severity of deficiencies. While number of deficiencies per home is one measure of quality, program review staff had asked if there were categories or degrees of deficiencies that may be indicators of better or worse quality. Unfortunately, such a yardstick for measuring

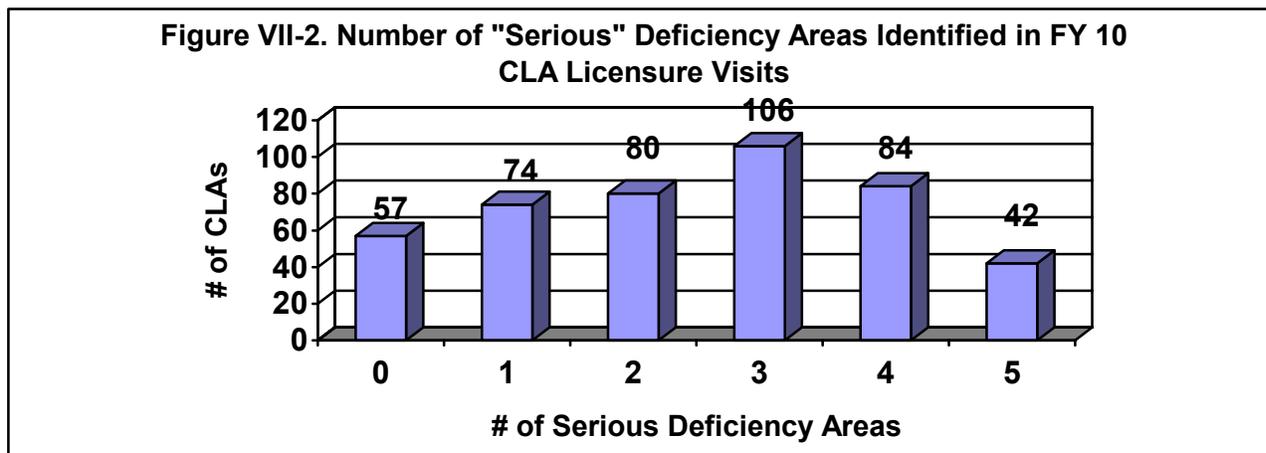
overall quality does not appear to exist for CLAs. The regulations indicate that DDS may issue a compliance order if a home fails to comply with certain regulations regarding licensed capacity, increasing staff support, requiring additional staff training, or correcting specific licensing citations. However, DDS licensing staff state no provider has been issued such an order in a number of years, and order issuance is not captured on the licensing database.

In discussing the issue of severity with PRI staff, DDS licensing inspectors identified the following areas as more serious deficiencies:

- emergency planning;
- health services;
- physical requirements;
- special protections; and
- staff development.

Figure VII-2 shows 57 of the 443 CLAs (13 percent of inspections) had *no* deficiencies in the more serious areas while 42 CLAs (10 percent of inspections) had at least one deficiency in *each* of the five important deficiency areas.

However, these areas cover most of the regulation categories, and once again, the lack of severity identification within the category is a shortcoming. PRI examined the citations in the health services category in greater detail and the results of that analysis are contained in Appendix D. That analysis found the most frequent citation within the health services category was around medication administration (34 percent of inspections), followed by coordination, assessment and monitoring of medical care (31 percent of inspections).



While no compliance orders have been issued recently, the department does require a plan of action for any inspection where citation of deficiencies occur. The provider must submit the plan to DDS within 15 days of receiving the summary of citation report. The department reviews the plan and, if sufficient, issues the license renewal. The department may “revisit” the home to follow up on a particular plan of correction, or the department may place a home on an annual licensing inspection schedule. However, as Table VI-1 indicated, only 37 inspections

(8%) were an annual licensing inspection, which would be fewer than five percent of the number of CLAs.

Review of Historical Licensing Visits

PRI focused its analysis primarily on the FY 10 licensing information, as that time period is the basis of other client and cost information in the study. However, the DDS licensing database contained information on more than 7,100 inspections of CLAs that occurred between July 1995 and February 2011, and a summary analysis of that data is presented in Table VII-4. It is important to note that the number of private or public homes has not been static over the period analyzed. The number of private CLAs increased from 410 in FY 95 to 732 homes in FY 10, a 78 percent increase, while the number of public homes has declined 30 percent, from 101 in FY 95 to 70 in FY 10.

The table shows the average number of deficiencies identified during the 7,761 licensing site visits occurring between July 1995 and February 2011. Overall, many more deficiencies are found during standard visits, rather than a revisit, which makes sense since revisits are often a follow-up to a plan of corrective action.

Table VII-4. Results of CLA Inspections 1995-2011	
<i>Type of Review</i>	<i>Average # of Deficiencies Cited</i>
Standard	9.8 (n=5,472)
Revisit	4.4 (n=1,223)
Other	5.6 (n=476)
TOTAL	8.6 (N=7,171)
Agency Type	
Public	11.5 (n=1,264)
Private	7.9 (n=5,907)
TOTAL	8.5 (N=7,171)
Licensing Period	
Annual	13.4 (n=626)
Biennial	8.2 (n=5,199)
Other	7.6 (n=1,346)
TOTAL	8.6 (N=7,171)
Announced/Unannounced Visit	
Announced	9.4 (n=5,872)
Unannounced	4.6 (n=1,299)
TOTAL	8.6 (N=7,171)
Source: PRI staff analysis of DDS licensing inspection results	

While revisits made up fewer than 20 percent of all inspections, they are much more likely to be unannounced visits – 80 percent of the time – whereas standard visits are unannounced only five percent of the time. Also, as indicated earlier, providers with compliance problems may be put on an annual licensing schedule. The data in Table VII-4 show that annual visits detect more deficiencies than biennial visits.

Also noteworthy are the results of public home inspections compared to the private CLAs – with an average of 11.5 deficiencies found in public homes compared to 7.9 in private residences over the 15 years. It also shows that in comparison to the FY 10 results, the average number of deficiencies has historically been higher, especially in the public homes. The number of citations in public homes appears to contradict concerns often raised by private providers that licensing inspections of public homes are not as thorough. On the other hand it does raise an issue regarding ongoing non-compliance, if the average number of deficiencies in public homes is that high.

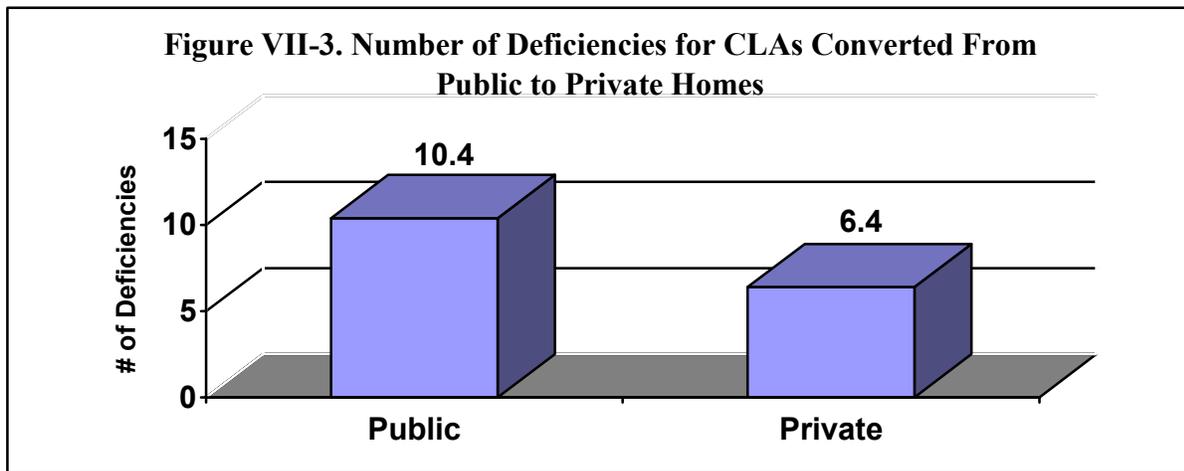
FY 10 Licensing Inspections

Table VII-5 compares several aspects of licensing inspections in public vs. private CLAs for FY 10. The percentage of reviews that were revisits is somewhat higher in public homes than private homes, but given that there are substantially fewer public homes (70 public versus 731 private) this might be expected. A very small percentage of both sectors homes are on an annual licensing inspection cycle. The only statistically significant difference between the two types of homes is in the average number of deficiencies, which is considerably higher for the public CLAs.

Table VII-5. Profile of Licensing Reviews Conducted in FY 10¹ for Public vs. Private CLAs			
	<i>Public CLA (n=42 inspections)</i>	<i>Private CLA (n=401 inspections)</i>	<i>Total (N=443)</i>
Type of Review			
Standard	28 (67%)	310 (77%)	338 (76%)
Revisit	13 (31%)	80 (20%)	93 (21%)
Other	1 (2%)	11 (3%)	12 (3%)
TOTAL	42 (100%)	401 (100%)	443 (100%)
Licensing Period			
Annual	3 (7%)	34 (8%)	37 (8%)
Biennial	37 (88%)	361 (90%)	398 (90%)
Other	2 (5%)	6 (2%)	8 (2%)
TOTAL	42 (100%)	34 (100%)	443 (100%)
Average Number of Deficiencies			
	10	6.4	7
¹ Type of licensing review conducted is for first visit if more than one visit occurred in FY 10. Source: DDS			

Public-to-Private CLAs. To further test the contention that public homes are treated differently than private homes, PRI examined the licensing inspection data from the 17 homes that were transferred over from DDS-run homes to private agencies. DDS was able to convert these homes after a number of direct care workers left state services in 2009 as a result of the Retirement Incentive Program (RIP). Figure VII-3 contrasts the findings from the last (public) licensing visit that occurred just prior to the conversion to a private CLA with the findings from the first licensing visit that occurred for the CLA as a private home. The results, depicted in the graph, show there were significantly more deficiencies for the CLA at the time it was a public home. In particular, when CLAs were public homes, they were more likely to have at least one deficiency in the area of staff development – 76 percent when public CLA vs. 35 percent when

private CLA. The CLAs were also likely to have more of the “serious” deficiencies when they were public homes compared to when they became private homes.



Overall, the analysis suggests that licensing inspections conducted by DDS do not “favor” public over private homes. However, apparent continued non-compliance -- indicated by historically and current higher deficiency numbers in the public homes -- is a matter of concern, and may call into question the strength of follow-up enforcement of public homes.

The committee directed staff to examine the issue of continuing non-compliance further. When deficiencies are found the provider must submit a written plan informing DDS how the deficiencies will be corrected. At the next regular inspection, if the corrections have not been made the inspector will cite that as a “plan of correction” deficiency. Thus, this citation would be a proxy for continued non-compliance. *PRI staff examined the FY 10 licensure data for this type of deficiency and found that only 13 percent of the private homes were cited for “plan of correction” deficiencies, while 38 percent of the DDS-operated homes were cited, almost three times the rate.*

The committee also asked that staff further analyze what types of deficiencies were found in the 17 CLAs pre- and post-conversion. Table VII-6 below shows the total number of deficiencies found by category when the homes were public and after the conversion to private. The analysis provided in the table shows that:

- *in all categories there were fewer deficiencies after the conversion to private homes;*
- *the average percentage drop in the total number of deficiencies was 44 percent; and*
- *in some categories the drop was dramatic – by 40 percent or more.*

The highest number of deficiencies for the public homes was in the area of staff development, which would include documentation that direct care staff have had training some time in the past two years in such areas as emergency procedures, communicable disease control,

and signs and symptoms of diseases and illnesses. A total of 54 such deficiencies was found in the last licensing inspections before the conversions, while after the conversions to private only 18 staff development deficiencies were found, a 67 percent drop.

<i>Category of Deficiency</i>	<i>Number of Deficiencies Pre-Conversion (public)</i>	<i>Number of Deficiencies Post-Conversion (private)</i>	<i>Percent Decrease After Conversion</i>
Plans of correction	5	3	40%
Physical plant/facility	33	23	30%
Emergency planning	16	13	19%
Staff development	54	18	67%
Special protections	23	12	48%
Individual records	2	0	100%
Facilitative services	19	15	21%
Financial records	6	4	33%
Health services	20	12	40%
Total	178	100	44%

Source: DDS licensing inspection data

The second-highest number of deficiencies (33) in public CLAs was in the area of physical requirements (e.g., residence and grounds free from debris, furnishings in good repair). This compared to 23 citations in that category at the same homes after they were converted – a 30 percent drop.

Thus the program review committee finds that overall quality in private homes is, on average, better, based on:

- *lower number of deficiencies;*
- *better compliance with plans of correction; and*
- *the drop in deficiencies in all areas in the homes that were converted from public to private CLAs.*

Quality Assurance in ICFs/MR

There are 69 private ICFs, operated by 14 different providers in various communities. While the facilities vary in size, all can accommodate at least four people and most have between four and six clients. In all, the private ICFs have about 382 beds.

There are approximately 680 certified ICF/MR beds in DDS facilities. For certification and inspection purposes, there are 37 certified public ICFs operated by DDS at five regional centers and Southbury. On average, then, the public ICFs have about 18 people per residence compared to 5.5 per home in private ICFs. Further, all the private ICFs are located in the community while none of the public ICFs is situated in a community, but are on campus-like settings.

The state Department of Public Health annually certifies all ICFs/MR (public and private), a necessary designation in order to receive federal reimbursement. PRI staff obtained

certification inspection information for those facilities for state FY 10, and the results are analyzed below.

Overall deficiencies. For ICFs/MR, there are approximately 400 different citations (or “tags”) of deficiencies under eight major areas such as client protections, facility staffing, active treatment, and health care services. DPH generates reports on the total number of deficiencies found during these inspections (also known as surveys) as well as a report containing deficiencies that are of a more serious nature, known as “conditions of concern”. PRI staff requested both types of reports for all ICFs/MR surveyed by DPH during state FY 10, the period selected for the purposes of the study. Table VII-7 shows the overall average number of deficiencies by private ICF compared to the public facilities.

Table VII-7. Deficiencies by Facility for ICFs/MR: FY 10			
<i>Type</i>	<i>Total deficiencies</i>	<i>Average per facility</i>	<i>Range</i>
Private ICFs N=67	195	2.9	0 – 16
Public ICFs N=36	127	3.5	0 – 18

Source: DPH survey data for FY 10

Sixty-seven of the 69 private ICFs/MR and 36 of the 37 public facilities were inspected during the state fiscal year, while two privates and one public ICF were not inspected during the FY 10 period. On average there were .6 fewer deficiencies found in the private ICFs/MR than in the public facilities. There was an average of 2.9 deficiencies for each private facility inspected, and 15 of the 65 (23%) homes had no deficiencies. The public facilities had an average of 3.5 citations and 6 public facilities (17%) had a deficiency-free inspection.

In addition, three facilities with many deficiencies were surveyed twice during the period reported. Two of the 37 public facilities (5.4%) were inspected twice, while one of the 69 private ICFs/MR (1.4%) was inspected a second time during the year. *As with the CLAs, program review staff finds that, based on the average number of deficiencies found, the quality of the private ICFs is somewhat higher than the public ICFs.*

Deficiencies by violation category. While the overall number of deficiencies is one assessment of quality, facility performance can vary depending on the measure assessed. PRI staff also examined the average number of deficiencies in each of the eight major categories and compared those between public and private facilities, as well as to the overall average. As Table VII-8 shows, in five categories – facility management, client protection, staffing, behavior management and physical environment – public facilities had higher than the overall average number of deficiencies. In three categories – active treatment, health services and dietary needs – however, the private sector facilities had a higher number of deficiencies than the overall average.

Table VII-8. Deficiencies by Citation Area: Comparison of Inspection results for Public (#36) vs. Private (#67) and Overall (#103) for FY 10			
<i>Category of Deficiency</i>	<i>Total # of Deficiencies and Average in this Category for All Facilities Inspected N=103</i>	<i>Number and Avg. Deficiencies in Category for Public Facilities Inspected N=36</i>	<i>Number and Avg. for Deficiencies in Category for Private Facilities Inspected N=67</i>
Facility Management: Records for each client; Staff has access to and records info; Privacy of records	N=17 Average = .16 per facility	N=12 Average = .33 per facility	N=5 Average .07 per facility
Client Protections: Ensures clients are not subject to abuse or punishment; Keep personal belongings; Ensures client privacy	N=86 Average = .83 per facility	N=43 Average = 1.2 per facility	N=43 Average = .64 per facility
Facility Staffing: Sufficient staffing to meet client needs; Coordination and monitoring of client program plan	N=25 Average = .24 per facility	N=10 Average = .27 per facility	N=15 Average = .22 per facility
Active Treatment Services: Opportunity for clients and family to participate in program and plan development; Clients' basic skills are developed and maintained	N=46 Average =.44 per facility	N=14 Average =.38 per facility	N=32 Average =.47 per facility
Client Behavior and Facility Practices: Intervention methods contain safeguards; Minimal use of physical restraints; Policies and procedures on use clearly defined	N=14 Average =.13 per facility	N=6 Average =.16 per facility	N=8 Average = .11 per facility
Health Care Services: Facility provides preventive and general health care services; All medicines administered without error; Nursing services provided	N=93 Average = .87 per facility	N=26 Average = .72 per facility	N=67 Average = 1.0 per facility
Physical Environment: Evacuation plans implemented and corrective actions taken; Adequate space and clients' housing promotes growth and development	N=34 Average = .32 per facility	N=14 Average = .38 per facility	N=20 Average = .29 per facility
Dietary services: Dietary needs adequately met	N=12 Average = .11 per facility	N=0 Average =0 per facility	N=12 Average =.17 per facility
Source: PRI staff analysis of DPH ICF/MR inspection results			

Deficiencies by facility bed-size. Table VII-9 shows the average number of deficiencies by number of beds per facility. A major drawback in conducting this analysis is the fact that there is not a mix of both providers of service for all sizes of facilities. All of the larger (over 10 beds) are public, while none of the six-bed facilities are public. Thus, it is difficult to state with any certainty whether the number of deficiencies is related more to bed size or the type of provider of the service.

Table VII-9. Number of Deficiencies by ICF/MR Facility by Bed Size and Provider Type – FY 10			
<i>Size of Facility</i>		<i>Deficiencies By Size and Type of Provider</i>	
5 beds or Fewer		Average # of Deficiencies	Range of Deficiencies
Total number of facilities	21	2.61	0-9
Number private	19	.73	0-9
Number public	2	3.5	2-5
Six Beds		Average # of Deficiencies	Range of Deficiencies
Total number	47	3.2	0-14
Number private	47	3.2	0-14
Number public	0	N/A	N/A
8-10 beds		Average # of Deficiencies	Range of Deficiencies
Total number	4	2	1-4
Number private	1	1	1
Number public	3	2.3	1-4
Over 10 beds		Average # of Deficiencies	Range of Deficiencies
Total number	31	3.6	0-16
Number private	0	0	N/A
Number public	31	3.6	0-16
Source: PRI staff analysis of DPH ICF/MR inspection data			

The report generated by DPH on the more serious violations or “conditions of concern” shows similar results. The violations typically are in the areas of health services, active treatment, or client protections. There were a total of 11 inspections that generated such a report, and 7 of those were at public ICFs/MR; in fact one of the public ICFs was cited twice during the FY 10 period. *Thus, 6 of the 30 public ICFs/MR (20 percent) were cited as having serious deficiencies, while only four of the 69 private ICFs/MR (6 percent) were cited.*

Therefore, based on this analysis, and the cost information discussed in previous sections, the program review committee finds:

- *a lower average number of total deficiencies in private ICFs;*
- *many fewer citations of more serious “conditions of concern” in private ICFs;*
- *private facilities had fewer than the average number of deficiencies in five of the eight major categories surveyed;*
- *fewer people per private home than the public ICFs;*
- *public ICFs/MR are located at campus facilities, and not in the community;*
and

- on average, residential care is provided less expensively at private ICFs.

From the results of both the ICF/MR certification surveys and the results of the DDS licensing inspections, the program review committee finds that the quality of residential care is not lower in private settings, even though less expensive on average. These findings all support a transition to a private residential system for DDS clients, as recommended in Chapter IV.

The program review committee recommends the results of quality inspections should be shared with all clients’ Planning and Support Teams, which would include guardians and families. The results can be part of an education process about private community settings, and may help some clients’ families reach a positive decision about moving from an institutional facility to the community.

The sharing of such information could be done either through the provider posting the latest inspection results on the agency’s website, if available, or posting the most recent report in a public area of the group home or facility itself.

Health Services

A particular concern around quality for clients with intellectual disabilities is the provision of health and dental care. Often, DDS consumers have special medical and dental needs, and may also have anxieties and fears of medical and dental procedures. This, coupled with low Medicaid rates, presents difficulties in locating providers who will treat Medicaid DDS clients. Program review staff had hoped to compare health services provided to DDS clients in the various residential settings. However, staff was unable to do so because it could not access comprehensive health care information for the DDS clients. The vast majority of DDS clients are dually eligible for Medicare and Medicaid; the covered services dually eligible clients might receive under each program are shown in Table VII-10.

Table VII-10. Covered Services by Program for Dually Eligible Clients	
Medicare (100% federal reimbursement)	Medicaid (50% federal reimbursement)
Acute care (hospital) services	Medicare cost-sharing (premiums and deductibles)
Outpatient, physician, and other supplier services	Transportation to medical appointments
Skilled nursing facility services (typically following hospital stay and with other limitations)	Nursing home care
Home health care	Home health not covered by Medicare
Dialysis	Optional services such as dental and personal care
Prescription drugs	A portion of prescription drugs
Durable medical equipment	Durable medical equipment not covered by Medicare
Source: Department of Social Services Presentation to Medicaid Management of Care Council, Oct. 2011	

Medicaid is intended to be the payor of last resort, and so, as the table shows, Medicare is the primary payer of most inpatient and outpatient services. However, because that program is operated and reimbursed totally by the federal government, no data on Medicare claims or payments were available, severely limiting any analysis of health services to the DDS dually eligible clients.

Dental care. As shown in the table, one service that is not a Medicare service is dental care. Connecticut is one of only 11 states that offer comprehensive dental care to adults as a Medicaid option. However, the difficulty is in locating dental providers that will accept Medicaid clients at the Medicaid payment rates offered – typically about half of the commercial insurance reimbursement levels.

PRI staff examined FY 10 Medicaid expenditures – which would be 50 percent federally reimbursable – for dental care for the clients in 24-hour residential care, which totaled \$518,459. However, only 2,800 of the 4,387 clients in 24-hour care had a Medicaid dental claim or payment. Thus, the average Medicaid dental costs for those clients with dental claims were about \$185. The most plausible explanation for the apparent underutilization is the lack of access to dental providers accepting Medicaid clients.

Because of the issue surrounding access to dental care, the Department of Developmental Services has a staff person who serves as dental coordinator for the agency’s clients. The role of the coordinator is to “educate, communicate, collaborate, and facilitate access to dental services for the consumers of DDS”. By working closely with consumers and their families, guardians, case managers, nurses and dental care providers, the department tries to make certain that each individual receives the dental care they need. In order to ensure access, the department operates four dental clinics to serve DDS clients. Table VII-11 summarizes information regarding the clinics.

Table VII-11. DDS Dental Clinics		
<i>Location</i>	<i>Staff</i>	<i>Consumers Served - by Type of Residential Setting</i>
Norwich	1 Full time dentist 1 Full-time hygienist	760 565 living in private settings 195 from public settings
Southbury at STS	1 Full-time dental director (dentist) 1 Part-time dentist 1 Full-time dental hygienist 2 Full-time dental assistants	1,002 420 Southbury residents 71 other public settings 511 from private settings
Ella Grasso Clinic (Stratford)	1 Full-time dental hygienist 1 Part-time dental assistant 1 dentist on contract 1 day per week	614 84 from public settings 530 from private settings
Norwalk Dental Clinic at Lower Fairfield Regional Ctr	1 Part-Time dental hygienist 1 Dentist on contract 1 day per week	306 285 Regional Center residents 21 from private settings
Source: DDS		

As the table indicates, a total of 2,475 people in 24-hour residential care have their dental needs met at DDS clinics. While this helps ensure that DDS clients have their dental needs met, the services provided are not reimbursable by Medicaid, unlike community dental provider services. Thus, operating DDS dental clinics may not be as cost effective as increasing Medicaid rates to develop a greater network of community dental providers.

Preventative health care. DDS has developed a comprehensive set of guidelines for minimum preventative care including regular physicals, routine lab work, and cancer screenings like mammograms and pap smears, with expected frequency by age group (see Appendix E). However, program review staff found that there is no systematic tracking to ensure these guidelines are followed. DDS quality assurance inspectors do review a sample of individual medical records when licensing inspections occur, but those are typically conducted only every two years, and the inspectors review only a sample of individual records. Further, the automated system for licensing inspection data is not a good management tool to assess system-wide actions or remedies.

Clients who have intellectual disabilities often cannot advocate for themselves, and are typically more reliant on a family member, guardian, and/or case manager to oversee and ensure that health care is received. With the expanding use of electronic medical records, it is possible in the future that information on preventative health services obtained will be readily and systematically available. In some states, Medicaid clients with disabilities are in a Medicaid managed care plan, which would track these prevention measures for its clients.

The committee believes there should be some method of systematically ensuring that clients with intellectual disabilities are receiving appropriate preventive health care. Because electronic records are still in development, and Connecticut does not have Medicaid managed care for its aged, blind, and disabled population, another practice should be employed for Medicaid clients with intellectual disabilities. Consideration was given to the idea that the Department of Developmental Services and the Department of Social Services develop a memorandum of understanding where data on encounters for the relevant screenings and other preventative care for DDS Medicaid clients could be shared. However, as shown in Table VII-11 above, Medicaid is not the primary payer for most outpatient services so the shared data would be of limited use in assessing what services the dually eligible clients have received.

The Department of Social Services, as the state's Medicaid agency, is aware of the unique challenges to delivering health care services to dually eligible clients. DSS cited a number of those obstacles in its grant application for a planning initiative to integrate care for dually eligible individuals. For example, there is:

- a focus on minimizing payments rather than investing in efforts to limit total spending in the two programs;
- not much emphasis on quality of care received;
- fragmentation of services among the two programs and among plans within each program; and
- difficulty in meshing Medicare and Medicaid rules and procedures, or in providing integrated care.

The department was successful in receiving a CMS planning grant to establish local Integrated Care Organizations (ICOs) “to establish a single system of accountability for the

delivery, coordination and management of primary, preventive, acute, and behavioral health integrated with long-term services and supports under one program.”²²

The plan recognizes the need for better linkages of use of Medicaid and Medicare, with the “development of an integrated database of all relevant Medicare and Medicaid data [as] the anticipated deliverable”.²³ DSS will start the project in 2012 with the elderly (65 and over) dually eligible population and then expand it to other dually eligible clients. Thus, comprehensive health encounter data for DDS clients as a result of the Integrated Care Organization initiative may not be available for at least another year. While this delay is an issue, it is probably more beneficial for DDS staff to be involved with assisting with the planning and data linkage efforts as part of the overall grant than for the department to develop its own tracking system for DDS clients.

In reviewing the planning team membership for the grant, however, it appears weighted toward agencies and advocacy groups supporting elderly residents who are both Medicare and Medicaid eligible, with not much involvement from agencies and groups with younger dually eligible clients. **Therefore, the program review committee recommends:**

The Department of Developmental Services ensure staff and client participation and involvement in the planning for the Integrated Care Organization model, especially as it pertains to dually eligible clients who are under 65. DDS should ensure that any health care delivery model reduces duplication, prioritizes preventive care, incorporates a data reporting system that easily tracks and reports on preventive care and screening clients have received, and can be used as part of a performance measurement and quality assurance system.

The program review committee recognizes that the first stage of this Integrated Care Organization plan will focus on the elderly dually eligible population, and thus that population may be overly represented on the planning team membership. However, elderly and non-elderly may have different needs both in terms of actual health care services, especially preventive health care, and also with the data that needs to be collected to oversee quality assurance and performance. For example, data that might be needed for clients in DDS Medicaid waiver programs could differ from data needed for elderly clients in a nursing home.

CMS Quality Assurance Requirements

As noted in Chapters I and VI of this report, CMS is currently revising its quality requirements and the standards and measures a state must report on in order to participate in the home and community-based waiver program. Many of the measures are client-based and revolve around client choice and satisfaction. DDS has received a grant to design and build a data system and adapt its data collection efforts in order to comply with these new quality service review directives. However, the system is still in development.

At the same time, though, two key national associations that represent state agencies responsible for implementing the CMS waiver services are protesting the new quality assurance

²² [Former] DSS Commissioner Starkowski’s application letter to CMS, February 1, 2011

²³ DSS application to CMS, February 1, 2011

measures as overly burdensome. In a January 11, 2011 letter to CMS, the executive directors of the National Association of State Directors of Developmental Disabilities Services and the National Association of States United for Aging and Disabilities wrote that:

The growing demands on states to implement increasingly complex quality management systems and improvement strategies are problematic because they: (a) deviate significantly from the original intent of the quality initiative, i.e., that CMS would review state systems of quality rather than monitor activities at the level of the individual beneficiary, (b) extend beyond the expectations specified in the HCBS Waiver Application Version 3.5 and related guidance, and (c) are being placed on states at a time when their fiscal and human resources are diminishing. (See Appendix F for the full letter.)

The program review committee acknowledges the burden that performance measurement and quality assurance can place on a state and believes that individual level monitoring of performance proposed by CMS is excessive. However, at the same time, the current DDS system cannot produce system-wide information that could inform managers, policymakers, or payors about basic activity information, such as how many female clients have not had the recommended mammograms for a certain age group. PRI believes that there should be some efforts to link quality data required for DDS clients and the current data improvements being undertaken at DSS.

Appendices

APPENDIX A

Acronyms

List of DDS Acronyms and Definitions

ABI	Acquired Brain Injury
ADA	Americans with Disabilities Act
ADD/ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
A/N	Abuse and Neglect
AO	Age Out–when a client goes from a LEA client to a DDS client at age 21
APRN	Advanced Practice Registered Nurse
APPROPS	Appropriations Committee
CAMRIS	DDS' internal client database, Connecticut Automated Mental Retardation Information System (also eCAMRIS)
CLA	Community Living Arrangement (Group Home)
CMS	Centers for Medicare and Medicaid Services – the federal regulatory and funding agency over both health programs
CO	Central Office of DDS
COTA	Certified Occupational Therapy Assistant
CP	Cerebral Palsy
CPAC	CT Parent Advocacy Center
CSHCN	Children with Special Health Care Needs
CTH	Community Training Home – comparable to a foster home for placement for clients with intellectual disabilities
DCF	Department of Children and Families
DD	Developmental Disabilities
DDS	Department of Developmental Services (formerly DMR)
DMHAS	Department of Mental Health and Addiction Services
DMR	Department of Mental Retardation (DDS as of 10-1-07)
DPH	Department of Public Health – inspects and certifies the ICF/MR facilities
DSO	Day Support Options – provide support to participants that lead to acquisition, improvement and/or retention of skills and abilities to prepare a client for work and/or community participation
DSS	Department of Social Services – Connecticut state agency responsible for Medicaid
FSW	Family Support Workers
GH	Group Home (also CLA)
GSE	Group Supported Employment – competitive employment situation in which a group of participants are working at a particular setting with some supervision and supports
HCBS	Home & Community Based Services – a reimbursable waiver program under Medicaid
HCFA	Health Care Finance Administration (now CMS)
HIPAA	Health Insurance Portability and Accountability Act
HRC	Human Rights Committee
HSC	Human Services Committee
ICC	Interagency Coordinating Council

ICF/MR	Intermediate Care Facility for the Mentally Retarded – a Medicaid reimbursable residential program, typically somewhat larger residences than CLAs. Certified by DPH
ID	Intellectual Disability
IDEA	Individuals with Disabilities Education Act
IDT	Interdisciplinary Team – group of persons most familiar with client’s need and service requirements. Responsible for establishing individual’s service plan
IEP	Individualized Education Program
IFS	Individual and Family Supports
IFSP	Individualized Family Service Plan
IHS	Individualized Home Supports (Previously SL or ISHab)
IL	Independent Living
IP	Individual Plan
IPS	Individual Plan Short Form
IS	Individual Supports
ISA	Individual Support Agreement
ISHab	Individual Supports Habilitation
LD	Learning Disability
LEA	Local Education Agency – funding agency for day/education before a DDS client is 21
LON	Level of Need assessment tool – from 1 to 8 on level of severity. Assessment used to determine a client’s service needs and funding guidelines
LPN	Licensed Practical Nurse
LTC	Long Term Care
MIR	Management Information Report – quarterly reports developed by DDS that provides service, caseload, funding, and resource information
MOA	Memorandum of Agreement (between agencies or parties)
MOU	Memorandum of Understanding (between agencies or parties)
MR	Mental Retardation
NR	North Region of DDS
OBRA	Omnibus Budget Reconciliation Act of 1993 – the set of rules enacted in the federal budget act covering nursing facility placement for persons with mental retardation, e.g. OBRA nurse
OT	Occupational Therapy/Therapist
PAR	Programmatic Administrative Review
PATH	Parents Available To Help
PCA	Personal Care Attendant
PDD/NOS	Pervasive Developmental Disorder/Not Otherwise Specified
PECS	Picture Exchange Communication System
PHC	Public Health Committee (legislative committee that oversees DDS activities)
PMT	Physical/Psychological Management Training
PPT	Planning and Placement Team
PRAT	Planning & Resource Allocation Team – regional DDS teams that review prioritize program service request for clients on the waitlist
PRC	Program Review Committee – internal DDS committee responsible for reviewing the use of behavior modifying medications and behavioral support plans for DDS clients
PST	Planning and Support Team

PT	Physical Therapy/Therapist
PTA	Physical Therapy Assistant
QA/QI	Quality Assurance/Quality Improvement
QM	Quality Management
QSR	Quality Service Review or Quality System Review
RC	Regional Centers – 3 in West Region-1 each in South and North
SAC	Self Advocate Coordinator
SDE	State Department of Education
SEI	Supported Employment (Individual)
SERC	Special Education Resource Center
SNF	Skilled Nursing Facility, otherwise know as a nursing home
SL	Supported Living – where DDS client receive supports but not in a 24-hour are setting
SLA	Supported Living Arrangement – an apartment of other residential setting where clients receive some staffing support, but not 24-hour care
SLP	Speech & Language Pathologist
SR	South Region of DDS
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STS	Southbury Training School
TBI	Traumatic Brain Injury
URR	Utilization Resource Review
VSP	Voluntary Services Program
WR	West Region of DDS
Source: DDS and PRI staff	

Appendix B
Commission on Nonprofit Health and Human Services
Financial Condition of Agencies (excerpt of commission final report)

Task: To determine the financial condition of the State's Private Provider Community.

Method: The workgroup researched and selected tools to produce a comprehensive view of the financial condition of the State's non-profit provider. The workgroup selected a sample group of 101 from the 490 Health and Human Services providers with revenues over \$300,000 who receive State funds. The workgroup then proceeded with the calculation of various financial ratios specific to nonprofits to test the financial fitness of the sample group. The results were compared to a recent study done in this area by the Urban Institute.

The Workgroup split the sample group into three categories for analysis purposes: Group 1– total revenue ranging from \$300,000 up to \$2,000,000 (32.8% of agencies sampled); Group 2 – total revenues from \$2,000,000 up to \$10,000,000 (36.54% of sample); and Group 3 – total revenue over \$10,000,000 (31.68% of sample).

The calculations were performed on the data taken from the in the private providers' audits conducted by certified public accountants, and provided to the State of Connecticut, as per the State's contracting regulations. The audit period used was SFY 2009. The following financial ratios were calculated:

- $DI = \text{Cash} + \text{Marketable Securities} + \text{Receivables} / \text{Average Monthly Expenses}$
- $\text{Liquid Funds Indicator (LFI)} = \frac{\text{Total Net Assets} - \text{Restricted Net Assets} - \text{Fixed Assets}}{\text{Average Monthly Expenses}}$
- $LFA = \text{Dollar Value of Unrestricted new Assets} - \text{Net Fixed Assets} + \text{Mortgages And Other Notes Payable}$
- $OR = \text{Operating Reserves} / \text{Annual Operating Expenses}$
- $\text{Savings Indicator (SI)} = \frac{\text{Revenue} - \text{Expense}}{\text{Total Expense}}$
- $\text{Debt Ratio (DR)} = \frac{\text{Average Total Debt}}{\text{Average Total Assets}}$
- $CR = \frac{\text{Current Assets}}{\text{Current Liabilities}}$

The Workgroup's analysis, similar to results of the Urban Institute's report, indicate that a large percentage of the Connecticut non-profit providers are in a financially precarious position, operating dangerously close to their margin and likely would not be able to maintain operations if they experienced unforeseen increases in expenses or a financially detrimental incident.

The difference between smaller and larger community based nonprofit providers, as it pertains to financial fragility, requires more careful analysis given the significant variables between organization's administrative costs, capital assets, fund development capacity, and ability to leverage debt.

Sources of Revenue

In regard to sources of revenue, the Workgroup analyzed: a.) State funding of the nonprofit community during the past decade, b.) the current revenue funding mix, c.) trends in philanthropy, and d.) possible future funding mixes.

- a) State Funding of Non-Profit Providers.** The Workgroup found that the COLA of 21.7% provided to non-profit providers over the past decade to the Medical CPI (42.2%) and Consumer CPI (27.7%).

- b) Current Revenue Funding Mix.** The Workgroup found that those with State revenues per year between \$300,000 and \$2.0 million had the highest percentage of Governmental Funding at 75.82%. Those with funding over \$2.0 million had very similar levels of Governmental Funding 64.00% and 62.08% respectively. Another interesting similarity is that providers with under \$10 million in State funds have the same exact percentage of funds coming from Philanthropy efforts at 9.5%, while those over \$10 million had a much lower percentage of funds from Philanthropy, with donated funds making up only 1.7% of their overall revenues.
- c) Trends in Philanthropy.** The Chronicle of Philanthropy reported on October 17, 2010, that donations had dropped 11% at the nation's biggest charities during this last year. This is the worst decline in two decades, with this year's decrease being four times as great as the next largest annual decrease that was recorded in 2001 at the rate of 2.8%.
- d) Possible Future Funding Mixes.** There is the possibility of changing the funding mix for services, and exploring more Medicaid reimbursed services; however, this opportunity involves a number of additional administrative requirements and issues for the providers and the State that should be considered prior to switching the funding source from grant funding to Medicaid funding:

Recommendations

- 40. We believe it is important to have data over a period of time. It is recommended that a retrospective calculation of financial ratios included in this report be conducted from 2007 to 2010, with the audits that are on hand at the OPM to determine if the results indicate trends. It is further recommended that the financial ratios be completed on an on-going basis so trends in the private providers' financial condition can be assessed over a period of time.
- 41. It is recommended that a special committee of providers and State officials, chaired by the Nonprofit Liaison to the Governor, be assembled to assess and report on financial trends and unforeseen expenses and analyze provider increases and fixed costs impacting the private providers' financial position and possible solutions.
- 42. It is recommended that when system wide technical requirements are imposed or expected of Nonprofit providers that the State takes a lead role in assisting providers by investigating the options, initiating a bidding process to attempt to achieve savings and by providing technical assistance to providers. The current method results in a duplication of effort and costs and often results in providers having not acquired the required product. It also results in a system that makes communication with State agencies and other private providers inefficient which further burdens the system because of a lack of consistency amongst the State Agencies.
- 43. A cost benefit analysis should be conducted for all revenue producing initiatives including Medicaid services, waivers, and Private Non-Medical Institution. This analysis should be conducted with not only the State's costs being considered but also the costs to private providers. It is recommended that the State be cautious in its attempts to change the payer mix. If the new costs to the entire system, including both the State and the providers, are more than the State will receive in reimbursement it should be understood that this will not be a cost effective change for the State and may result in a need to continue to provide grant funding for non-reimbursable expenses. When providers do not have the investment dollars to establish the infrastructure necessary to successfully make the change in the payer mix, it results in audit findings and significant repayment of funds only further jeopardizing the providers' financial condition.
- 44. It is recommended that mechanisms be developed to compensate not for profit providers doing business with the state for necessary costs that occur outside the control of the provider.

These necessary costs most commonly occur due to vacancies, admission delays, discharge delays, transfer delays, or unfunded continued occupancy (aka overstays)

45. It is recommended that a break-even analysis be done when changing service models and funding streams to determine if the funding model matches the program type and size and that the census requirements are realistic for the provider to remain financially viable. Consideration should be given to the size of the program, turnover and average billable units of care. The best practices movement to smaller settings may make previous rate setting and funding models less effective and appropriate than the target services they were created for decades ago

Appendix C DCF Overtime Reduction Plan

DCF conducts several different types of business units. The Central Office and Area Offices generally adhere to a standard work week. Work that can only be completed outside of the general work week requires overtime. The Hotline and the Institutions are 24/7 operations with the majority of the posts being considered coverage positions, requiring overtime for sick calls and other types of time off. Because of the varied requirements and types of overtime the Department is submitting its plan based on three different categories. The first category will address the steps the Department is taking to contain overtime in all unity. The second category is containment of overtime in Central Office and Area Office locations, and the third category will represent the steps being taken in our 24/7 operations, such as the Department's Hotline for Child Abuse and Neglect calls and the DCF Institutions where there are coverage mandates.

All new practices in controlling overtime will appear in bold print below.

DCF's Overall Plan for all Locations

All overtime that can be preapproved will be approved by a manager. The only exception to this practice is in 24/7 operations, responsible for coverage and shift work. If a sick call comes in shortly before the shift will begin, the on-site supervisor will assess the need for overtime and make arrangements for the overtime. The manager on-call will be notified during the shift update. The manager will evaluate the schedule and staffing at the beginning of the next on site shift.

Overtime is only allowed for essential and emergency purposes.

Senior managers are given a detailed overtime report by employee monthly to evaluate assignment of overtime, usage and trends.

Senior managers will be given a pay period by pay period comparison with cumulative totals, indicating their progress in meeting the 10% reduction for the year.

Managers have been notified that overtime usage will be considered to be a general performance indicator.

Overtime Plan specific to Area Office Operations

A standard system and workflow for Area Office overtime is being put in place (see attached). The Area Office system will make individual managers accountable for the use of overtime within their unit. Reporting will be provided on a monthly basis to top office administrators and the individual managers.

All overtime assignments will be filled by the appropriate job class. Employees at a higher job class will not be filling in for lower paid employees.

Employees booking overtime will fill out a worksheet with various pieces of information including the authorizing manager, date, time, time estimate for task, reason, and the name of the employee filling the overtime. This report will be inputted for data analysis to assess manager performance in curtailing overtime, the causes of overtime, the usual hours of overtime, and for verification in the case notes of the performance of the overtime. Assessments of the reports will allow top management to adjust scheduling and request the investment of resources to reduce overall costs.

Overtime in 24/7 Operations

The booking manager will begin preparations for filling long term staff outages, for vacancies, FMLA, and worker's compensation three days prior to the new pay period beginning, assessing when workers are expected to begin reporting to work. The manager will move staff as available due to double coverage days, low census in units, etc., and fill as many mandatory coverage openings as possible before scheduling workers on overtime.

Previously, the manager would then begin booking shifts of overtime using the bargaining unit rotation lists. This practice is now changing. The manager will book each day's overtime shifts 24 hours in advance. This change is being made because it is believed that there are many variables that can occur in a two week period that might make a shift overtime unnecessary when the day actually arrives on the schedule. It is believed this new approach will allow the 24/7 operations to reduce their overtime.

Call outs made just prior to the shift will be covered by the Supervisors staffing the Supervisors office. **All shifts filled by Supervisors will be communicated to the on-call manager and evaluated by the booking manager for necessity and appropriate assignment during the booking manager's next shift.**

APPENDIX D
Licensing Inspection Findings Concerning Health Services

Table D-1. Specific Health Services Deficiencies Cited in FY 10			
	N=504	N=38	N=542
<i>Specific Health Services Deficiency Present</i>	<i>CLA</i>	<i>ICFMR</i>	<i>Total</i>
Medication Administration Regulations	172 (34%)	19 (50%)	191 (35%)
Coordination, assessment, monitoring of medical services	156 (31%)	14 (37%)	170 (31%)
Medical testing and follow-up	84 (17%)	12 (32%)	96 (18%)
Ongoing health and injury	67 (13%)	7 (18%)	74 (14%)
Planning and implementation of staff training	60 (12%)	5 (13%)	65 (12%)
Medical documentation	39 (8%)	4 (10%)	43 (8%)
Dental exams and follow-up	29 (6%)	5 (13%)	34 (6%)
Special diet requirements	17 (3%)	1 (3%)	18 (3%)
Medication self-administration	16 (3%)	1 (3%)	17 (3%)
Medical exams assured	15 (3%)	1 (3%)	16 (3%)
Medical treatment consent	6 (1%)	0 (0%)	6 (1%)
Nursing service provision	5 (1%)	1 (3%)	6 (1%)
Administration of medication consent	4 (1%)	1 (3%)	5 (1%)
Dental documentation	3 (1%)	0 (0%)	3 (1%)
Dietary	3 (1%)	0 (0%)	3 (1%)
Disposal of medication	2 (<1%)	0 (0%)	2 (<1%)
Dietary policy	1 (<1%)	0 (0%)	1 (<1%)
Source: DDS			

Comments pertaining to “medication administration regulations” deficiencies included:

- Due to lack of documentation, could not determine if client’s required hourly turning/positioning-recline was occurring
- Lack of nursing oversight and care coordination as evidenced by nursing quarterly reports not completed for 1+ years
- Staff did not follow weight recheck requirement for 5 pound gain or loss for client who lost 10 pounds

Comments pertaining to “coordination, assessment, monitoring of medical services” included:

- Although client’s record notes that if body temperature is less than 95 degrees, 911 should be called, there was no record of staff calling 911 or the individual receiving any follow up medical when body temperature fell below 95 degrees
- Prescribed medication following a podiatry appointment was not ordered or started, with an absence of explanation for the delay documented
- Individual’s medical record did not contain signed physician’s order following a previous verbal medical order

Appendix E

DDS Preventative Health Guidelines



STATE OF CONNECTICUT
Department of Developmental Services

Minimum Preventive Care Guidelines For Persons With Intellectual/Developmental Disabilities

Procedure	19-39 Years	40-49 Years	50-64 Years	65 and Over
Preventive Health Visit				
<ul style="list-style-type: none"> ▪ Height & weight ▪ Blood pressure ▪ Skin exam ▪ Breast /Testicular exam 	Annually	Annually	Annually	Annually
Lab Work				
Cholesterol screening	Men over 35 - every 5 years	Women over 45 - every 5 years	Every 5 years	Every 5 years
Diabetes Screening	Once every three years or as clinically indicated			
Liver Function	Annually for Hepatitis B carrier; At frequency indicated for monitoring secondary to medication use			
Thyroid Function	Every 3 years for persons with Down Syndrome; clinical discretion for others	Every 3 years for persons with Down Syndrome; clinical discretion for others	Every 3 years for persons with Down Syndrome; clinical discretion for others	Every 3 years for persons with Down Syndrome; clinical discretion for others
Screenings				
Hearing and Vision screening	Annual; Re-evaluate if change	Annual; Re-evaluate if change	Annual; Re-evaluate if change	Annual; Re-evaluate if change
Vision Exam for Glaucoma screening	Persons at high risk	Ever 2 - 4 years	Every 1 - 2 years	
Hypertension	Annually	Annually	Annually	Annually
Osteoporosis screening (Bone density testing)	High risk persons (mobility impairments, certain meds that can affect bone density)		Post-menopausal women or High risk persons	Post-menopausal women or High risk persons
Dysphagia and Swallowing Risk screening	On-going observation for signs of difficulty swallowing especially in high risk populations; Further evaluation including Modified Barium Swallow as appropriate to symptoms and health history.			
Cancer Screenings				
Breast Cancer: Breast Exam	Clinical breast exam by PCP annually; Monthly examination only by PCP as recommended; Self-examination instruction as appropriate			
Breast Cancer: Mammography	Not indicated except for those women identified at risk	Every 1-2 years		
Cervical Cancer: Pap Smear	Every 3 years	Every 3 years	Every 3 years	Not indicated if no prior abnormal results
Colorectal Cancer: Stool for Occult Blood (set of 3 guiac cards & rectal exam)	Clinical discretion	Clinical discretion	Annually	Annually
Colorectal Cancer: Sigmoidoscopy/ Colonoscopy	Not indicated	Clinical discretion for high risk	Every 5-10 years	Every 5-10 years
Testicular Cancer: Testicular exam	Clinical testicular exam by PCP; Self-exam instruction as appropriate			
Prostate Specific Antigen (PSA)	Not indicated	Not routine except for men at high risk (family history)	Clinical discretion	Clinical discretion



STATE OF CONNECTICUT
Department of Developmental Services
Minimum Preventive Care Guidelines For Persons With Intellectual/Developmental Disabilities

Procedure	19-39 Years	40-49 Years	50-64 Years	65 and Over
Cardiac Screening				
Electrocardiogram (EKG/ECG)	Not indicated unless advised due to use of certain medication	Baseline testing at 40		
Echocardiogram	Obtain baseline for persons with Down Syndrome if no record of cardiac function available.			
Mental Health				
Depression Screening	Ongoing observations for signs that indicate changes in sleep patterns, appetite, weight status, and activity level that may indicate depression			
Dementia Screening	Ongoing observations for signs that indicate changes in ability to perform daily living activities	Ongoing observations for signs that indicate changes in ability to perform daily living activities especially in persons with Down Syndrome after the age of 40.		
Infectious Disease Screening				
Tuberculosis screening	Mantoux Tuberculin Skin Testing (TST) recommended every two years			
Hepatitis B and C	Clinical discretion if risk factors present			
Human Immunodeficiency Virus (HIV)	Periodic testing if at risk			
Chlamydia and Sexually Transmitted Diseases (STDs)	Screen all sexually active under 25 yrs. Over 25 years, screen only those with risk factors such as multiple partners, or inconsistent use of barrier contraceptives.			
Immunizations				
Polio, MMR, Tdap	As recommended by the CDC throughout the adult lifespan			
Varicella	As recommended by the CDC but verification of disease immunity for persons who live/lived in group settings is critical			
Influenza Vaccine	Annually	Annually	Annually	Annually
Pneumococcal Vaccine	Once before age 65 if at risk			Once over age 65
Hepatitis B vaccine	Recommended series once; Check antibody status as necessary			
Hepatitis A vaccine	High risk	High risk	High risk	High risk
Herpes Zoster Vaccine (Zostavax)	Not indicated		Once over age 60 for those who lack evidence of immunity (documentation of vaccination or evidence of infection)	
Human Papilloma Virus (HPV)	Series recommended for potentially sexually active women between 9 and 26	Not indicated	Not indicated	Not indicated
X-Ray				
Cervical spine to rule out Atlanto-Axial Instability	Persons with Down Syndrome			
Counseling				
Lifestyle counseling	Annually (Includes information on health and wellness, accident prevention, sexuality information, safety considerations as appropriate)			

Letter to the Centers for Medicare and Medicaid Services

NASDDDS

 **NASUAD**

January 19, 2011

Barbara Edwards
Director
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Edwards,

We are writing in regard to the Centers for Medicare and Medicaid Services (CMS) recent developments in the Continuous Quality Improvement strategy for the 1915(c) Home- and Community-Based Waiver program.

Quality is a dimension of service delivery in home and community programs that has rightly become a prominent focus of consumers, elected officials, the public, the Centers for Medicare and Medicaid Services and the state agencies managing service systems. The development and adoption of the Quality Framework by CMS in 2002 provided a solid foundation for CMS and state agencies to collaborate in the development of an approach to assuring and improving quality that was relevant, practical, and accountable.

In 2003, CMS responded to media reports about serious problems in home- and community-based services and demands for improvement from Congress by developing a set of strategies to improve services provided by the states and the federal government's oversight of state programs. Those strategies included: a series of letters to State Medicaid Directors disseminating information on quality practices, the provision of technical assistance to states, and the redesign of the processes for approving state applications to provide home- and community-based waiver services and for conducting federal oversight of state programs.

Recognizing that home- and community-based services are operated and also funded by state governments, CMS made an important decision to initiate a working relationship with state agencies to develop these strategies. State Medicaid agencies, developmental disability agencies and state aging agencies were involved. This unique and positive federal/state collaboration produced the key component of the new CMS quality strategy – the 1915(c) waiver application. In line with the Quality Framework, the waiver application focused attention on the design of state service systems. It required states to describe, in considerable detail, the structure and functioning of the overall program and especially the state's approach to assuring and improving quality utilizing the core functions outlined in the Quality Framework – discovery, remediation and improvement.

Accompanying the development of the waiver application was the adoption of the Interim Procedural Guidance (IPG) which changed the federal approach to oversight of the program. Prior to the IPG, CMS regional staff routinely conducted site visits to state programs, visiting a handful of consumers receiving services in an effort to evaluate the extent to which state agencies were meeting CMS assurances. Recognizing the ineffectiveness of inspection strategies in such large state systems and the need for an evidence-based approach, CMS revamped its oversight protocol to obligate states to provide data to CMS measuring the state's performance in meeting the waiver assurances. The data provided by the states would enable CMS to determine if the state had a credible quality management strategy, and over time, whether states were effectively identifying and acting upon areas that needed remediation and improvement.

As the waiver application has been modified since its adoption in 2003, there has been considerable growth in the requirements for states to both collect data and report to CMS. Assurances have expanded to include subassurances, states are being required to identify performance measures for each assurance and subassurance with considerable specificity, remediation is not only required but states must now report on remediation activities with person specific detail.

It is these more recent developments in the implementation of the CMS Quality Strategy that are problematic.

Performance Measures and Compliance

The number of performance measures: An effective quality management system is one that focuses on a limited number of important, critical, and strategic problems. It engages all those involved in the delivery of service in the design and implementation of remedies as well as the evaluation of whether the remedy has been effective. This requires a longitudinal view of systems to determine whether systems improvements are having an effect over time.

Currently, states are being required to provide detailed information on the performance measures for each assurance and subassurance, including the sampling methodology, the frequency of data collection, the data sources, and the entity gathering the data. The number of performance measures in waiver applications now ranges from 35 to 70.

Nowhere else in the Medicaid or Medicare programs is this number of performance measures being required. Such a significant number of performance measures creates an extraordinary data collection burden and overwhelms state agency staff. It is a standard rule in the field of Quality Management that "if you measure everything, you measure nothing." Overwhelmed by data, managers become paralyzed.

100% compliance: Presentations by the National Quality Enterprise make it clear that the only acceptable level of performance across all assurances and subassurances is 100%. This requirement has the inevitable consequence of compelling states to report on every measure every year in perpetuity, since 100% compliance in any system of any size is impractical and virtually unachievable. Such a requirement also eliminates consideration of a test of substantial compliance or the use of a measurement threshold that would

determine that a finding is systemic rather than idiosyncratic. The 100% standard is unreasonable, particularly in large waiver programs serving several thousand beneficiaries. The requirement also impedes the ability of a state to carry out true quality management practice because it requires resources to be directed to issues that may be incidental at the expense of issues that have a substantial impact on the quality of services and people's lives.

Remediation at the Individual Level

An essential aspect of quality management is remediation of serious issues. While a state must describe its method for prompt follow up and remediation of identified problems at the individual level in its 1915(c) waiver application, the focus of remediation, as conceptualized in the Quality Framework and the initial discussions between CMS and the states, was to be on provider and systems level improvements. That is, when an area of program management was found to be deficient and out of compliance, the state was expected to analyze the root cause of the systems performance failure and institute a system wide remedy. Systems remedies could include new policies, new business practices, and changes in the design of the program. On going performance measurement would determine whether the system remedy was effective over time.

Guidance provided by CMS regarding the development, implementation and monitoring of the 1915(c) Medicaid waiver programs does not require or even reference the development of Quality Improvement Strategies to assure and report on 100% compliance at the individual level. The HCBS Waiver Application Version 3.5 (Appendix H, Section b (i)), requires only that a state identify its "method for addressing individual problems as they are discovered" and to "include information regarding responsible parties and GENERAL methods for problem correction." The detailed Instructions, Technical Guide and Review Criteria (2008) for Waiver Application Version 3.5 emphasize in Appendix H Systems Improvement that the process must include: "the measures and processes employed to correct identified problems;" "aggregate and analyze trends in the identification and remediation of problems and establish priorities for, and assess the implementation of, systems improvements (p. 242)." The focus on systems improvement is additionally reflected in the CMS Interim Procedural Guidance for Conducting Quality Reviews of Home- and Community-Based Services (HCBS) issued February 6, 2007, Guide on Assessing Annual State 372 Reports, which focuses on the state's submission of timely and accurate data, compliance with approved cost and utilization limits, and the documentation of problem resolution, both in terms of individuals affected and systemic modifications to prevent problem recurrence in the future (p. 12).

The recently instituted practice of requiring states to report remediation at the individual level in every performance area deviates significantly from the concept of improving systems. While findings that the health and safety of any individual is in jeopardy must be remedied quickly, findings in many areas of performance such as untimely plan authorization, late eligibility determinations, or failure to deliver services authorized in the plan cannot be remedied after the fact. The bigger and more important issue is whether the number of times these things occur is significant rather than occasional, whether the state has identified the systemic reason for the performance shortfall and has instituted a meaningful remedy. The final question is whether performance improves over time as a result of the systemic remedy.

The current practice of requiring states to report remediation for each individual and whether action was taken within 30, 60, and 90 days is a survey and certification practice, practical at the provider level but highly impractical in systems that serve as many as 25,000 people or more. With 35-70 performance measures and hundreds of individuals sampled, it is highly likely that there will be many hundreds of issues to be tracked and reported whether or not there was substantial compliance with the assurance or whether or not the health and welfare of any individual is jeopardized. In many cases the finding may be based simply on missing documentation; for many it will be failure to provide a unit of service on a timely basis – a common occurrence at least once for every individual.

More importantly, focusing on remediation at the individual level is at the expense of determining whether the overall system is designed and operated adequately. Some states report that they are now struggling to maintain two reporting systems – one to provide CMS with individual remediation information and one to actually measure and improve the quality of the system.

Data Collection and State Resources

The new data collection expectations are unreasonable and appear to be escalating. Most recently, one state was required to track the training of all direct care staff which involves 10,000 employees of hundreds of private provider agencies. This mandate is necessitating the development of additional information technology and a new requirement that provider agencies routinely report the training completed by each employee.

The only alternative to the development of an information technology system is additional staff to receive reports from provider agencies, enter it into a data base, track provider reporting and analyze the data for compliance.

States do not have resources for additional employees or to develop information technology systems.

Building a quality management system that is dependent on people to manually collect data separate from everyday business practices is impractical, unreliable and during these times, simply impossible. The only viable tool for collecting and analyzing data efficiently and reliably is Information technology (IT). However, it has been difficult to identify resources for IT development during good financial times; today it is near impossible.

While a few states have succeeded in obtaining enhanced federal financial participation (FFP) to support contracting with Quality Improvement Organizations and developing information technology systems to manage service delivery and quality, doing so has been arduous and approval has often come after implementation. Initial outlays of funding by states with the hope of obtaining enhanced FFP for these necessary system components is no longer an option for any state. Reductions in the number of state personnel limit the states' ability to navigate the rules and application process for obtaining approval for enhanced FFP. Increased expectations of states to improve quality must be accompanied by increased resources and assistance.

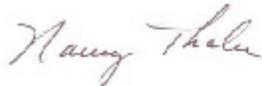
In Summation

The growing demands on states to implement increasingly complex quality management systems and improvement strategies are problematic because they: (a) deviate significantly from the original intent of the quality initiative, i.e. that CMS would review state systems of quality rather than monitor activities at the level of the individual beneficiary, (b) extend beyond the expectations specified in the HCBS Waiver Application Version 3.5 and related guidance, and (c) are being placed on states at a time when their fiscal and human resources are diminishing.

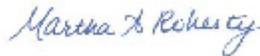
Our members fully appreciate the need to both assure and monitor quality and the necessity of CMS to have confidence that states are in fact doing so. However, the current growth in performance measures and reporting requirements significantly exceeds the level of measurement and reporting necessary for CMS to have such confidence.

We would respectfully request that actions to further expand waiver application requirements and reporting requirements be suspended and that CMS use it's working relationship with state agencies to develop expectations that are time and resource efficient and achieve the outcomes we all desire.

Sincerely,



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Appendix G: Agency Response



Dannel P. Malloy
Governor

State of Connecticut Department of Developmental Services

DDS

Terrence W. Macy, Ph.D.
Commissioner

Joseph W. Drexler, Esq.
Deputy Commissioner

February 21, 2012

Carrie E. Vibert, Director
Legislative Program Review and Investigations Committee
State Capitol Room 506
Hartford, CT 06106

Dear Ms. Vibert:

Thank you for the opportunity to review and comment on your committee findings and recommendations related to the *Provision of Selected Services for Clients with Intellectual Disability*. I understand that the focus of this study was to compare the cost of providing public and private services (residential and day) to individuals with intellectual disability who are consumers of the Department of Developmental Services (DDS). I appreciate the time and effort that has gone into studying this important issue that impacts many individuals in our service system.

DDS is responsible for the planning, development, and administration of complete, comprehensive, and integrated statewide services for persons with intellectual disability and persons medically diagnosed as having Prader-Willi Syndrome. DDS provides services within available appropriations through a decentralized system that relies on private provider agencies under contract or through support agreements with the department in addition to state operated services. These services include residential placement, in-home supports, day and employment programs, early intervention, family support, respite, case management, and other periodic services such as transportation, interpreter services, and clinical services. Additionally, the DDS Autism Division operates a program for adults with autism who do not have intellectual disability.

Since I became Commissioner of Developmental Services almost a year ago, I have repeatedly said that DDS's current Legacy System is an unsustainable paradigm. For many, there is an expectation that services should follow a specific path: Birth to Three followed by school, transition to a day program, and finally adulthood in a group home. I strongly believe that we need to embrace a new paradigm that focuses on building a larger service network around families supporting individuals longer and more comprehensively in their homes. Our future support system will need to be more flexible and less regulatory-based; it should have strong performance standards while offering more choices for in-home supports, day and residential supports. Any shift will need to be extremely mindful of the existing waiver programs which garner a significant amount of federal revenue that ultimately helps to cover a large portion of the cost of DDS services in Connecticut.

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As a private provider executive prior to coming to DDS, I have firsthand knowledge of the great work done by our network of private providers. I also know of the many challenges they currently face. While private sector services have proven to be a less expensive option, the legislature is aware of the strain some have experienced from years of no cost of living adjustments. Governor Malloy's proposed COLA in his FY2013 budget adjustments is a positive first step toward helping providers who have continuously been asked to do more with less.

Having started my career in the public sector, I can also tell you that the public sector has much to offer as we look to a shift towards a more sustainable service system. I see a clear role for many of the state's current employees going forward as we look to increase support services to families. I appreciate the work being done in the public sector and the quality staff will continue to play a role in our future service system, especially on services focused on individual and family supports.

Regarding the specific recommendations supported by committee members, I certainly appreciate the committee's position. However, I would caution implementing legislation that might restrict the department's ability to make necessary changes to processes within the current paradigm shift. As the agency seeks to create systemic change, maximum flexibility is needed. The department issued its Five Year Plan (2012-2017) to the legislature last week. For those of you who haven't yet seen it, but are interested, it can be found on our website: www.ct.gov/dds. I believe you will see that the goals outlined in the plan are in line with the recommendations that the LPRIC staff have arrived at. I would request that the committee give DDS time to begin implementing aspects of the Five Year Plan before codifying specific recommendations of the LPRIC study.

Additionally, I must comment on the concerns raised by the committee about compliance with requirements set by the Centers for Medicare and Medicaid Services (CMS) governing reimbursement under the 1915(c) waivers. I can assure you that federal funds are claimed only for services that are actually delivered, and that recipients of service are afforded the freedom to choose among qualified service providers. Connecticut has made significant efforts to comply with the waiver requirements by ensuring that the transition from a cost-based to a fee-based methodology does not jeopardize access to or quality of care. Connecticut is committed to full compliance with CMS requirements and will continue to improve internal systems as necessary to stay in compliance.

I have attached a more detailed response to the individual recommendations that I hope you will take into consideration. Again, thank you for the opportunity to respond to the committee's final report.

Sincerely,



Terrence W. Macy, Ph.D.
Commissioner

Attachment: DDS responses to LPRIC recommendations

Recommendation 1: The Department of Developmental Services should evaluate all residents receiving 24- hour care at the five regional centers for possible placement in the community. Using the interdisciplinary team concept established by the Southbury Training School Consent Agreement, each team would exercise its professional judgment in recommending the “most integrated setting” appropriate to the needs of each regional center resident. For purposes of the agreement, the “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.” For residents of Southbury and the regional centers, a rejection of a community placement should be revisited periodically. If the interdisciplinary team makes a recommendation for a community placement, which is rejected by the guardian, or family member, or client, the team should evaluate the resident’s situation each year and present its recommendation for a family, guardian, or client decision.

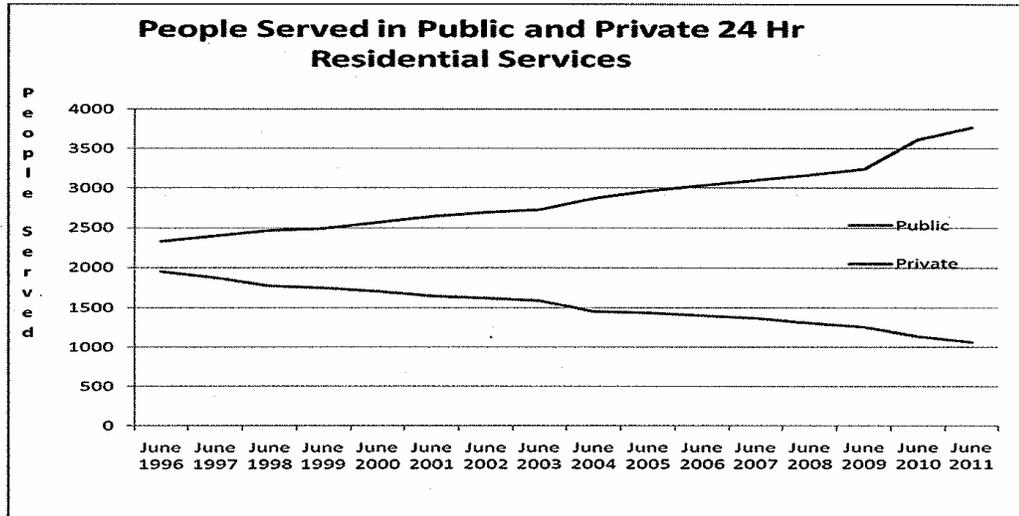
DDS Response: This recommendation mirrors the language of the Settlement Agreement in Messier vs. Southbury Training School (STS). The Settlement Agreement required DDS to inform individuals at STS and their families/guardians of community placement options available to them. DDS intends to employ a similar process for individuals residing in other congregate settings operated by the department; however, legislation is unnecessary for the department to address this issue. This intent has been outlined in the Department’s Five Year Plan as submitted to the legislature. DDS is not planning, nor is it authorized to extend, the court approved Settlement Agreement to other settings, but will utilize the concepts embodied in the Settlement Agreement to comply with the Americans with Disabilities Act, such as extending the team training required in the Settlement Agreement to Regional Centers.

Recommendation 2: The Department of Developmental Services should continue its phasing out of providing 24-hour residential care in any of its DDS settings, but that it accelerate its efforts through:

- Using DDS CLAs only for residential placements for clients from more restrictive public settings like Southbury or the regional centers, and as a transition phase only;
- DDS should not refill any direct care or direct service positions vacated through attrition in any of its residential or day program; and
- DDS should conduct a staffing assessment at its residential locations in light of the 16 percent reduction in clients. For the clients still residing at DDS homes and facilities, DDS should use the LON assessment tool to determine the level of staffing needed (as it would in contracting for private placements.) Where staffing levels are higher than comparable in the private sector, DDS should redeploy staff to serve clients on the residential care waiting list in their homes or to provide respite care, within labor contract provisions.
- Ultimately, the only residential care that should be operated by DDS is to provide care for extremely hard-to-place clients and for those clients that the superior or federal (not probate) court directs into DDS care. This should involve about .5 percent of the 24-hour residential care population or 25 people.

DDS Response:

The Department of Developmental Services (DDS) supports this recommendation. It is consistent with the long term trend for services provided to people with intellectual disability. The graph below illustrates this trend since June of 1996.



While reducing the size of DDS-operated services, the department has attempted to balance a variety of individual, employee and organizational issues. DDS does not support restrictions on the placement of people within the public sector. While the recommendation would be appropriate for many placements, there may be specific circumstances that require a placement into the public sector.

Additionally, DDS does not support restrictions on the hiring of direct care staff. DDS will continue to provide direct services in the near future, even with a continued focus on reducing the number of public operations. At times it will be necessary to hire direct care staff in order to provide quality services, manage overtime, and meet organizational needs. This should be evaluated on a case by case basis while being mindful of the long term direction of the department. The department will continue to do staffing analyses as public facilities close and community placements increase, to ensure the most appropriate balance of staff.

Recommendation 3: DDS should reduce its overtime by at least 10 percent as recently required by the Office of Policy and Management, including through implementing those measures similar to those recommended by the Department of Children and Families in its overtime reduction report to OPM.

DDS Response: DDS agrees with this recommendation. DDS faces unique challenges in reducing overtime in that the department is simultaneously attempting reduce the number of direct care staff in public programs. To ensure the health and safety of individuals in our care, as well as to maintain compliance with ICF/MR and Department of Public Health licensing requirements, adequate staffing must be maintained. Nevertheless, in response to Secretary Barnes' September 22, 2011 memorandum, DDS submitted an overtime reduction plan on October 21, 2011 with an update / addendum submitted on October 28, 2011. This submission will be made available to the committee upon request.

Recommendation 4: In future contracts DDS has with private providers, the department should examine the salaries paid to direct care workers considering:

- **what they are paid relative to the agency's executive director's salary;**
- **relative to wages needed for self sufficiency standards as calculated periodically by the Office of Workforce Competitiveness and the Office of Policy and Management and those that may be developed by the DDS Sustainability Subcommittee; and**
- **income levels that qualify persons and families for eligibility for state Medicaid and other assistance.**

DDS Response: DDS fully appreciates the importance of sustainable wages for employees who are employed to support individuals with intellectual disability. Governor Malloy's proposed COLA in his FY2013 budget adjustments, which is being targeted at wages and benefits for employees, is a positive first step toward helping providers who have continuously been asked to do more with less. DDS representatives routinely participate in initiatives to review issues relating to employee compensation. Separate internal analysis would be redundant and would lack the support of stakeholders necessary for implementing improvements.

The decision of compensation for agency executives rests with the governing body of the agency and it would be their determination to compensate above the current \$100,000 threshold. In accordance with Section 7 of Public Act No. 07-238, the total cost allowance for the salary of the director to any organization or facility which provides employment opportunities or day services, or services in a residential facility, for persons referred by the Department of Developmental Services, Mental Health or Human Services, or any other state agency shall not exceed \$100,000 unless increased by an amount not to exceed the percentage increase of any cost of living increase provided under the terms of the contract of the organization. DDS currently limits the reimbursable part of the Executive Director's Salary. We believe this approach is effective regarding executive level salaries.

Recommendation 5: As a condition of future contracts with a private provider, the Department of Developmental Services should also ensure that the provider has complied with the requirements of cost reporting, including the submission of forms on executive director's salary.

DDS Response: DDS will revise the FY2012 annual report to require the reporting of the executive salary for private providers of day and residential services with a purchase of service contract, whether it reimburses the director more than \$100,000 or not.

Recommendation 6: The Department of Developmental Services should continue to phase out the provision of public day/work programs, with the overall goal to implement a single private delivery system for day/work services. The department should not refill any positions that are, or become, vacant in public programs, and shall redeploy existing staff to other direct services in the community as opportunities allow.

DDS Response: The Department of Developmental Services (DDS) supports the recommendation to continue to phase out the provision of public day / work programs. The decision to fill vacancies will need to be made on a case by case basis. The department will continue to do staffing analyses as public day programs are phased out to ensure the most appropriate balance of staff.

Recommendation 7: Further, the Department of Developmental Services should conduct a staffing assessment of its current staffing levels for its public day programs, using the day/work LON scores in the private programs as a guide for level of resources needed, and redeploy staff resources over those levels to other services.

DDS Response: Public day programs have been closed to admissions for the past ten years. Public day census decreased by 50% statewide between 2004 and 2011 (865 individuals in 2004 versus 437 individuals in 2011) and continues to downsize on a continual basis. During the past ten years, at least 39 public day staff have been re-assigned to work in private administration, community training homes, training and employment supports across the state. Given that public day is already in the process of continuous closure and re-assignment of staffing, DDS is already acting on this recommendation.

Recommendation 8: As recommended for clients receiving 24-hour staffed residential services, the Department of Developmental Services should adopt a centralized utilization review process for clients exceeding the day/work program funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.

DDS Response: Implementing such a centralized system would be a hardship on private providers, especially small and medium-sized providers who serve people with intensive support needs in only one region. Small and medium-sized providers constitute the majority of providers in the state and they already believe the current Utilization Resource Review (URR) process in each region is an administrative burden and overtaxes their administrative responsibilities. DDS

currently uses a uniform URR process in each region for residential and day services, which is overseen by the Regional Director's designee from each DDS division, including Public Residential and Day Services, Individual and Family Services, Private Administration and Self-Determination. The URR process is consistently reviewed jointly by the Waiver and Planning and Resource Allocation Team managers in each region in order to ensure continuity and consistency of practice. The URR process needs to remain a regional process with centralized coordination for the following reasons: 1) Case managers assigned to work with each individual and monitor individual plan implementation and oversight are based in each region; 2) Resource management staff who provide fiscal and quality oversight for each provider is based in each region; 3) Case manager supervisors and resource manager supervisors are based in each region; 4) Division directors who oversee support services provided by DDS are based in each region; 5) While some providers operate throughout the state, the majority of providers are based in each region and it would be a hardship for them to travel to a centralized site for URR reviews; 6) Thorough reviews of staffing levels require announced and unannounced observations, and the staffing for such observations are based in the regions; and 7) Thorough review of staffing levels require detailed knowledge of consumers and providers; and 8) DDS is utilizing the same database in all regions and will soon be able to generate the type of data requested for the Management Information Report (MIR).

Recommendation 9: Each client's Planning and Support Teams (PST) should review each client's day program relative to his/her LON. The objective for each client should be that he or she is participating in the most productive, meaningful work or day program in the most inclusive environment as possible. The client's PST should also be examining results of programs, such as day service options, that are geared to building skills to transition a client to a more competitive environment to ensure these outcomes are measured.

DDS Response: The department implemented a new employment policy in April 2011 that requires individuals with a Level of Need of 1, 2, or 3 to have a competitive employment goal in their Individual Plan. (link attached)

http://www.ct.gov/dds/lib/dds/dds_manual/ic5/ic5pr001_employment_first.pdf

The DDS Five Year Plan also outlines specific employment goals.

Recommendation 10: The Department of Developmental Services should adopt a centralized utilization review process for clients exceeding the residential funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.

DDS Response: Implementing such a centralized system would be a hardship on private providers, especially small and medium sized providers who serve people with intensive support needs in only one region. Small and medium sized providers constitute the majority of providers

in the state and they already believe the current Utilization Resource Review (URR) process in each region is an administrative burden and overtaxes their administrative responsibilities. DDS currently uses a uniform utilization resource review process in each region for residential and day services, which is overseen by the Regional Director designee from each DDS division, including Public Residential and Day Services, Individual and Family Services, Private Administration and Self-Determination. The URR process is consistently reviewed jointly by the Waiver and Planning Resource Allocation Team Manager in each region in order to ensure continuity and consistency of practice. The URR process needs to remain a regional process with centralized coordination for the following reasons: 1) Case managers assigned to work with each individual and monitor individual plan implementation and oversight are based in each region; 2) Resource management staff who provide fiscal and quality oversight for each provider as based in each region; 3) Case manager supervisors and Resource Manager Supervisors are based in each region; 4) Division directors who oversee support services provided by DDS are based in each region; 5) While some providers operate throughout the state, the majority of providers are based in each region and it would be a hardship for them to travel to a centralized site for URR reviews; 6) Thorough reviews of intensive staffing level require announced and unannounced observations, and the staffing for such observations are based in the regions; 7) Thorough review of intensive staffing levels require detailed knowledge of consumers and providers; and 8) DDS is utilizing the same database in all regions and will soon be able to generate the type of data requested for the Management Information Report (MIR).

Recommendation 11: The Department of Developmental Services should remind its case managers of the importance of keeping client automated records up to date.

DDS Response: DDS agrees with this recommendation and will remind case managers of the importance of keeping demographic information up to date and accurate. A memorandum has recently gone out (February 2012) to Case Managers and Case Management Supervisors to remind them that as information changes, automated records need to be updated in a timely fashion.

Recommendation 12: The Department of Development Services should randomly audit a sample of cases in its client demographic database to ensure client information is accurate.

DDS Response: DDS currently performs a variety of audit functions focused on compliance with waiver requirements. If in this process issues with demographic information are identified they will be corrected. DDS believes that a continued focus on auditing related to federal waiver requirements is the best use of limited resources.

Recommendation 13: The results of quality inspections should be shared with all clients' Planning and Support Teams, which would include guardians and families. The results can be part of an education process about private community settings, and may help some clients' families reach a positive decision about moving from an institutional facility to the community.

DDS Response: Quality Service Reviews (QSR) and Community Living Arrangement (CLA) licensing results are currently posted on the DDS Website. QSR results are located within each Provider Profile. CLA licensing results are located under Quality Management and Licensure-CLA Licensing/Inspection reports. Therefore, there is no need for legislation to address this issue. Additionally, quality measures will be reviewed by department stakeholders in the near future, as addressed in the department's Five Year Plan.

Recommendation 14: The Department of Developmental Services should ensure staff and client participation and involvement in the planning for the Integrated Care Organization model, especially as it pertains to dually eligible clients who are under 65. DDS should ensure that any health care delivery model reduces duplication, prioritizes preventive care, incorporates a data reporting system that easily tracks and reports on preventive care and screening clients have received, and can be used as part of a performance measurement and quality assurance system.

DDS Response: The Department of Social Services has been awarded a contract from the Centers for Medicare and Medicaid Services (CMS) to design a system to integrate care for dual eligible individuals. The Department of Developmental Services (DDS) has been participating as a stakeholder in the planning and development phases of this initiative. A key element of the system focuses on promoting healthy neighborhoods, consisting of clusters of medical and non-medical providers that would offer a team-based approach to serving the dual eligible population. This model would focus on integrated care management that incorporates the coordination of medical, behavioral, and social support needs. To identify and address health and wellness issues for dual eligible persons with intellectual disability, DDS will hold focus groups comprised of consumers, families/guardians, and providers. DDS and stakeholders will contribute to the development of performance quality measures for the demonstration project that will examine the quality and cost outcomes for the target population. As the integrated plan model becomes fully developed, DDS will advocate for clear and useful reports that will allow the department to utilize this information as part of its quality assurance efforts.