

**PUBLIC/PRIVATE PROVISION OF
SELECTED SERVICES
IN CONNECTICUT**

Connecticut

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LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

FEBRUARY 1994

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

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

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EXECUTIVE SUMMARY

The Legislative Program Review and Investigations Committee authorized a study comparing the services delivered by state agencies and by private providers in three different program areas: community residential programs in the Department of Mental Retardation; alcohol detoxification programs in the Department of Public Health and Addiction Services; and case management services in the Department of Mental Health. The study examined four major components in comparing the services delivered -- costs; management factors including financial and budgeting systems, and staffing composition; quality assurance measures; and market structure for the provision of services. The objective of the study was to collect information that compared and contrasted the public and private provision of services rather than reach a policy conclusion about privatizing services in general.

The emphasis of the study focused on the community residential services program, as it consumes the greatest resources of the three programs. Analysis conducted during the study indicates that the service areas examined can generally be offered less expensively through private providers. But the committee believes that cost cannot be the only factor considered in a decision about privatizing of services. Two major considerations that prevent broad privatization are the greater obligation of the state to serve all clients, and the current contract language in collective bargaining contracts with state employees that prohibits layoffs of full-time employees due to the state exercising its option to contract out for services.

The program review committee's findings and recommendations emphasized that the goal of the service delivery must be to operate efficiently to maximize the number of clients able to receive the service. The committee determined that all three agencies needed to develop a better framework for establishing the level of services necessary for different clients. Agencies also must establish financial management systems that are able to generate cost figures for providing services in a state or private setting. The committee found that while private providers are held to certain financial accounting and reporting systems by the agencies with which they contract, these state agencies meet no such requirements.

The committee also concluded that to ensure services, public or private, operate at optimal efficiency, agencies must also develop better systems to measure utilization and client outcomes. With both financial and utilization review systems in place, agencies can measure whether clients are receiving the services needed with effective outcomes, and in the most cost-effective manner.

The committee adopted the following 14 recommendations aimed at promoting competition and improving efficiency in the way that services are delivered, as well as measuring their outcomes:

RECOMMENDATIONS

1. **Efforts undertaken by the Department of Mental Retardation to bolster utilization review (see recommendation #11) shall comprise an evaluation of health care services provided.**
2. **The ICF/MR status shall be abandoned, and DMR shall seek to place these homes under the Home and Community Based Waiver program.**
3. **DMR shall expand its efforts at promoting new housing options, that renting existing dwellings is preferable to purchasing residences or building new dwellings in most cases, and that the option to purchase or build be used as only as a last resort.**
4. **The Department of Mental Retardation shall calculate room and board rates for the homes it operates and the social services department shall incorporate those rates into its computerized system, and assistance payments shall reflect those rates.**
5. **DMR shall explore innovative pilot programs that would foster competition in community residential programs.**
6. **DMR shall establish standards for appropriate staffing levels based on the number and types of clients served, review staffing levels at all its DMR-operated community homes, and where DMR determines the home is overstaffed, redeploy those personnel to provide family supports to clients on the waiting list.**
7. **Both the Department of Mental Retardation and the Department of Social Services shall seek approval from the federal Health Care Financing Administration for both expansion of the waiver for the types of services allowed, and where the services can be provided.**
8. **DMR, DPHAS, and DMH, as management objectives, shall begin designing and implementing financial management information systems based on cost centers.**
9. **DMR shall continue basing its revenue retention formula on surplus amounts, but providers be allowed to retain 50 percent of the surplus during any given fiscal year. Further, no cap shall be placed on the actual dollar amount providers may retain.**
10. **Funding for community residential programs shall be combined into one account. DMR and private providers shall have the flexibility to use this account as deemed appropriate and move clients to the most suitable living arrangements. Further, no census caps shall be placed on any type of community residential program.**

11. **DMR shall establish a utilization review team responsible for examining placement and service usage on a systemwide basis. This team shall plan and coordinate client movement to the different types of community residential placement models used by the department. It shall focus on issues affecting client movement on a statewide, rather than regional level, yet receive input from regional placement committees and case managers. The team shall be comprised of staff currently within the IPR/UR Unit of the Quality Assurance Division.**
12. **DMR central office shall develop a centralized tracking system of client placements statewide, and that placement utilization information be kept in a standardized format from region to region to assist the statewide utilization review team.**
13. **DMR shall examine all the services required to be provided by case managers. For those services the department determines private providers can effectively and efficiently administer, it shall allow private providers the ability to provide such services.**
14. **DPHAS shall improve its automated client information system so that all facilities public and private are able to input client data on-site.**

INTRODUCTION

In February 1993, the committee authorized the study comparing the private and public provision of selected services in Connecticut. The services compared included community residential services within the Department of Mental Retardation (DMR), alcohol detoxification services within the Department of Public Health and Addiction Services (DPHAS) (formerly CADAC), and case management services within the Department of Mental Health (DMH).

There is consensus in the literature on privatization that any decision to privatize a service is generally based on three major factors: 1) a policy determination that a particular service appropriately belongs in the private sector; 2) an evaluation of the costs and benefits of providing the service in the private or public sector, including traditional costs of salaries, fringe benefits, and administrative overhead, as well as societal costs like access to service and non-discrimination in service and employment; and 3) an assessment of the program's effectiveness, including elements of competition, responsiveness to service demands, and quality of service.

The program review committee believes that, since all three of the services examined are currently provided by both public and private providers, the policy decision concerning the appropriateness of non-public sector provision of those services has already been made. Thus, the focus of this report is to provide information on the costs and benefits of the services provided, and to some extent the outcomes of the services, to assist policymakers in making decisions about whether the initial policy taken was the correct one, and if so, whether the policy should be expanded.

The scope of this study called for an examination of four components within each of the three programs: costs; management -- including financial and budgeting systems, and staffing composition; quality assurance; and market structure for the provision of services. The objective of the study was to collect information that compared and contrasted the public and private provision of services in these areas, rather than reach a policy conclusion about privatizing services in general.

The committee concentrated most of its time and effort on analyzing the four elements in the community residential program within DMR, as it consumes the most resources of the three agency programs. Analysis conducted indicates the three service areas examined can generally be offered less expensively through private providers. But cost, while important, cannot be the only factor guiding the decision to privatize or not, or to expand the privatization of services, especially human services. There are several other factors that weigh just as heavily as cost in such a decision.

Obligation of the state. There is a greater legal commitment on the state's part to serve clients than there is on the part of a private provider. None of the services examined is considered an entitlement, where anyone who is eligible must receive the service. However,

once a person has been determined to need the service, the state has a greater obligation to provide that service than a private provider.

This difference in obligation was reinforced in a recent Connecticut Superior Court decision involving private non-profit child caring agencies. Judge Robert Satter stated in his decision that "... providers are private agencies. They are not obligated to accept children recommended to them by the state, and the state cannot compel them to accept such children."¹ The program review committee assumes the same legal conclusion would be made for mentally retarded, alcoholic, or mentally ill clients. Thus, there is a need for some of the services to be provided by public agencies.

The state's obligation, however, is linked to the issue of whether the public programs operated by the state serve more difficult clients than the private programs because the state is considered the provider of "last resort". The committee found the claim of serving a more difficult population is substantiated with the DMR population. With the other two programs, comprehensive client data were not readily available to draw a similar conclusion.

Contract language. A second factor limiting the state's ability to broadly privatize services, at least over the short-term, is the current language written into collective bargaining contracts between the state and its employees prohibiting any full-time employee from being laid off due to the state exercising its option to contract out for services. Any state employee displaced by privatization must be offered a position elsewhere in state government, or trained for another position, at no reduction in pay.

While both the legal interpretation that the state has a greater obligation and the state's current contract commitments may preclude widescale privatization, this should not lull state agencies into believing the services provided by the public sector should not be as efficient or effective as those in the private sector. The program review committee believes every effort should be made within the three departments' service areas to improve their operations. In this age of competition and scarce resources, taxpayers demand they receive the best service value for public money spent, regardless of who provides the service. In fact, the Purchase of Services Project, an outgrowth of the Harper-Hull Commission, is currently examining ways to increase competitiveness in the way the state provides and purchases all human services.

Given the waiting lists and demand for service, the goal of state agencies -- and the providers with which they contract -- must be to operate each program efficiently to maximize the number of clients able to receive the service. To do this, all three agencies must develop a better framework for establishing the level of services necessary to serve different levels of client needs. The committee recognizes that there is difficulty in establishing standards in the

¹ Ct. Association of Child Caring Agencies v. Senatore, Superior Court, Hartford, CT. Memorandum of Decision, September, 1993.

realm of human services for individuals with varied needs, but without standards there is no way to judge what service levels, and corresponding costs, are appropriate.

Agencies must also establish financial management systems that are able to generate cost figures for providing services in a state or private setting. The program review committee found that while private providers are held to certain financial accounting and reporting systems by the agencies with which they contract, these state agencies meet no such requirements.

Finally, to ensure that services, public or private, operate at optimal efficiency, agencies must also develop better systems to measure utilization and client outcomes. With both the financial and utilization review systems in place, all three agencies -- DMR, DMH, and DPHAS -- could measure whether clients are receiving the services needed, with effective outcomes, and in the most cost-effective manner. These systems will allow state agencies to easily compare the costs of their services to those in the private sector and take the necessary steps to make their operations more efficient. Some of these efficiency measures that agencies must take -- redeploy staff, reduce administrative and regulatory overhead, or reduce unnecessary levels of medical care -- are identified in this report. However, if state agencies fail to use the information provided by the systems to adjust their operations, then efforts to gradually diminish state services in favor of private services should be pursued.

Methods. A variety of research methods and sources were used to carry out this study. State statutes, regulations, and budget documents pertaining to the areas under review were examined. Relevant reports developed by Connecticut governmental agencies, other state governments, and private sector consulting firms regarding privatization of services and related issues were also reviewed.

Interviews were held with agency staff and private providers in the three service areas, as well as staff from the comptroller's office, the Bureau of Collections Services, and the Department of Social Services. Committee staff also met with officials of the Connecticut State Employees Association, the New England Health Care Employees Union (District 1199), and the Association of Retarded Citizens of Connecticut. Committee staff made several site visits to DMR-operated and private community residences for mentally retarded clients, and accompanied DMR quality assurance staff on licensing inspections and federal regulatory compliance reviews required for ICFs/MR. Committee staff visited private and state-operated alcohol detoxification facilities, as well as both private and DMR-operated mental health case management services.

Committee staff collected extensive financial and program data on a sample of 120 randomly selected private and public residences for mentally retarded clients. A supplementary survey on costs and program information was also distributed to the private providers contained in the sample. The data were analyzed and the tabulated versions of those data collection sheets are contained in Appendices B and C.

Report outline. This report includes six chapters. Chapter I is a profile of the community residential services system in DMR. Chapter II analyzes the costs of the community residential services, including a comparison of costs between the public and private sectors. Chapter III describes the funding processes and includes findings and recommendations to improve financial management and cost settlement. Chapter IV provides analysis and findings and recommendations on utilization review and quality assurance of the community residential system within DMR. Chapter V analyzes the alcohol detoxification programs operated by DPHAS and private, non-profit organizations, and Chapter VI discusses mental health case management services.

CHAPTER I

COMMUNITY RESIDENTIAL SERVICES IN DMR

BACKGROUND

The committee's comparison of public and private services within DMR focused on community residential programs, which mainly include community living arrangements and facilities certified as Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). While the study does not cover all residential services, it is difficult to ignore any piece of the residential services structure because of the relationship each has with the others.

Throughout the study, the committee recognized that the entire residential structure, including the way residential services are provided, is experiencing a major paradigm shift. The Mansfield Training School closed in April of 1993, moving the last number of clients back to the communities, and redeploying the remaining training school staff as well. In addition, the governor last year announced that the other large state institution, Southbury Training School, should also close. The DMR commissioner appointed a task force to explore closing Southbury.

At the same time, DMR was also closing major portions of the New Haven Regional Center and moving clients to DMR-operated community living arrangements, but the transition to those homes is not yet complete. Also, in just the past few months both the DMR five-year plan and a report released by the Council on Development Disabilities, call for major changes in the way DMR provides services to its clients.

The program review committee believes these efforts move the department away from providing institutionalized residential care for people with mental retardation or developmental disabilities. This would be a significant achievement in terms of meeting the department's mission statement to have mentally retarded persons make choices, have relationships with family and friends, and experience "presence and participation in Connecticut town life".

The committee also believes the current DMR examination of the entire residential system is necessary and long overdue in order to correct the problem of some clients being overserved while others on the waiting list receive few services. The problems created by the current residential system, however, are not the result of deliberate public policy, but rather the consequence of several converging factors: 1) an inherited system from another era that promoted institutional living; 2) the influence of federal regulations states must follow to obtain reimbursement for residential programs, and 3) the result of the court case and subsequent consent decree that closed Mansfield Training School.

Historical synopsis. Until the 1960s, it was believed the best way to serve mentally retarded citizens was to house them in institutions, away from their families and community. (In Connecticut, more than 900 residents still live in at Southbury Training School.)

In 1972, authorization was given under the federal Medicaid program to reimburse states for services provided to mentally retarded persons in ICFs/MR. These services could be provided in large state institutions (or parts of the institution), or in smaller facilities in the community, as long as the standards for a safe environment and appropriate treatment were met. Thus, federal Medicaid reimbursement was a strong inducement to provide residential services through an institutional or medical facility model. Efforts during the 1970s and early 1980s in Connecticut to provide community residences for mentally retarded persons, predictably favored this model.

In 1978, DMR became the target of a federal class action suit, known as *CARC v. Thorne*, whereby the plaintiffs charged that care given to residents at Mansfield Training School violated their civil rights. The case was settled through a consent decree that called for improved service coordination for clients, increased community placements, and other program supports, and the significant downsizing (and ultimate closing) of the training school. The consent decree resulted in rapid expansion of community placements for the Mansfield population in group homes providing 24-hour supervision. As this report will indicate, this model is an expensive one.

The approach of placing clients in community settings often resulted in expensive new construction or extensive renovation to existing structures. Further, though providing comfortable residential settings, considerable staffing, and other services for class members, it excluded many others on the waiting list from being served. In the 1990 Legislative Program Review and Investigations Committee report on the Department of Mental Retardation, the committee noted that cost had not been a significant factor in the department's decision making, and cited DMR's selection of the most expensive community residences, CLAs, as its basic residential model as an example.

With the proposed closing of Southbury, advocates for clients on waiting lists for services are opposing such efforts anticipating that the department will replicate the Mansfield deinstitutionalization effort and their family member, friend, or client will never be served. DMR recognizes this concern and the need for new approaches to serve more of its clients currently waiting for service. The department has put forth proposals in its 1994-1999 Five Year Plan to expand options and develop more personalized support services that allow people to live and work in places where the responsibility for providing necessary supports is shared.

The specific findings and recommendations in this report are made recognizing that the residential system is undergoing a major redirection. The findings and recommendations advance two major themes for the residential system restructuring: 1) the system should be as flexible as possible, while improving client choice and increasing DMR's ability to serve more clients; and 2) the system should promote competition among all providers, including DMR, and at all levels of the service system so that clients, the department, and the state's citizens are getting the most value for money spent.

PROFILE OF DMR RESIDENTIAL PROGRAMS

An overview of how and where the Department of Mental Retardation provides community residential services to its clients is provided below. Information presented includes the type of residence, type of operation (public or private sector), and number of clients served. The overview also describes how clients apply for services, how eligibility is determined, and the placement of clients.

Number of community residential facilities statewide. Connecticut has more than 600 private and public community residential service facilities currently operating that fall under the scope of this study. These facilities are spread among the six DMR regions as shown in Figure I-1.

Public and private residences. As discussed in the introduction to this report, the vast majority of community residential services in Connecticut are provided through the private sector. In fact, as Figure I-2 shows, the private sector operates more than *three-quarters* (78 percent), of the community residential facilities in the state, while the public sector (DMR) operates 22 percent.

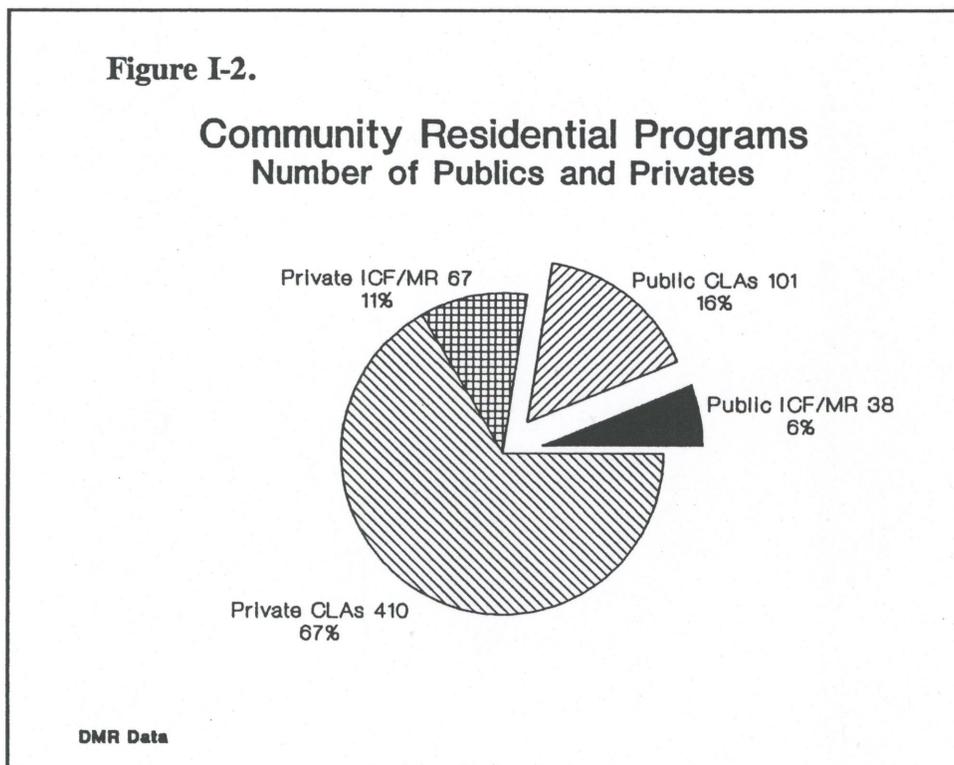
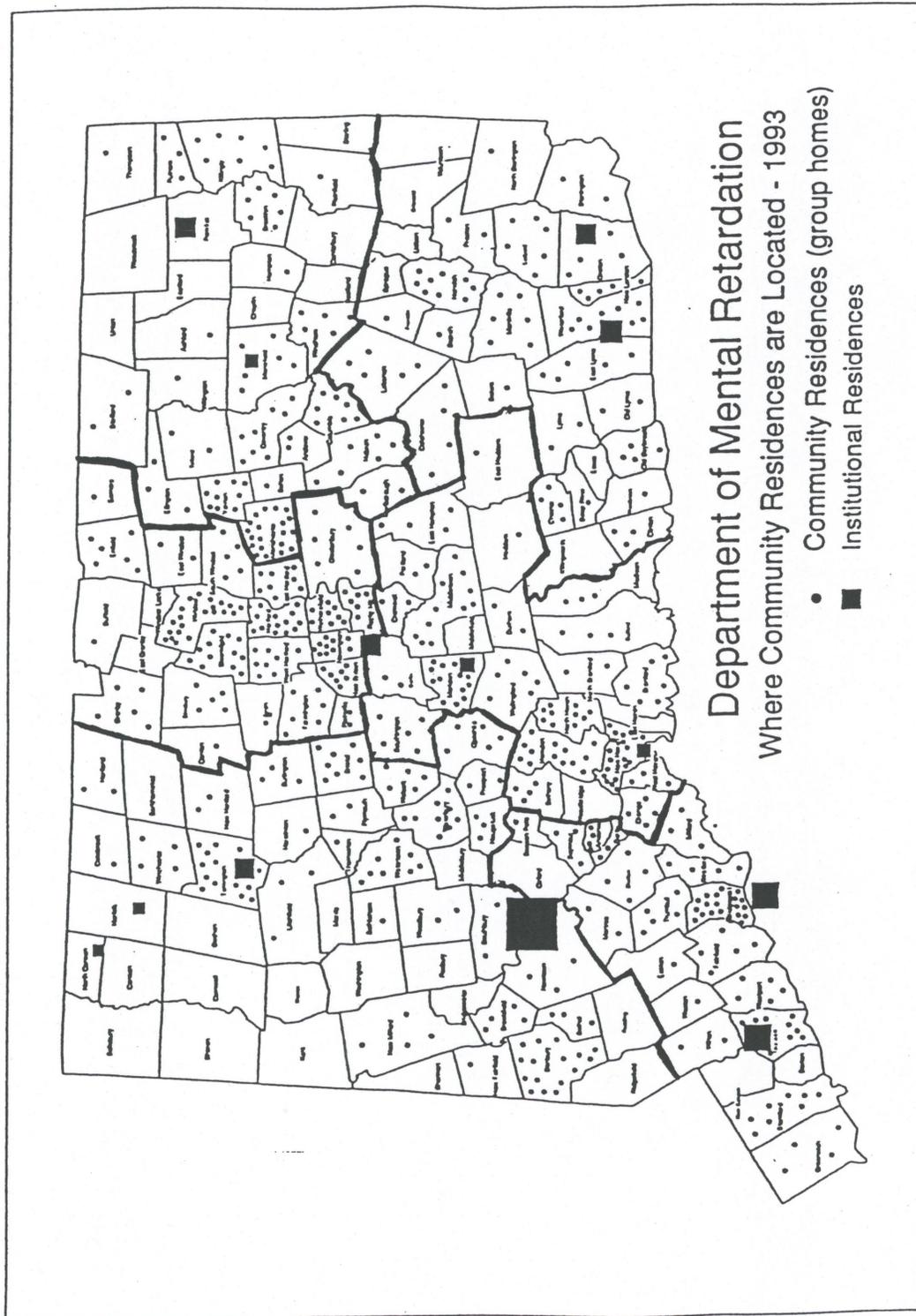


Figure I-1. Location of Community Residences.



TYPES OF COMMUNITY RESIDENCES

The type of residence impacts the costs for services (i.e., rates), how rates are set, the way payment is made to the providers, which agency or agencies pay for the service, how services like medical care are provided to the client, and the potential impact on a clients' cash entitlements and earnings. Generally, there are four ways residential services are provided in the community whether facilities are operated by the Department of Mental Retardation or private contractors. They include:

- group homes that are certified as Intermediate Care Facilities for the Mentally Retarded (ICF/MR), which are 24-hour care residences;
- group home or community living arrangements (CLAs) that are not ICF/MR residences, but provide 24-hour care;
- community training homes (CTH) which are family foster care arrangements; and
- supported living arrangements (SLAs), where the clients receive less than 24-hour staff support in their own (or shared) apartment.

The first two types of facilities listed are included in the scope of this study and described in detail below.

Intermediate Care Facilities for the Mentally Retarded

Currently, approximately 105 private and public Intermediate Care Facilities for the Mentally Retarded are operating as group homes in Connecticut. There are also a number of these facilities operating at Southbury Training School and at DMR regional center campuses. Campus units are not included in this study since they are not part of the community residential services program.

All ICF/MR facilities are certified by the Department of Public Health and Addiction Services, formerly the Department of Health Services. Private ICFs/MR are funded entirely through the budget of the former Department of Income Maintenance, now the Department of Social Services (DSS). That agency is reimbursed 50 percent by the federal government through the Medicaid program. Each ICF/MR has 24-hour staff coverage. Also, clients are more likely to receive medical coverage and other health care through ICF/MR services than from health care providers in the community. Clients living in an ICF/MR facility are entitled to a monthly needs allowance of only \$30; all other assistance and earnings must, under Medicaid rules, go towards the cost of their care.

Certification and licensure. To become ICF/MR certified, a facility must first receive approval from the Department of Mental Retardation and a "certificate of need" from DSS (formerly a function of the Commission on Hospitals and Health Care). To remain certified,

the facility must undergo an annual individual program review and semi-annual utilization reviews. These reviews are discussed in greater detail in Section V. All ICF/MR facilities must also be certified for medical eligibility by the Department of Public Health and Addiction Services.

Rate-setting. The daily rates that ICFs/MR charge are prospectively established by the Department of Social Services. Annually, each private facility files a report called a long-term care cost report with a private accounting firm under contract to the state. The firm then develops a rate, based on the facility's costs for the prior year, that must be filed with and approved by DSS. The rate for the ICF/MR includes costs for room and board, and day programs, as well as direct care services. The commissioner of social services is required to establish the rates based on a determination of "reasonable payment for necessary services, which basis shall take into account as a factor the costs of such services" (C.G.S. Sec. 17-314(a)). A similar process is followed by DMR with DSS to establish rates for the ICFs/MR it operates.

Community Living Arrangements (CLAs)

Most community residences for mentally retarded clients are non-ICF/MR group homes, or community living arrangements (CLAs). As Figure II-2 above indicates, there are 410 private and 101 public CLAs in Connecticut. Like ICFs/MR, these group homes provide 24-hour staff support. These residences have an average of four clients, but range from one to 20 clients. Almost all clients participate in day programs that are not part of the CLA residential program, including vocational training, supported work, or employment.

Licensure. Private CLAs must be licensed by the Department of Mental Retardation. A license is issued to each individual group home, not its operating organization, and is renewable annually. While, DMR-operated CLAs are not required to be licensed, they are inspected and "certified" by the central Quality Assurance Division as meeting the same standards as private facilities. A more detailed discussion of these standards is provided in Chapter IV on quality assurance. Federally required licenses or certifications are not necessary for community living arrangements. However, almost all private and public CLAs are approved for a Home- and Community-Based Waiver under Medicaid, which allows the state to be reimbursed for half of the service costs of the CLAs.

Rate-setting. Privately operated community residential facilities must have a portion of their rates approved by the Department of Social Services. The portion of the CLAs' costs related to room and board costs must be approved by DSS; service costs (i.e., staffing), which are paid for by DMR, are not, but DMR approves them through the funding negotiation process described earlier. Public residences operated by DMR do not have to submit room and board costs for non-ICF/MR homes to DSS for approval. The costs of client day programs, also funded by DMR, are not included in the CLA service costs for either public or private homes.

For clients living in private CLAs, the Department of Social Services calculates clients' room and board expenses as part of the overall cash assistance they are entitled to receive, after considering the disregards that must be applied to both earned and unearned income, as required by federal and state regulation. The assistance check is sent to the client and the private provider is then responsible for collecting the rent portion from the client. Typically, after room and board deductions are made, the client keeps about \$120 a month.

REGIONAL PROFILE OF COMMUNITY RESIDENCES

A profile of community residential programs in the six regions, which includes a breakdown of ICFs/MR and non-ICFs/MR by region, and the DMR-funded bed capacity for each type of residence by region is provided in Tables I-1 and I-2. Table I-1 contains data for private homes, while Table I-2 shows the same information for public homes.

TABLE I-1. Number of Private Group Homes and Residents by Region.							
Residence Type	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	State Total
ICFs/MR	29	14	4	9	11	0	67
Non ICFs/MR	66	85	60	63	88	48	410
Total Residences	95	99	64	72	99	48	477
ICF/MR Beds	152	71	29	57	64	0	373
Non ICF/MR Beds	333	351	232	305	447	221	1,889
Total Beds	485	422	261	362	511	221	2,262
Source: DMR Reports on Capacity and Licensed CLAs.							

Residences. The tables show a total of 616 residences in the state -- 477 privately run and 139 operated by DMR. As already noted, most residences -- 410 of the 477 private sector (86%), and 101 of the 139 public sector (73%) -- are non-ICF/MR facilities. The tables also indicate that there are regional differences in the numbers of private facilities as well as bed capacities. Even adding the private and public facilities together, there are still variances by region in the number of homes. However, those differences appear to relate to size and population of the regions served. For example, Region 2 is the Hartford region and Region 5 is the New Haven region. While both have a high number of homes and beds, both also have high numbers of clients waiting for residential placement, as will be discussed in Chapter III, indicating they are not currently overserved.

TABLE I-2. Number of DMR-Operated Group Homes by Region.							
Residence	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
ICF/MR	8	13	7	1	6	3	38
Non ICF/MR	5	21	26	9	17	23	101
Total	13	34	33	10	23	26	139
ICF/MR BEDS	62	107	47	8	44	22	290
NON ICF/MR BEDS	27	128	101	53	50	99	458
TOTAL BEDS	89	235	148	61	94	121	748

Source: DMR Report on Capacity of DMR Units.

Number of beds. The number of beds in the public sector totals 748 (25%), while the private sector has 2,262 (75%). These percentages vary somewhat from the residence ratios cited on page 7, indicating that public homes have slightly greater bed capacity per facility than do private residences. This is reflected in Table I-3, which shows that, generally, the average number of clients per facility served in the private residences is lower than the public facilities. For example, with the ICF/MR facilities, only Region 3 had the same average number of beds in private and public homes, while in Region 2, the public ICF/MR served, on average, 4 more clients per home than did the private facilities. The average bed capacity of the public and private non-ICFs/MR is more similar, with 3 of the 6 regions having the same average number. In fact, in Region 5 the average bed capacity in the public non-ICFs/MR is less than the privates.

TABLE I-3. Average Number of Beds by Type of Facility and Region.						
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
ICF/MR Private	5	5	7	6	6	0
ICF/MR Public	8	9	7	8	7	7
CLA Private	5	4	4	5	5	5
CLA Public	5	6	4	6	3	4

Source: DMR ACOR Data for Private Facilities; DMR Report on Capacity of DMR Units.

APPLYING FOR SERVICES

There are three ways a client can enter the system to receive services from the Department of Mental Retardation; they include: 1) the regular application process; 2) through placement by a probate court if the placement is involuntary; or 3) via an emergency placement.

Regular application process. Requests for services may be submitted to DMR by or on behalf of any state resident who is, or believes he or she is, mentally retarded. Upon initial contact with the department, the requesting party is informed in writing of his or her rights regarding eligibility for residential services. Not everyone seeking to reside in a community residential facility is immediately placed. Even after a client is deemed eligible for such services, he or she may be placed on a waiting list.

Regional protocols developed by DMR state that intake workers or case managers will assist applicants in preparing "Request for Services" forms along with the appropriate releases for gathering information. All initial service requests must include the following information:

- a medical history of the applicant;
- a certificate signed by a physician stating the applicant is free from any communicable diseases; and
- a written psychological report stating a psychologist has examined the applicant not more than 90 days prior to the application date, along with the results of a psychometric assessment (not more than one year old), and an evaluation of the applicant's current level of adaptive functioning.

In the event of an emergency placement to a residential facility, the medical and psychological reports may be submitted within 30 days following the admission.

Involuntary placements. Involuntary placements to DMR may be made either through a probate court or directly to DMR in the case of an immediate placement. If the placement is made by a probate court, an application is first filed with the court and a hearing arranged.

If, after a hearing, the court determines the person's need for placement is critical, it can order DMR to temporarily place the person in the most appropriate placement available. DMR is required to report back to the probate court on its progress in finding appropriate, permanent placement for the person. If the court-ordered placement with DMR is not considered an emergency, the department is required to wait-list the person for placement in any residential facilities it identifies as appropriate after an evaluation of the applicant is conducted. If no placement becomes available within 60 days, the department is to report to the probate court and continue to do so every 30 days thereafter until proper placement is found.

Emergency placement. In the event a person or agency has reasonable cause to believe someone is mentally retarded and in need of immediate care, a written report can be filed directly with DMR. The department is then responsible for promptly determining whether the person is mentally retarded and if the department should assume care of the person. Once a decision is made, the department has 24 hours to: 1) notify the Office of Protection and Advocacy; and 2) file an application with the probate court for the district where the person resided prior to emergency placement whereby a hearing is then scheduled.

Determining Eligibility

In order to be eligible for DMR services, a person must: 1) be a Connecticut resident or referred from another state through the Interstate Compact on Mental Health; and 2) have mental retardation as defined by C.G.S. Section 1-1g, which defines mental retardation as "a significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." State law also specifies that individuals committed to the department's care for competency training by Probate Court (or in the case of juvenile delinquents, Superior Court), or through specific federal law, are eligible for services.

After a person makes an application to receive DMR services, a determination of eligibility must be made. This decision is based on the application and additional information such as:

- medical history and diagnosis;
- recent psychological test reports and historical reports prepared by a psychologist that include formal intelligence and adaptive test results;
- school records, especially those which establish the presence of mental retardation prior to the age of 18; and
- an interview with the applicant.

Regional directors have final decision-making authority regarding eligibility. If an applicant is not eligible for DMR services, a written notice outlining the reasons for denial, as well as a description of the appeal process, is sent to the applicant following the eligibility decision.

Appeal process for ineligible applicants. An administrative hearing before DMR may be requested by any applicant deemed ineligible for services. After the request is made, a hearing officer is assigned, the applicant is notified, and a hearing is held. After a decision is reached by the hearing officer, the final decision regarding the appeal is made by the commissioner. The applicant is then informed of the determination, as well as his or her right to appeal an adverse finding to Superior Court.

Placement to a Community Living Arrangement

Once a person becomes eligible for DMR residential services, he or she can be placed in a public or private community residence. The overall responsibility of ensuring that clients are placed in proper facilities and receive adequate treatment rests solely with the Department of Mental Retardation. As mentioned earlier, statewide protocols for use in conjunction with applicable laws and regulations have been established to help guide the department.

Central/regional office roles. In addition to a central office, DMR has six regional offices throughout the state. Each has specific responsibilities and functions with regard to client placement.

Regional offices are mainly responsible for handling client admissions to the system, determining client placement in a residential facility, coordinating placements with other programs and services through case management, maintaining lists of clients waiting for placement, and ensuring the proper care and treatment of clients by private and public providers. Regions are also responsible for overseeing program and property development, administering contracts made with private providers, and negotiating contract changes such as increases in daily service rates.

The central office is responsible for the overall planning and direction of the department. It collects and analyzes financial data submitted by private providers, issues licenses to private providers, certifies public homes, and inspects public and private residential facilities. It also handles most quality assurance matters with respect to licensing, certification, and inspections. However, some additional quality assurance functions are conducted at the regional offices.

Waiting list prioritization. The protocols used by the department state that regions are to review requests for residential services at least biweekly to match needs of those requesting placement with existing vacancies. If no vacancies are available, names are put on a waiting list and reviewed regularly.

Waiting lists are arranged according to four status levels. The most crucial is emergency status followed by Priorities 1, 2, and 3. Clients classified as emergency status are determined to need a new living arrangement within three months. Factors contributing to the emergency classification include:

- death or incapacity of the person's principal support provider;
- health or safety of the person (or others) in the current living arrangement is endangered;
- person can no longer be cared for by his or her family or current residential provider;
- person is homeless due to the emergency situation; or

- court requirement of immediate placement.

For clients classified as Priority 1, a new living arrangement should be found within one year because the person's current living situation is unstable or deteriorating. A Priority 2 classification means that a person needs a new living arrangement within two years because the current living condition is becoming increasingly unstable or inappropriate. Clients classified as Priority 3 need a new living arrangement within five years. This classification is given if the person's current living condition is stable and services are adequate, but his or her living situation or needs are expected to change substantially within the next five years.

As of July 1, 1993, there were 1,103 people throughout the six DMR regions living at home and waiting for placement in a residential facility. Each region maintains its own waiting list and places clients into community residential facilities from that list whenever an appropriate vacancy becomes available. In addition, the DMR central office maintains a statewide waiting list updated on a monthly basis. Table I-4 shows the number of clients on waiting lists by region as well as by priority level.

TABLE I-4. Waiting List Population by Region and Priority as of July 1, 1993.*					
Region	Emergency	Priority 1	Priority 2	Priority 3	Total by Region
1	2	18	109	73	202
2	8	101	51	47	207
3	9	22	14	23	68
4	11	52	38	135	236
5	11	31	52	174	268
6	7	20	27	68	122
Column Totals	48	244	291	520	1,103

* Waiting list data are for all persons currently living at home and waiting for placement.

Source: Department of Mental Retardation.

As Table I-4 indicates, approximately 4 percent of those with mental retardation living at home are on waiting lists and considered emergency placements, while 22 percent are Priority 1, 26 percent are Priority 2, and 47 percent are Priority 3. On a regional basis, Region 5 has the largest waiting list, 268 people, which equates to 24 percent of the total waiting for placement statewide. Region 3, has the smallest list with 68 people, or 6 percent of the statewide waiting list.

Aside from waiting list priorities, DMR clients are not given any type of classification as to their needs. This has not always been the case. Until the closing of Mansfield, clients were assessed and rated according to their level of needs, using a number system. By rating clients in this manner, DMR and private providers were able to coordinate the demand for placements, particularly associated with the Mansfield closing, with available supply of programs and residential facilities in both the public and private sectors.

The department no longer uses numerical levels-of-need ratings. Instead, clients are assessed using a broader methodology that analyzes their overall abilities and tries to match them with the appropriate services offered by the department and private providers. The outcome of this assessment method is an overall plan of services, which is an individualized strategic plan that identifies clients' needs, including residential placement, and finds programs that best fit these needs within available resources. The rating practice was changed because clients were being classified at artificially high levels which increased costs.

Overall plan of services. Once a client enters the DMR system and either resides in a staffed residential facility, such as a community living arrangement, or receives day services funded by the department, an evaluation and assessment of the client's needs is completed. This evaluation is done by a interdisciplinary team of individuals with direct knowledge of the client described in more detail later. The evaluation is developed into a plan known as the overall plan of services (OPS).

The OPS is designed to guide the delivery of services to a client for up to one full year. It is geared towards helping the client achieve developmental growth, individualization, integration, use of generic services (i.e., transportation), support of natural settings, and full citizenship status. The plan includes the following information:

- a list of the client's strengths, weaknesses, and preferences;
- a list of prioritized goals;
- measurable behavioral objectives for each goal;
- teaching strategies detailing how staff will assist clients to accomplish new skills and/or behaviors; and
- procedures to evaluate the teaching strategies.

There are instances when an overall plan of services is not warranted for a particular client. For example, clients may only need occasional services from DMR such as transportation. Also, for clients who already have an OPS, the evaluation team may decide that a client has become more independent and no longer needs the services required by the plan. In these circumstances, a "Follow-Along Plan" is developed. This type of plan is not as resource-specific as a regular OPS but still addresses the client's needs.

Interdisciplinary Team. The Interdisciplinary Team (IDT), as defined in DMR's policy manual, is a group of people whose participation is relevant to identifying the needs of a client, devising ways to meet these needs, writing a client's overall plan of services, and reviewing the plan's effectiveness. The team is considered interdisciplinary because it consists of individuals from different professional backgrounds (i.e, case manager, psychologist, physical therapist, etc.). Each person, however, is associated with the client and his or her needs in some capacity.

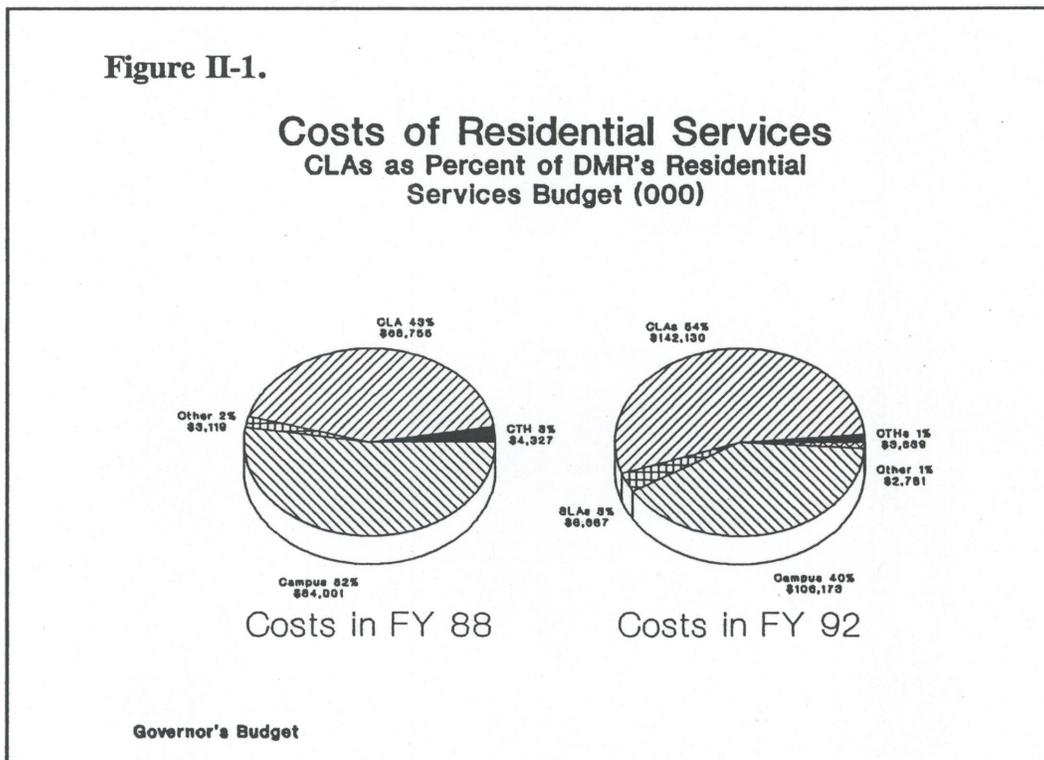
CHAPTER II

COSTS OF COMMUNITY RESIDENTIAL PROGRAMS

This chapter examines the costs of community residential services for mentally retarded and developmentally disabled persons in Connecticut, including an overview of the overall costs in Connecticut, and a comparison with other states. The process for setting rates and contract negotiation is also discussed. The chapter also compares the costs of providing community residential services between the private sector homes and DMR-operated facilities, including direct care costs, room and board expenses, health care costs for clients, and administrative overhead. Finally, the chapter discusses market structure influences and ways to enhance competition.

OVERVIEW OF COSTS

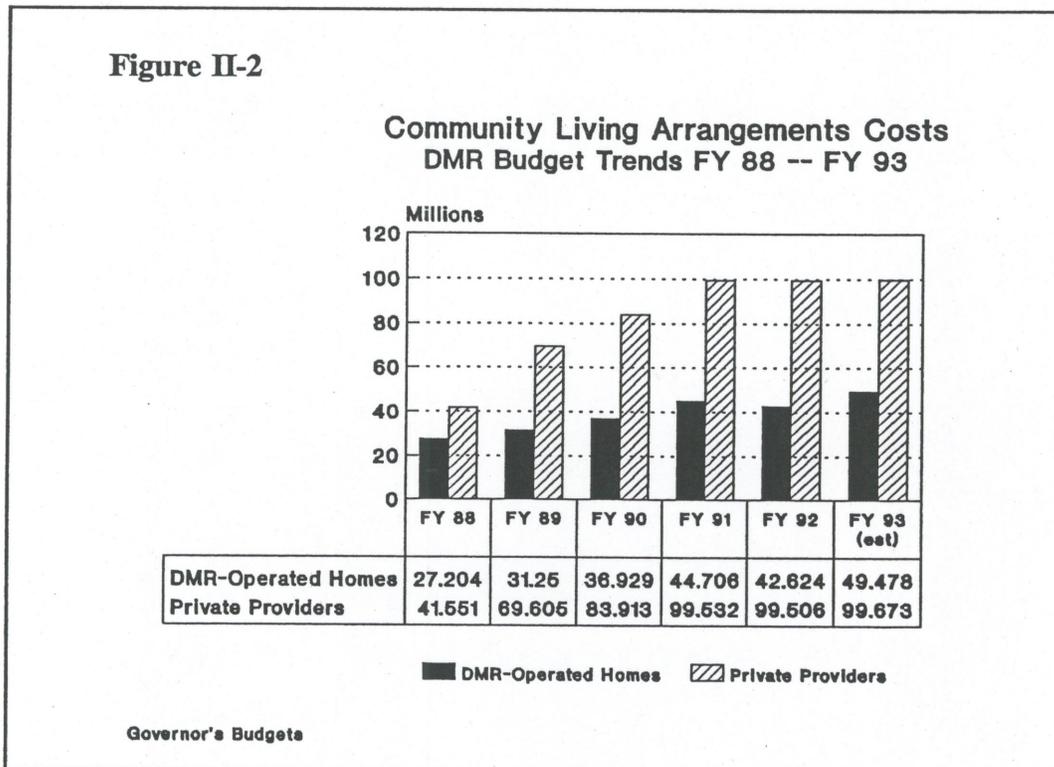
Residential programs, including the institutional programs, consume a large portion of DMR's budget; more than any other single program. Of the agency's residential program budget, community living arrangements now receive more than any other category of residence, including the still-costly campus units. Figure II-1 depicts DMR's residential program expenditures for two separate years -- FY 88 and FY 92.



In FY 88, the expenditures for campus facilities was about \$84 million, accounting for 52 percent of the residential facilities' budget. By FY 92, even though the capacity of campus facilities had declined with the closure of Mansfield Training School, and the percentage of all residential funding that goes to campus units had declined to 40 percent, campus units still accounted for more than \$106 million of DMR residential costs. Moreover, between FYs 88 and 92, the CLA component of the residential services program had more than doubled -- from almost \$69 million to more than \$142 million. As a portion of residential program costs, CLAs accounted for 43 percent of the costs in FY 88, and grew to 54 percent by FY 92. Community training homes and supported living arrangements expend much less of the department's residential program dollars (4 percent).

CLA Funding

Figure II-2 shows the annualized trends in the CLA program within DMR, by private provider and by DMR-operated CLAs. The biggest increase in the budget occurred in FY 89, when the CLA funding grew by \$32.1 million, a 46 percent increase. The figure also shows that in FY 88, DMR had a greater portion of the CLA funding -- 39 percent in FY 88 compared to 34 percent in FY 89. This share dropped to about 30 percent for each of the next three years, and then increased to 33 percent in FY 93. Since FY 91, the budget for private providers has been about the same -- approximately \$99.6 million. During the same period, DMR's own funding was cut nearly \$2 million from FY 91 to FY 92, but increased about \$7 million in FY 93.



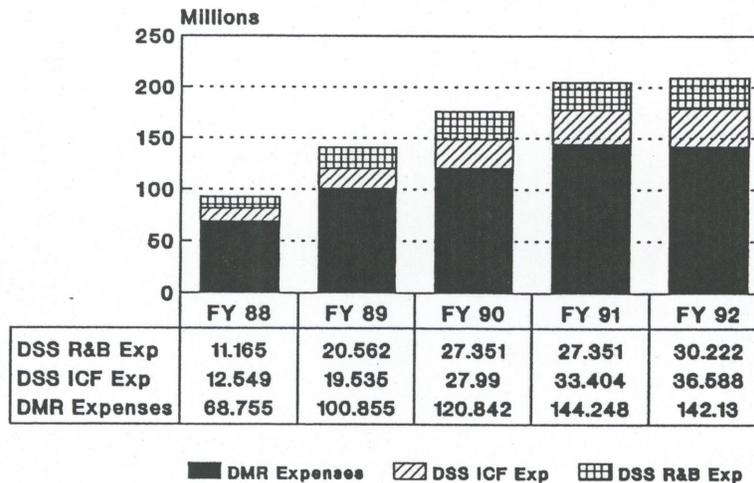
The DMR funding to private providers covers most costs, other than room and board costs. In some cases, providers receive revenue from other sources, such as fundraisers, that offset some costs, but largely revenues from DMR accounts for most of the providers' income. DMR funding to private providers covers the costs of direct care staffing, support and administrative staff, and operational program costs like transportation. On the other hand, costs that appear in the program budget for DMR CLAs mainly include the personnel costs for direct care staff in the homes.

Total Costs

In addition to the costs discussed above, the Department of Social Services is responsible for funding the private ICF/MR costs as well as the room and board costs for the private CLAs. Figure II-3 below, shows the overall costs of providing community residential services in FY 92. The figure combines: 1) staffing cost in all CLAs which is funded through DMR; 2) room and board costs for private CLAs; and 3) total costs of all private ICFs/MR. The latter two components are funded through the Department of Social Services' budget. Most of the expenses are eligible for federal reimbursement. About 50 percent of ICF/MR category expenses are reimbursed under Medicaid, while all the costs for the vast majority of the CLAs, other than room and board, are eligible for 50 percent reimbursement under a Medicaid waiver known as the Home- and Community-Based Waiver.

Figure II-3.

Total Costs of Community Residences DMR and DSS Expenses



Governor's Budgets and DMR ACOR Reports

Comparison With Other States

Connecticut spends more on residential care for each mentally retarded or developmentally disabled client than most other states. The cost and client data used in Table II-1 are somewhat dated, but useful for comparison purposes. The table shows Connecticut ranks at the top of the 51 states and Washington, D.C. in dollars spent per residential client (both institution and community) at \$77,152. Several other factors were compared for the Northeastern states, including the total amount spent for residential care in each state, the number of clients in residential care, the resulting cost per client, the percentage of funding for community care (less than 16 beds), and the percentage of community funding supported by state revenues.

TABLE II-1. Comparison of Connecticut with other Northeast States.

State	(A) Total Res. \$(000)	(B) Total Resident Clients	(C) \$ per Res. Client*	(D) % Spent on Community Care	(E) % of Community \$ from State	Rank of State in Fiscal Effort in MR/DD
CT	\$382.6	4,959	\$77,152	61	83.9	4
ME	\$55.1	1,140	\$48,333	55	33.5	16
NH	\$63.0	1,119	\$56,300	73	64.5	8
NY	\$1,118	27,227	\$66,111	55	66.7	5
VT	\$30.0	587	\$51,107	56	45.9	11
MA	\$605.8	8,242	\$73,501	45	87.1	9
NJ	\$476.6	9,307	\$51,209	40	64.5	26
RI	\$82.2	1,915	\$42,924	69	55.6	2

* Calculated using data from columns A and B

Source: David Braddock et al., *The State of the States in Developmental Disabilities*. Paul H. Brookes Publishing, Baltimore, MD, 1990.

In FY 88, Connecticut spent more than any other state in the Northeast on residential care per client, and actually led the nation in per-client residential costs. Connecticut also spent more than most states in this region as a percentage of funds going to community residences (those with fewer than 16 beds). However, the majority of these residences in Connecticut were paid for with state funds, while most other states had more success in obtaining federal reimbursements to pay for community care. Connecticut also ranked second-highest in the Northeast, and 4th nationwide, in overall fiscal effort for providing services to mentally retarded and developmentally disabled persons, as measured by state spending on these services as a percent of \$1,000 of personal income in the state.

PROCESSES FOR DEVELOPMENT, FUNDING, AND RATE-SETTING

When resources for development of community residential programs for clients or, in particular new facility construction, are available, the Department of Mental Retardation follows specific processes to allocate them. The processes are outlined in Figure II-4.

The availability of funds for either program or property development depends on both budgetary and policy guidelines specified by the legislature. DMR is guided by legislative directives such as the type of client to be served and the type of living arrangement that should be developed (e.g., community or supported living, community training home, etc.) when making decisions on program and property development.

Program development. In addition to the actual physical construction of a community residential facility, a program of services for individual clients needs to be developed. Program development simply means that funds are available for DMR to place a client into a community residential facility and that a plan of services can be developed.

The process begins with the DMR central office informing the regions that the legislature has appropriated funds and what priorities have been established regarding use of the funding. Once the regions know their allotments, they develop program requirements to meet the legislative directives.

Private providers are then notified of available funding to develop a community residential program, as well as the requirements of the program. Providers must demonstrate their ability to adhere to the program specifications and submit a letter of intent to the appropriate region. Information detailing their organization and what methods they will use to fulfill program requirements must also be provided to the regional office. Regional staff then meet with all interested providers to discuss the proposals and decisions are made as to which providers best meet the region's requirements.

After this preliminary review is completed by the region, and the number of providers is pared down, the remaining providers each develop a more detailed plan of the services and resources they will provide. Prospective residents then are given the opportunity to meet with the providers, who best match their needs and choose the provider with whom they feel comfortable. Once this step is completed, the selected provider creates a residential services plan that is reviewed and finalized by the region.

Property development. DMR also has a process, outlined in Figure II-4, for developing property to be used for community residential facilities. This process is for selection and approval of the actual residence to service DMR client(s).

Figure II-4. Community Living Arrangement Program and Property Development Processes.

PROGRAM DEVELOPMENT PROCESS

Step 1. Notice of Availability of Funds

- A. DMR central office informs regions regarding resource allocations and target priorities
- B. Region meets with all interested providers

Step 2. Interested Providers Submit Letter of Intent

- A. Provider agency describes what it intends to do
- B. Provider describes history of organization, other programs it operates, and financial records

Step 3. Region Meets with Providers to Review Letters of Intent

Step 4. Region Selects Providers

- A. Letter of Agreement sent to providers
- B. Type of program to be developed is specified
- C. Names of residents are assigned to providers

Step 5. Providers Develop Residential Services Plan

- A. Providers meet prospective residents, DMR staff
- B. Budgets, staffing patterns, and support services are specified

Step 6. Region Reviews Residential Services Plans

- A. Plans are finalized, including budgets
- B. Letter of Commitment is sent to provider chosen by resident

PROPERTY DEVELOPMENT PROCESS

Step 7. Property Development Stages

- A. Provider finds suitable property
- B. Region approves site and cost estimates
- C. DMR central office reviews/approves request
- D. DSS reviews request; agrees to fund
- E. Property renovations begin, if necessary
 - 1. Certificate of occupancy (town)
 - 2. Sanitation report (town)
 - 3. Fire Marshal approval (town)

Step 8. Provider Hires and Trains Staff

Step 9. Licensing Inspection by DMR Central Office

The provider is responsible for finding the property that meets DMR and town requirements. Staff of the region where the property is located is responsible for approving the site and cost estimates associated with the purchase and renovation of the property. Once this is completed, the provider staffs the residence. Pending a successful final inspection of the residence, DMR then issues a license to operate the facility.

FUNDING PROCESS

Overall annual funding for both public and private community residential facilities is determined by an appropriation level in DMR's budget set by the legislature. The legislature also establishes budgetary guidelines that outline the direction DMR must take as far as community residential facilities and placements are concerned. Using these guidelines, the department then decides how the funding will be allocated. Funding is program- or residence-based, not client-based. This means that rates are set for a particular residence (or program) and do not "follow" a client if he or she changes residences.

Service contracts. The department then allocates the appropriated funding through annual written contractual agreements with private agencies to administer community residential facilities. Initial contracts are made between DMR and private providers following a "request for proposal" (RFP) process. RFPs are issued whenever new funding is available for community residential development, or changes occur within existing residential programs. An RFP includes a description of the client to be served, the needs of the client, and program cost ranges. These cost ranges, calculated by DMR, are used as guidelines by providers when responding to the RFP.

Contracts between DMR and private providers are valid for one-year periods coinciding with the state's fiscal year. They are renewed annually following a satisfactory review of the contractor's performance, but established contracts are not put out for rebidding. Each year each of the DMR regional offices renegotiates the contract amounts with the service providers.

RATE SETTING

Ultimately, the total costs for community residential programs in Connecticut is reduced to a per diem or daily per-client cost. These costs are calculated through a complicated, unwieldy process that, in many cases, yields questionable rate results. The rates are established differently and involve varying state and private agencies depending on the type of community home involved. For a diagrammed synopsis of the rate-setting process for different categories of residences, see Figure II-5.

Figure II-5. Rate Setting Processes for Community Residences.

ICFs/MR	Non-ICF/MR Private Homes	Non-ICF/MR Public Homes	
<p>Costs for previous year are submitted to Ernst and Young Accounting Firm</p> <p>Ernst and Young submits long-term care costs reports to DSS; rates are proposed based on prior year's costs</p> <p>DSS approves rates as authorized under C.G.S. Sec. 17-314. Rates are issued prospectively and are effective July 1</p> <p>Rates sent to DAS, Bureau of Collections for reimbursement from Medicaid and others</p>	<p>Costs submitted to DMR from private facilities in ACOR in October</p> <p>DMR reviews ACORS; any cost settlements are negotiated</p> <p>DMR "negotiates" new rates in May based on prior year's ACOR</p> <p>Rates established prospectively in July</p> <p>Rates issued to DSS and Bureau of Collections from Medicaid and others</p>	<p>Costs sent from DMR to DSS via ACOR in December, after DMR review</p> <p>Rates for room and board costs approved based on prior year's costs, with added inflation factor</p> <p>DSS incorporates the new rates into system; clients cash assistance payments reflect room and board rates</p> <p>Clients pay the providers the room and board portion from assistance payments</p>	<p>Costs sent from regions to DMR central office</p> <p>DMR central office attempts to verify costs before allocating them to functions or expense categories</p> <p>DMR central office allocates costs similarly to rate model used by Ernst and Young for ICF/MR</p> <p>Once costs are developed, sent to Comptroller's Office</p> <p>Comptroller develops a blended regional rate; certain costs are added (e.g. fringe benefit and statewide allocation costs)</p> <p>Rates sent from Comptroller's Office to DAS, Bureau of Collection Services for payment from private payors and Medicaid. Rates for Medicaid are minus the estimated room and board portion</p>
<p>No formal costs developed</p> <p>No room and board rates are set</p> <p>No development of room and board into assistance payments</p> <p>Collection of rent payments from client funds done informally at each residence</p> <p>No rate is developed for Bureau of Collection Services to collect from clients in DMR group homes; estimated rate of \$50 a day is used</p>			

Source: LPR&IC Staff Analysis

As the figure illustrates, there is no singular process for the development of rates. The responsibilities for collecting cost data, allocating costs to the appropriate function code (expense category), analyzing cost information, calculating rates and distributing them, and collecting reimbursement from Medicaid and other payors, is not uniform and is dispersed among many participants.

An example of the process yielding questionable results is given in Table II-2. The comptroller is required by law to "at least annually determine the cost per capita per diem for the support of persons in 'humane institutions'" (C.G.S. Sec. 17-295), which includes group homes operated by DMR. Based on cost information largely supplied by DMR, the comptroller sets these group home rates for each region for distribution to DAS's Bureau of Collections to collect reimbursement from clients, legally liable relatives, and Medicaid. Those rates for the past two years are contained in Table II-2.

TABLE II-2. Public Group Home Rates Issued by Comptroller for FYs 92 and 93.		
Region	Per Capita Per Diem Rate -- FY 92	Per Capita Per Diem Rate -- FY 93
Region 1	453.15	238.08
Region 2	317.99	246.14
Region 3	313.96	308.67
Region 4	341.08	254.91
Region 5	549.48	113.14
Region 6	312.68	406.62

Source: Letters from the comptroller furnishing rates to DAS, March 1992 and June 1993.

As the table indicates, there are vast differences in CLA rates from region to region, and a precipitous drop in rates in Regions 1 and 5. DMR fiscal staff believe there are a couple of explanations for this. First, there were changes in the way the Comptroller's Office allocated educational and training expenses to rates for group homes between the FY 92 and FY 93 rates. Second, the accounting for actual costs at the regional level is not given enough attention, and therefore the cost basis on which the rate is established is not always precise. If cost data proves inaccurate in one year, the rate would be adjusted the following year to compensate for that, which may partially explain the volatility in rates.

But to ensure more stability in rates, DMR must be guarantee that the fiscal data on which those are based is as accurate as possible. Thus, the program review committee believes it is imperative that DMR develop a cost-centered accounting system that will allocate costs by individual group homes, and makes a recommendation for such a management control on page 71. This will permit cost data collection to be conducted consistently among regions, hence resulting in the establishment of more accurate rates.

Program service rates for private providers. The results of the rate-setting systems involving private group home costs appear less questionable, since the basis for establishing those rates is contained in the ACOR system which private providers are required to use. The following tables present data on the FY 92 rates for the private sector homes. Table II-3 contains information on the service portion of the rates that are funded by DMR.

As the table indicates, rates vary. One-quarter of the residences have service rates of less than \$100 a day per client, while 30 percent have rates of between \$201 to \$250 per day. A few residences charge more than \$350 per day, with one exceeding \$900 a day. These residences are usually very heavily staffed to serve the few clients needing one or more staff per client at all times. Further analysis of staffing costs and direct care will be discussed later in this section.

TABLE II-3. Per Client Per Diem Rates for Private Sector CLA Program Services.							
	< \$100	\$101-150	\$151-200	\$201-250	\$251-\$300	\$301-\$350	> \$350
Region 1	14	8	18	12	6	6	0
Region 2	29	19	15	14	2	2	5
Region 3	8	8	13	13	9	7	1
Region 4	19	14	6	14	2	2	0
Region 5	34	27	15	7	8	1	0
Region 6	10	10	16	7	1	2	0
Total	114 (25%)	76 (17%)	68 (15%)	135 (30%)	28 (6%)	20 (4%)	6 (1%)

Source: DMR Licensed CLA Report, March 1993.

Room and Board Rates. As explained earlier, non ICF/MR homes do not include room and board expenses in their service rates. These expenses are paid from the DSS budget through cash assistance to clients. The room and board rates are approved by DSS and include property costs, local property taxes (if assessed), property insurance, interest on working capital, and operational costs such as food, utilities, and repairs. Table II-4 categorizes the rates and shows the number of providers whose rates fall in each category by region.

TABLE II-4. Private Sector CLA FY 92 Per Client Per Diem Room and Board Rates by Region.						
	< \$20	\$21 - \$40	\$41 - \$60	\$61 - \$80	\$81 - \$100	\$101 - \$150
Region 1	7	13	20	26	5	1
Region 2	3	35	21	18	6	1
Region 3	2	14	24	13	3	0
Region 4	4	18	17	17	1	2
Region 5	4	36	32	8	5	3
Region 6	2	21	11	9	1	0
Total	22 (5%)	137 (34%)	125 (31%)	91 (23%)	21 (5%)	7 (2%)
Source: DMR Licensed CLA Report, March 1993.						

As the data in Table II-4 show, there is less variation in room and board rates than the services rates shown in Table II-3. More than 60 percent of the private providers have daily rates falling between \$20 and \$60 per day. Only five percent have rates below \$20 per day. At the other end of the range, 2 percent of the providers have room and board rates above \$100 per day.

Property costs. The most expensive room and board item is property-related costs. DSS staff who approve room and board rates state that usually the property costs are about half the overall room and board costs. Of the 390 residences for which property cost information was available, 294 had costs exceeding \$20,000 per year, while 96 had costs less than \$20,000 per year.

Most of the private provider residences have been developed by the Corporation for Independent Living (CIL), which acquires residences and leases them to individual provider agencies. In addition, CIL has developed a few homes for the Department of Mental Retardation. CIL issues tax exempt bonds with the Connecticut Development Authority (CDA) to finance the purchase and renovation of these homes and serves as the mortgagee. Since 1983, CIL has serviced the financing of 321 properties. Purchase and renovation costs paid by CIL have exceeded \$95 million. The payments that providers make to CIL for leases are included in the room and board rates paid by DSS. At the completion of a lease period, the provider owns the property.

Interest on working capital. In addition to financing property, CIL has recently begun a working capital loan program which is funded through CDA bond issues and then loaned to non-profit organizations, including many of the community residential programs. CIL provided about \$10 million to agencies through this program in 1991 and 1992. The interest on these loans is paid to CIL and is reimbursable through the room and board rate paid by DSS.

In FY 92, a total of more than \$325,000 was included as interest payments on working capital, as part of all private providers' room and board costs reimbursable through DSS. However, there is no breakdown of what portion of this amount was payment on loans through the CIL working capital loan program.

Recently, the state auditors issued a letter and report seriously questioning the propriety of this loan program, including whether the DSS reimbursements were actually on interest payments as required, or on the principal of the loan. Subsequent to the auditor's report, CIL's working capital loan program has ceased issuing new loans under the program.

ICF/MR RATES

Unlike the rates for CLAs, rates for ICFs/MR include all costs related to both staffing and room and board costs. These rates are set solely by DSS. Table II-5 below categorizes the daily rates being charged and the number of ICFs/MR whose rates fall into each category. As the table shows, the total range of rates for ICFs/MR is broad -- from slightly more than \$100 to more than \$500 per day. However, the range of rates for most of the providers is much narrower, with slightly over half of the 74 private facilities falling between \$251 and \$350 a day.

TABLE II-5. Daily Rates of ICFs/MR: April, 1993.*		
Category of Daily Rate	Private ICFs/MR	Public ICF/MR
\$100 - \$150	3	
\$150 - \$200	1	
\$201 - \$250	13	
\$251- \$300	12	
\$301 - \$350	26	12
\$351 - \$400	7	16
\$401 - \$450	8	
\$451 - \$500	2	
>\$500	2	

* Rates include day service costs

Source: DSS Policy Transmittal on Long Term Care Rates, April 1993.

COMPARISON OF COSTS IN THE PRIVATE AND PUBLIC SECTORS

Methodology. The major charge of this study was to compare total costs of operating public vs. private community residential services programs. A random sample was taken from the more than 600 community residences to make data collection and analysis manageable. Sixty residences were randomly selected from the private sector, or 12 percent of all private CLAs, and 60 homes, or 43 percent, of all public CLAs. The sample was geographically stratified to ensure adequate regional representation.

Obtaining cost information for the sampled homes proved a daunting task. First, expense data were not readily available for the state-operated homes. Secondly, even when the data were available for the homes, they were not always captured in the same way and many data manipulations and calculations were performed to achieve similar expense categories for each sector. Ultimately, usable cost data were obtained for 57 private serving 287 clients, and 50 public homes serving 293 clients.

Some data for the private homes were not available from the Audited Consolidated Operational Reports filed with DMR by providers, so a supplementary questionnaire was sent to all sampled private providers to gather information on benefits, sick time, and workers' compensation use.

In addition to the expense categories for operating the residences themselves, other overhead costs had to be added. Some of the costs were the result of the provider's overhead, while others were due to DMR, other state, or federal regulation. For a full accounting of how costs were calculated, see the Cost Methodology in Appendix A.

Cost comparisons were also confounded by two major differences between the private and public sector community residences. First, as pointed out in the briefing report, public sector homes (especially ICFs/MR) are larger residences on average. Given that almost 40 percent of the community residential beds in the public sector are in ICFs/MR, more of DMR's residential clients than private sector clients reside in larger homes. Thus, varying residential sizes made the comparisons more difficult.

Physical and mental differences in clients served in the two sectors also proved to be complicating factors. As will be discussed in greater detail later in this report, DMR homes serve a higher proportion of clients with acute needs than would be expected, given that public homes only serve about 25 percent of all residential clients. The significance of these differences was statistically tested in four different client characteristic areas: severe or profound mental retardation level; dual diagnosis of mental illness and mental retardation; psychotropic medication; and immobility or low levels of mobility.

The results indicate the differences in serving these more acute clients are more than random, and that overall, DMR homes serve a disproportionate share of challenging clients.

For example, of all residential clients, private providers serve three of every four. But, these providers serve only one of every five profoundly retarded clients. DMR, on the other hand, serves only one of every four clients overall, but one of almost every three DMR clients is profoundly retarded. Similarly, a higher percentage of clients in DMR homes require psychotropic medication than in private homes. Slightly more than one in three DMR clients require such medication, compared to one in four clients in private homes. Further, the disproportionate number of challenging clients served by DMR are concentrated in a smaller number of homes, which no doubt has some bearing on home costs.

The differences in cost between the two sectors for homes serving clients with acute needs, by isolating homes that serve the most disabled clients. But, because needy clients are dispersed throughout the system, and because home selection was also dependent on equal numbers of beds, identifying such residences from the sample was difficult and generated low numbers of homes for comparison. Thus, analysis was conducted on costs for homes serving "similar" clients, but cautions against using the results for projecting the costs on a systemwide basis.

Once those homes identified as serving needy clients had been separated out of the sample for analysis, the direct care cost data for those homes -- those with a greater mix of clients -- remaining in the overall sample was also examined. Other factors, (e.g., type of facility, regions, and unionization) that may potentially impact costs, are also examined in this section.

Cost Comparison Results. Overall, the cost of operating group homes -- including all the staffing costs, benefits, all internal and external administrative and overhead costs, and health care cost -- are about 40 percent higher *per home* in the public sector, but because the DMR-operated homes typically serve more clients in a home, the costs *per client*, on average, are about 21 percent higher. Recognizing that DMR homes serve higher numbers of clients, and a greater concentration of more challenging clients, this difference in average costs is still difficult to justify. Average costs for each expense component are provided in Cost Profile sheets in Appendices B and C.

DIRECT CARE STAFFING AND COSTS

Direct care staffing is one of the largest expenses incurred by both DMR and private providers in caring for clients in community living arrangements. Direct care staff include residential managers, residential supervisors, and aides/counselors who provide the daily assistance needed by persons with mental retardation. Staffing for CLAs in both the public and private sectors is on a continual, 24-hour basis.

As noted earlier, making cost comparisons between public and private community residential facilities is a difficult and complex task. In its attempt to compare direct staffing costs between the two sectors, committee staff selected a sample of community residential facilities to make analysis manageable. However, as with any type of sample unless it is very large, the overall number of residences, and their similarities in different areas, becomes limited.

On the other hand, any cost comparison on a per client basis is even more difficult because client characteristics, and levels of severity within these different characteristics, are so varied. In fact, committee staff attempted to examine costs on a per client basis by weighing the degree of severity of each characteristic, but found the characteristics too disparate to analyze.

Instead, costs were analyzed on a per-residence basis by selecting homes where certain client and residential characteristics might impact direct care staffing. By identifying specific client characteristics, the analysis takes into account DMR facilities serving a higher concentration of clients with more staff-intensive characteristics. However, analyzing costs on a per-residence basis also has inherent difficulties because of the possibility of a low number of residences from which to compare costs -- as seen in some of the tables in this section. Further, with such few residences to compare in some circumstances, the committee cautions against projecting these particular direct care staffing cost results on a systemwide basis.

No matter which way direct care costs are analyzed, per residence or per client, there are going to be numerous analytical obstacles. Nonetheless, the program review committee finds in its analysis of community residential facilities that the results consistently show direct care staffing costs higher in the public sector.

Findings

The program review committee makes the following findings with regard to direct care staffing costs:

- Overall, the costs for direct care staffing of the sampled residences were eighty-five percent higher in the publicly operated homes than homes operated in the private sector.
- The ICF/MR certification corresponds with higher costs in both sectors.
- Unionized homes sampled in the private sector have higher direct care costs (by 20 percent) than private non-unionized homes, but there is a larger difference in staffing costs between public homes and unionized private homes (66 percent).
- The difference in costs, on average, between the public and private residences sampled has more to do with higher staffing levels in the public homes than with average salaries. In public facilities, the average number of direct care FTEs per public residence is 52 percent higher than private residences, the average FTEs per bed is 40 percent higher, while the average salary is only 28 percent higher than private homes.
- Staffing coverage for first and second shifts is, on average, 40 percent higher in the public residences sampled than the private homes; there is little difference for third shift.

- Public homes, on average, have one additional client per home than do private homes, or about 20 percent more clients per residence. This factor would account for some of the overall differences in staffing costs, but certainly not for such disparity in costs shown.
- There are regional differences in all of the factors analyzed, and explanations are offered for some, but not all differences can be explained.
- The cost of homes sampled with the same number of beds (3-bed homes) was 75 percent higher in public residences than private.
- From the analysis of the sample, not all differences in staffing costs can be explained by examining client characteristics. Even when homes with the same number of beds serving similar clients are compared, public residences were always higher in terms of costs, and in most cases substantially higher.
- While the number of observations is low for both public and private homes sampled serving clients in need of more supports, there appears to be a greater difference in costs among homes serving more challenging clients than those serving less challenging residents.
- When homes sampled with clients of similar characteristics were removed from the analysis, and the costs of the remaining homes serving a mix of clients were compared, costs in the public facilities were still substantially higher than private residences.

Analysis

Several different factors dealing with direct care staffing were analyzed for the residences sampled, including: 1) total cost per residence; 2) average salary; 3) number of full time equivalents (FTEs) per residence; 4) number of FTEs per bed; and 5) shift coverage hours. These factors are first compared on a broad basis between public and private residences sampled; more detailed analysis comparing factors such as region, type of facility (ICF/MR or non-ICF/MR), and unionization is also presented. Direct care staffing costs of homes with the same number of clients having either the same, or similar, mental retardation levels, as well as other characteristics were examined. This analysis was done as a way of comparing residences that were as similar to each other as possible.

Overall direct care staffing cost. Table II-6 shows an overall comparison of public/private direct care staffing factors of the residences sampled. It should be noted that overtime costs and hours are included in direct care costs and FTEs, but are not considered in shift coverages.

Table II-6. Public/Private Comparison of Average Direct Care Staffing per Residence: FY 92.		
CATEGORY	PUBLIC FACILITIES (N=50)	PRIVATE FACILITIES (N=57)
Cost	\$307,080	\$166,119
Beds per Res	5.9	5.0
Salary	\$28,959	\$22,585
Total FTEs	11.1	7.3
FTEs Per Bed	2.1	1.5
	PUBLIC FACILITIES (N=48)	PRIVATE FACILITIES (N=23)
First Shift (Hours)	113.9	81.3
Second Shift (Hours)	145.8	104.6
Third Shift (Hours)	71.6	67.6
Source: Sample data analysis.		

As the table shows, direct care staffing comparisons between sampled public and private residences differ sharply for most of the factors analyzed. For example, the overall average cost of direct care staff in public residences was \$307,080, which is almost double the average cost of \$166,119 for private facilities. Overall, direct care staffing costs for the public sector residences sampled ranged from \$53,841 to \$701,511, and from \$61,248 to \$365,028 for the private sector homes sampled.

With respect to average salary for direct care staff, again the public facilities sampled showed a higher overall direct care staff annual salary than the private facilities. In the private sector, the average direct care staff salary was \$22,585. The average salary for DMR's direct care staff, however, was \$28,959 -- a 28 percent difference.

Also examined, was the average number of full time equivalent (FTE) direct care staff per residence, as well as the average number of FTEs per bed. Analysis shows that the average number of direct care FTEs per residence was 11.1 for DMR's facilities, and 7.3 for private facilities -- an average of 52 percent more staffing per residence in public sector facilities.

Although public facilities average more direct care staff per residence than private facilities, the average number of beds per public residence is also higher in the public residences. To account for this, the number of direct care FTEs per bed was analyzed which found that the average number of direct care FTEs per bed for DMR facilities was 2.1, and 1.5 for private facilities -- a 40 percent difference.

As previously mentioned, direct care staffing for CLAs is provided on a 24-hour basis. In order to get shift coverage information for public and private residences, the staffing schedules for 23 of the private residences sampled and 48 of the public facilities were reviewed. The total number of hours by shift were compiled for each residence and then an average per shift was determined for each sector as shown in Table II-6.

Public residences averaged more staff hours per shift than the private residences. Most of the coverage differences occur in the first and second shifts where the public residences scheduled 40 percent more staffing hours than the private facilities. There is, however, little difference on the third shift.

Direct care costs by facility type. In addition to comparing direct care staffing factors on an overall basis, the same staffing factors as they relate to facility type (ICF/MR or non-ICF/MR) were compared. Table II-7 provides a breakdown of the direct care staffing factors for the public and private ICF/MR and non-ICF/MR facilities sampled.

The program review committee concludes that ICF/MR facilities have higher overall direct care staffing costs than non-ICF/MR facilities, and the difference is more profound in the private sector. As Table II-7 shows, the average cost per residence for direct care staffing is higher in ICF/MR facilities than non-ICF/MR facilities for the public and private homes sampled. For the public ICF/MR homes, the overall average cost for direct care staffing was \$326,045, while in public non ICF/MR homes the cost averaged \$297,310 -- a difference of almost \$29,000 (or 10 percent) per residence. For the private sector homes sampled, the average direct care staffing cost was \$227,868 per ICF/MR residence and \$160,182 per non-ICF/MR residence -- a cost difference of almost \$68,000 (or 42 percent) per residence.

In terms of salaries, direct care staff in the public non-ICF/MR facilities sampled had higher average salaries than direct care staff in public ICF/MR facilities. In ICF/MR residences, the average salary for direct care staff was \$26,039 a year. However, in non-ICF/MR facilities, the average yearly salary was \$30,463 -- a 17 percent difference.

Table II-7. ICF/MR and Non-ICF/MR Average Direct Care Staffing Comparisons per Residence: FY 92.				
CATEGORY	PUBLIC ICF/MR (N=17)	PRIVATE ICF/MR (N=5)	PUBLIC NON-ICF/MR (N=33)	PRIVATE NON-ICF/MR (N=52)
Cost	\$326,045	\$227,868	\$297,310	\$160,182
Beds per Res	7.8	5.6	4.9	5.0
Salary	\$26,039	\$23,816	\$30,463	\$22,466
Total FTEs	13.0	9.5	10.1	7.1
FTEs Per Bed	1.6	1.8	2.3	1.5
	PUBLIC ICF/MR (N=16)	PRIVATE ICF/MR*	PUBLIC NON-ICF/MR (N=32)	PRIVATE NON-ICF/MR (N=23)
First Shift (hours)	119.2	----	111.1	81.3
Second Shift (hours)	173.3	----	132.1	104.6
Third Shift (hours)	61.2	----	76.8	67.6
*Insufficient data. Source: Analysis of sample data.				

On the other hand, annual average salaries for direct care staff working in the private sector residences sampled were slightly higher in ICF/MR facilities than non-ICF/MR facilities. The average salary for direct care staff in private ICFs/MR was \$23,816, while those in non-ICFs/MR averaged \$22,466 -- a difference of 6 percent. Because of the small number of private ICFs/MR in the sample (5), the results of the cost and staffing analysis could not be projected to the overall population.

When public and private sector direct care staff salaries are compared, there is a wider disparity in salaries for non-ICF/MR facilities than ICF/MR residences. Salaries for direct care staff in ICFs/MR averaged \$26,039 in the public sector and \$23,816 in the private sector -- a difference of just over \$2,200. However, staff in the public non-ICF/MR facilities sampled had an average salary of \$30,463 in FY 92, while direct care staff in private sector non-ICFs/MR averaged \$22,466 -- a difference of almost \$8,000.

In terms of direct care FTEs, the public ICFs/MR sampled averaged 3.5 more FTEs per residence than private ICFs/MR (13 compared to 9.5). This difference is largely due to the number of beds in a facility. The public ICF/MR facilities sampled averaged more than 2 additional beds per residence than the private ICF/MR facilities. However, when direct care staff FTEs on a per-bed basis were analyzed, private ICFs/MR were slightly higher than public ICFs/MR -- an average of 1.8 for private residences and 1.6 for public facilities. For non-ICFs/MR, public facilities averaged slightly under 1 more direct care FTE per bed than private non-ICFs/MR -- 2.3 compared to 1.5.

Unionization. Throughout this study, the committee was made aware that an assumed key factor in the overall cost of operating a community residential facility was whether or not the staff of a particular facility is unionized. Of the total 476 private community residences operating throughout the state, 170 (about 36 percent) are unionized. In the sample, nine providers, representing 40 percent of the private residences sampled, had unionized direct care staff. In the public sector, all direct care staff are unionized. Table II-8 provides an overview of direct care staffing factors as they relate to unionized and non-unionized community residential facilities.

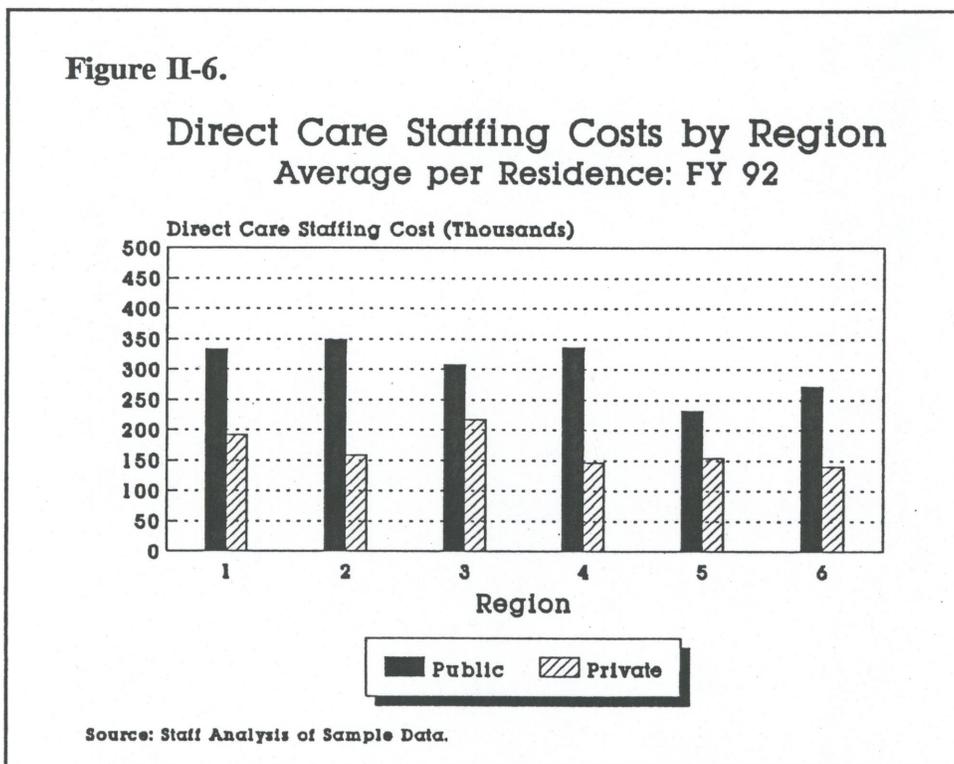
Table II-8. Comparison of Average Direct Care Staffing of Unionized/ Non-Unionized Residences: FY 92.			
CATEGORY	PUBLIC (N=50)	PRIVATE UNION (N=23)	PRIVATE NON- UNION (N=34)
Cost	\$307,080	\$184,774	\$153,500
Beds per Res	5.9	4.6	5.3
Salary	\$28,959	\$23,618	\$21,886
Total FTEs	11.1	7.7	7.0
FTEs Per Bed	2.1	1.8	1.3
	PUBLIC (N=48)	PRIVATE UNION (N=4)	PRIVATE NON-UNION (N=19)
First Shift (Hours)	113.9	98.8	77.6
Second Shift (Hours)	145.8	109.5	103.5
Third Shift (Hours)	71.6	73.3	66.3
Source: Analysis of sample data.			

Overall, in most of the categories the differences between private unionized and non-unionized residences sampled are not as marked as those between public and private. For example, the difference in average direct care staffing costs per residence is only 20 percent between private unionized and non-unionized residences. However, this same cost in public facilities averaged two-thirds higher than private unionized facilities, and double that of private, non-unionized residences.

In terms of average number of direct care FTEs, again, the difference is not as distinct between private unionized and non-unionized facilities as it is between the public and private sectors. Private unionized homes averaged only 10 percent more FTEs per residence than private non-unionized facilities. Public facilities, on the other hand, averaged 44 percent more direct care FTEs per residence than private unionized homes, and 59 percent more than private non-unionized homes.

This same trend holds true for average salary and direct care FTEs per bed. It does not occur, however, in number of beds per residence. Public sector homes, averaged more beds per residence than private facilities, yet private unionized homes had fewer beds per residence than non-unionized homes.

Cost by region. In addition to examining direct care staffing costs from an overall perspective, by facility type, and in terms of unionization, direct care costs on a regional basis were analyzed. Figure II-6 shows the results of the analysis.

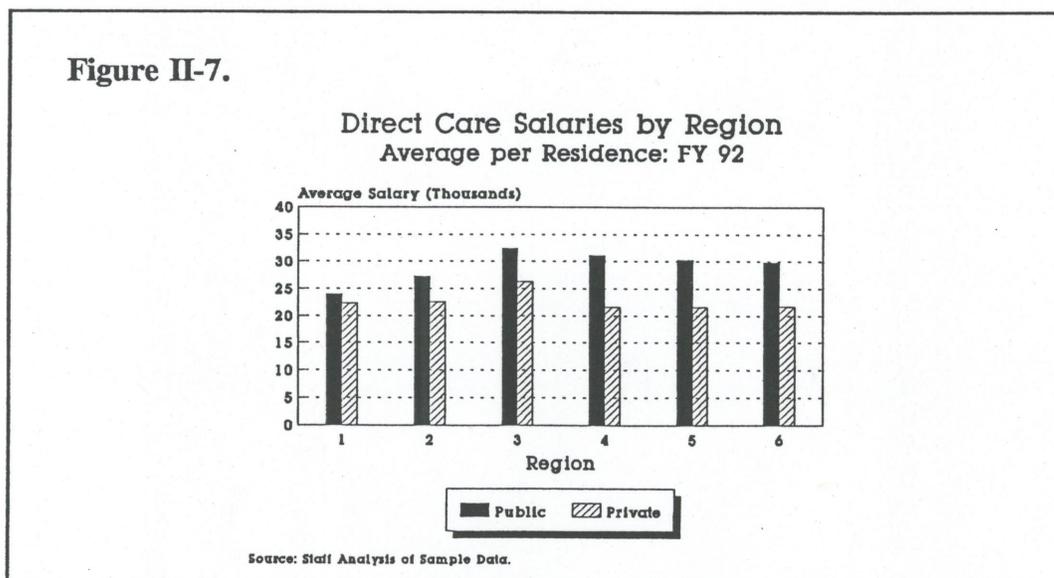


Within the public sector, the average per residence cost for direct care staffing in regions 1, 2, 3, and 4 is over \$300,000. Region 6 has an average cost of \$272,000. In Region 5, however, the average cost per residence for direct care staff is around \$230,000.

One explanation for the lower direct care costs in Region 5 is possibly due to this region having the lowest average number of beds per residence for both public ICF/MR and non-ICF/MR facilities in each of the six regions, as pointed out earlier. Another reason may be that public facilities in Region 5 are not as heavily staffed in terms of direct care when compared with the other regions. Further, Region 5 has the fewest direct care staff FTEs per residence (8.2) of all public facilities sampled. Even though Region 5 does not have the lowest average staff salary, it has the fewest direct care staff FTEs to pay per residence.

Analysis of direct care staffing costs for private residences shows that regions 2, 4, 5, and 6 all have costs between \$140,000 and \$158,000 per residence. In regions 1 and 3, however, the average per-residence staffing costs are higher at \$191,485 and \$217,064 respectively. The program review committee believes several reasons account for this difference. First, private direct care staff in regions 1 and 3 have relatively high average salaries compared to the other regions. Second, regions 1 and 3 have more direct care FTEs per private residence than the other four regions. Third, almost all private residences in Region 3 are unionized. Combined, these factors result in higher regional staffing costs.

Figure II-7 depicts average salaries by region for direct care staff for FY 92 as taken from the sample. As expected, direct care staff working in public facilities earn more, on average, than those working for private providers. The greatest disparity between public and private sector salaries is in Region 4 where DMR staff earned an average of \$31,060 in FY 92, while private sector staff earned an average of \$21,614 for the same year. One possible reason for this difference may be that few of the private residences in Region 4 are unionized. In contrast, salaries paid to direct care staff in Region 1 were very comparable between public and private staff. Salaries for public direct care staff averaged \$23,947, while those in the private sector averaged \$22,319.



In addition to analyzing direct care staffing cost information by region, the average number of direct care staff FTEs per residence as well as the average number of direct care FTEs per bed were analyzed. Table II-9 shows the results of the analysis.

Of the community residential facilities sampled, public residences averaged more direct care staff FTEs per residence than private facilities. Again, one of the main reasons for this is public facilities averaged more beds per facility than private residences.

In light of public facilities being larger than privates in terms of average number of beds, direct care FTEs per bed were analyzed. Analysis shows that public residences averaged more direct care FTEs per bed than private residences in all regions but Region 3. What this indicates is that of the residences sampled, public facilities use more direct care staff on average than private facilities, both per residence and per bed.

TABLE II-9. Average Direct Care Staffing FTEs by Region: FY 92.				
REGION	PUBLIC FTEs	PRIVATE FTEs	PUBLIC FTEs/BED	PRIVATE FTEs/BED
1	14.1	8.5	1.9	1.6
2	12.9	7.0	2.5	1.4
3	9.3	8.1	1.7	1.8
4	11.3	6.7	1.9	1.3
5	8.2	7.0	1.9	1.5
6	10.1	6.4	2.4	1.8

Source: Analysis of Sample Data.

Number of beds. As mentioned, public facilities averaged more beds per residence than private facilities. Overall, public residences averaged almost one additional bed per residence (5.9 compared to 5.0) than private facilities, which equates to 18 percent more beds per residence.

To remove the bed-size factor as a contributor to costs, homes in each sector with the same number of beds were analyzed. Three-bed homes were chosen because they represented the most number of residences from each sector in the sample. The results of the analysis are given in Table II-10.

Table II-10. Average Direct Care Staffing for Three-Bed Residences: FY 92.		
CATEGORY	PUBLIC RESIDENCES (N=12)	PRIVATE RESIDENCES (N=14)
Cost	\$251,864	\$143,799
Salary	\$30,704	\$22,800
FTEs	8.3	6.2
FTEs per Bed	2.8	2.0

Source: Analysis of sample data.

As the table shows, there is a difference in direct care costs of approximately \$108,000 (or 75 percent) between average direct care staffing costs for three-bed public and private residences. Another notable difference is the number of direct care FTEs per bed. Public facilities had almost one additional direct care staff per bed than private facilities. Couple the larger staff size with higher average salary for three-bed facilities in the public sector, and the result is the substantially higher cost per residence and client.

Client characteristics. The information presented in the different analyses above gives a broad overview of direct care staffing costs as well as more defined comparisons in terms of facility type, unionization, region, and bed size. Although examination of how these factors relate to direct care staffing costs is useful, the analysis would be incomplete without looking at costs of community residential facilities serving the same number of clients with very similar characteristics. Yet, selecting homes with clients who have the same combined physical and/or mental characteristics is extremely difficult.

The department's automated client database, known as CAMRIS (Connecticut Automated Mental Retardation Information System), contains numerous characteristics, as well as different variations for each characteristic. However, finding clients with exactly the same combination of characteristics, as well as degrees and levels of each characteristic, within the sample was not possible. Instead, committee staff narrowed its selection method to reviewing residences with clients having particular characteristics. The characteristics used to select specific homes included mental retardation level (MR level), dual diagnosis, and whether a client receives psychotropic medication. These criteria were chosen because throughout the study, the committee was informed that these characteristics had the most impact on the amount of residential staffing needed.

Each of the three criteria used for analysis was examined independently. In addition, the residences identified as having similar client characteristics (of the four characteristics analyzed) from the overall sample were removed and the direct care costs of the remaining heterogeneous facilities were examined.

With regard to mental retardation level, the MR level for each client living in the residences sampled was reviewed, and only homes with clients having either the same, or very similar, MR levels were chosen. For analysis purposes, MR level was divided into three categories: 1) high - at least two-thirds of the clients had MR levels of profound and the rest severe, or at least two-thirds of the clients had MR levels of severe and the rest profound; 2) low -- at least two-thirds of the clients had MR levels of mild and the rest moderate, or at least two-thirds of the clients had MR levels of moderate and the rest mild; and 3) mid-range -- half of the clients had severe or profound MR levels and the other half moderate or mild. Table II-11 shows the results of this analysis.

Table II-11. Comparison of Average Direct Care Staffing Costs for Residences with Clients Having High MR Levels: FY 92.		
NO. OF BEDS	PUBLIC	PRIVATE
3	\$315,795 (N=2)	\$157,207 (N=9)
Source: Analysis of sample data.		

As shown in the table, public residences with three beds had an average direct care staffing cost more than double that of similar residences in the private sector. In trying to determine possible reasons why such a large difference existed, the impact of client characteristics, other than MR levels, on the difference in costs was analyzed. To do this, analysis focused on residences having clients who were dually diagnosed and/or who required psychotropic medication.

The two public residences sampled each had a high concentration of clients who were dually diagnosed and/or required psychotropic medication. In the three-bed private residences, however, there was a mix of residences having clients with high MR levels who were also dually diagnosed and/or requiring psychotropic medication.

This being the case, direct care staffing costs of only those private residences having a concentration of clients who were dually diagnosed and/or required to take psychotropic medication were analyzed. In each of these homes, direct care staffing costs were still substantially lower than the cost for the public homes. Overall, then, the committee believes

that the client characteristics examined, other than high MR levels, did not contribute to the notably higher direct care staffing costs in the public sector.

In addition to comparing direct care staffing costs for residences with clients having high levels of mental retardation, costs for residences with clients having low MR levels were examined, as shown in Table II-12.

Table II-12. Average Direct Care Staffing Costs for Residences with Clients Having Low MR Levels: FY 92.		
NO. OF BEDS	PUBLIC	PRIVATE
3	\$184,526 (N=6)	\$176,564 (N=2)
Source: Analysis of sample data.		

Again, three-bed facilities sampled produced the highest number of observations to compare. However, there is a much smaller difference in the average direct care staffing costs per residence in homes with lower MR levels than those with higher MR levels described above.

Community residential facilities having an even distribution of clients with MR levels at either the high or low end, as defined earlier were also analyzed. The results of this analysis are shown in Table II-13.

Table II-13. Comparison of Average Direct Care Staffing Costs for Residences with Clients Having Mid-Range MR Levels--FY 92.		
NO. OF BEDS	PUBLIC	PRIVATE
6	\$322,322 (N=2)	\$178,265 (N=3)
Source: Analysis of sample data.		

Only six-bed facilities were comparable for analysis. Again, public facilities had a higher direct care staffing cost, on average, than private facilities. The direct care staffing cost for public residences was \$322,322, compared to \$178,265 in the private sector -- a difference of \$144,057 or 81 percent.

Similar to residences having clients with high MR levels, the committee tried to determine if the difference in average cost for the six-bed residences sampled might be due to one sector serving more clients who were dually diagnosed and/or requiring psychotropic medication. It was found that none of the private sector facilities examined had clients who were dually diagnosed and/or required psychotropic medication, while the two public residences had several such clients. Thus, client characteristics examined, other than MR level, may have contributed to the higher average staffing cost in the public residences sampled.

Dually-diagnosed. As previously mentioned, residences were selected from the sample having at least two-thirds of the clients diagnosed with mental retardation *and* mental illness. The total number of observations analyzed was 8 in the public sector and 6 in the private. The results, in Table II-14, show the average direct care staffing cost in the public residences was \$243,204, or more than 50 percent higher than the \$159,797 average for private residences.

Table II-14. Comparison of Average Direct Care Staffing Costs for Residences with Dually Diagnosed Clients: FY 92.		
NO. OF BEDS	PUBLIC	PRIVATE
3	\$243,204 (N=8)	\$159,797 (N=6)
Source: Analysis of sample data.		

Psychotropic medication. The last client characteristic analyzed in terms of its impact on direct care staffing costs was whether or not the clients living in a residence required psychotropic medication. Sampled residences where at least two-thirds of the clients required such medication were selected for analysis. Three-bed facilities again generated the highest number of observations. The results, outlined in Table II-15, are similar to previous analyses -- average cost for direct care staffing is substantially higher in public facilities than private facilities.

Table II-15. Average Direct Care Staffing Costs for Residences with Clients Requiring Psychotropic Medication: FY 92.		
NO. OF BEDS	PUBLIC	PRIVATE
3	\$228,198 (N=6)	\$166,823 (N=5)
Source: Analysis of sample data.		

Heterogeneous mix of client characteristics. As previously mentioned, it was found that in terms of client characteristics, most community residential facilities in both the public and private sectors have a heterogeneous mixture of clients. This being the case, the ability to make adequate cost comparisons among facilities is extremely difficult.

In addition to comparing direct care staffing costs for residences with clients having the same or similar characteristics, direct care costs of residences with truly varied clients from each sector were also compared. To do this, residences with clients sharing similar characteristics identified in the previous analysis on MR level, dual diagnosis, or required psychotropic medication use were removed for analysis purposes. Once these residences were extracted from the sample, the remaining homes were considered to have heterogeneous client mixtures. The results of this analysis are shown in Table II-16.

Table II-16. Average Direct Care Staffing Costs for Residences with Non-Similar Clients: FY 92.		
NO. OF BEDS	PUBLIC	PRIVATE
3	\$242,044 (N=4)	\$76,935 (N=2)
6	\$299,856 (N=3)	\$178,298 (N=15)
7	\$342,219 (N=6)	\$176,519 (N=3)
Source: Analysis of sample data.		

In looking at the table, two differences are notable. First, there is a wide variation in direct care costs between public and private facilities with three beds. Second, as the bed size of residences in the public sector increases, the average direct care staffing costs also increases, as one would expect. However, for private residences, the same occurrence is not true. As the table shows, the average direct care staffing cost for six-bed residences is almost the same as seven-bed facilities.

To help explain the cost differences between public and private facilities, differences in client characteristics impacted direct care staffing costs were analyzed. It was found that several of the public three-bed residences had clients who were dually diagnosed and/or required

psychotropic medication. However, each of the four residences sampled tended to have a mix of clients with high MR levels.

In the two private sector three-bed facilities, one residence had one client who was dually diagnosed and requiring psychotropic medication. Unlike the public sector homes though, these facilities tended to serve clients with more mild or moderate MR levels.

It is very difficult to pinpoint all of the reasons for cost differences in the three-bed homes shown in Table II-16. It is also difficult to compare such a small number of facilities. Nonetheless, the committee believes that differing client characteristics, particularly with respect to MR levels, between three-bed residences with a varied mix of clients in the two sectors, is a factor in the difference in cost between the public and private homes.

Within the private sector homes sampled, Table II-16 shows six- and seven-bed facilities to be very similar in cost. Yet, in terms of client characteristics, it was found that each of the six-bed facilities tended to serve disproportionately more clients -- in terms of the overall number of clients DMR serves -- with profound or severe MR levels, dual diagnosis, and psychotropic medication use than the seven-bed facilities. This being the case, it is more likely that average direct care staffing costs would be comparable between the two facility types.

OVERTIME USE AND COSTS

Overtime costs are a chronic budgetary problem for the entire department. In FY 92, DMR's overtime costs were more than \$20 million, or 10.7 percent of all the personal services dollars spent by the department. Compared with other state agencies, DMR ranked second only to the corrections department in terms of overtime costs as a percentage of its personnel budget.

Overtime is one of the major cost drivers in the operation of state-run group homes. Based on the sample of 50 DMR homes, the total amount of overtime dollars spent for FY 92 was \$2.9 million dollars. This translated to an average of \$59,789 in overtime costs for each group home, or enough to pay the salaries of at least two additional staff people.

The overtime hours and overtime costs, for the residences sampled are at least 10 times higher in the DMR-operated facilities than they are in private homes. In 37 private homes, the average number of overtime hours worked was 378, while in DMR homes overtime hours averaged 3,772. This translated to overtime costs per private residence of \$4,618 compared to the almost \$60,000 figure cited above for DMR homes.

Workers' compensation. It is difficult to pinpoint the causes of the high overtime use. There are most likely several factors, including the department's high incidence of workers' compensation. For FY 92, the department's claim costs were the highest of any department in state government. For that fiscal year, DMR's claims costs totalled \$22.7 million compared to the Department of Corrections' (DOC) total of \$12.9 million, which was the second-highest. Overall, DMR's workers' compensation costs were 34 percent of the state's entire workers' compensation costs of \$66.3 million.

Workers' compensation use in DMR, translated to a per-employee basis, shows that there were 19.7 lost work days per employee in DMR overall, including Mansfield and Southbury. If only the direct care (the NP-6 bargaining unit) staff are considered, the rate of lost workdays per employee jumps to 28.9 days, or about 9 percent of the employee's total workyear. By comparison, correctional officers in DOC had a lost-workday rate of 11.8 in FY 92.

Table II-17 below shows the total lost workdays for direct care workers and the lost workdays per employee for each of DMR's six regions. These workers are those employees working directly with DMR clients, mostly in residential settings other than at Southbury or Mansfield. As the table shows, during FY 92 the average number of lost workdays is over 20 per-employee statewide. The table also provides data for FY 93 and shows that DMR has made substantial improvement over its FY 92 record, but that the use of workers' compensation is still a problem.

TABLE II-17. Workers' Compensation – Lost Workdays for Direct Care by Region: FY 92 and FY 93.				
Region	Total Lost Workdays FY 92	Total Direct Care Staff	Average Lost Workdays by Employee FY 92	Average Lost Workdays by Employee FY 93
1	4826	225	21.4	21.3
2	6721	295	22.8	15.15
3	2106.8	185	11.4	4.9
4	5682	214	26.6	16.9
5	2189	202	10.6	9.6
6	7946	305.2	26.0	14.7
Total	29,471	1426.2	20.6*	13.7
* Lower than 28.9 cited above because Mansfield and Southbury excluded				
Source: DMR Reports on Sick Leave and Workers' Compensation FY 92 and FY 93.				

Workers' compensation costs add significantly to the overall cost of providing direct care. DMR workers on compensation are paid the same base salary as they would be if they were working, if the injury occurred while attending to or restraining a client. Using a conservative estimate of \$75 in wages per worker per lost workday, \$2.2 million is spent in salaries alone as a result of workers' compensation claims. These lost workdays usually mean some other coverage has to be found: calling in other workers on an overtime basis; holding staff over for additional shifts; or hiring new employees. These alternatives add substantially to operating costs because the department has already paid for the staffing coverage.

When compared with private sector homes sampled, DMR's record for workers' compensation is also poor. Information from 36 of the private residences was obtained showing that on average, there were 19.2 lost days *per home* due to workers' compensation claims. All the data were not available to analyze DMR's workers' compensation record on a *per-home* basis. However, given that DMR's lost days are 20.6 *per-worker*, and the private providers use is 19.2 days *per home*, the difference *per home* no doubt would be substantial.

Analysis of why DMR homes have such a poor record of work injuries compared to the private sector (and even other state agencies), and the legitimacy of all of claims, would require additional study. Some plausible explanations are offered, however. First, DMR workers may be taking care of clients that require more physical activity, and are at greater risk of injury. The DMR homes do care for 49 clients -- 6.7 percent of DMR's residential clients -- that are totally immobile; yet private homes care for 103 -- 4.6 percent of private sector clients -- similarly disabled clients.

Secondly, studies have shown that workers' compensation claims tend to rise when workers' jobs are threatened and when there are problems between labor and management. Both of these issues existed around the closing of Mansfield, and may have contributed to some of the workers' compensation use within DMR.

Finally, there also may be a difference in attitude between workers in DMR and the private sector about the use of workers' compensation. Working in a large state agency may foster the belief among department staff that there is sufficient funds and staffing to cover customary workers' compensation use, while those workers in the private sector may believe that use of workers' compensation will strain both the monetary and staffing resources of the provider.

Use of sick time. Paid sick time for DMR employees is covered by contract -- 15 days per year for full-time staff, (pro-rated basis for part-time employees). For sampled private providers the average number of paid sick days available per employee is 9.5, according to ACOR records filed by private agencies with DMR.

On average, DMR direct care employees use close to the full sick time allowed. Table II-18 illustrates the use of sick time by region for direct care staff, excluding the two institutions, for FY 92 and FY 93. Taken collectively among the regions, direct care staff used 18,700 days of sick time in FY 92, or an average of 13.5 days per direct care employee. Similarly to the lost workdays for workers' compensation, these days or shifts most likely are covered by overtime staffing.

**TABLE II-18. Sick Leave Use for DMR Direct Care Staff by Regions:
FY 92 and FY 93.**

Region	Total Sick Days Used: FY 92	Total Number of Direct Care Staff	Avg Number of Sick Days Used per Employee: FY 92	Avg Number of Sick Days Used per Employee: FY 93
Region 1	2,699	225	12	13
Region 2	3,123	295	10.6	10.3
Region 3	2,733	185	14.8	11.4
Region 4	2,951	214	13.8	13.4
Region 5	3,612	202	17.9	14.8
Region 6	3,582	305.2	11.7	10
Statewide Total	18,701	1426.2	13.5	12.1

Source: DMR Report on Sick Leave and Workers' Compensation.

Staff reductions. Finally, the department indicates that the use of overtime is related to staffing shortages in direct care personnel, because of both budget cutbacks and not being allowed to fill all authorized positions. To some extent, the department has experienced a decrease in direct care staffing in the regions. According to the DMR Report on Sick Leave and Workers' Compensation Use, all but one region had fewer direct care staff in FY 92 than in FY 91; a total decrease of 51 staff in five regions. In Region 3 -- the Northeast Region -- direct care staff increased by 20 persons; all most likely transferred from Mansfield which lost 23 direct care staff during that period. Thus, there has been a net loss in staff of 31 positions; however, out of a staffing base of approximately 1,400 positions, this translates to a 2 percent loss. Further, based on the staffing levels at DMR homes in the study's sample, those homes are significantly higher in numbers of personnel than homes in the private sector, yet overtime use in private homes is substantially less than in DMR-operated homes. Therefore, understaffing in the public homes does not provide a solid argument for their high use of overtime.

HEALTH CARE COSTS

Both the health care services received by clients living in community residences and the associated costs vary by type of facility and health care service provider. Four types of health care costs incurred by clients living in private facilities were identified by the committee: 1) that furnished by the provider itself; 2) health care for which the provider contracts out; 3) care provided by DMR health professionals; and 4) that provided to the client in the community and paid for by Title XIX (Medicaid). In DMR-operated homes, the first type of health care is not provided.

The costs of providing each of these health care services in DMR or private homes are outlined in Table II-19. The table is organized to show the differences in health care costs in the two categories of facilities, (i.e., ICF/MR and non ICF/MR) and between both DMR homes and those that are privately operated.

TABLE II-19. Average Per-residence Cost of Providing Health Care Services in Community Residences.						
Category of Health Service	DMR ICF/MR	DMR non-ICF/MR	Weighted Avg in all DMR Homes	Private ICF/MR	Private non-ICF/MR	Weighted Avg in all Private Homes
Private Provider	0	0	0	\$25,121	\$4,773	\$6,558
DMR Health Care	\$45,727	\$12,503	\$23,799	\$1,576	\$1,332	\$1,354
Contracted	\$11,579	\$5,722	\$7,713	\$2,959	\$4,494	\$4,360
Medicaid	\$16,585	\$15,539	\$15,895	\$11,683	\$15,804	\$15,442
Total	\$73,891	\$33,764	\$47,407	\$41,339	\$26,403	\$27,714
Source: Analysis of Cost Data from Provider Sample.						

As the table indicates, the average cost of providing health care is almost \$20,000 less per home in the private sector than it is in the DMR homes. Some of the difference is due to the higher number of clients in DMR homes. But most of this difference in cost can be attributed to DMR health care costs in the ICF/MR facilities, compared to the non ICF/MR, and because there is a higher number of ICFs/MR in the public sector, that adds considerably to overall health care costs in DMR homes. The ICF/MR status demands more intense health care services to meet the federal standard that clients are receiving "active treatment".

However, the ICF vs. non-ICF difference does not explain all the disparity between the two sectors. If the costs of non-ICFs/MR are compared, the private sector's homes spend \$7,631 less on health care, or 29 percent, than the public non-ICFs/MR.

A data factor could contribute partially to the difference. Medicaid costs could be higher in the private sector than actually appear in the table. The Medicaid data, as pointed out in Appendix A, provide a total of the expenses for DMR clients living either in ICFs/MR or in homes that are eligible for the Medicaid waiver (almost all homes), but the aggregate cost data don't differentiate whether those expenses are incurred by public or private clients. Thus, it is possible that a higher percentage of those Medicaid costs are being incurred by clients in private residences.

These are the ready explanations at the surface of the data. There are a number of other questions raised by the data for which answers are not as available. For example, are the clients served in the public sector in that much greater need of health and related services than those in the private? Related to that is a question of utilization review of health care services, and whether clients in DMR homes are being overserved while those in the private homes are underserved. The data to assess these two questions are not readily available, and especially absent are data that indicate client outcomes to make a judgement about whether the clients benefit from any additional health care services they receive. Analysis of utilization review and types of clients served are discussed later in the report.

It is more likely that the number of DMR health professionals on staff and time they spend in DMR homes (whether necessary or not), is the greater contributor to the higher costs in the public sector than the salaries paid to these health care employees. DMR staff have stated it is difficult to hire health professionals, especially physical therapists, to work for DMR since they can command higher salaries elsewhere. Salary data to conduct an analysis of pay differences were not assembled, but the rates and salaries (as indicated in the ACOR) being paid for health care staff in the private sector, especially contracted professionals, did seem at least as high, if not higher, than those paid in DMR.

In summary, the program review committee found that the health care costs are considerably higher in the DMR homes than they are in the privately run homes, but could not determine whether those costs are justified based on the types of clients served, whether clients in DMR homes are overserved in health care, or whether clients in the private homes are underserved. Finally, no client outcome measures exist to evaluate if, because of the additional health care services received in DMR homes, those clients do better than those in private homes. **Therefore, the program review committee recommends that efforts undertaken by DMR to bolster utilization review (Recommendation on page 84) comprise an evaluation of health care services provided.**

If the results of the utilization review indicate DMR clients are overserved, then DMR should make efforts to redeploy those staff to support clients currently underserved, but only if these services can be reimbursed through Title XIX, similar to DMR's case management services. If DMR health care services cannot be reimbursed, then the department should carefully consider downsizing its health care staff through attrition, and allowing clients to seek those health care services from private providers. This would promote client choice -- first whether the client needs the service, and second who he or she selects to provide it. A good portion of the DMR health care was begun while clients were in institutions; as the clients move from institutions to decreasingly supported residential services, it is reasonable to expect that less formalized, less structured health care will follow.

ADMINISTRATIVE AND GENERAL (A&G) COSTS

In addition to direct care costs, one of the other large expense areas is administrative, or overhead, costs like management, accounting and business costs, and clerical expenses. Summarized below are the costs of these services for both DMR and the private sector.

The difficulty in comparing the A&G costs between the private and public sectors is that they do quite different things. The private sector for the most part provides the actual residential and day programs to clients. The private sector furnishes those services for approximately three-quarters of the community residential and day clients. The department, on the other hand, provides day and residential services to about one-quarter of the clients. But, in addition, the department performs a variety of other functions -- for example, quality assurance, case management, and early intervention programs -- that ultimately are the responsibility of DMR management.

DMR overall management costs. The total cost for management services in the Department of Mental Retardation is \$18,040,716. This includes the costs of all management services at both the Central Office and regional offices, but excludes Southbury. The cost is derived from the FY 93 actual costs for management services minus the costs for maintenance and skilled tradespersons and the like. The \$18 million also reflects the costs that were subtracted from DMR's management services budget and allocated to the private providers (See Methodology in Appendix A).

Private provider management costs. In total, *all* the private providers of both residential and day programs that contract with DMR expend \$18,110,815 in management (administrative and general) costs, as reported to DMR through ACOR reports. However, unlike DMR, which is a multi-service agency that provides more than day and residential programs, the \$18 million in management costs for the private providers covers only day and residential programs.

Per-residence administrative costs. To assess these administrative and general costs in other than overall terms, administrative costs on a per-residence basis were analyzed to determine their impact on overall costs for the sampled residences. The residential A&G costs that the private providers filed with their ACOR were used, as was the ACOR method of allocation for DMR residences. The results, shown in Table II-20, indicate that on average the administrative costs in private homes add slightly more than \$20,000 more to the costs than in DMR homes. This is largely because the administrative costs in DMR are spread over a wider base than just residential programs.

TABLE II-20. Average Administrative and General Costs Per Residence.	
Public Residential A&G Costs	Private Residential A&G Cost
\$27,790	\$48,690
Source: Analysis of Cost Data from Sample.	

Management staffing. One of the major expenses of management costs of course is management personnel. The number of FTEs were analyzed in management and administrative and clerical support functions in DMR and those similar positions in the private sector. In DMR, there are about 124 managers and 256 administrative, clerical and financial personnel that work in the central or one of the regional offices (Southbury was excluded from the analysis), resulting in an agency count of 380 management services personnel.

To put this in perspective, the 380 were first analyzed and compared to the 2,957 direct staffing full-time equivalents (FTE). (Anyone not in management services, administrative and clerical support, or maintenance and housekeeping staff). This analysis showed that the DMR's total management services personnel as a percent of all direct services personnel was 12.8 percent, or 1 manager, administrative, or support staff to every 7.7 direct line FTE. Most of this was in administrative support (8.6%), while managers (in the MP classes) accounted for (4.1%).

In the private sector, the number of managers per agency averaged 3.6, and the range for the 52 sampled private agencies with available information was a low of .98 to a high of 8.6 managers. When the managers were added to administrative and clerical support, this average totalled 9.1 persons in management services. The range of total management services staff among the private providers varied from a low of 1.41 to a high of 31. The aggregate management services staff for all providers in the sample was 476 administrative persons to 2,901 FTEs providing direct service.

When private provider management services staff (managers and clerical and administrative support) was taken as a percent of the total direct care staff (residential and day), the analysis showed that overall the average number of administrative staff to direct line staff was 16.4 percent or 1 administrative person to every 6.2 direct line staff. Thus, comparing the management services in the public sector to the overall sampled private sector indicates that DMR has no more managers to direct care full-time equivalent staff than does the private sector.

But, there are two notes of caution before concluding there is management efficiency in DMR versus the private sector. First, as with many of the comparisons conducted in this report, there are wide variations among private providers. By taking the private sector as a single provider, the efficiencies in one provider are masked by the inefficiencies in another. This is confirmed when the administrative staff to direct care FTEs for individual providers is examined and the range is 1 staff person to every 4.5 direct line FTEs at the Kennedy Center to 1 to 23 at the Connecticut Institute for the Blind.

Secondly, a low ratio of managers to direct staff does not necessarily indicate efficiency. It could also mean that both management and direct staff are over- or understaffed. Finally, some of the providers are so small, and employ so few staff, that they are at somewhat of a disadvantage when the ratios are compared.

Administration to clients served comparison. Another ratio examined to assess administration was the number of administrative staff to the number of clients served. This comparison yielded a ratio of 1 manager to every 15.9 day and residential clients in DMR, and 1 manager to every 12.9 clients in the private sector, ranging among individual private agencies from 1:2.8 clients to 1:36 clients. Thus, if DMR and the private sector are considered single agencies for comparison, then DMR's management to client ratio compares favorably, but if DMR's ratio is measured against those of some of the individual private service providers, then the department's results compare poorly.

EXTERNAL ADMINISTRATIVE AND GENERAL COSTS

In addition to the managers and administrative staff, another major contributor to the costs of operating a home are the external overhead cost of regulating, setting rates, performing case management functions, and the like. Most of these functions are performed by DMR, DPHAS, or DSS, but are conducted in private as well as public homes; therefore, adding to the costs in both sectors. (See the Methodology in Appendix A for information on how these cost allocations were made.)

The program review committee found these activities contribute another \$867,032 (or \$17,340 per home) to the costs of providing service in the 50 DMR-operated homes. In the private sector, this cost was \$466,355, or \$8,182 per home. Two factors contribute to the greater costs in the DMR homes than in the private sector homes: the higher portion of ICF/MR homes; and the higher Statewide Cost Allocation Program (SWCAP) costs, which are largely the costs of the statewide support functions like personnel, payroll, legal, and accounting services.

The ICF/MR homes consume a larger portion of these costs, because the regulation, certification, and rate setting are based on the long-term care model, and are more involved than with a regular group home. In the 17 DMR ICFs/MR sampled these state administrative and regulatory overhead costs account for \$556,619, or \$32,742 per home, while in the 33 sampled regular DMR group homes, those costs accounted for \$310,413, or \$9,406 per residence. Secondly, the statewide overhead added \$271,600 to the costs of the DMR homes overall, or \$5,432 a home, while on the private side, those costs added \$59,920, or \$1,051 per residence.

Because of the additional costs of administering and regulating the ICFs/MR, the program review committee recommends that the ICF/MR status be abandoned, and that DMR seek to place these homes under the Home- and Community-Based Waiver program.

The committee believes this recommendation would allow resources currently devoted to regulating ICFs/MR to be more wisely spent monitoring utilization throughout the residential care system. Twenty years ago, ICFs/MR were the first step to deinstitutionalization, but now they are outmoded, with too much emphasis on the medical model as required under the Medicaid "active treatment" standards. Further, there is no systemwide evidence that the most difficult clients are being cared for in ICFs/MR.

Also, as indicated in a later section, even when clients are considered to no longer need "active treatment", the system cannot accommodate them elsewhere, so they stay in the ICF/MR. ICFs/MR were the only type of community residence that was eligible for federal reimbursement until the state received approval for its Home- and Community-Based Waiver. Now, there is no fiscal advantage to the state to maintain the ICF/MR status. Finally, ICF/MR clients are only allowed to keep about \$30 a month for personal needs under Medicaid rules, while other clients in non ICFs/MR are able to keep a greater portion of their assistance and earnings. If the ICF/MR status were eliminated, then it would remove the artificial barriers that prevent clients from retaining equal amounts of their earnings and entitlements.

Employee Benefits

Related to staffing expenditures are the costs of providing fringe benefits to those staff. (See Appendix A for fringe benefit allocation). The cost of offering benefits was analyzed several different ways by the program review committee. DMR's total agency fringe benefit cost was calculated to be \$64.6 million, to cover benefits for more than 4,000 employees. The total benefit costs for providers in the sample was \$40.7 million. Because of the obvious drawbacks of viewing these two large sectors as two individual providers that could be compared, benefit costs on a residential basis were examined. The average cost of benefits in a DMR home was \$102,919, while in the private homes those benefit outlays totaled \$34,811, or about one-third the cost.

Some of that cost difference is due to somewhat more generous vacation and sick time benefits, but most of the major variation is in other areas. For example, of the 37 private providers responding to our survey:

- 26 percent provide a pension plan;
- 35 percent provide dental insurance; and
- 98 percent provide health insurance, but 66 percent require the employee to pay part of his or her own health insurance, and only 53 percent cover dependents.

While the cost differences in these specific benefits areas were not analyzed, because the financial data were not available, the fact that the state as an employer provides these benefits, and a good portion of the private sector providers do not is significant.

Staff turnover. No doubt all of these differences in the employment situation between the private providers and DMR contribute to the significantly different turnover rates measured in the sampled facilities. In the DMR-operated homes, the simplified turnover rate (see Methodology) was 4.9 percent. However, private residences experienced a turnover rate of 23.9 percent, meaning one of every four positions was vacated sometime during the year. The variation among the private providers' turnover rates was tremendous, with some relatively stable residences, while others incurred staff turnover rates exceeding 100 percent (the equivalent of each position being vacated more than once during the year).

ROOM AND BOARD COSTS

Room and board rates include property costs, as well as insurance, property taxes, working capital, and operating costs like food, utilities, repairs, laundry, and the like. These expenses do contribute substantially to the costs of operating a group home. However, calculating exactly how much those costs are and the differences among the categories of homes is complicated by the fact that these costs are paid for in different ways depending on the type of home, as discussed previously in the rate-setting section of this chapter.

To conduct a comparison of room and board costs between the two sectors, expense information was collected from the ACORs filed by the private facilities. For DMR-operated homes, DMR regional offices provided original cost information on room and board expenses for each of the homes in the sample. These data, coupled with information from the Comptroller's Office on insurance and payments in lieu of taxes, form the basis of the room and board costs for public homes.

Costs of room and board. One of the few components that was less expensive in the public sector than the private was room and board. Overall, room and board costs of sampled residences averaged about \$38,282 per residence per year in the public sector, and about \$63,022 in the private sector, or about two-thirds higher.

The expense categories that make up room and board costs in the two sectors are contained in Table II-21, along with average cost for that category in each sector. The total room and board costs add up to more than the sum of the categories because there are several other categories (e.g., interest on working capital) in room and board where specific expenses were not allocated but included in the total.

Property costs. As the table indicates, the average total room and board expenses in the private sector homes are about two-thirds higher than they are in the public sector. The major reason is property costs. The costs of property in the public sector accounted for about 41 percent of room and board expenses.

TABLE II-21. Comparison of Average Room and Board Costs per Residence.

Expense Category	Private Sector N=52 homes (5.0 clients/home)	Public Sector N=50 homes (5.8 clients/home)
Food	\$10,788	\$10,787
Utilities	\$4,892	\$6,210
Repairs	\$5,610	\$3,186
Insurance	\$1,659	\$364
Taxes	\$2,563	\$1,603
Laundry	\$43	\$444
Housekeeping	\$1,454	0
Property	\$31,363	\$15,688
Average Total Room and Board	\$63,022	\$38,282

Source: ACOR and DMR expense data for sampled homes.

For this sample, public sector property costs average about half the private sector's costs for a number of reasons. The department can use state bonding funds to purchase property without incurring the same degree of financing charges as the private sector. Also, costs that private providers assume in developing or financing property -- like fees for lawyers, accountants, and accountants -- are not included in the *room and board costs* of public homes. However, these costs have not been ignored, but have been allocated to DMR homes through the Statewide Cost Allocation Program. Finally, DMR believes that the costs of initial renovations are included in the purchase price for the houses in the sample, but that major repairs which may have been done since the purchase would have been included in a state bonding package and would not be included in these costs. Private providers are reimbursed for property costs by DSS, while DMR is not.²

² The DSS reimbursement for property costs is based on the actual property costs or the fair rent value, whichever is lower. The fair rent value is in lieu of interest on mortgages, other property financing costs, depreciation on buildings and non-moveable equipment, and rental charges. It is calculated to yield a constant amount each year instead of interest and depreciation charges, and is based on a 30-year life from the date of first use as a licensed residence for DMR clients. The principal amount is the base value of the property, other than the land, and the rate used is 1.5 times the Medicare rate, applied on the unamortized base value. The rate is readjusted every 10 years, as it is with nursing homes.

Most of the homes were developed in the 1980s when real estate costs were high and when there were no limits placed on the price of developing a group home. It was not unusual for homes to cost \$500,000 dollars. In fact, of the 50 homes that were developed by one developer in 1988, 24 of them cost more than \$400,000. Since 1990, DSS has imposed HUD guidelines, which set a cap on costs based on the number of bedrooms -- currently \$361,363 for a 6-bed group home. A great many of the homes were built or extensively renovated to accommodate handicapped clients, also raising the costs. Thus, even with the HUD caps in place, DMR has spent an average of \$311,347 per residence in the past two years in bringing the last of its own homes on line to house Mansfield clients.

A great number of the private provider homes, (and a few DMR homes), were established by the Corporation for Independent Living, a private non-profit developer, which developed at least 320 properties for DMR clients. While most people contacted during the study agreed that CIL performed a much-needed service in quickly developing these properties when they were needed to house clients returning from Mansfield, the costs have been high. Development expenses for CIL homes alone have been \$95 million. When DSS reimbursement for property and financing costs, for CIL homes and other private providers homes, is considered over the long-term, those costs are multiplied substantially. The state will not own the property in the end.

It is true that the state is not taking any financial risk in developing or owning these properties, but on the other hand the ownership of this type of property ties the hands of the state in terms of changing service providers. The Department of Mental Retardation is less likely to pull a contract of a poorly performing service provider who may be stuck with a large property debt, than if the department owned the residence, or it was rented. Partly to address this, some other states, Rhode Island and Michigan for example, own all the community residences and only contract out for the service portion. In Connecticut, DMR does not contract for private services in any of the homes it owns, but both the department and private contractors do provide staffing in homes or apartments that are rented. However, the department has fostered other housing alternatives, including where the clients sign the lease and pay the rent through their cash assistance.

As pointed out earlier in this section, the department will have to be more innovative and more flexible in its approach to housing clients if it hopes to make a dent in the agency's current waiting list. The resources are no longer available to build or purchase houses that could accommodate the most handicapped of clients, even if that is not who lived there. Therefore, **the program review committee recommends that DMR expand its efforts at promoting new housing options, that renting existing dwellings is preferable to purchasing residences or building new dwellings in most cases, and that the option to purchase or build be used as only as a last resort.**

There are a number of reasons that the rental option appears preferable. First, renting homes, condos, or apartments allows the service provider (DMR or private) to concentrate on the staffing services to clients, and not spend time managing property and maintaining buildings.

Further, the appropriateness of the state, or even non-profit agencies, as landlord for individual residences is questionable. These homes are residences for small numbers of individuals, not large office buildings or institutions. Secondly, the costs of either building or purchasing and renovating have been so expensive that continuing that as a standard option is unrealistic. Thirdly, the rental option, especially when the clients are able to sign the lease, will avoid bureaucratic obstacles the department must undergo when it buys or leases.

The client is also given more choice when he or she is allowed to check out several living situations, before making a decision, rather than having to come into the home after all the choices have been made. The committee also believes DMR, as a purchaser of service, is more likely to terminate the contract of a substandard provider if the provider is not also tied up with the ownership of the residence. Finally, when the property is not owned by the state or the non-profit provider, it obviates the local property tax issue.

The program review committee realizes that for a certain segment of the DMR community residential clients, homes specifically designed or rehabilitated to their needs are necessary. But, the committee believes that to expand this highly specialized housing stock would be costly and unnecessary. Instead, DMR should examine, as part of its utilization review process, recommended in a later section, all clients' needs for handicapped accessibility and other physical plant requirements, and match those needs up with the residences now available.

Clients who are determined not to need handicapped-accessible housing, or adaptive bathroom equipment and the like, and are living in houses that provide such equipment should be given more suitable housing. Other clients, for example those returning to the community from Southbury, whose needs require the intensively modified housing, could then live in those houses.

Other room and board costs. To a somewhat lesser extent, the DMR-operated homes incur lower costs in property taxes and insurance. In most cases, the private providers are paying property taxes, although some have received exemptions from towns, and others don't pay because they rent the property. The figure shown in the table for property taxes paid by the private sector homes is an average including those who don't pay any. On the public side, the state makes payments to towns in lieu of taxes (PILOT), and the amount shown in Table II-21 is calculated based on DMR's portion of those PILOT costs spread among DMR-owned homes. (See Appendix A). Similarly, DMR homes pay less property insurance because the state purchases one policy, through the state insurance purchasing board, for all state property and thus realizes premium savings on individual properties.

Another aspect that should be considered in the cost differences between the two sectors is that on average the public homes are actually serving almost one additional person per home than in the private sector. Thus, additional per-person room and board savings are realized in the public homes.

Reimbursement for room and board costs. How clients pay for their room and board is as varied as the types of homes in which they live. If a client is living in an ICF/MR, which is considered a medical facility, he or she receives only \$30. per month personal needs allowance. Other assistance and income go to provide for care. If the client is living in a privately run non ICF/MR, the DSS sets the room and board rate for those homes, and the rate is included in the entitlement payment system, so that the client's assistance payments reflect the room and board rate.

Some clients live in residences they lease themselves, where DMR provides the staffing. In these situations, the clients pay the landlord with their assistance payments. For non ICF/MR homes that DMR owns or leases, the system for reimbursement from the client to pay for room and board is a lot less formal and dependable.

Until late 1992, there was no system in place to collect money from clients living in these DMR homes. Since then, the Bureau of Collection Services (BCS) within DAS has begun collecting some reimbursement from the clients in DMR homes. However, the records of which clients must reimburse are not very reliable -- according to BCS staff numerous DMR case managers informed BCS that it was billing clients for room and board costs for which they already paid through payments to landlords and buying their own groceries. Further, the collection results have been weak, with slightly more than \$100,000 being reimbursed for FY 93.

The committee believes a much better reimbursement strategy for clients in DMR homes would be to adopt a system similar to those clients living in private homes. **Therefore, the program review committee recommends that the Department of Mental Retardation calculate room and board rates for the homes it operates, DSS incorporate those rates into its computerized system, and that assistance payments reflect those rates.**

Both departments could develop a strategy for collections of the room and board monies owed DMR. For example, the DSS might issue the payment to the client with the room and board already deducted, and make a single transfer to DMR of those monies at regular periods.

This system would rectify a number of problems. First, it would require DMR to develop records for which clients reimbursement needs to be collected and how much. Second, it would replicate the system in place for clients in private homes. Finally, the costs to DMR of providing room and board should be lessened if collection from clients for room and board expenses were improved.

MARKET STRUCTURE AND ENHANCING COMPETITION

Another component related to costs is the market structure for providing community residential services for mentally retarded and developmentally disabled clients. The private provider market was first examined to determine whether it is sufficiently large and diverse enough to ensure vigorous competition. More than three-quarters of the community residential services is supplied through the private provider network. Currently, there are 75 different

provider organizations operating throughout the state. A breakdown of providers by region appears in Table II-22. The categorization of providers shown is by region of primary operation. But, providers can and do operate in more than one region, thus the number of providers actually operating in a given region is higher than the number indicated in the table, signifying healthy competition.

TABLE II-22. Private Provider Organizations by Region.

Region	Total Number	# For-Profits	# Unionized
Region 1	15	4	0
Region 2	15	0	2
Region 3	9	0	4
Region 4	10	0	4
Region 5	18	1	3
Region 6	8	3	4
Statewide	75	8	15

Sources: ACOR and DMR Information.

Of the 75 organizations providing residential services for DMR clients statewide, few of the providers are "for-profit" organizations and few are unionized. As the table indicates, 20 percent of all private providers are organized, however, because some of the larger providers are unionized, thus more than one-third of all private residences are unionized. Private providers indicate the percentage could increase as their employees become increasingly disgruntled with the wage disparity between themselves and public employees.

Market share by region. The overall number of providers suggests the pool of residential services operators statewide is sufficient. However, the market is actually comprised of several component markets that vary in terms of competition. Residential services were categorized into ICF/MR and non-ICF/MR markets. Each market was then examined by the total number of beds in a region, and the number of beds managed by the top provider in that region. The percentage share that the top five providers acquired of the total FY 92 community residential service funding statewide was also analyzed. These data are presented in the following four tables (Tables II-23 - II-26).

TABLE II-23. Breakdown of Private ICF/MR Market by Region: Number of Beds by Top Service Providers FY 92.			
Region*	Total Beds for Region	Top Provider	# Beds Top Provider
Region 1	160	DATAHR	118 (62%)
Region 2	78	Conn. Institute for the Blind	54 (69%)
Region 3	15	Greater Coventry ARC	8 (53%)
Region 4	35	CT. Institute for the Blind	12 (34%)
Region 5	36	Institute for Professional Practice	30 (83%)
Total Beds Statewide All Providers (13)	324	N/A	222 (69%)
* (Region 6 has no ICF/MR beds) Source: DMR Data from ACOR Report			

TABLE II-24. Top Five Private Providers Market Share of Total Statewide ICF/MR Expenditures for FY 92.		
Provider	Provider Total Expenses	Percent of Total Statewide ICF/MR Expenses
DATAHR	\$9,553,326	31 Percent
CT Institute for Blind	\$7,988,036	26 Percent
Institute for Professional Practice	\$4,078,496	13 percent
Community Residences, Inc.	\$2,557,591	8 percent
IAIPD	\$1,176,434	4 percent
Total of Top 5 Providers	\$25,353,883	82 percent
Statewide ICF/MR Total All Providers (13)	\$30,436,836	
Source: DMR ACOR Data.		

TABLE II-25. Market Share of Private Non-ICF/MR Services: Number of Private Provider Beds By Region for FY 92.			
Region	Total Private Beds By Region	Top Provider	Number of Beds of Top Provider
Region 1	386	Community Systems, Inc.	56 (15%)
Region 2	387	CT. Institute for the Blind	66 (17%)
Region 3	270	CT Institute for the Blind	54 (20%)
Region 4	345	Kennedy Center	55 (16%)
Region 5	545	Meriden Wallingford Society for Handicapped	77 (14%)
Region 6	252	Caring Community of CT., Inc.	39 (15%)
Statewide Total All Providers (75)	2,186	N/A	347 (16%)

Source: DMR Data from ACOR.

TABLE II-26. Market Share of Private Non-ICF/MR Residential Services: Top Five Providers by Percent of Total DMR Expenditures FY 92.		
Providers	Total Expenses	Percent of Statewide Total
CT. Institute for the Blind	\$20,637,250	15%
Bethphage Lutheran Services	\$8,049,624	6%
Whole Life, Inc.	\$5,920,533	4%
NCDC Inc.	\$4,866,440	4%
Institute of Professional Practice	\$4,262,476	3%
Total of Top Five Providers	\$43,736,323	32%
Total Statewide CLA Expenses Total Providers (75)	\$135,503,291	

Source: DMR Data from ACOR.

ICF/MR provision of service. As the data in the tables show, the provision of services is markedly different between the ICF/MR area than it is with regular group homes. First, the number of private ICF/MR beds is small -- only about 15 percent of the number of regular group home beds. There are only 13 current ICF/MR providers, with the top five providers capturing 82 percent of the ICF/MR funds in the state. On a regional basis, the concentration of services in one provider is more pronounced, with the top provider having more than 50 percent of the beds in all but one region. Thus, the market in providing ICF/MR services does not appear competitive, however, the overall number of ICF/MR beds is so small in some regions, the limited number of providers may be reasonable.

One of the reasons for the more restricted supply of providers in this area is that there are more regulatory obstacles to establishing an ICF/MR, including the approval of a "certificate of need" by the Commission on Hospitals and Health Care (now conducted by DSS). Further, the regulatory oversight with ICFs/MR is more stringent than with non-ICFs/MR, perhaps discouraging some providers from seeking this status. Also, reimbursement for capital expenditures and the like can take as long as 18 months to be built into the rate, thus creating potential cash flow problems for ICF/MR facilities. Finally, prior to the state being granted the home and community based waiver, there was a clear financial incentive for the state to grant ICF/MR status for the facilities it funded, since only they were eligible for the 50 percent reimbursement from Title XIX. This incentive dissolved with the federal waiver allowing Medicaid reimbursement for non-ICF/MR facilities as well.

Non-ICF/MR market. The regular group home network is more competitive in terms of total providers available to provide service. For example, even though there are some large providers operating statewide, no single provider has more than 20 percent of the beds in any given region. Further, the largest private provider in the state, the Connecticut Institute for the Blind, receives more than \$20 million dollars to operate non-ICF/MR groups homes, but that is only 15 percent of the entire funding. In fact, the five largest providers in the state account for only one-third of the funding, indicating that the other 70 providers are competing for two-thirds of the market.

In addition to the separation of the market along regional and the regulatory differences in non-ICF/MR and ICF/MR categories that influence the market, there are other systemic factors that also lessen competitiveness.

Contracts. As mentioned earlier in this chapter, DMR contracts with private agencies for community residential services, and once a contract is bid and awarded, it is really that provider's to keep unless the department cancels it. In other words, the contracts are not rebid. Further, rates are cost-based, and yearly rates are based on amounts that were set when the contract was first awarded. The department can renegotiate the amounts, but almost always provider rates are increased across the board by the increase appropriated in DMR's budget. On rare occasions, the rate is decreased as a result of ACOR cost settlements, which will be described in the next chapter.

Property and other fixed costs are borne by the private provider (although reimbursed by the state), so there is some reluctance to move toward more competitive contracting, because providers who lose a residential contract might also be "stuck" with the properties. The Purchase of Service Project, an outgrowth of the Harper-Hull Commission, is currently examining the issue of rebidding all human service contracts.

DMR involvement. DMR currently operates about 139 (22 percent) community residences for mentally retarded persons. These homes are staffed with DMR employees and are not part of any competitive bidding or contracting. In fact, as indicated in the introduction, contract language prevents workers from being laid off as a result of the state's exercising its right to contract out, eliminating the public sector from competition.

The Department of Mental Retardation is essentially the only purchaser of residential care for mentally retarded and developmentally disabled persons, creating another non-competitive aspect. The receivers of the care (the clients) have no real financial incentive to opt for less costly services. But because the department's resources are limited, and the residential services that DMR offers are not entitlement programs -- whereby anyone who is mentally retarded and who asks for the service is entitled to receive it -- substantial numbers of clients have gone without services. In effect, there is an imbalance in the "market", where those clients receiving residential services may receive more than they need because there is a third-party payor (DMR), while other clients receive no services.

Clients served. The type of clients being served, and the type of service being provided also suppress competitiveness in the market. Purchasing residential care and habilitative services for mentally retarded persons is very different from purchasing paper products for state offices. Those purchasing a *product* are more likely to take risks to save costs than they are with contractors providing a *human* service. Because some of the clients are physically or mentally fragile, stability and the relationships between the provider and the client are as much a concern as marginal costs savings.

Enhance Competition

The program review committee believes that segmentation of the market, the category of clients being served, cost-based rate setting, contracts that are not rebid, third party payment by a state agency, and provision of services by a state agency in about one-quarter of the homes all combine to form a market that is not driven by competition.

The committee, however, does not propose the rebidding of DMR residential service contracts at this time. It recognizes that this subject may well be part of a comprehensive recommendation by the Purchase of Service Project for all human service contracts in the near future. Thus, any recommendation by the committee in this area is deferred so issues that need to be addressed uniformly for a rebidding system -- like time frame, consistency of review procedure, and establishment of standards and policy for review and award of contracts -- can be addressed systemwide by the Purchase of Service Project.

Pilot programs. The program review committee recognizes that the current system for purchasing and providing residential services for mentally retarded clients should be more competitive and recommends that **DMR explore innovative pilot programs that would foster competition in community residential programs.** For example, clients or their families might be given vouchers to purchase the services now being provided and paid for by DMR. If the client (or his family or advocate) could locate a provider who would offer the client acceptable services for less, all three parties (client, DMR, and the provider) could share in the savings.

DMR is sensitive to client choices, but the current service delivery system limits the ability of the client to truly exercise options. This recommendation would enhance client choice, putting the client and his or her family, or advocate, in charge of making the decision of what services are appropriate, rather than DMR being the arbiter of what the client should receive. Secondly, a voucher system promotes competition in having providers compete for clients and offer the services at competitive prices.

Redeploy DMR staff. The department also must explore ways of making its own homes competitive in terms of staffing and costs. As the previous discussion on direct care costs pointed out, state-operated homes are on average about twice as expensive as private homes in providing direct staffing. Even when homes with challenging clients were compared, DMR costs were substantially more than private providers.

The committee could not compare current staffing levels with any established standards, since none exist. Staffing levels are program based and somewhat linked to the needs of the clients in those homes. But without parameters, it is difficult to judge what staffing and cost levels are sufficient or warranted. Yet, even without established standards, it must be the responsibility of DMR management to make judgments about what appropriate levels of staffing are, especially in the agency-operated homes. Recognizing that current contract language prohibits the department from laying off state employees in order to exercise privatization, DMR must explore other avenues to pare costs.

Therefore, the program review committee recommends that the department establish standards for appropriate staffing levels based on the number and types of clients served, review staffing levels at all its DMR-operated community homes, and where DMR determines the home is overstaffed, redeploy those personnel to provide family supports to clients on the waiting list.

DMR should use the cost analysis provided in this report as a basis for its staffing review. The committee believes it is a poor use of current resources to provide more staff than necessary at state group homes, while the need for services among other clients goes unmet. The redeployment of staff should not add materially to costs, since the services would be provided with existing personnel. Further, establishing staffing standards should prevent overstaffing, and regional or other disparities shown in the committee's analysis.

State employee contract language. The staff redeployment and creation of standards, along with other steps DMR management should take to address overtime and workers' compensation issues, should mitigate some of the factors that impair DMR's competitiveness compared to private agencies. However, over the longer-term, the state as an employer should address the contract language that precludes layoffs as a result of the state' exercising its option to privatize services. This significantly limits the state's ability to offer services in another manner, even if those services could be provided more efficiently or effectively elsewhere.

Pursue federal reimbursement. In addition to redeploying its staff to serve more clients, DMR should also aggressively pursue the expansion of the Home and Community Based Waiver to serve more clients and to expand the services for which reimbursement can be claimed. As pointed out earlier in this chapter, Connecticut had not been in the forefront in pursuing federal revenues (see Column E in Table II-1). In FY 88, only five states had a higher percentage of its funding coming from state revenues than Connecticut. Further, while the Home- and Community-Based Waiver under Medicaid had been in existence since 1981, Connecticut did not obtain approval under the waiver until 1987; 33 states had already received authorization.

Connecticut has improved its record since 1988, and for FY 92 collected more than \$95 million dollars under the Home- and Community-Based Waiver program for the mentally retarded. Further, DMR acknowledges the need for additional federal revenue enhancement, and has indicated in its budget options several efforts it will pursue to maximize that reimbursement. The committee commends the department's proposals, but DMR should seek every opportunity to maximize the federally reimbursed services under the Medicaid waiver, and to broaden the interpretation of where the services can be provided. **Therefore, the program review committee recommends both the Department of Mental Retardation and the Department of Social Services seek approval from the federal Health Care Financing Administration for both expansion of the waiver for the types allowed, and where the services can be provided.**

Other New England states have already begun collecting reimbursement for services being provided in supported living arrangements under the Home and Community Based waiver. Maine has a waiver in place (since April of 1992) to obtain federal reimbursement for: adaptive equipment, environmental (physical plant) rehabilitation; and personal support services provided in the home of a mentally retarded or developmentally disabled person to help with daily living skills.

CHAPTER III

MANAGEMENT CONTROLS

The number of community residential facilities, particularly private CLAs, has increased dramatically since the CARC v. Thorne consent decree was issued in 1984. With the upsurge in the number of community residences, DMR has developed a specific controls to manage this tremendous growth. These controls, including the process used by the DMR to fund CLAs, the different types of data and information used to make funding decisions, as well as findings and recommendations in terms of management controls are described below.

FUNDING PROCESS AND CONTRACT MANAGEMENT

Annual funding for both public and private community residential facilities is determined by an appropriation level set by the legislature. The legislature also establishes budgetary guidelines outlining the direction that DMR must take concerning community residential facilities and placements. Using these guidelines, the department decides how the funding will be allocated. It should be noted that funding is program- or residence-based not client-based. This means that rates are set for a particular residence (or program) and do not "follow" a client if he or she changes residences.

DMR has created a formal process, described below, for dispensing yearly appropriations to private providers and tracking providers' performance. No similar process, involving each phase required for private providers, exists for DMR-operated residential facilities.

Service contracts. The Department of Mental Retardation enters into written contractual agreements with private agencies to administer community residential facilities. The vast majority of these agencies are non-profit and not unionized.

Initial contracts are made between DMR and private providers following a "request for proposal" (RFP) process. RFPs are issued whenever new funding is available for community residential development or when changes occur within existing residential programs. An RFP includes a description of the client to be served, the needs of the client, and program cost ranges. These cost ranges, calculated by DMR, are used as guidelines by providers when responding to the RFP.

Contracts between DMR and private providers are valid for one-year periods coinciding with the state's fiscal year. They are renewed annually following a satisfactory review of the contractor's performance. Each contract details the services that a provider is to render, and at what cost, along with other criteria that must be met. Service and cost provisions of contracts are determined at the regional level. Contract administration is also performed by the regions.

The Department of Mental Retardation has the ability to cancel contracts at any time for reasons it deems appropriate. A private provider may also cancel a contract if DMR is notified in advance. DMR also has authority to cancel a contract within 24 hours if it determines the health or welfare of a client is endangered. If a contract is canceled by a private provider, DMR is responsible for either placing the client in a public or private residential facility or rebidding the contract so residents would not have to move.

Operational plan. Once an agency has a contract with DMR and is operating a community residential facility, it is required to file an operational plan (OP). The operational plan is, in essence, a prospective look at a private provider's budget for the upcoming fiscal year. The plan shows the provider's forecasted revenue and expenses. Each provider is required by regulation to annually file the plan with the primary DMR regional office by the beginning of April.

DMR supplies standardized forms that include expense and revenue categories to all private agencies operating community residential facilities. This helps assure that all expense and revenue data submitted by providers are consistent in form and content so that statewide comparisons can be made. A needs assessment, which includes the programmatic needs of each client residing in a provider's residence, serves as the basis for the cost elements in the provider's operational plan.

Contract negotiation. Once a provider's operational plan is submitted to the regional office, it is reviewed by DMR staff responsible for contract management. The region then schedules meetings with each private provider to review the OP before the start of the new fiscal year. At these meetings, providers explain to regional DMR staff the information contained in the OP and reasons for any expense increases or decreases.

These meetings are also intended to serve as a "negotiation" between the region and the private provider to determine what increase, if any, the provider will receive from DMR for the next fiscal year. The increase is actually made to the daily rates paid to the provider by DMR for a given residential program.

In addition to analyzing providers' budgets when entering contract negotiations, DMR regional staff review information such as: 1) management reports developed by the DMR central office; 2) licensing and inspection data provided by the Quality Assurance Division; and 3) reports concerning incidents that may have occurred at a provider's residence over the last year. This information is also used to help regions decide the funding level that a provider will receive for the next fiscal year.

Once program rates are negotiated and agreed upon, DMR certifies and issues them. If for any reason negotiations fail to result in an agreed-upon rate by May 15 of a given year, the department is required to give the its last best offer and issue rates accordingly.

Program review committee staff attended several rate negotiation meetings and observed little actual negotiation. Instead, most providers were given the same increase in their budgets as the overall increase given to DMR by the legislature. In other words, the increase is merely added to the providers' funding base for the prior year; rates are not fully renegotiated.

During its discussions with regional DMR staff responsible for contract management, it was noted that DMR has periodic contact with private providers throughout the year. Thus, financial condition of providers is known by the regions prior to when the meetings are held to review the operational plans.

Audited consolidated operational report. Each *private* agency operating a DMR-funded program, including a community living arrangement, is required to file an audited consolidated operational report (ACOR) with the primary DMR regional office. The ACOR, used by DMR since 1987, is a retrospective look at a private provider's actual costs, revenues, and client data for the preceding contract year. The report must be completed in accordance with generally accepted accounting principles and audited in accordance with generally accepted auditing standards. A report is for the previous fiscal year and filed annually in mid-October.

The information contained in the ACOR is tracked and analyzed by DMR's central office. The central office is responsible for providing regions with management reports using the ACOR data. These management reports are then used by the regions during a process known as cost settlement which is described below.

Exemptions to filing an ACOR may be granted to providers by DMR. However, all private providers operating community living arrangements must file ACORs with DMR. A provider may be exempted from the ACOR process if it only operates supported living programs and not day or residential programs, or if the DMR contract portion of its budget accounts for five percent or less of the provider's overall budget. The department also considers whether the financial impact on small providers to file an audited report may be too burdensome in relation to their overall budget.

Cost settlement. Cost settlement is the process used by DMR to determine if private providers have either under- or overspent their specified contracted funding amounts for a given year. If a provider spends more than what was negotiated at the beginning of the contract period, it is responsible for finding the resources to cover the amount overspent. However, if a provider underspends its contracted amount, 90 percent of the surplus must be returned to DMR at the end of the year. The audited consolidated operational report is the main analytical tool used for determining the provider's expenditures for the previous year.

Until last year, cost settlement was completed using a line-item method whereby the expenses in three separate categories were examined. The categories were administrative and general expenses, nonsalary and support costs, and direct care staff salaries. The system is transitioning to using a provider's bottom-line surplus or deficit to determine cost settlement.

During the last round of cost settlement, providers were given the choice of whether to use line-item or bottom-line cost settlement. The vast majority selected the bottom-line method.

Cost settlement decisions must be made within approximately four months after a private provider submits its ACOR. If cost settlement is required, and a provider is ceasing operation, all costs must be reimbursed entirely to DMR. Otherwise, reimbursable costs will be deducted from payments made to the provider by DMR for the three months following a cost settlement decision.

FINANCIAL MANAGEMENT INFORMATION SYSTEM

The committee has found that private providers are held to different standards than the department has in place for its own operation of community residential facilities. One of the main areas where DMR holds private providers to higher standards is financial reporting. The department currently requires the providers it contracts with to submit detailed financial information on a cost center basis, yet does not have a system in place to collect the same type of information for its own facilities.

As previously mentioned, all private providers are required to submit detailed financial and client information to DMR through the ACOR system. This system provides the department with a retrospective look at a provider's actual costs, revenues, and client data for the previous fiscal year. Costs found in the ACOR system form the basis for both the program and room and board rates for private sector homes.

DMR, on the other hand, does not have a comparable data collection system for public facilities. While the department maintains direct care personnel costs for each home and some of the operating costs, like utilities, allocated by home, no other costs are continuously maintained on a cost center basis for public facilities. Thus, the department cannot easily determine the total costs for any given public home, nor accurately determine its per diem rate. To compare similar cost and client data between public and private facilities, information for public facilities must be collected from several different sources and is often not readily available.

Private providers have expressed concerns to the committee that information currently collected for private facilities via the ACOR is not being compiled for public facilities. The providers have also said the ACOR process is time consuming, costly, and much of it unnecessary. DMR, realizing that the amount and types of data required from providers is often burdensome and superfluous, is in the process of refining the ACOR system.

Department staff further indicates that an improved financial management information system is being developed. However, the system will not be implemented for two to three more years, and will be based more on program categories (i.e., CLAs, ICFs/MR etc.), than individual residential cost centers. The program review committee believes these efforts are a

step in the right direction, but do not go far enough in developing a system that will enable the department to fully analyze the costs of its residences.

The committee recognizes the need to have a financial management information system that: 1) is balanced between the public and private sectors in terms of the type of financial information collected; 2) collects only information that is useful for analytical purposes; and 3) provides accurate and timely financial reports to be used for oversight and planning. The program review committee, therefore, recommends that **DMR, as a management objective, begin designing and implementing a financial management information system based on cost centers.**

Financial data based on cost centers will allow the department to properly oversee the management of its community facilities and ensure they are competitive with the private sector. The committee further believes such a system will be extremely beneficial to the department by providing the necessary information for thorough planning and policy making.

Cost Settlement

In FY 92, 73 private providers were awarded contracts for community living arrangements worth \$102 million. Twenty-one providers had surplus amounts totalling \$243,556, and 52 providers overspent their funded amounts by \$2.3 million. Of the total surplus amount, private providers were able to retain only \$50,075. (During the change-over of the cost settlement process from a line-item to bottom-line method, providers were able to choose between the two methods which is why the amount retained by providers exceeded the current 10 percent cap).

Although more private providers had deficits than surpluses during FY 92, it is known that: 1) community residential services are provided far less expensively by the private sector than public sector; 2) many private providers are relatively new to the community residential business, yet have been receiving large numbers of clients placed in private residences since the late 1980s; and 3) state resources and private provider contract amounts actually declined from FY 91, an event probably not anticipated by providers. The program review committee believes that combined, these factors most likely attribute to the provider deficits in FY 92.

The committee also believes the current cost settlement system does not provide enough incentive for private providers to find ways to cut costs and increase reserves. If a provider knows that most of any year-end surplus must be returned to DMR, there is little true incentive to find cost savings. In fact, the opposite is more likely to occur. Providers may actually try to spend their entire funded amount instead of returning it to DMR.

Cost settlement methods used by other states. Formulas used by other states for surplus revenue retention differ, both on the percentage of revenue retained and the ways such amounts are calculated. In New England, for example, Massachusetts allows providers to keep up to 5 percent of surplus amounts, and surpluses retained may also be accumulated over time

but cannot exceed 20 percent of a provider's previous year's gross revenues. In Rhode Island, providers had been able to keep 8 percent of the contract amount in unexpended revenue until the state started experiencing budget problems. New Hampshire, on the other hand, allows 12 percent of the total contract amount to be rolled over to the next year, with future contracts subject to negotiation.

Nationally, Wisconsin allows providers to retain surplus revenues of up to 5 percent of contract amounts, but no more than \$3,000 to cover a future year's contract deficit; an additional \$2,000 may be retained if the provider and state renew the contract. In Pennsylvania, providers can retain up to 3 percent of their contract amounts with no cap on gross revenue. In Kansas and Virginia, however, private providers must return all surplus amounts back to the state.

New cost settlement formula. It is apparent that states around the country use different formulas to determine what, if any, surplus amounts private providers may retain. The committee believes, however, that Connecticut's system of allowing providers to retain only 10 percent of any year-end surplus does not provide a realistic incentive to find increased efficiencies. The program review committee recommends, therefore, that **DMR continue basing its revenue retention formula on surplus amounts, but providers be allowed to retain 50 percent of the surplus during any given fiscal year. The committee further recommends that there be no cap placed on the actual dollar amount providers may retain.**

By allowing providers the ability to keep a larger portion of surplus amounts, a greater incentive is created to look for efficiencies. Although the department currently permits providers to keep a portion of surplus revenue, the amount is not sufficient enough and may actually cause providers to spend their entire contract amounts. The committee further believes that by allowing providers to retain more surplus amounts, those resources could be used to increase reserves helping providers during tight fiscal years. This recommendation does not, however, eliminate DMR's ability to include the results of cost settlement in contract negotiations.

Local Boards of Directors

The program review committee found that management controls in the private sector are increased because most providers, as non-profit organizations, are accountable not only to DMR, but also to individual boards of directors. These boards play a pivotal role in the overall management of providers -- something not found in the public sector.

Most boards of directors are made up of people from, or having ties with, the communities where providers operate their residences. This helps put providers in closer contact with the families, neighbors, and towns where group homes exist than a large bureaucracy like DMR. If concerns or problems arise with a particular facility, board members have a vested interest in seeing they are quickly resolved. This level of local citizen oversight does not exist with the operation of DMR's community residences.

The committee recognizes the value of local participation in overseeing the operation of community residential facilities, and believes the department should develop and nurture community participation where DMR group homes are located. Steps are being taken by the department in this area. In its 1994-99 strategic plan, DMR acknowledges greater community involvement is a departmental goal, and good relations with the communities where people with mental retardation live is vital to the success of the community residential system.

Flexibility

The literature on privatization cites that one of the primary advantages of having the private sector provide services, is its high degree of flexibility compared to the public sector. Increased flexibility, as noted throughout this report, allows for quick response to events or problems, implementation of innovative programs, greater efficiency, and lower overall costs, which are the primary reasons why the DMR contracts with private providers.

The committee found, however, that even though the state contracts with private providers because of their increased flexibility, it confines this flexibility partially due to rigid funding mechanisms currently in place. These mechanisms apply not only to private providers, but to DMR as well.

Separate accounts and census caps currently exist for residential programs such as community living arrangements and supported living arrangements. Each account receives a certain funding level for a given year, and use of funds between accounts is not permitted. The result is a system that inhibits the ability to place clients in more appropriate living arrangements if the pre-determined census/funding level for that alternative living arrangement has already been reached.

As the system now operates, a residential client determined to need a different type of living arrangement (i.e. on-call staff instead of 24-hour staffing) cannot be moved if the census cap for the more appropriate arrangement is already met -- even though funds may exist in other accounts that, if used, would accommodate the move. As a result, the system uses more resources than necessary, and less effectively, because some clients are being overserved in terms of staffing and costs, while others are underserved because they are not provided the opportunity to live as independently as possible, or receive services at all.

The committee believes that by having only one residential funding account, DMR would have the necessary flexibility it needs to most efficiently and effectively use community residential program resources. Therefore, **the program review committee recommends that funding for community residential programs be combined into one account. DMR and private providers should have the flexibility to use this account as deemed appropriate and move clients to the most suitable living arrangements. Further, no census caps should be placed on any type of community residential program.**

This recommendation will help DMR and private providers maximize their community residential programs potential. DMR would have a single, but larger, pool of resources with which to work, creating more opportunities and flexibility to move clients to the most appropriate placements, yet remain within its appropriated budget. Thus, allowing greater system flexibility to place clients in the most effective and efficient setting would undoubtedly have a positive impact on both placements and costs within the system.

CHAPTER IV

UTILIZATION REVIEW AND QUALITY ASSURANCE

As part of its overall quality assurance responsibility, DMR is charged with making sure each client is placed in the most appropriate living arrangement according to his or her needs. This process, referred to as utilization review (UR), assesses the placement needs of clients and ensures clients are neither over- or underserved in terms of supports.

To ensure that clients receive the most appropriate care and treatment, placements are periodically reviewed in several different ways. Reviews range from determining the proper program for a client to checking a client's medication. Client assessments and evaluations are performed by professionals, with family/guardian participation whenever possible.

When a client enters the DMR community residential system, a case manager, and Interdisciplinary Team (IDT) are assigned to that client. The IDT is required to meet within 30 days to review the individual's needs and capabilities. In addition, each client, guardian, or advocate is required to receive notice of this meeting two weeks prior to the meeting date.

The IDT, led by a case manager, is the main link between the client and the varied services offered by DMR and private providers. The IDT develops the initial overall plan of services and reviews it every six months since a client's capabilities and needs may change at any time. Once a client's initial OPS is developed, it is reviewed by the Interdisciplinary Team. At this time, the IDT submits written reports to the case manager on the progress of the client.

The OPS is rewritten at least annually to ensure it is adequately meeting the client's needs. However, a formal team review of the plan may be requested by the IDT at any time. All substantial changes to the plan require formal agreement and documentation from the team. If a client (or other person responsible for the client) appeals the decision of the IDT, no changes to the OPS are made until the appeal is resolved.

PROGRAM REVIEW COMMITTEES

In addition to reviewing whether a client's placement is proper, other areas such as the clinical side of a client's program are reviewed. This clinical review is conducted by a program review committee (PRC) established in each region and each training school. Program review committees are appointed by regional directors and training school directors.

Program review committees are made up of regional managers, executives of agencies contracted with by DMR, and specialists in special education, medicine, and psychology. Clients, parents or family members, guardians, and advocates may attend committee meetings to hear presentations and make their views known. The committees are required to meet monthly.

Several of the primary responsibilities of PRCs include reviewing programs that use aversive procedures to alter a client's behavior and reviewing control procedures used as part of a client's clinical program, such as physical or mechanical restraint or physical isolation. The committees also: review clients' behavior modifying medications (i.e., psychotropic drugs) to ensure their clinical soundness and that they are being used according to department policies; review occurrences when emergency intervention is used on a client; and make reports to the appropriate people associated with the client.

HUMAN RIGHTS COMMITTEES

Each region and training school is required to have a human rights committee which is appointed by the regional director or training school director. The committees consist of six to ten members, each appointed to three-year terms. Committee membership includes at least a physician, lawyer, and parent of a client. There are no DMR employees on these committees.

The committees provide objective reviews for the sole purpose of ensuring a client's rights are being respected and protected. They respond to complaints concerning potential violations of a client's human and/or civil rights. In addition, trends or patterns involving the use of behavior-modifying medication or restraints are examined. The committees also serve as recommending and referring bodies but have no approval or disapproval authority regarding a client's programs.

If a human rights committee receives a complaint it may, as a referring body, ask the regional director or training school director to review or investigate the complaint. The committees also provide directors with written reports concerning client behavior programs that include aversive procedures within 30 days of the program's implementation. An annual report prepared by each regional human rights committee assessing its impact is also sent to the respective regional director.

INDIVIDUAL REVIEWS

As part of a client's overall plan of services, case managers are required to complete individual reviews every six months. During these reviews, clients are questioned regarding critical areas in their lives such as residential program placement, medical care, appropriateness of planning and services, restraint and medication use, and staff training. If a client indicates that he or she is not satisfied with any of the service areas, the case manager views this as a "red flag," meaning a possible critical situation may exist.

Whenever a red flag situation is indicated, the case manager is responsible for notifying the client's family, guardian or advocate, and a member of the regional or training school executive staff assigned to oversee resolution of the problem. Red flag information is also reported to the DMR commissioner on a monthly basis by the department's central Quality Assurance Division to ensure that resolution is occurring and clients are being protected.

ADMINISTRATIVE REVIEWS REQUESTED BY CLIENTS

Any client, or any person acting on behalf of a client, may request an administrative review by the regional director. Such reviews may be sought for several different reasons including placement evaluation, program assignment, or an examination of a client's overall plan of services. If the client is a Mansfield Training School class member, a special review before an independent hearing officer can also be made regarding either the failure by an IDT to recommend community placement or objections to the use of psychotropic medication or aversive procedures as approved by the regional director.

Clients placed with DMR involuntarily by a probate court may request a review of their placement by the court at any time following the original placement order and annually thereafter. DMR must notify all involuntarily placed clients at least annually that they have a right to a placement review hearing. Further, if a person involuntarily placed with DMR has not requested a hearing within five years after placement, the department is required to notify the probate court and a review hearing must be scheduled.

ICF/MR UTILIZATION REVIEW

Utilization review is done differently for ICF/MR and non-ICF/MR facilities. For ICF/MR residences, utilization review is the responsibility of the Department of Social Services (DSS) because ICFs/MR receive Medicaid funding through DSS, thus making them accountable to federal regulations.

The social services department contracts with DMR and the Department of Public Health and Addiction Services (DPHAS) to perform these responsibilities. DPHAS certifies ICFs/MR as eligible to participate in the Medicaid program, while the Individual Professional Review/Utilization Review Unit within DMR ensures that clients receive "active treatment", through individual professional reviews, and that they are placed in the most suitable ICF/MR facility through client utilization reviews. Active treatment is defined as a continuous program of specialized and generic training, treatment, health care, and other related services.

Reviews for clients living in ICFs/MR are conducted twice a year by the IPR/UR Unit. There are 14 people, in addition to 3 administrative staff, in this unit who perform the reviews. All 17 positions are federally funded since the utilization review process for ICFs/MR is a federal requirement.

The review process used for clients living in ICFs/MR consists of two types of reviews. First, an Individual Professional Review (IPR) is performed to assess whether the overall program administered by a residence meets federal standards. A key standard is whether the clients are receiving active treatment, defined as continuous specialized and generic training, treatment, health services, and other related services. Such treatment must be designed to help clients function as independently as possible.

IPRs are done annually by specific teams. Each team includes a nurse coordinator, a registered nurse, and two facility inspectors. The teams are responsible for: observing client behaviors and the interaction between clients and staff; conducting interviews with clients; and reviewing clients' records. Following a review, a team meets with facility staff to discuss its findings. If the IPR reveals that a client is not receiving active treatment, a follow-up review is conducted within one to three months. During the follow-up review, the IPR team again observes the clients to see if they are receiving proper active treatment.

Monthly management reports are also developed by the IPR teams using the results of performance reviews. After the reports are prepared, the information is shared with DMR central office and regional staff, and the Department of Social Services.

During FY 92, 1,373 IPRs were conducted. These reviews included clients in public and private community ICF/MR facilities, as well as ICF/MR facilities operating on campuses statewide. Of the reviews completed, 69 percent determined that clients were receiving proper active treatment. After follow-up reviews were completed, the percentage of clients receiving active treatment increased to 91 percent.

The second review method used by the IPR/UR Unit for clients living in ICFs/MR is Utilization Review (UR), which is a process to determine if a client is appropriately placed in a residential facility. To make this determination, client records are reviewed and facility staff interviewed. Utilization reviews are conducted twice a year, one at the same time as the Individual Performance Review and the other six months later. Monthly management reports are also developed. Information is shared with DMR central office and regional staff, and the Department of Social Services.

Similar to IPRs, the UR process relies on a team approach. Teams of three or four people from the IPR/UR unit review client records and conduct staff interviews to determine if clients are appropriately placed. Once a review is completed, the team decides: 1) whether the services provided by the ICF/MR are appropriate for the client; or 2) if the services are no longer appropriate, whether the client should be transferred to another ICF/MR facility or moved out of the ICF/MR system of care entirely. If the utilization review reveals that a client is not receiving appropriate services, a follow-up review is conducted usually within two to three months. Should the team decide that a client has not been properly admitted (placed) to an ICF/MR facility, has graduated beyond the services offered by the facility, or needs more intense services (i.e., medical) than those provided by the facility, it can recommend placement to a more suitable facility.

In FY 92, 2,732 utilization reviews were completed for clients living in both community and campus ICF/MR facilities. DMR data show that 55 clients were determined not to need placement in an ICF/MR facility, 321 were found to need placement in another ICF/MR facility, and 2,350 of the clients were properly placed. Information for the remaining six clients was not reported.

ICF client movement. As mentioned, clients in ICFs/MR can remain in their current living arrangement, be moved to another ICF/MR, or if ICF/MR-type care is no longer warranted, be moved to another type of living arrangement. Utilization review data were compiled for clients living in non-campus ICF/MR facilities, and the results are shown in Table IV-1.

TABLE IV-1. Utilization Review Results for Community-based ICFs/MR: 2/93 Through 7/93.				
Facility Type	# Reviewed	Appropriately Placement	Transfer To Other ICF/MR	Not In Need Of Continued Stay
Public	258	208 (81%)	37 (14%)	13 (5%)
Private	378	352 (93%)	14 (4%)	12 (3%)
Totals	636	560 (88%)	51 (8%)	25 (4%)
Source: DMR IPR/UR Unit.				

As the table shows, of the 635 utilization reviews conducted during the six-month period, the vast majority of clients (88 percent) were determined to be living in residential placements that best met their needs. On the other hand, 8 percent of the clients warranted transfer to other ICF/MR facilities, and only 4 percent were found not to need continued stay in ICF/MR facilities. The program review committee believes that the lack of alternative placement options for clients may have some bearing on the low numbers of clients either requiring transfer to other ICF/MR placements, or not in need of continued stay in the ICF/MR residential model.

In addition to examining the number of clients in need of more appropriate placement, the time needed to obtain that placement was also analyzed. The results of this analysis are shown in Table IV-2.

Sixty-nine percent of the clients living in *public* ICFs/MR and not in need of continued stay as determined by the utilization review team, were still living in the ICF/MR within three months after the initial recommendation was made for alternative placement. For the other 31 percent of clients, more than 13 months passed without alternative placement. The same scenario is also true for clients recommended for transfer to another ICF/MR facility. Forty-six percent of these clients had not been transferred within three months of the initial recommendation, while 54 percent had been waiting for eight months or longer to be transferred.

TABLE IV-2. Number of Months Clients Inappropriately Placed in ICFs/MR for UR Reviews Conducted 2/93 through 7/93.				
Time (months)	PUBLIC ICFs/MR		PRIVATE ICFs/MR	
	NCS	Transfer	NCS	Transfer
0-3	9	17	8	5
4-7	0	0	1	1
8-10	0	5	3	4
11-13	0	0	0	2
> 13	4	15	1	2

NCS = Not in need of continued stay in ICF/MR model, but not yet discharged.
 Transfer = Transfer to other ICF/MR residence recommended, but not yet transferred.

Source: IPR/UR Unit.

For clients in *private* ICF/MR facilities determined not in need of continued stay in the ICF/MR model, 62 percent had yet to be moved within three months of the initial recommendation of the UR team, and almost one-third had been waiting for a new placement for eight months or longer. Thirty-six percent of the clients that UR teams recommended be transferred to other ICF/MR residences, had yet to be transferred within three months of the recommendation, while 57 percent had not been transferred for eight months or longer.

Overall, roughly one-third of the clients in public and private ICFs/MR who were recommended for placement out of the ICF/MR model, were still living in ICFs/MR at least 8 months after the initial recommendation was made to move them. Further, over half of the clients in ICFs/MR, either public or private, in need of transfer to other ICFs/MR, had not been transferred in at least eight months following the UR team's initial recommendation.

Though the number of clients in ICFs/MR needing alternative placement is low compared to the total number reviewed, the vast majority of those clients remained inappropriately placed for relatively long periods of time. The committee believes that the lack of alternative placement options contributes to clients not being moved quickly, in addition to explaining why the overall low number of clients recommended for alternative placements is low.

NON-ICF/MR UTILIZATION REVIEW

The UR process for non-ICF/MR facilities is not as structured or as comprehensive as that for ICFs/MR. There is no specific unit within the Quality Assurance Division at the central office responsible for overseeing the process, as there is with ICFs/MR. Instead, utilization review is conducted in each region as part of the review of a client's Overall Plan of Service (OPS), as well as on a limited basis through case managers' contact with clients during residential visits.

If the OPS review or the individual case manager indicates the current placement for a client is inappropriate, a request for another placement can be made through the regional office's placement committee. That client is then given a priority rating for placement like all other persons on the waiting list. As of June 30, 1993, there were 267 clients living in CLAs waiting for other placements.

Case managers, as developers and reviewers of the Overall Plan of Service, play a major role in ensuring clients in non-ICFs/MR are living in the most appropriate community residential placements. The program review committee finds, however, that this link is diminished for several reasons. First, case managers have numerous responsibilities in addition to their utilization review function. Second, according to departmental policy, the decision to move clients into different residential arrangements must be approved by a consensus of the client's Interdisciplinary Team members, and not solely that of the case manager. Although case managers are part of IDTs, they cannot act unilaterally to move clients to different arrangements. Third, even if the case manager and IDT agree that an alternative placement would be more appropriate for the client, there is no guarantee the placement committee will agree or that an alternative placement can be found.

Non-ICF client movement. The number of clients living in non-ICF/MR community living arrangements who moved to other facilities in FYs 92 and 93 is shown in Table IV-3. As the table illustrates, most of the clients moving from CLAs were placed in other CLAs, which is expected since the CLA model has been the one most utilized by the department in terms of community residential placements. The next most frequently used placement, when clients moved from CLAs, was supported living arrangements (SLAs), which are residences receiving less than 24-hour staffing support.

Although information is available on the movement of clients living in non-ICF/MR facilities, and where those clients were eventually moved, it is not as complete or readily available as that for ICFs/MR. For example, information such as the date the client was identified as needing a new placement, the reason(s) a new placement was needed, and the number of months between when an alternative placement was recommended and when the move actually occurred, is not centrally kept in a standardized format. Further, even though this information is maintained by individual regions, it is not uniform among regions, nor is it related to cost data. Thus, any attempt at systemwide planning or coordinating of placements, and

relating placement usage to overall costs, is complicated by the lack of a complete utilization review system.

TABLE IV-3. Client Placements from Community Living Arrangements: FY 92 and FY 93.		
New Facility	FY 92 (N=202)	FY 93 (N=213)
CLA	133 (66%)	126 (59%)
SLA	54 (27%)	60 (28%)
Other	15 (7%)	27 (13%)
Source: DMR.		

With a lot of attention given to individual clients being served, the program review committee believes it is easy to lose sight of the broader community residential system, including those clients on waiting lists. A comprehensive UR system needs to determine if clients are either being over- or underserved in terms of supports and programs, and coordinate clients' needs with placements statewide, which the committee believes is presently not being done effectively.

The program review committee, therefore, recommends that DMR establish a utilization review team responsible for examining placement and service usage on a systemwide basis. This team should plan and coordinate client movement to the different types of community residential placement models used by the department. It should focus on issues affecting client movement on a statewide, rather than regional level, yet receive input from regional placement committees and case managers. The team should be comprised of staff currently within the IPR/UR Unit of the Quality Assurance Division.

The committee also recommends that the DMR central office develop a centralized tracking system of client placements statewide, and that placement utilization information be kept in a standardized format from region to region to assist the statewide utilization review team.

The program review committee believes that by establishing a statewide utilization review system, the focus of utilization review will be on the entire community residential system rather than individual clients. It will provide consistency and uniformity for collecting and analyzing the data produced by regions and better coordinate the needs of clients with available placements on a systemwide basis. By working closely with others in the department, the new utilization review system team will enable the department to create alternative placements.

The recommendation made earlier to eliminate ICF/MR certification of homes will free up the personnel who conduct reviews of ICFs/MR to serve on the utilization review team. The current certification and review staff are totally federally funded, however, the loss of federal funds should be offset by the decrease in costs presently incurred with regulating ICFs/MR. Further, the committee believes the department should examine whether utilization review functions meet guidelines for any type of federal reimbursement, such as targeted case management.

The new utilization review process will be augmented through implementation of the committee's recommendation to combine all community residential funding accounts to one residential placement account. Together, these recommendations will strengthen efforts to ensure clients currently in the system are neither being over- or underserved, as well as expand the flexibility of where clients can be appropriately placed.

CASE MANAGEMENT SERVICES

Each client under DMR's care is supposed to be assigned a case manager. Case managers perform a variety of different responsibilities, including: 1) directing, coordinating, and monitoring services for clients from the time they enter the system, until they are discharged; 2) identifying and attaining services to meet clients' needs; 3) ensuring that a client's Overall Plan of Service is developed and reviewed, and carried out by the provider; and 4) providing overall client and family support. For the most part, case managers are the only link between the department and clients living in community residential facilities.

Over the course of this study, questions have been raised as to whether the current system for providing case management is the most efficient system possible. Some people believe case managers have too many responsibilities, and that due to large caseloads, their services have been "spread too thin." The following analysis is directed at this question.

Case managers' caseloads are impacted by the Mansfield consent decree, which stipulates any caseload that includes a class member cannot exceed 40 clients per case manager. Thus, the caseloads of case managers were analyzed with and without Mansfield Training School class members to determine the average number of clients each case manager is responsible for. The results are presented in Table IV-4.

As the table shows, the average number of clients assigned to case managers with at least one Mansfield class member is 47, which is somewhat above the 1:40 limit set by the consent decree. Case managers without class members have an average of 59 clients on their caseloads.

TABLE IV-4. Statewide Comparison of Case Manager Caseloads: As of 12/13/93.

Group	Number of Clients*	Number of Case Managers	Case Manager to Client Ratio
W/ Class Members on Caseload	5,322	112.31	1:47
W/out Class Members on Caseload	4,659	79	1:59
Totals	9,981	191.31	1:52

* Does not include clients living at Southbury Training School.

Source: Analysis of DMR Data.

In order to base these caseloads against some type of standard, literature from The Arc, which is a national organization on mental retardation, was reviewed. Recognizing that a manageable caseload for any case manager is dependent upon many factors, this organization maintains that, in general, good practice is for service coordinators (i.e., case managers) to serve no more than 25-30 individuals.³ Using this as a standard (although arbitrary) against which to base Connecticut's caseloads, the program review committee finds that DMR's case managers, on average, have high numbers of clients on their caseloads.

In addition to large caseloads, the committee finds that not all clients entitled to case management services are receiving these services. Although not noted in Table IV-4, there were 525 more clients throughout the state who did not have case managers assigned to them at the time the data used in the table were compiled.

Given the average caseload sizes for case managers in Connecticut compared to the one supported by The Arc, as well as the number of clients not receiving these services, the program review committee believes case managers cannot perform the myriad of duties and responsibilities they are required to perform to their fullest capacity. In addition, many private providers have told the committee that they have been providing some of the necessary case management services needed by their clients, mainly due to the department's case managers having large caseloads and not being able to serve clients on their caseloads in a timely manner.

³ "Individual Service Coordination for Individuals with Mental Retardation," The Arc, p. 2, Revised July 1992.

The program review committee, therefore, recommends that DMR examine all the services required to be provided by case managers. For those services the department determines private providers can effectively and efficiently administer, it should allow private providers the ability to provide such services.

The program review committee believes case management services can be shared between the department's case managers and private providers without sacrificing the effectiveness or delivery of the service to clients. Private providers work with their clients on a daily basis and should know the needs of these clients. If a client needs a service quickly, and this service would normally be the case manager's responsibility but because of a large caseload cannot be performed in the required time, there is no reason the provider should not be able to provide this service. Shared service provision also offers an added dimension of flexibility advocated for by the entire system. The recommendation also affirms what is actually already occurring.

The Department of Mental Retardation and case managers are fully aware of the issues and problem areas surrounding case management services. For this reason, the two have formed a joint labor/management committee to address these problems. The areas of concern, particularly caseloads and how to attain the 1:40 ratio, are being discussed by local work groups at the regional level. Following their work, which is scheduled to conclude soon, these groups will compile their recommendations and develop guidelines for case management services.

QUALITY ASSURANCE

Quality assurance is an important component of the Department of Mental Retardation's community residential service system. The quality assurance function provides some insurance that care is being given to clients served by both the public and private sectors in the best, safest manner possible. The quality assurance and case management activities currently in place are mainly conducted by DMR staff in both public and private homes.

The Quality Assurance (QA) Division within the Department of Mental Retardation central office is responsible mainly for: licensing and certification of residences; inspections; collecting, maintaining, and reviewing quality assurance data and reports; and conducting the individual professional reviews and utilization reviews of ICF/MR facilities (as described earlier). A description of each of the division's main functions, analysis of QA reports, and findings and recommendations is provided below.

LICENSING AND INSPECTIONS

Before a private agency can operate a residential facility, particularly a community living arrangement, within the state and receive client placements, it must first be licensed by DMR. Since 1988, residences owned by DMR have been required to receive certification before operating. Both licensing and certification are functions of the department's Quality Assurance

Division. According to the division, criteria and standards used for licensing and certification are the same.

Licenses for private providers are issued according to residence type and whether the facility is providing permanent or respite (i.e., temporary) services. Licenses are only issued to a single residence, except for residential schools, condominiums, or apartment complexes where up to five individual sites may be grouped under one license.

Residential facility licenses are not transferable. Further, any structural changes to a residence after it is originally licensed will negate the license. Licensees are required to notify DMR at least 60 days in advance if any structural changes are going to be made to a licensed residence, if the residence is to be sold, or if the provider plans to discontinue operation. In the event of changes in a provider's administration, DMR is to be notified as soon as possible.

License application process. Before a private provider can receive an original license to operate a community residential facility, an application process must be completed. The process includes obtaining a certificate from the local fire marshal, the requirements for which vary substantially depending on whether the residence has more than three occupants. Other criteria include acquiring adequate insurance and ensuring that the proper health inspection reports are obtained. In addition, the licensure process requires providers to furnish DMR with the following information:

- a plan detailing the training that direct contact personnel will complete, prior to the opening of a residence, in areas such as handling food and communicable diseases, signs and symptoms of illness, and emergency procedures;
- assurance that medications will be administered by certified or licensed staff in accordance with applicable laws and regulations; and
- a copy of a financial audit completed within the past year by a licensed or certified public accountant if the provider is an existing corporation.

Community residential facility licenses are renewable annually and a filing fee of \$50 is required for residences housing four or more residents. DMR also requires that licensing packets be submitted by providers at least 30 days prior to the anniversary date of the original license.

License denial or revocation. DMR may, for several reasons, deny applications for an original license as well as renewals for providers who are already licensed and fail to comply with licensing laws or regulations. The department has the ability to require provider compliance, restrict operation of a residence, and deny or revoke a license. Any provider who is denied a license or has a license revoked may request an administrative hearing with the department.

Inspections. Inspections are conducted prior to issuing an original or renewal license or certification for operation of a residential facility. Inspections are usually conducted by one inspector who visits the home to survey whether it is safe and provides adequate living space for the clients. Inspectors also review all records kept at the residence, such as the clients' program plans, medication administration, and staffing schedules. Facility staff are interviewed to determine if they are complying with specified regulations.

An inspection report is to be prepared no later than 15 days after the inspection is completed. The report outlines any discrepancies found during the site visit and whether or not the residence is in compliance with regulations. After reviewing the report, the provider of the facility is responsible for submitting a plan of correction outlining the actions it will take to address any problems within 15 days from receiving the report. Once the plan is accepted by the Quality Assurance Division, a license renewal is granted.

In the past, inspections have been done at initial licensure and annually thereafter for license renewal. Regulations concerning inspections have changed, however. The division now has up to two years to inspect a facility for license renewal. The Quality Assurance Division has five inspectors who have an average yearly caseload of approximately 115 homes. In addition, one part-time inspector inspects about 60 homes a year.

If facilities exceed a certain number (or type) of deficiencies, more frequent inspections may be conducted. Between October 1992 and June 1993, only 5 percent of about 225 full inspections conducted resulted in facilities being licensed on a one-year basis, instead of two years, due to health or safety deficiencies. The licensing/inspection unit is also responsible for tracking facilities with identified deficiencies on a monthly basis, and reporting specific homes not adhering to licensing requirements to regional directors. This enables regions, as well as the unit, to spot possible systematic trends or problems.

During this study, concerns were expressed regarding a possible conflict in having DMR responsible for certifying and inspecting its own facilities. In the examination of community residential facilities, program review staff attended several inspections conducted in both public and private facilities. Overall, no differences were found in the way inspections were conducted in either type of residence. Inspections of private and public homes each lasted a full day, and were conducted in a professional manner by DMR inspectors using the same standards. The inspections included a thorough health and safety check of the homes, as well as detailed reviews of client and provider records. There was also sufficient dialogue with facility staff as to what deficiencies were detected and what needed to be done to correct them in both types of homes.

The program review committee believes there will always be a need for health and safety inspections of community residential facilities. Because the committee finds no difference in the standards used to inspect public and private homes, or their application, the committee believes that DMR should continue to conduct these inspections. The committee also believes inspections can be done on two-year cycles without compromising the integrity of the inspection system.

INCIDENT REPORTS

One of the department's primary quality assurance tools is a self-reporting system. Operators of community residential facilities are responsible for reporting incidents involving clients in the following areas: 1) allegations of abuse or neglect; 2) use of both planned and emergency restraints; 3) accidents and injuries; 4) other incidents such as client behavioral incidents, clients walking away from a facility, and medication errors; and 5) deaths. When a report is received by DMR, the information is entered into the department's automated client information system (CAMRIS). The information is reviewed monthly by the Quality Assurance Division and reports are prepared for the commissioner.

The program review committee believes the self-reporting system currently in place is important for ensuring client and staff safety. The committee finds, however, that there is a wide variation in the number of reports made by residences in each sector. Table IV-5 shows the results of an analysis of incident reports filed by 123 residences sampled by committee staff.

The department compiled FY 92 data for the five QA areas noted above for all residences included in the sample. The data for three components -- abuse and neglect; use of restraints; and other incidents -- were analyzed and compared in terms of public and private residences. The results are displayed in Table IV-5.

TABLE IV-5. Comparison of Quality Assurance Factors Self-Reported by Sampled Public and Private Providers: FY 92.				
Clients in Public Facilities (N=344)			Clients in Private Facilities (N=311)	
QA Category	Number of Incidents or Allegations	Incidents per Client	Number of Incidents or Allegations	Incidents per Client
Abuse/Neglect	27	.07	17	.05
Restraints (all)	915	2.65	263	.84
Emergency Restraint	336	.97	72	.23
Planned Restraint	579	1.68	191	.61
Other Incidents	959	2.78	484	1.55

Source: Analysis of DMR Quality Assurance data.

Even though there were roughly the same total number of clients in the public and private sector homes sampled, the difference in the number of incidents reported between the two sectors is considerable for most categories shown in the table. A significant number of residences reported no incidents in each category while a few reported high occurrences in each component analyzed. The program review committee believes two possible reasons contribute to this variation. First, the system relies on self-reporting of incidents from providers. Since private providers reported substantially fewer total incidents, providers' diligence in reporting incidents may be somewhat lacking.

The other possible factor leading to the difference may be related to the level of difficulty of clients served. Clients in the public sector may have greater challenges than those in the private sector, thus more incidents may occur in public residences. As cited earlier in the report, public facilities sampled served a disproportionate share of difficult clients than private residences.

Caution should be used in reaching conclusions about quality based solely on this analysis. Despite the obvious shortcomings of such a system, however, the committee believes there will always be a need for providers to self-report client incidents. Given that quality assurance staffing resources are finite, there is no possible way to fully monitor every incident in every residence. But, to improve the reliability and integrity of the quality assurance system, providers, whether private or public, need to be consistently reminded of the importance of reporting client incidents.

Because of the gravity of abuse and neglect violations, additional data concerning these allegations are presented in Table IV-6. The table shows the type of abuse or neglect alleged, the alleged perpetrator, and the outcome status.

TABLE IV-6. Type and Disposition of Abuse and Neglect Allegations: FY 92.					
Public Facilities			Private Facilities		
Type of Abuse Alleged	Alleged Perpetrator	Outcome Status	Type of Abuse Alleged	Alleged Perpetrator	Outcome Status
12 Physical	21 DMR	19 Not Substantiated	9 Neglect	16 Provider	13 Not Substantiated
13 Neglect	3 Provider	8 Substantiated	7 Physical	1 Family	5 Substantiated
1 Verbal	3 Unknown	1 No Investigation was completed (One allegation investigated by two agencies)	1 Verbal		(One allegation investigated by 2 agencies)
1 Sexual					

Source: Analysis of DMR Quality Assurance Data.

Based on the information provided in the table, the type of abuse alleged most frequently is "neglect", followed closely by physical abuse allegations. For the second component examined, alleged perpetrator, in public facilities it is DMR, while providers are the most common in private residences. The table also shows that, after investigation, which is almost always conducted internally, most allegations are not substantiated. In fact, in both private and public facilities, the percentage of substantiated cases was identical at slightly less than 30 percent.

OUTCOME-BASED PERFORMANCE MEASURES

Until recently, emphasis in measuring the quality of human services has focused primarily on how well service providers complied with standardized processes and specific regulations in areas such as health, safety, and client behavior. It has been difficult to develop good outcome measures in the human services field for two reasons: first, outcome factors to be measured have not been fully understood; and second, problems occurred with how such outcomes should be measured.

There has been a steady shift, however, away from examining how well service providers adhere to specific processes and regulations, to developing ways of measuring the quality of client achievements. Such measures, known as outcome-based performance measures, are geared towards enhancing the quality of human services.

According to the Accreditation Council on Services for People with Disabilities (ACSPD), which is a national quality enhancement organization in the field of disabilities, outcome-based performance measures should focus on outcomes for people, rather than the organizational processes that contribute to the outcomes.⁴ In its effort to advance such measures, the council has designed specific person-centered outcomes for use by service providers of people with disabilities nationwide. The outcomes formulated by ACSPD emphasize responsiveness to individual needs, and are based on priority outcomes that people with disabilities indicated are most important to them.

The program review committee believes the Department of Mental Retardation recognizes the need of examining client achievements and has made some progress toward achieving this in several ways. First, the department recently set up pilot programs to implement the outcome-based performance measures developed by ACSPD. The measures are being piloted with 49 clients living in all types of community residential facilities throughout the state as well as Southbury Training School.

⁴ *Outcome-based Performance Measures*, The Accreditation Council on Services for People with Disabilities, 1993.

Second, as part of the department's process to review clients' supports (Overall Plan of Service reviews), a written description of a client's preferences and dislikes in several areas is required. A listing of the major accomplishments in the client's life during the last year, programs, activities, or services added or discontinued, as well as a "description of the vision for the person's future" is also required at the reviews.

Third, in its 1994-99 Five Year Plan, the department stresses it will emphasize quality assurance measures that are mission and outcome oriented. The department also notes it will work toward a decrease in "red-tape", simplifying regulations, and increasing its consistency in interpretation and application of standards.

In addition to DMR's attempts at examining outcome-based performance measures, the Purchase of Service Project is currently looking at developing such measures to be used by human service agencies statewide. Similar to those being piloted by DMR, the project's anticipated measures would emphasize client achievements rather than traditional regulatory or activity guidelines.

These combined efforts point to a systemwide move focusing more on outcomes for clients than how well private providers comply with stringent regulations and standards. The committee believes that once implemented, outcome measures are a move in the right direction and will enhance the quality assurance process for all community residential providers.

CHAPTER V

ALCOHOL DETOXIFICATION PROGRAMS

Background. The second program area included in the study scope is an examination of the alcohol detoxification programs operated by Department of Public Health and Addiction Services (formerly operated by the Connecticut Alcohol and Drug Abuse Commission) and those operated by private agencies, but receiving some of their funding through DPHAS. Alcohol detoxification is the first step in the treatment of alcoholism. The client is given medical attention until the client the alcohol withdrawal period is complete, usually from one to three days.

There are four state-operated facilities and three private non-profit agencies that provide alcohol detoxification services. Table V-1 lists the facilities and the number of beds in each facility. As the table indicates, the state-operated facilities account for 88 of the 157 alcohol detoxification beds, or 56 percent, while the private facilities provide 70 beds, or 44 percent. Two additional private programs that receive some state funding -- one in Bridgeport, and one in New Haven -- have recently begun operations, but are not part of this analysis.

TABLE V-1. Number of Beds in State-operated and Private Non-profit Alcohol Detoxification Facilities.	
Funded Private Facilities	Number of Beds
Alcohol and Drug Recovery Centers	35
Rushford	15
Southeastern Council on Alcohol and Drug Dependence	20
Total Private Beds	70 (44%)
State-operated Facilities	Number of Beds
Dutcher	24
Boneski	20
Berkshire Woods	19
Blue Hills Hospital	25*
Total State-Operated Beds	88 (56%)
Total All Facilities	157
<p>* Blue Hills Hospital has 25 funded beds, however, 13 beds were closed due to renovations for most of FY 93. Source: DPHAS Management Information Systems.</p>	

There are other private substance abuse treatment programs in the state that offer alcohol detoxification services, but they do not serve the medically indigent (i.e., where clients have no medical insurance, are not eligible for Medicaid or Medicare, and cannot afford payment themselves). The private non-profit facilities under review receive third-party payment through insurance, Medicare, or General Assistance medical payments from towns. But they also depend on DPHAS for a large part of their funding.

All of the state-operated facilities are accredited by the Joint Commission on Accreditation of Hospitals (JCAH), and one of the private programs, Rushford, is also accredited. The state public health department licenses private alcohol detoxification programs, and also now is responsible for program and fiscal monitoring of all funded private alcohol and drug prevention and treatment programs. (This had been a CADAC function prior to reorganization.) DPHAS has five program monitors who review the operational components and four fiscal monitors who examine financial operations of funded programs and their adherence to their contracts.

ANALYSIS AND FINDINGS

Similar to community residential programs in DMR, making comparisons among private and public alcohol detoxification programs is complicated by a number of factors, including the types of clients served, how the clients are referred or admitted, and bed utilization. The program review committee, however, attempted to compare several aspects of the alcohol detoxification programs, including daily rates, staffing coverage, utilization rates, and clients served.

PROGRAM COSTS OF PROVIDING THE SERVICE

The costs of both the state-operated and state-funded programs are condensed to arrive at a per-diem rate or daily rate for each client based only on the operating costs of the facilities. However, neither the costs of managing contracts nor statewide overhead fees were added as they were in DMR; time did not allow for that in-depth data collection and analysis. Table V-2 shows per diem rates for the alcohol detox facilities examined. Committee staff used only facility operating costs, divided by the number of occupied patient days, to arrive at these rates. This yields a higher per diem rate than would result if the rate were calculated using all available patient days. All data were provided by DPHAS and were not independently verified.

As the table indicates, the daily rate of providing alcohol detoxification services is about 35 percent higher in the public sector than in the private sector facilities. Annualized, the public sector detoxification beds cost about \$26,645 more per year (\$73 per day x 365 days).

TABLE V-2. FY 92 Per Diem Costs of Alcohol Detoxification Facilities.	
Private Facilities	Per-diem rate
SCADD	\$170
Rushford	\$278
ADRC	\$162
Average Private Per-diem Rate	\$203
Public Facilities	Per-diem rate
Blue Hill Hospital	\$284
Boneski	\$256
Berkshire Woods	\$252
Dutcher	\$314
Average Public Per-Diem Rate	\$276
Source: DPHAS and Funded Programs Data.	

Staffing. Because human and health-related services like alcohol and drug treatment are labor intensive, one of the biggest costs is staffing. However, DPHAS does not allocate the costs of staffing its facilities to cost centers or services, like detoxification. But committee staff did obtain staffing schedules and organizational charts that generally allocate staff to particular programs, and those are shown in the Table V-3.

The results in Table V-3 show little variation in the ratio of direct care FTEs per bed in any of the facilities, public or private. In fact, the ratio in the private facilities appears to be slightly higher than in the state-operated programs. The average ratio of FTEs to beds in the public facilities is .72, while in the private non-profits the ratio is .73. There is, however, a major difference in physician coverage between the public and private facilities. None of the private facilities has a physician on staff, instead contracting for a certain number of hours of medical coverage per week. The state facilities provide much more medical coverage. At least one physician is on the detoxification unit during the first shift, while another covers the facility; additional medical coverage is provided through an on-call physician after hours, who is also on-site.

It appears that the state-operated facilities pay higher salaries on average than the private centers, but because there are differences in allocations of salaries to different programs at each facility, and what those programs cover in addition to detox services, the committee cannot state this with certainty.

TABLE V-3. Comparison of Staffing Levels in Detox Programs.

State-operated Detoxification Facilities: FY 93				
Facility	# Detox Beds	Total Direct Care Staff	Direct Care FTEs per Bed	Total Number of Physicians
Dutcher	24	17.4	.72	2 MDs 1 Psychiatrist* 1 MD on-call; on-site after hrs.
Boneski	20	13	.65	2 MDs** 1 Psychiatrist* 1 MD on-call; on-site after hrs.
Berkshire Woods	19	16	.84	1 MD 1 Psychiatrist* 1 MD on-call; on-site after hrs.
Blue Hills	25	17	.68	2 MDs 1 Psychiatrist* 1 MD on call; on-site after hrs.
Privately Operated Detoxification Facilities: FY 92				
Facility	# Detox Beds	Total Direct Care Staff	Direct Care FTEs per Bed	Total Number of Physicians
SCADD	20	12.25	.61	2 MDs on call (total 15 hrs/wk)
Rushford	15	12*	.80	1 MD (14 hours/wk)
ADRC	35	27.8	.79	1 MD on call
* Some of these staff serve patients in other programs, not just the detox unit. ** 1 MD serves as Medical Director covering admissions, detox, and the rehab units.				
Source: Organizational Charts and Staff Schedules from Facilities.				

Use of sick time and workers' compensation. The use of workers' compensation and sick time can contribute to higher overall staffing costs. Employee use of this time at each of the public and private facilities was analyzed and the results are shown in Table V-4.

Table V-4 shows that neither private or public employees lose a great number of days because of workers' compensation claims. Staff in both sectors use more sick days than workers' compensation days. But the private sector staff uses less of both -- one day for every 2.5 days in the public sector.

TABLE V-4. Use of Sick Time and Workers' Compensation by Facility: FY 92.		
Public Facilities		
Facility	Workers' Compensation Lost Days per Employee	Sick Days Used per Employee
Blue Hills	1.44	13.10
Boneski	11.33	13.89
Berkshire Woods	3.51	11.61
Dutcher	7.09	16.69
Private non-profit Facilities		
Facility	Workers' Compensation Lost Days per Employee	Sick Days Used per Employee
ADRC	6.9	6.7
Rushford	0	4.7
SCADD	0	4.2
Source: Data Provided by DPHAS and Individual Private Facilities.		

Types of Clients Served

Admission records. As with the DMR programs, the state-operated facilities indicate they serve more difficult clients. Unlike DMR's client information system, however, there is no similar client database that can readily be accessed to determine the differences in client characteristics and evaluate the acuity of client needs. There are, however, some basic data collected at the time the client is admitted for detox. Completed admission forms are sent to DPHAS and entered on the department's Client Information Collection System (CICS). The aggregated data provide a profile of patient admissions at the state-operated and private facilities. However, the accuracy of the data are disputed by the private providers. (DPHAS admits that the system has expanded its parameters, and not all the flaws have yet been removed.) All three private agencies have automated systems, where client information is entered on-site. None of the state-operated facilities has similar automated records.

The program review committee used the data obtained from the CICS system (with some explanations and caveats) because currently it provides the only systemwide data available. However, because of the questionable reliability of the data, the program review committee recommends that DPHAS improve its automated client information system, so that all facilities public and private are able to input client data on-site.

Data on admissions. As indicated in Table V-5, the private facilities have a higher percentage of readmissions, or recidivist clients, in alcohol detoxification than the public facilities. It is important to note that these readmissions are of total admissions, and not of individual clients, who may account for multiple admissions.

TABLE V-5. Admissions: First-time and Readmits by Facility – FY 93.					
State-operated Facilities					
Facility (# of Beds)	Total Admissions	First-time Admissions	%	Readmissions	%
Blue Hills Hospital (25)	1,396	654	46.8	742	53.1
Boneski (20)	1,423	606	42.6	817	57.4
Berkshire Woods (19)	1,206	499	41.4	707	58.6
Dutcher (24)	1,474	683	46.3	791	53.7
Total (88)	5,499	2,442	44.4	3,057	55.6
Private Non-Profit Facilities					
ADRC (35)	3,541	412	11.6	3,129	88.4
Rushford (15)	1,317	705	53.5	612	46.5
SCADD (20)	1,030	399	38.7	631	61.3
Total (70)	5,888	1,516	25.7	4,372	74.3
Source: DPHAS Client Information System.					

As indicated in the table, while recidivism, or repeat admissions is a problem in both the public sector (55.6 percent) and the private sector (74.3 percent), it is somewhat expected given the type of service offered and the clients served. Clients are not necessarily interested in longer-term treatment that would normally follow the detox period; instead, they often leave detox only to return within weeks. In fact, SCADD kept statistics on repeat admissions and found that during FY 93, 26 individuals had four or more admissions.

One of the major reasons the private facilities receive more repeat admissions is because each of the three serve as the "medical triage" service for a given geographic area. This "medical triage" was established through P.A. 90-209 in an effort to reduce the volume of intoxicated individuals being seen in emergency rooms. Those services include: medical assessment of substance abuse symptoms; determination of the need for treatment; and either provision of treatment at that facility or assistance in obtaining appropriate treatment. Ambulances, police, and other providers who come in contact with intoxicated persons, now may take clients to these sites first for treatment or referral. Clients are admitted at that facility under most circumstances. The public facilities, on the other hand, take referrals from the private facilities if clients cannot be treated there.

Emergency commitments. In addition to referrals from "triage facilities", public facilities also take patients under an emergency commitment while private facilities do not. By statute (C.G.S. Sec. 17a-626) an intoxicated individual who: 1) is a danger to himself or others unless committed; 2) needs medical treatment for detoxification for potentially life threatening symptoms of withdrawal from alcohol or drugs; or 3) is incapacitated from alcohol, may be committed for emergency treatment not to exceed five days, if a certificate declaring the need for such treatment is signed by a physician.

The statute would allow private facilities to admit clients under these emergency commitments if they were approved by DPHAS to do that, but currently none are approved. One of the reasons cited is that public facilities have locked units to detain these patients, while private facilities do not. Thus, one of the primary differences in the type of client served in public facilities is the involuntary client, one who is admitted on a physician's emergency certificate (PEC), a form signed by a physician.

The use of commitments through the PEC appears to vary depending upon the area and the referring hospital. The following two tables show data on PEC admissions. Table V-6 shows the percentage of PEC admissions of all admissions for each state-operated facility, and Table V-7 indicates the top five general hospitals issuing PECs in the state. (It should be noted that the data provided by DPHAS on PECs showed somewhat different admission totals than those used in Table V-5.)

TABLE V-6. PEC Admissions by Facility – FY 93.		
Facility	Number of PEC Admissions	PECs as % of Total Admissions
Blue Hills	424	24.4%
Boneski	851	56%
Berkshire Woods	393	26.5%
Dutcher	958	62.6%

Source: DPHAS Data.

The results of Table V-6 show that more than 60 percent of the admissions at Dutcher Treatment Center are generated through PECs, which means that most clients were first brought to a general hospital. These results are linked to the hospital usage data shown in Table V-7, which shows the top five hospitals generate more than 56 percent of the PECs statewide. Three of those hospitals -- Middlesex, Yale-New Haven, and Veteran's Memorial -- that issue one-third of all PECs in the entire state and use the Dutcher treatment facility in Middletown. This may explain why Dutcher had the highest number of admissions among public facilities in FY 93.

TABLE V-7. Statewide Use of PECs by Hospitals -- FY 93	
General Hospital	Percent of PECs Generated
Middlesex Memorial -- Middletown	21.87%
Lawrence and Memorial Hospital -- New London	13.29%
Norwalk Hospital -- Norwalk	9.77%
Veteran's Memorial -- Meriden	5.98%
Yale-New Haven -- New Haven	5.64%
Source: DPHAS Data.	

The results of the analysis raise questions about why PEC clients comprise such a high portion of the overall admissions at Dutcher and Boneski. The data indicate more than half of the clients admitted to these two facilities were brought to hospitals first to have a PEC signed. Thus, it appears one of the goals of the legislation passed in 1990 (P.A. 90-209), to lessen the involvement of hospital emergency rooms in seeing intoxicated individuals, is not being met in some areas of the state.

The committee cannot say conclusively why there is such variation in the use of PECs, depending on the area of the state and the referring hospitals. Explanations may be that law enforcement officials and ambulance personnel are continuing to bring intoxicated individuals to hospitals despite the change in the law, or it may be that those state-operated facilities like Boneski and Dutcher make it difficult to admit a client without a PEC, as some private providers claim.

Utilization. Admission statistics show that private providers admit about 7 percent more clients than the state-operated facilities, even though the public programs have about 25 percent more beds. The program review committee attempted to analyze whether this was due to lower utilization among the state-operated facilities. The data for utilization is calculated using the

number of admissions multiplied by the average length of stay, which equals used patient days. Then the used patient days are divided into the total available patient days (bed capacity x 365 days). The data on average length of stay may be somewhat questionable because they are produced by CICS, although the data below do compare closely with those kept by the private facilities on their own systems. Table V-8 provides the result of patient utilization analysis.

TABLE V-8. A Comparison of Utilization: FY 93.					
Facility	Available Patient Days	Admissions	Average Length of Stay	Used Patient Days	Utilization Rate
State-Operated Programs					
Blue Hills*	5,979	1,396	3.8	5,305	88.72%
Boneski	7,300	1,423	4.0	5,692	77.97%
Berkshire Woods	6,935	1,206	4.8	5,789	83.47%
Dutcher	8,760	1,474	5.3	7,812	89.17%
Total	28,974	5,499	4.5*	24,598	84.89%
Private non-profit facilities					
ADRC	12,775	3,541	3.4	12,039	94.23%
Rushford	5,475	1,317	2.8	3,688	67.36%
SCADD	7,300	1,030	6.5	6,695	91.71%
Total	25,550	5,888	3.8**	22,422	87.75%
<p>* Blue Hills normally has 25 beds, but 13 of those were closed for renovation during FY 93, resulting in 5,979 available patient days rather than 9,125 days.</p> <p>** Weighted Average</p>					
Source: Data from CICS System.					

Table V-8 shows that private facilities have a higher average utilization rate than public facilities. Despite clients in private facilities having shorter lengths of stay, on average, those facilities admit more clients resulting in the higher utilization. One reason for the longer length of stay in state-operated facilities may be due clients admitted on PECs, as previously discussed. The PEC allows up to five days of commitment in detox, which may impact the overall length-of-stay statistics in state-operated facilities.

The other reason contributing to different utilization rates between the two sectors is that state-operated facilities indicate they admit clients who need detoxification primarily from substances other than alcohol, while the private facilities primarily take persons primarily requiring alcohol detoxification. Table V-9 below shows data on which **primary** substance the client was admitted for detox, since all treatment centers indicate a great majority of their clients abuse multiple substances.

TABLE V-9. Primary Substance Requiring Detoxification by Facility: Percent of Admissions FY 93.				
Public Facilities				
Facility	Alcohol	Heroin	Cocaine	Other
Blue Hills	44%	43.5%	10.9%	1.6%
Boneski	74.3%	19.9%	3.3%	2.5%
Berkshire Woods	39%	46.3%	12.8%	1.9%
Dutcher	66.2%	19.3%	13.2%	1.3%
Private Facilities				
ADRC	100%	0	0	0
Rushford	69.3%	17.5%	11.4%	1.8%
SCADD	96%	1.9%	1.7%	.4%
Source: DPHAS FY 93 CICS Admissions Data.				

The results in Table V-9 indicate that the state-operated facilities do admit a higher percentage of clients requiring detoxification from substances other than alcohol. According to DPHAS data, approximately 45 percent of admissions to state-operated facilities require detoxification from cocaine, heroin or another substance other than alcohol, while only 12 percent of admissions to the private facilities require detoxification primarily from drugs.

Thus, the higher number of admissions requiring detoxification primarily from drugs and not alcohol, and the volume of PECs at some of the state-operated facilities, may somewhat explain clients' longer length of stay there, but not the lower average utilization rate or higher costs.

CHAPTER VI

MENTAL HEALTH CASE MANAGEMENT SERVICES

BACKGROUND

The final program component examined in this study is case management services within the Department of Mental Health. DMH case management provides a person with psychiatric disabilities the services needed to stay in the community instead of hospitalization. Those services include: assessing the client's needs and developing a service plan to meet those needs; periodically checking the individual's progress and monitoring the impact of services; and serving as the client's advocate.

The manner in which case management services are delivered varies tremendously, depending on the particular program model and the clients being served. The services provided can be geared to the homeless or to another specific population. Another case management model, known as Assertive Community Treatment (ACT) teams, includes an on-call psychiatrist, a nurse, and a social worker, and offers intensive case management as well as treatment to keep the person functioning in the community.

Clients must be poor or medically indigent, and their mental illness must be of a serious and long-term nature, to be eligible for DMH case management services. Most of the clients receiving services have been hospitalized recently for psychiatric treatment at a general hospital or a state hospital.

PROVIDERS

Statewide in FY 93, more than 7,600 clients received mental health case management services through 57 different programs. Table VI-1 provides program and client statistics statewide.

TABLE VI-1. Profile of Provision of Services Statewide: FY 93.			
Provider Sector (# of Providers)	Number of Programs	Number of Clients (%)	Average Number of Clients per Program
Private (28)	43	5,123 (67%)	119
DMH-operated (7)	14	2,505 (33%)	179
Total	57	7,628	149

Source: DMH Data.

As the table indicates, DMH-operated programs serve only 33 percent of clients statewide, but because DMH operates only 14 programs, each of the programs serve about 50 percent more clients than private organizations.

The total amount allocated by DMH to all case management services in FY 93 was \$14,347,599. Private providers supplemented that funding through small amounts from third-party payments or other grants. DMH receives 50 percent federal reimbursement under a Medicaid waiver for expenditures on case management, whether provided by DMH or privately.

PROGRAM STATISTICS

Table VI-2, on the following page, provides a breakdown of DMH-operated and privately provided case management services by region. Total program funding for private providers listed in the table includes funds allocated in each region by DMH as well as amounts from third party payors, or other grants. The total number of clients served and the total staff hours spent providing the service are also shown in the table. Program review staff calculated the cost of providing those services -- per staff hour and per individual client -- from the total program costs and program data. The ratios are also indicated in the table.

The data in the table indicate a wide variation in all variables between public and private sectors, but also among providers in each sector. Obviously, some of the differences in total client numbers and total dollars spent in a region are related to the region's size and population. For example, Region IV covers Hartford and Region II covers both the New Haven and Middletown areas, and includes both Connecticut Valley Hospital clients as well as the Connecticut Mental Health Center. Statewide, the average cost to provide mental health case management services is less expensive in the private sector than in DMH programs, but that is not consistent among all regions. For example DMH case management services in Region IV are provided less expensively per client, than by private providers in four of the five regions.

Similarly, there is a great disparity in dollars spent per staff hour, and correspondingly, the hours spent per client, according to DMH data. In almost every region though, DMH consistently show that its programs devote more hours per client than private providers -- statewide, DMH clients received about one third more staff hours. This may be linked to the type of client DMH serves.

It is agreed by all service providers that clients served by the ACT teams require the most intense case management services. However, two key pieces of information -- the costs for services and the number of clients served by ACT teams -- are not broken out for those DMH programs. Both private programs and DMH operate ACT teams, but the financial and program statistics are not segregated for DMH's own programs. If the information were segregated, it would help relate costs to type of client served, and facilitate comparison of services in the two sectors. Again, state agencies lag behind their private sector counterparts in developing cost-centered accounting. **Thus, the program review committee repeats the recommendation on page 73 concerning financial management systems for the Department**

of **Mental Health**. Without such financial management systems, there is no way to link costs to actual cost centers or services performed.

TABLE VI-2. DMH Case Management Services: FY 93 Program Measures.						
Providers by Region (# Providers)	Total Clients	Total Staff Hours	Hours per client	Total Program \$	\$ per Staff Hour	\$ per client
Private Providers						
Region I Private Providers (4)	454	13,174	29.0	\$1,054,782	\$80	\$2,323
Region II Private Providers (8)	2,142	39,352	18.3	\$2,635,262	\$67	\$1,230
Region III Private Providers (4)	725	29,778	41.0	\$1,564,970	\$53	\$2,158
Region IV Private Providers (7)	940	26,887	28.6	\$2,141,230	\$80	\$2,277
Region V Private Providers (5)	862	11,805	13.7	\$1,915,715	\$163*	\$2,222*
Private Provider Totals (28)	5,123	120,996	23.6	\$9,311,959	\$77	\$1,818
DMH Providers						
Region I DMH-operated (2)	425	18,673	43.9	\$1,677,580	\$89	\$3,947
Region II DMH-operated (2)	544	29,727	54.6	\$1,152,755	\$39	\$2,119
Region III DMH-operated (1)	282	13,576	48.1	\$1,297,167	\$96	\$4,600
Region IV DMH-operated (1)	958	17,335	18	\$1,798,323	\$104	\$1,877
Region V DMH-operated (1)	296	11,885	40	\$863,854	\$73	\$2,918
DMH Provider Total (7)	2,505	91,196	36.4	\$6,789,679	\$74	\$2,710
<p>* In addition to DMH funding, one of the private providers in Region 5 receives a large grant, for which the staffing hours are not accounted, thus increasing the total increasing the hourly rate for this region</p> <p>Source: DMH Data on Case Management Funds</p>						

QUALITY ASSURANCE STANDARDS

Until recently, there was no statewide effort to uniformly measure or evaluate public or private mental health programs. As part of the grant process, some Regional Mental Health Boards (RMHB) conducted evaluations of funded programs, but the efforts were inconsistent among regions. As well, DMH also reviewed fiscal, and to a lesser extent, program components, related to the contracts with private agencies. However, efforts at establishing, monitoring, and evaluating standards were not done consistently or uniformly.

During the past year, DMH has developed quality assurance standards for most of the programs it operates or funds, including case management services. The standards include client outcomes as well as program structure and process. DMH is only beginning to pilot these standards to assess interpretation and data collection efforts. Thus no results are available yet.

APPENDICES

APPENDIX A

METHODOLOGY FOR COST ALLOCATIONS

Throughout this cost allocation exercise, every attempt was made to allocate costs the same way for the privates and the publics. Where different methodologies had to be employed, program review notes the different method. Also, in all but a few cases, FY 92 cost data were used. For the private sector, those costs were obtained from the ACOR, and for the public homes, from a variety of different sources. In a few cases, the DMR-operated residences we chose in our sample had opened sometime after the beginning of FY 92, or where FY 92 costs could just not be gotten, we used FY 93 data. FY 93 data were also used for management services costs in DMR. In discussions with DMR fiscal staff, we determined that later year management services costs were more accurate, because the FY 93 figures reflected the department's efforts to more accurately align staffing and costs to the programs incurring them, with the remaining costs appropriately placed in management services.

Contract management costs. For DMR's management of private provider contracts, that program review staff allocated to the privates -- committee staff took the costs that we view as associated with the monitoring of programs, the management of contracts, and business services likes accounts payable and attendant personnel cost. To get at those costs, we took: 1/4 of Regional Director's salary (typically the organizational charts have the Regional Director overseeing four main components); 1/2 of the fiscal administrative manager's salary along with 1/2 of all staff in business services; 2/3 of the salaries of positions identified with contract management (assuming that CLA residential services are about 2/3 of the total DMR contract dollars); 1/2 of the Assistant Regional Director for Residential Services (if the Region had that position existed) and averaged out over all the regions = \$317,804.20. To get a statewide total that was multiplied by 6 = \$1,906,824.

To allocate the costs of overseeing the private provider operations at DMR's Central Office, program review designated the staffing costs of the following sections of Financial Management: 1/2 of Revenue Development; 1/2 of Financial Management; 1/2 of Audit/Fiscal Reporting; and all of the OP/Plan and ACOR. None of Facilities Management or the Business Office at Central Office were included. This equalled a central office cost to allocate to the privates of \$326,786. This was added to the \$1,906,824 million above to get a cost of \$2,233,610. Program review staff then divided that by the number of clients being served in private CLAs and ICFs/MR (2,467) = \$905.00 per resident. To arrive at a residential cost for a CLA, this was multiplied by the number of clients in the home.

Administrative and general costs. To get a total A&G (i.e., administrative overhead) cost for the agency, committee staff took the personal services costs (salaries, overtime, longevity) figures that DMR furnished for Management Services for the Central Office and all of the regions. Program Review subtracted from this the salaries (\$91,422) -- which were

obtained by taking the mid-salary level for each job classification from the personnel classification manual -- of all the Support 2 personnel (i.e maintainers, craftworkers, food

service workers, and the like), which are typically budgeted in Management Services, because we allocate those costs later to particular residences (as the private providers do). With those costs extracted, management services includes both management (MP classes) and any clerical, accounting, business or personnel staffing functions.

The average regional costs allocated for private contract management that we cited above identified above (\$326,786). Finally, we also subtracted the salaries of the Quality Assurance staff that are included in DMR's budget (\$797,651), because we apportioned that to individual residences as well. Thus, central office A&G was $\$4,335,890 - (\$91,350 + \$326,786 + \$797,651) = \$3,120,103$ for personnel costs. The same procedures and sources were used to calculate A&G costs for the regions -- $\$11,852,545 - (\$3,641,286 (\text{support 2}) + \$1,906,824 (\text{services for privates})) = \$6,304,435$. This figure, plus the central office personnel costs = $\$9,424,538$ and is the amount used for total management salaries for the public homes. To get a total A&G cost, this personnel cost of $\$9,424,538$ was then multiplied by 33.56 percent for fringe benefits ($\$3,162,875$) and the "other expenses" (like rents for regional and central office, travel, telephone, etc.,) allocated for management services $\$5,453,303$ -- these figures were also obtained from DMR Fiscal Services -- were added. This results in a total A&G cost for DMR of $\$18,040,716$.

To get a residential cost of A&G, staff used the private A&G per-residence costs reported in the ACOR, and used the same methods employed in the ACOR to calculate the A&G costs for DMR-operated homes in the sample. Basically, this method aggregates all the costs to run a particular residence, the room and board and property costs, plus an allocated amount for employee benefits, then calculates that total amount as a percentage of all the operating costs of the agency and applies that same ratio to the total A&G costs of the agency to arrive at an A&G cost for each residence.

To calculate agency operating costs of DMR, program review staff aggregated all personnel costs x 33.56 for fringe; plus the other expenses. Not included was any funding to other providers. DMR's total operating costs including fringe, was calculated to be $\$306,228,665$. The total costs of each of the DMR residences were summed and divided into the entire agency cost to get a ratio. Then that same percentage was calculated of the DMR entire A&G costs, to arrive at an A&G costs per home. A&G as a percent of direct care was determined by taking the residential A&G costs arrived at above as a percentage of the direct care costs of the residence.

The staffing that comprises management and support services was also examined. Management Full time equivalents (FTEs) for the public are the classifications within the Department that are the Management/Professional (MP) classes at either the regional or central offices; Southbury management is not included. "Other" are the classifications that program review identified as Support 2 staff -- like maintainers, skilled tradesman and the like. Again,

this number provides a department total excluding Southbury. Finally, the Support 1 or clerical includes all the administrative and clerical staff that are not managers and are in the central or regional offices.

Additional Administrative and General Costs

The DMR contract management figure was calculated as described on page 1, and then allocated only to clients living in **private** residential settings. The total contract management amount for a residence was the annual cost per client (\$905) x number of clients in that home. There are other costs that are incurred with public funds that provide services to private residences that also have to be allocated. Those services include case management, DMR health care services, quality assurance, and rate setting.

Case management. DMR professional time sheets were used to determine where case managers spend their time. The same percentage of time that was spent in a category of residence was then divided into the total DMR case management budget; the resulting figure was then divided by the total number of clients in that type of residential setting (e.g., private CLA or State ICF/MR) to get a per-client cost for case management. This was multiplied by the number of residents in the home to get a cost for the residence.

The department's Quality Assurance cost allocation was done by taking DMR total expenses of Quality Assurance (without the contracted amount that DSS pays DMR to do ICF/MR QA, and not including fringe) and dividing that by the total number of private and public CLAs to get a figure of \$1,561 per home. For ICFs/MR, the contract amount that DSS pays DMR to conduct reviews in ICFs/MR was divided by the total number of private and public ICFs/MR to get a residential cost of \$5,115. The ICFs/MR also need to be certified by the DPHAS. To get those DOHS certification expenses for ICFs/MR, program review staff obtained from DPHAS the costs to that department to conduct ICF/MR certification, and that figure was divided by the total number of ICFs/MR to get a cost per residence.

Rate-setting. Another cost associated with ICF/MR is the expense of collecting the cost data and calculating the rates, which is done via a personal services contract with Ernst and Young accounting firm. The contract is a three-year contract so program review annualized the cost and then divided that by the total number of nursing homes and ICFs/MR that there are in the state to get the per-home rate-calculation cost. There is also a rate review function for both ICFs/MR and CLAs that occurs at DSS. DSS Personnel supplied the salaries (without fringe) of that division within DSS. Since that division conducts a wide variety of rate reviews, program review staff asked the rate review personnel how much time they spend doing rate review functions for residences serving mentally retarded (ICF/MR and non ICF/MR). Based on those time estimates, we took that percentage of the salary costs to get a total rate review cost for ICF and non ICF/MR. These two respective amounts were divided by the total number of CLAs and the total number of ICFs/MR to get a rate-setting cost for each type of residence.

Statewide cost allocation program. The Statewide Cost Allocation Program (SWCAP) is a program employed by the state, through the Office of the Comptroller, to designate state allowable overhead costs to different agencies. This allocation is done for reimbursement purposes, most often from the federal government. For the committee's study purposes, the SWCAP was calculated by taking the total SWCAP amount that the Comptroller allocated to DMR for 17 different support services. The costs that were allocated to support Southbury and Mansfield were excluded, as well as the DMR parent account (which was very small). The costs for the insurance purchased by the State Insurance Purchasing Board as well as the payments in lieu of taxes were excluded here, and these costs were allocated separately to DMR homes. Program review staff then made judgements about whether any of the support costs should be allocated to the private homes as well as the public homes. Staff determined that a portion of four support costs, which are allocated to DMR through SWCAP, should be allocated to the privates -- 1/2 of the State Treasurer's costs, 1/3 of the Comptroller's costs; 1/2 of the Bureau of Collections, and 1/2 of the Attorney General's costs. The basis for the decision on what to include was admittedly subjective, based on general notions, and discussions with the Comptroller's staff about allocation methodologies, of what services, and how much, these support agencies provide to private agencies. The total SWCAP amount allocated to the privates was then divided by the number of day and residential clients served in private programs, resulting in a per-client SWCAP cost in the private sector of \$214.

The remainder of all the SWCAP costs was allocated to the public homes; that was then divided by the number of residential and day clients served in DMR-operated programs to arrive at a per-client SWCAP cost of \$776. Committee staff recognizes there is double-counting occurring in the day and residential programs, however that seemed less problematic than to apportion all the state overhead costs to residential programs, or to residential clients.

Provider benefits. The total cost of provider benefits for DMR was calculated by taking the FY 92 actual amount for all personal services in the department and multiplying that by 33.56 percent. (This is the 45.46 percent figure the Comptroller's Office uses for fringe minus the 12 percent used for the unfunded pension liability.)

The benefit costs for the residence is the total direct care staffing costs x the 33.56 percent. The number of paid holidays, vacation and sick days, are taken from the employee contract. The number of sick days used is taken from the department's report on use of Sick Time and Workers' Compensation.

Staff turnover is a simplified turnover rate that indicates how many times positions became vacant as a percentage of the total number of staff positions. The data for this measure for the private homes is contained in the ACOR. For the public homes, program review calculated the turnover rate in the same manner using computerized data of all separations during calendar year 1992, provided by DMR's personnel office.

Staffing and Direct Care Costs

Direct care costs and full-time equivalent positions were obtained from personal services cost accounts furnished by the department for each of the residences in the sample. This figure includes salaries, overtime costs, longevity payments and the like. Overtime costs are also indicated separately, but are not double-counted in the overall costs. The number of FTEs are calculated from the staff roster or staff schedule from each home, which gives the positions and percentage of FTEs those positions are. If the position was indicated as vacant it was not counted. The overtime hours divided by 1,820 (hours = FTE) were then added to the FTE count from the schedule, for a total FTE count for each residence. If overtime hours were not available; program review took the overtime costs, and divided by \$15. an hour, divided by 1,820 hours to arrive at the overtime FTEs. This total FTEs was then divided by the number of beds licensed (the same as clients served) to get an FTE per client. (Two cautionary notes: The staff schedules and rosters were current as of the summer of 1993, while the costs were, with a few exceptions, FY 92 costs; thus the two pieces of data are not exactly a match, but the best available. The second note is that program review staff always used the number of beds for which the residence was licensed. To the extent that the number of clients actually differ from the number licensed, the costs and the FTEs will not reflect the true figures. However, a few homes are over the number licensed, and a few are under the number, so overall, the costs and FTEs per bed should be balanced. Further, the number of beds occupied is a more erratic figure, and may not be as closely tied with the staffing and costs of a residence as the beds licensed.) Weekly staffing coverage for each shift was obtained by counting the hours on each shift worked by from the schedules supplied by that residence.

Total costs for support staff were arrived at by taking all the classifications for the Support 2 identified above (maintainers, skilled craftworkers, cooks etc) and assigning the mid-level salary range from the classification manual, and aggregating these cost for all regions and central office (which had only three such positions). Southbury's support staff was not included. The total amount for Support 2 may be somewhat understated because this figure accounts only for straight salaries, and does not include overtime, longevity, or shift differentials, and the like. The FTEs were allocated on a residential basis by first taking the total FTEs, and dividing by the number of residential clients served in DMR-operated homes or regional centers (but excluding Southbury). This translated to a per-client FTE, which was multiplied by the number of residents in that CLA, to get FTEs for the residence. Average salary was simply total salaries for Support 2 personnel divided by total FTEs in Support 2.

Health Care Costs

Health care costs were determined by taking time allocations for DMR health care staff spent in different types of residential settings, as indicated on professional time sheets from DMR. Those same percentages were then taken of the total cost of DMR specialized supports and health services costs for FY 92. The resulting DMR health care cost designated for that type of residence was then divided by the total number of clients living in that category of

residence (i.e. state CLA, private ICF/MR, etc.) to arrive at a per client cost. To get a residential cost, the per-client cost was multiplied by the number of residents in the home.

The DMR health care services for which DMR contracts, were also allocated. The contract amounts for different types of services and where those services were provided were provided by each of the DMR regional offices. From that cost and service information, program review staff apportioned these contracted health care costs on a per-client basis to clients in DMR residences in each of the regions. (None of these costs were allocated to clients in private settings, as they were negligible).

The costs for Title XIX (Medicaid) were for community health care expenses (and not the costs of residential program services which are also covered by Medicaid for most homes). The Medicaid costs for health care are for federal fiscal year 1992, and were obtained by DMR from the Medicaid payment database that DSS contracts Electronic Data Systems (EDS) to operate. The costs are split between those clients in ICF/MR homes and those in the CLAs that have Medicaid waivers (almost all of the CLAs are in the waiver). The Medicaid costs for clients in an ICF/MR was \$2,086, while the costs for those clients in non-ICF/MR residential settings was \$3,185.

Room and Board Costs

The additional costs associated with operating a particular residence are typically what are considered "other expenses" in the public sector. They include food, utilities, rent, repairs, property taxes, and insurance. For the private sector residences, these costs were taken from ACOR for each residence. Most of the cost information for the sampled public homes was obtained from the DMR regional offices' accounting systems. Where certain pieces of cost data were missing from that system, the regional offices, or the residences themselves, provided them. Basically, these "other expenses" aggregated form the room and board costs that DSS approves for the private CLAs. To get a similar room and board cost for the public homes, these same costs were aggregated via the computer.

To arrive at a fair rent value for homes DMR had purchased, program review staff amortized the total purchase costs for the homes (assuming a 6.5% interest rate on state bonds) over 30 years, which yielded an average annual cost for those purchased homes of \$12,861.

APPENDIX B

DMR SAMPLE: OVERALL PROFILE

COMMUNITY RESIDENTIAL SERVICES: AVERAGE FIGURES FOR FY 92

GENERAL PROFILE

Residences Sampled: 50

CLAs Sampled: 33 ICFs/MR Sampled: 17

Funded Beds Sampled: 293

CONTRACT/ROOM & BOARD

Dietary: \$10,787 Repairs: \$3,186

Utilities: \$6,210 Laundry: \$444

DEVELOPMENT

Purchase Price: \$169,576 Real Estate Tax: \$1,603 Fair Rent Value: \$15,688

ADMINISTRATIVE & GENERAL

A&G Costs: \$18,074,716 A&G as % of Direct Care: 9%

Salaries: \$9,424,538 Management FTEs: 124 Support 1 FTEs : 246

Other FTEs: 194 Residence A&G Cost: \$27,790

ADDITIONAL ADMINISTRATIVE & GENERAL

DMR Case Management \$5,776

DMR Quality Assurance \$1,561 (ICF/MR) \$5,115 (Non ICF/MR)

DIM Rate-Setting \$88 (ICF/MR) \$71 (Non ICF/MR) SWCAP \$5,432

Ernst/Young (ICF/MR Only) \$3,556 DOHS (ICF/MR Only) \$6,101

BENEFITS

Cost of Provider Benefits: \$64,563,869 Cost Center Benefits \$102,919

Paid Holidays: 12 Paid Vacation Days: 12-15 Paid Sick Days: 15

Pension: YES Health Insurance: YES Dental Insurance: YES

DIRECT CARE STAFF

Total Direct Care Staff Cost: \$307,080

Average Salary for Direct Care Staff: \$28,959

Direct Care FTEs: 11.1 Direct Care FTEs Per Bed: 2.1

1st Shift Coverage (Hours): 113.9 2nd Shift Coverage (Hours): 145.8

3rd Shift Coverage (Hours): 71.6

SUPPORT 2 STAFF

Total Average Cost for Support 2 Staff: \$33,558

Salary for Support 2 Staff: \$18,725 Support 2 FTEs: .81

HEALTH CARE

Total Cost for Health Care: \$46,269

RESIDENCE OPERATIONS

Other Expenses: \$2,681 Transportation: \$6,365

Total Workdays Lost per Home as a Result of Workers' Compensation Incidents: 20.6

Hours in Work Week: 35 Simplified Turnover Rate: 4.9%

Sick Days Used per Home: 13.5

Overtime Hours Worked per Home: 3,772 Overtime Costs per Home: \$59,789

- Average Cost for Private Residences Sampled = \$547,601
- Average Per Client Cost for All Private Residences Sampled = \$93,447

APPENDIX C

PRIVATE PROVIDERS SAMPLE: OVERALL PROFILE

COMMUNITY RESIDENTIAL SERVICES: AVERAGE FIGURES FOR FY 92

GENERAL PROFILE

Residences Sampled: 57

Providers Sampled: 38

CLAs Sampled: 52 ICFs/MR Sampled: 5

Funded Beds Sampled: 287

Unionized Providers Sampled: 9 Unionized Residences Sampled: 23

Unionized Beds Sampled: 106

CONTRACT/ROOM & BOARD

DMR Contract: \$248,898 DMR Per Diem: \$153.31

DIM Room & Board: \$31,659 DIM Room & Board Per Diem: \$46.23

Dietary: \$10,788 Housekeeping: \$1,454 Repairs: \$5,610

Utilities: \$4,892 Laundry: \$43

DEVELOPMENT

Developers: 8

Purchase Price: \$192,776 Cost of Renovation: \$71,784

Real Estate Tax: \$2,563 Fair Rent Value: \$31,363

ADMINISTRATIVE & GENERAL

A&G Costs: \$956,030 A&G as % of Direct Care: 29.1

Salaries: \$499,045 Executive Director's Salary \$64,173

Management FTEs: 3.6 Support 1 FTEs : 5.6 Other FTEs: 5.1

Residence A&G Cost: \$48,690

ADDITIONAL ADMINISTRATIVE & GENERAL

DMR Case Management \$3,352 DMR Contract Management \$3,690

DMR Quality Assurance \$5,115 (ICF/MR) \$1,561 (Non ICF/MR)

DIM Rate-Setting \$88 (ICF/MR) \$71 (Non ICF/MR) SWCAP \$1,031

Ernst/Young (ICF/MR Only) \$4,476 DOHS (ICF/MR Only) \$6,101

BENEFITS

Cost of Provider Benefits: \$1,071,826 Cost Center Benefits \$34,811

Paid Holidays: 9.8 Paid Vacation Days: 12.1 Paid Sick Days: 9.5

Pension: 26% YES 74% NO Health Insurance: 98% YES 2% NO

Health Insurance Costs by Provider: \$418,295

Dental Insurance: 35% YES 65% NO

DIRECT CARE STAFF

Total Direct Care Staff Cost: \$166,119

Average Salary for Direct Care Staff: \$22,585

Direct Care FTEs: 7.3 Direct Care FTEs Per Bed: 1.5

1st Shift Coverage (Hours): 81.3 2nd Shift Coverage (Hours): 104.5

3rd Shift Coverage (Hours): 67.6

SUPPORT 2 STAFF

Total Average Cost for Support 2 Staff: \$12,178

Salary for Support 2 Staff: \$22,367 Support 2 FTEs: .04

TEMPORARY/NON HEALTH CARE CONTRACTED STAFF

Total Cost for Temporary Staff: \$765

HEALTH CARE

Total Cost for Health Care: \$27,714

RESIDENCE OPERATIONS

Other Expenses: \$171,805 (ICF/MR) \$3,913 (Non ICF/MR)

Transportation: N/A (ICF/MR) \$10,401 (Non ICF/MR)

Workers' Comp. Insurance: \$104,239

Workers' Comp. Incidents per Home: 1.33

Total Workdays Lost per Home
as a Result of Workers' Compensation Incidents: 19.2

Hours in Work Week: 39.4 Simplified Turnover Rate: 23.9%

Sick Days Used per Home: 29.9

Overtime Hours Worked per Home: 378 Overtime Costs per Home: \$4,618

Employee Pays Portion of Health Insurance Costs: Yes 66% No 47%

Percent Paid: 17.3%

Health Insurance Coverage Includes Dependents: Yes 53% No 47%

Employees Pay Portion of Health Insurance Costs for Dependents: Yes 94% No 6%
Percent Paid: 73.9%

- Average Cost for Private Residences Sampled = \$387,773
- Average Per Client Cost for All Private Residences Sampled = \$77,007

APPENDIX D
AGENCY RESPONSE



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH

March 23, 1994

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

Dear Mr. Nauer:

Thank you for the opportunity to comment on the recommendation included in the Committee's report on Public/Private Provision of Selected Services in Connecticut. I appreciate the amount of time and effort your staff devoted to reviewing public and private case management programs which are funded or operated by the Department of Mental Health.

As noted in the report, we have spent the past year developing performance measures for all DMH funded or operated programs. Related to that effort and the Purchase of Service Project, contracts for SFY 1995 will include client-oriented outcome measures as well as activity measures. This will improve the Department's ability to monitor and evaluate the services provided to adults with serious mental illness.

The report recommends that DMH begin designing and implementing a financial management system based on cost centers. This would provide us with comparable information for contracted and DMH-operated services. DMH concurs with this recommendation and began such an effort with a restructuring of the DMH Uniform Chart of Accounts and implementation of a General Ledger Module of our MIS system. We will continue these efforts.

Thank you again for the opportunity to respond.

Sincerely,

A handwritten signature in cursive script, reading "Albert J. Solnit".

Albert J. Solnit, M.D.
Commissioner

AJS:HTC:mo

