

Staff Findings  
and Recommendations

Provision of Selected  
Services for Clients with  
Intellectual Disabilities

December 20, 2011

Legislative Program Review  
& Investigations Committee

**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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# Introduction

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

Connecticut is one of 18 states that operate a dual system of public and private provision of community residential services. The department provides 24-hour residential services at the Southbury Training School (STS), five of the eight regional centers, and 70 community living arrangements (CLAs). The private sector operates another 800 group homes and 69 intermediate care facilities for intellectually disabled clients.

This report examines the existing funding structure, the factors that affect costs, and how those differ among public and private service providers. Individual client acuity levels and how they impact the cost of care and/or the settings in which clients receive care is also discussed. PRI staff found the public delivery of residential services, even after controlling for client level of need, is much more expensive than services delivered by private providers. However, while the ultimate state goal should be to eliminate this very costly dual delivery system and shift to a privately provided one, PRI staff does not recommend the closure of either Southbury Training School (STS) or the five regional centers that provide 24-hour residential care at this time.

Instead, committee staff believes that the provisions of the November 2010 court-approved settlement agreement be vigorously implemented. Allowing the process delineated in the agreement to work by offering clients to voluntarily choose a community placement, rather than requiring them to leave, seems a more humane, less litigious, and less costly option. PRI staff recommends a similar process be used for clients at the regional centers, offering community alternatives to residents there as well. Already more than 20 clients have taken advantage of the opportunity and are expected to move to community placements over the next year.

However, even as residents voluntarily relocate from Southbury and the regional centers, there is the complication of the staff currently employed at those facilities. Current labor agreement provisions prohibit layoffs as a result of contracting out, and also impose geographic limitations on transfers.<sup>1</sup> Further, as a result of the August 2011 agreement between The State Employees Bargaining Agent Coalition (SEBAC) and the state of Connecticut, and concessions made by the state employee unions, there are broad no-layoff provisions now in force for four years.

Acknowledging the dual system is a costly one, (as this report's analysis finds as well) the department had been implementing a policy of not accepting new admissions to any of its homes or facilities as a way to gradually reduce public residential services. In fact, as a result of the retirement incentive program (RIP) the state offered in 2009 and the number of DDS employees who retired, the state was able to convert 17 DDS-supported homes to private

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

providers. Five additional closures of public residential programs are being implemented in the current budget cycle.

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

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

The report notes that the new rate setting system will apply only to private providers. The more inequitable differences in funding between public and private providers will continue as long as there is a dual system. In the interim, PRI staff believes a staffing assessment should be conducted at the existing public residential programs using similar resource guidelines as employed when contracting in the private sector. DDS staffing patterns should be adjusted based on client's level of need, and DDS staff redeployed as the system gradually transitions to a private provider framework for direct care.

Also supporting the private provider model for provision of residential services are the findings noted in the report on quality of care. Based on the lower number of deficiency citations in both private and group homes and intermediate care facilities compare to the public settings, program review staff believes that the quality is not lower in the private sector. Given the lower costs for private residential care, the quality findings bolster a move to a single private system of direct services.

## **Report Organization**

The report is divided into four sections. Section I examines residential care and costs of care across the different settings and it identifies the key factors that contribute to the cost. Section II examines the costs involved in providing day or work programs to clients who receive 24-hour residential services. Section III describes the rate-setting methodology the department will begin implementing in 2012, and provides analysis on the system-wide impact that will occur in funding private providers. Section IV compares quality among public and private providers and across the different types of residential settings.

## Section I: Residential Care and Costs

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### Trends in Residential Care by Setting

The PRI committee directed staff to examine the costs of providing 24-hour residential care to DDS clients by type of setting and determine the factors that influence those costs. This section describes trends in overall and per-diem funding among the public and private delivery system, and explains the shift in residential support for clients from public to private settings over the last four years. It also examines the factors that contribute to the cost of care, and compares them among the different residential settings.

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

PRI staff also examined the components that drive costs in private CLAs and present analysis on the factors that influence costs the most. Based on the analysis, PRI staff present findings and recommendations at the end of this section.

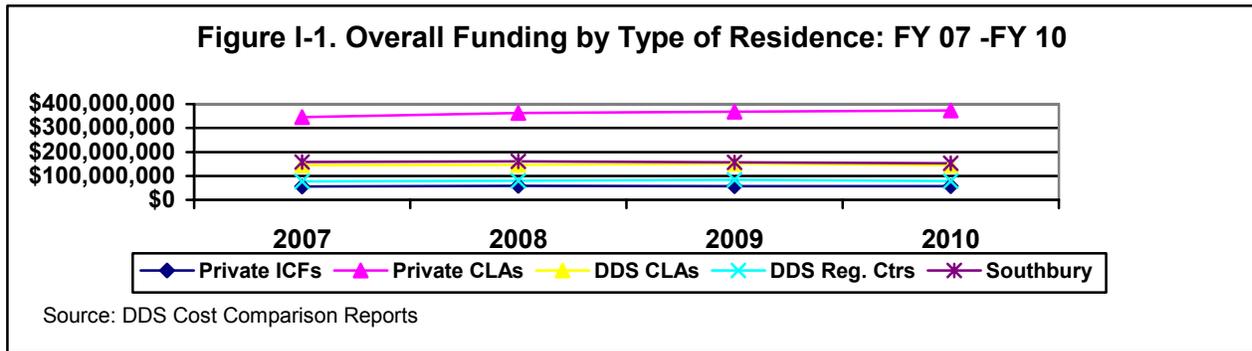
### Overall Funding

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

Table I-1 provides the funding totals to each of the five residential settings over the four years examined. As shown, private CLAs receive the largest amounts – in FY 07 \$345.5 million -- which grew to about \$373.9 million in FY 10 (an 8.2 percent increase). At the same time funding to three of the settings remained essentially flat, and Southbury’s funding declined by almost three percent.

<b>Table I-1. Overall Funding by Residential Setting: FY 07 – FY 10</b>					
<i>Facility Type</i>	<i>FY 07</i>	<i>FY 08</i>	<i>FY 09</i>	<i>FY 10</i>	<i>% Ch FY 07-10</i>
Private ICFs	\$56,459,276	\$58,572,746	\$57,295,063	\$57,280,049	1.4%
Private CLAs	\$345,454,088	\$362,734,922	\$367,927,518	\$373,857,195	8.2%
DDS CLAs	\$144,345,890	\$145,646,863	\$151,743,447	\$144,740,807	0.1%
DDS Regional Ctrs	\$77,676,820	\$79,094,726	\$83,380,995	\$78,134,956	0.6%
Southbury	\$157,852,710	\$160,823,878	\$157,469,510	\$153,433,679	-2.7%
Total	\$781,788,784	\$806,873,135	\$817,816,533	\$807,744,686	3.3%
Source: DDS Cost Comparison Reports					

As Table I-1 also shows, FY 10 funding for the three public settings declined over FY 09 levels. This decrease was largely due to reductions in staffing resulting from the state's 2009 retirement incentive program, which allowed for the conversion of 17 public CLAs to private homes, and further downsizing of Southbury and regional centers. (See further discussion of Southbury and regional centers later in this section.) Figure I-1 below shows the four-year trends in funding for the various 24-hour residential settings that are the focus of the PRI study.



### Residential Population Trends

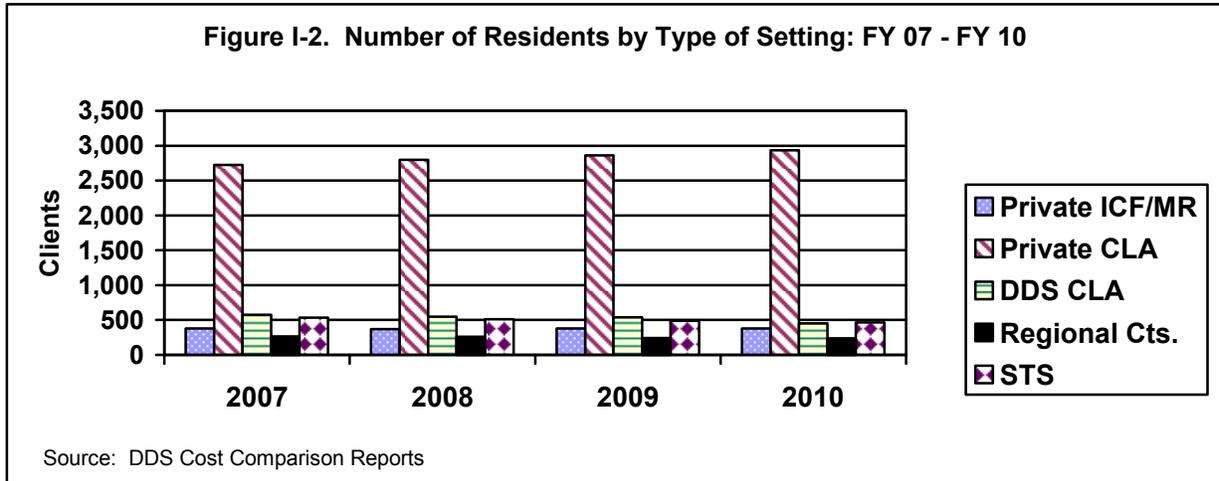
Examining funding trends alone, without also looking at changes in residential populations in the various settings, can be misleading. As the table and figure below indicate, there is a disconnect between the funding and population trends. While the number of people in 24-hour residential care remained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

This finding verifies the claim that private providers make that they have been flat-funded over the past few years, as any increase in overall funding has been offset by serving an increasing number of clients. At the same time, in the three types of DDS public settings, the population has declined by 223 residents (16 percent), while the funding has remained virtually unchanged. (The numbers of clients were taken from DDS Annual Cost Comparison Reports; they may vary somewhat from numbers from other sources such as e-CAMRIS or DDS' Management Information Reports).

**Table I-2. Trends in Residential Population by Setting:**

<i>Residential Setting</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>% Change</i>
Private ICFs	379	368	381	378	-0.2
Private CLAs	2726	2799	2863	2932	7.5
DDS CLAs	575	549	537	453	-21.2
DDS Regional Centers	265	260	240	236	-10.9
Southbury	536	510	487	464	-13.4
Total	4481	4486	4508	4463	-0.40

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



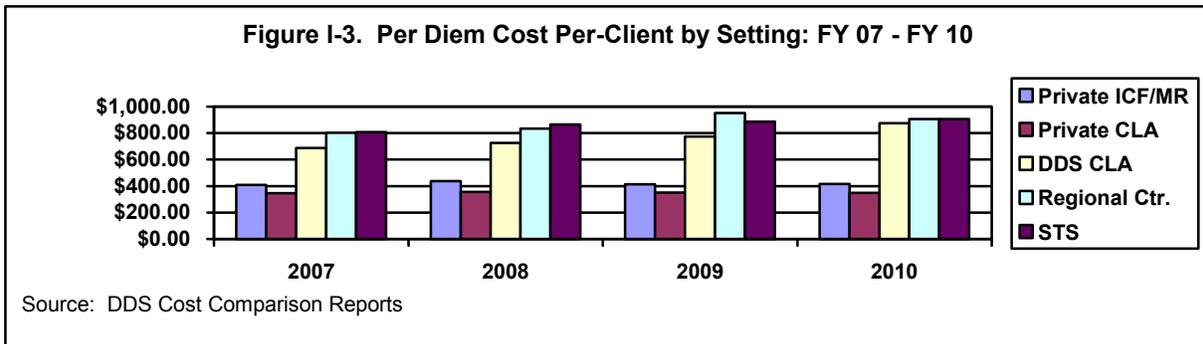
### Per Diem Cost Trends

The reduction in the number of clients served in DDS-operated residential programs has resulted in an ever-increasing per diem cost for each resident there, illustrated by Table I-3 and Figure I-3. While the costs, or more accurately what is paid, to serve a client in public residential settings has increased by as much as 27 percent in three years, the privately run CLAs and ICFs<sup>2</sup> have received very little funding increasing for each client's residential care.

**Table I-3. Per Diem Per Client Costs by Setting: FY 07 – FY 10**

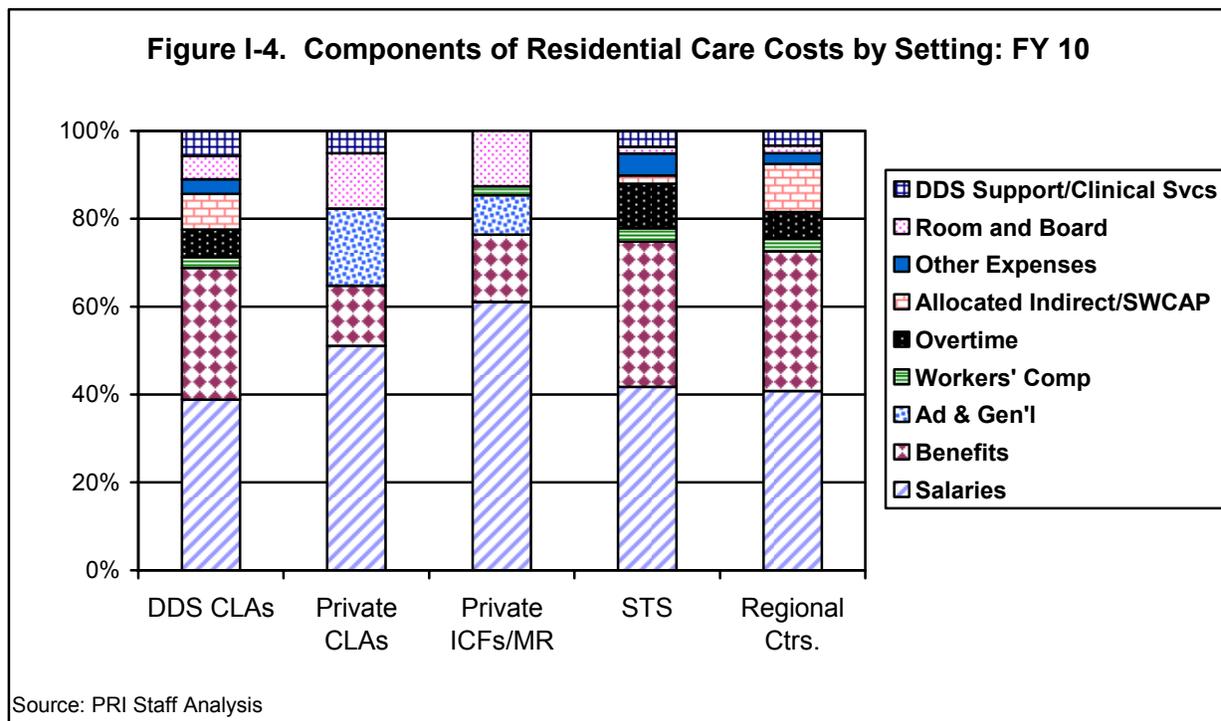
<i>Residential Setting</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>% Change</i>
Private ICFs	\$408.13	\$436.37	\$412.41	\$415.46	1.8
Private CLAs	\$347.19	\$355.02	\$352.04	\$349.31	0.6
DDS CLAs	\$687.77	\$726.84	\$774.18	\$875.39	27.3
DDS ICFs	\$803.07	\$833.45	\$951.84	\$907.07	13.0
Southbury	\$806.85	\$864.80	\$886.79	\$905.96	12.3

Source: DDS Cost Comparison Reports



<sup>2</sup> The federal Centers for Medicare and Medicaid are proposing a modification in regulations to change the name to Intermediate Care Facilities for Intellectually Disabled. This should take effect early in 2012.

**Cost components.** The briefing report compared many aspects of costs in the different 24-hour residential settings. The committee was interested in seeing the various components that make up the costs as a graphic. While all cost components are not categorized and labeled the same for each type of residence, PRI staff attempted to portray the various components by a percentage of the overall costs in the various settings. It is important to note that this does not compare overall dollar amounts in total or by category, only the portion each component contributes to the overall costs. These are shown in Figure I-4.



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

One of the most obvious differences is the percentage of costs that goes toward employee benefits in the private versus the public sector. For example, the portion of funding for employee benefits is about 14 percent in the private CLAs, while it is double, 30 percent, in public CLAs. As discussed in the briefing, one of the biggest contributors to the cost of benefits is health care, and the state's employee health benefits on the whole are more generous, and more costly than the private sector.

However, there is anecdotal information that certain low-paid direct care staff who work for private providers may indeed qualify for state medical assistance, so there may be hidden costs shifted to the public sector. PRI staff obtained a list of the 100 employers in the state with the highest number of employees on Husky (family Medicaid). While none of the private provider agencies under contract with DDS was on the top-100 list, it may be that they do not

have that many employees, and is not a confirmation that no employees of these private agencies are eligible for Medicaid, or other assistance.

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

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

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

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

Secondly, some parts of the room and board costs may indeed be higher in the private residential program, because the state as an entity is treated differently. For example, many private providers – 406 of the 712 private CLAs and 49 of the 69 private ICFs paid local property tax in FY 10. State properties on the other hand incur payment in lieu of taxes (PILOT), which, for most facilities, is 45 percent of what the tax would have been. Another reason is likely that there have been no recent purchase of public CLAs or ICFs in many years.

**Overtime.** Another large difference is the overtime component. Private providers do not account for overtime separately; it is built into staffing costs as part of the rate. Therefore, PRI staff were not able to separate out the portion of private labor costs are for overtime. Because DDS does not have a prospective rate set for residential care as do the private providers, there is not the same incentive to keep overtime costs down. As noted in the briefing report, DDS

overtime is decreasing, but not proportionate to the declining number of clients in DDS residential and day settings.

As noted in the briefing report, DDS overtime costs for FY 10 totaled \$45 million. PRI staff calculated the portion that overtime contributes to the costs in the public sector residences – it ranged for 6.1 percent at the regional centers to 10 percent at Southbury. In FY 10, overtime costs were more than \$15.5 million for Southbury alone or an additional 24 percent to the personnel costs there. On a per-client basis, overtime costs at Southbury account for about \$94 per day.

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

Other overtime may well be used by staff in order to elevate salaries prior to retirement, as the Hartford Courant reports was occurring in some state agencies<sup>3</sup>. In response to those newspaper articles and other criticism of overtime in state agencies, the governor, in August of this year, called for a thorough review of the use and need of overtime pay stating that “we have got to be more mindful of overtime . . . as well as the reaction of taxpayers to it, as well as the impact over a long period of time on our pensions.” In October, the Office of Policy and Management (OPM) prepared reports of overtime in FY 11 in 47 state agencies, which totaled more than \$200 million; DDS was the third-highest. The Secretary of OPM then required certain state agencies to submit plans on how overtime could be reduced by 10 percent. PRI obtained the submitted proposals and references them in the recommendations later in this section.

### **DDS-Operated Public Institutions**

**Southbury Training School.** According to the DDS June 2011 Management Information Report, 429 people live at Southbury, 97 fewer people (18 percent) than lived there just four years ago. Admissions to the facility were stopped by federal court order in 1986 amid concerns of the U.S. Department of Justice over the care and conditions for residents.<sup>4</sup> In 1997, the Connecticut General Assembly statutorily prohibited the DDS commissioner from accepting new admissions. At the same time, the federal court appointed a Special Master to find out why the state’s efforts were showing poor results in improving conditions. In 1998, a remedial plan was established in a consent decree with specific outcomes and criteria to be met as conditions for compliance. The federal court found in 2006 that the state had met all requirements of the consent decree.

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<sup>3</sup> Hartford Courant, Articles by John Lender, June 22, 2011, August 23, 2011, and October 2, 2011.

<sup>4</sup> United States v. Connecticut, 931 F. Supp. 974 (D Conn. 1986)

Following years of litigation, a federal judge issued a decision in June 2008 on another related case concluding that although the state had satisfied the consent decree requirements it had not done enough to relocate Southbury residents voluntarily into the community.<sup>5</sup> Hearings to determine the next steps were scheduled in 2010 and on November 18, 2010, United States District Court Judge Ellen Bree Burns signed an order approving the settlement agreement in the 1994 class action *Messier v. Southbury Training School (STS)*. The agreement, negotiated by the parties, which includes The Arc of Connecticut as a plaintiff and the Department of Developmental Services (DDS) as a defendant, was filed with the U.S. District Court on July 12, 2010.

The order requires the state to evaluate all residents of the Southbury Training School for possible placement in the community. DDS must train and establish interdisciplinary teams, who are required to use professional judgment in recommending the “most integrated setting” appropriate to each individual’s needs for each STS class member. For purposes of the agreement, the “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”<sup>6</sup>

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

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

The average cost of care at the five regional centers (\$907.07 per diem) was even higher than at STS (\$905.96) in FY 10. Further, the quality at regional centers was found deficient in a number of areas in FY 10 (see Section IV). PRI staff believes that the state should offer the residents at the regional centers the same opportunities as STS residents to live in private community settings. Therefore, PRI staff recommends that:

- 1. The Department of Developmental Services should evaluate all residents receiving 24-hour care at the five regional centers for possible placement in the community.**

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<sup>5</sup> *Messier v. Southbury Training School*, 562 F. Supp. 2d 294 (D. Conn. 2008).

<sup>6</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

**Using the interdisciplinary team concept established by the Southbury Training School Consent Agreement, each team would exercise its professional judgment in recommending the “most integrated setting” appropriate to the needs of each regional center resident. For purposes of the agreement, the “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”<sup>7</sup>**

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

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

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

The department has also been active in bringing providers in to meet with Southbury residents, and their guardians and families. The provider community has responded, and given the number of bids to the RFPs for the two CLA contracts, PRI staff believes that if the funding were available, there is interest and capacity in the private system to provide services to all but a few clients at Southbury and the regional centers.<sup>8</sup> Furthermore, according to DDS staff, there has been a greater willingness on behalf of Southbury clients (and their families or guardians) to consider community settings as cottages are closed and clients must relocate elsewhere on campus.

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<sup>7</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>8</sup> In some instances, DDS as an agency may be required to provide direct services through court orders or stipulated settlements. An example is the McCoy consent decree – in 1992 U.S. district court directs [then DMR] that specific measures for care and treatment of two plaintiffs that might have been so costly and intensive a private provider may not have been able to comply.

## Costs of Provision of Residential Services

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

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

### Total Costs for Clients in 24-hour Residential Care

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

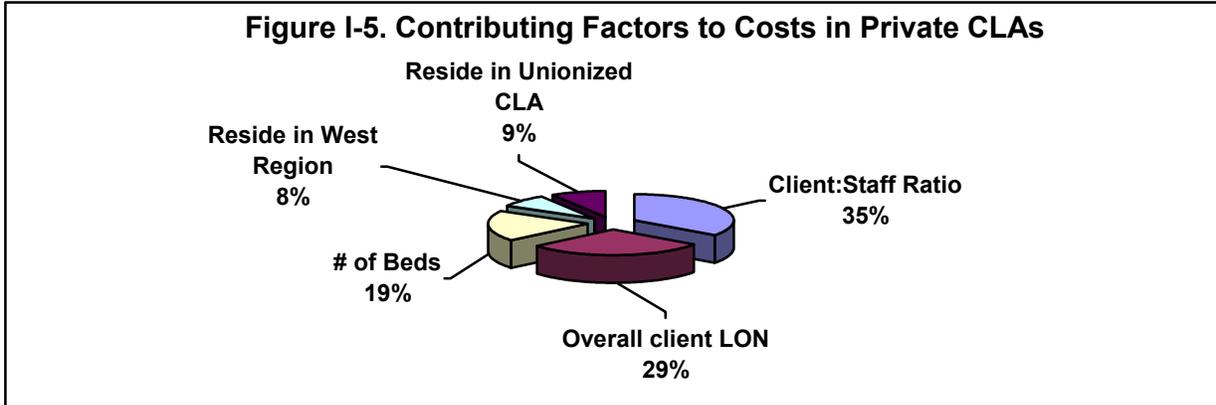
- higher staff to client ratios – higher costs were found for clients living in private CLAs with more staff relative to the number of residents
- higher level of need (LON) scores<sup>9</sup> – clients who had higher overall residential LON scores (using the assessment tool that measures a client’s need and assigns a numeric score from lowest (10 to highest(8) -- also had higher client costs
- fewer beds in the home – as the number of beds in the CLA got smaller, the costs per client became greater
- living in the Western DDS Region – clients in CLAs in the Western DDS region had relatively higher costs than clients residing in the Northern and Southern regions
- living in a unionized CLA – the cost for clients living in unionized private CLAs was higher than the cost for clients living in non-unionized private CLAs (\$150,396 vs. \$134,429)

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

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<sup>9</sup> Almost all clients have a level of need assessment using a standardized instrument to determine each client’s LON. Each client has a separate residential score based on outcomes of the assessment. DDS has issued funding guidelines based on LON scores, which are described more fully in Sections II and III.

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**Contrasting clients with relatively higher and lower total costs.** To further illustrate factors driving the total costs for clients living in private CLAs, the clients with the highest costs (top 10 percent) were contrasted with clients having the lowest costs (bottom 10 percent). As shown in Table I-5, the 290 clients with the highest costs are three times as likely to be living in a unionized home. Not surprisingly, the highest-cost clients also live in CLAs that have more staff and fewer beds-- there are twice as many staff per client for those residing in CLAs with the highest costs. However, the more intensive staffing pattern is associated with a significantly greater overall LON. Higher total costs for clients living in private CLAs were also associated with more recently opened homes, younger clients, and fewer deficiencies found in the most recent DDS licensing inspection.

**Table I-5. Comparing Characteristics of Clients and CLAs -- High vs. Lows Costs**

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

Source: PRI Staff Analysis

At the committee briefing, the committee asked if there may be too many private providers operating in Connecticut. PRI staff attempted to compare the number of providers with those in neighboring states, but the data for comparison were not readily available. One of the factors examined for this analysis was the number of homes a provider has, which is a proxy for size of provider. If smaller or larger size of provider were a cost factor it might indicate that smaller ones are more inefficient and contribute to higher costs, or conversely that large providers dominate that market and charge higher costs. However, the number of homes (i.e., size of provider) was found not to be a factor in costs. Further, DDS indicates that CMS

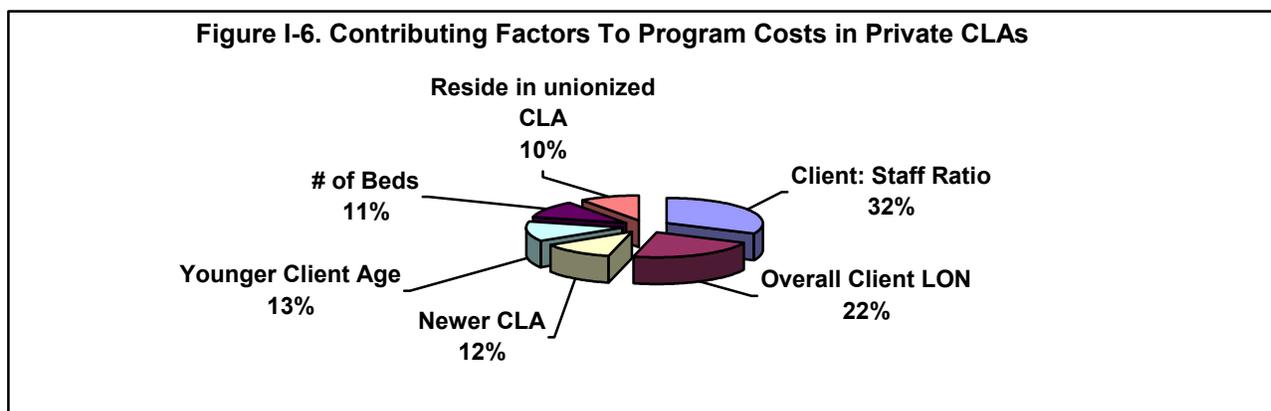
requirements mandate that any qualified provider be allowed to serve clients under the waiver program, and thus DDS cannot limit the number of providers who offer services.

### Factors Associated with Higher Client DDS Annual Program Services Costs

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

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

Figure I-6 shows the relative contribution of each of these factors in predicting the DDS program services cost for a client living in a private CLA.



**Contrasting clients with relatively higher and lower DDS program services costs.** To further illustrate factors driving the DDS home services cost for clients living in private CLAs, the clients with the highest costs (top 10 percent) were contrasted with the clients with the lowest

costs (bottom 10 percent). As shown in Table I-6, the 289 clients with the highest costs are more than five times as likely to be living in a unionized home. The clients with the higher costs are also living in CLAs that have more staff and fewer beds. This configuration contributes to the higher costs -- there are twice as many staff per client for those residing in the CLAs with the highest DDS program services costs. The more intensive staffing pattern is associated with a significantly greater overall LON. Another factor, not shown in the graph, but associated with higher program service costs for clients in private CLAs is fewer deficiencies found in the most recent DDS licensing inspection.

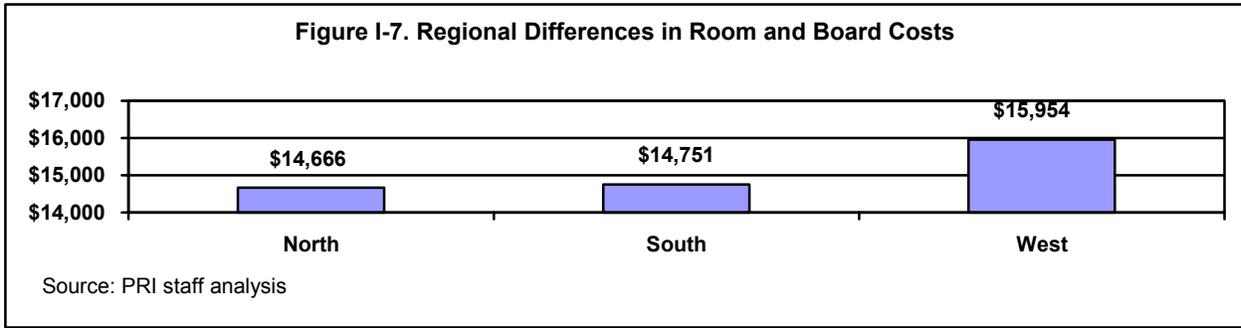
### Factors Associated with Higher Client DSS Annual Room and Board Costs

Staff also examined factors using only the room and board cost component. The room and board costs do not make up a large portion of the private CLAs' overall costs; about 12 percent as shown previously in Figure I-4. In comparison to the total client costs and DDS program services costs, fewer factors appear to predict the DSS annual room and board costs for clients living in private CLAs. As might be expected, the most salient predictors are the total number of beds in the CLA and the region within which the home is located.

<b>Table I-6. Comparison of Factors Contributing to High vs. Low Costs of Direct Care</b>		
<b>Factor</b>	<b><i>Clients with Highest DDS Home Services Cost (above \$154,067)</i></b>	<b><i>Clients with Lowest DDS Home Services Cost (below \$60,169)</i></b>
Live in a unionized CLA	40%	7%
Average # of beds in CLA	3.7	5.1
FTE direct care staff in CLA	7.6	4.8
Average # of staff per client (ratio)	2.8	1.3
Overall Residential LON	6.0	3.6
Average # of years CLA open	12	19
Average client age	39	51
Average # of deficiencies	5.6	7.5
Source: PRI Staff Analysis		

**Regional cost differences.** For illustrative purposes, the clients with the highest DSS annual room and board costs (top 10 percent of the 2,742 clients for which this information was known) were contrasted with the clients with the lowest costs (bottom 10 percent). Not surprisingly, clients who had the highest annual room and board costs live in CLAs with fewer beds (3.7 beds vs. 5.4 beds). Figure I-7 shows the average annual room and board cost for each of the three DDS regions. As might be expected, the West Region (which includes Fairfield County) has higher room and board costs, which includes housing costs and property taxes.

The major costs for caring for clients in private CLAs in each of the DDS regions are shown in Table I-7. As discussed, the program services makes up most of the costs. While the average annual DSS room and board costs are higher for clients in the West Region, the DDS program services costs are lower than those found in the North and South Regions, contributing to an overall total cost that is not significantly different across the three regions.



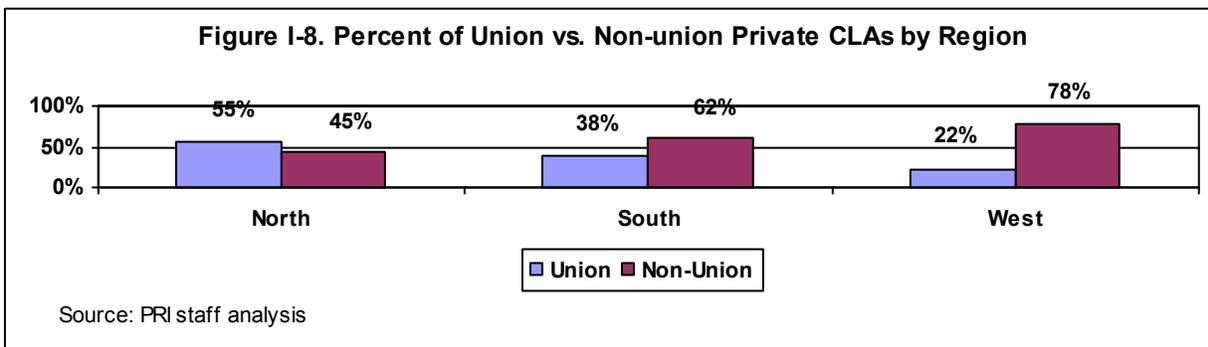
**Table I-7. Overall Per-Client Cost Differences Among Regions**

Components	North (n=983)	South (n=924)	West (n=834)	Total (N=2,741)
DDS Program Services Costs	\$105,569	\$101,291	\$99,764	\$102,361
DSS Room and Board Costs	\$14,666	\$14,751	\$15,954	\$15,087
Total Costs <sup>a</sup>	\$141,698	\$140,558	\$139,375	\$140,607

<sup>a</sup>There are additional costs, such as one-time payments, that are not otherwise shown in this table.  
Source: PRI staff analysis

### Unionization Differences

Only 16 percent of private providers statewide have unionized employees. However, because the larger agencies tend to have unionized employees, 36 percent of the private CLAs have unionized staff. CLAs with unionized staff were more likely to be found in the northern region and less likely in the western region (Figure I-8). Also, unionized CLAs were more likely to: care for clients with higher overall level-of-need residential scores (5.5 vs. 4.8 average overall residential LON); and have fewer deficiencies found at DDS licensure site visits (4.6 vs. 7.0).



### Wait List for Services

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

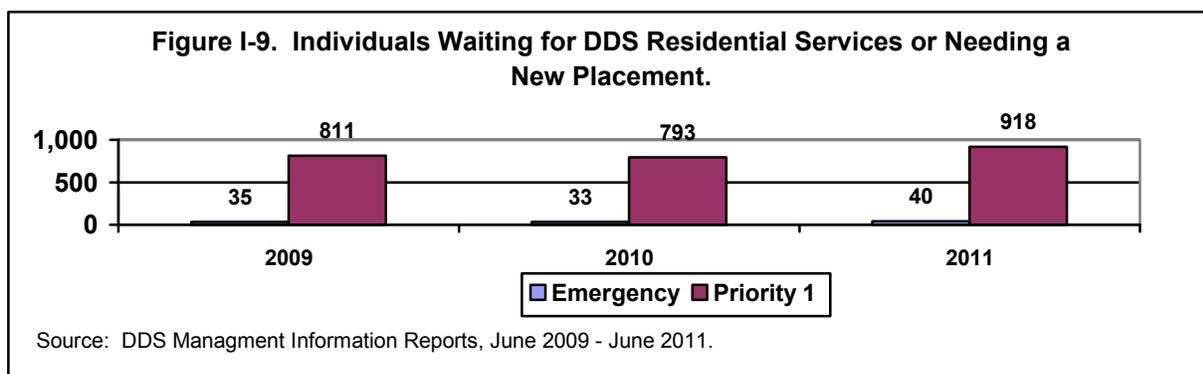
maintains wait and planning lists based on a priority ranking system to guide allocation decisions and determine who receives services.

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

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

Program review committee staff reviewed the growth in the number of individuals waiting for services on just the wait list (not the planning list) to examine if the wait list had grown since the end of the wait list initiative. Figure I-9 shows in June 2009, at the end of the five-year settlement agreement, there were 846 individuals on the wait list. Of these, about half (482) lived at home with no support and 21 were considered needing an emergency placement; while the other half were receiving support from DDS but needed a new placement. By June 2011, there were 958 individuals waiting for DDS services. Of these, 549 individuals had no DDS supports and 25 were considered an emergency.

Figure I-9 shows the number of individuals living at home receiving no DDS services or support and those waiting for a new placement increased 13 percent over the two-year period. The recent growth is more dramatic since, in 2009 there had been a decrease of 113 from the prior year, while by June 2011 there were an additional 132 individuals on the waitlist.



## FINDINGS AND RECOMMENDATIONS

*The analysis above and information contained in the briefing report show that:*

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

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

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

Based on that policy objective, program review staff recommends the following:

2. **The Department of Developmental Services should continue its phasing out of providing 24-hour residential care in any of its DDS settings, but that it accelerate its efforts through:**
  - **Using DDS CLAs only for residential placements for clients from more restrictive public settings like Southbury or the regional centers, and as a transition phase only;**
  - **DDS should not refill any direct care or direct service positions vacated through attrition in any of its residential or day program; and**
  - **DDS should conduct a staffing assessment at its residential locations in light of the 16 percent reduction in clients. For the clients still residing at DDS homes and facilities, DDS should use the LON assessment tool to determine the level of staffing needed (as it would in contracting for private placements.) Where staffing levels are higher than comparable in the private sector, DDS should redeploy staff to serve clients on the residential care waiting list in their homes or to provide respite care, within labor contract provisions.**
  - **Ultimately, the only residential care that should be operated by DDS is to provide care for extremely hard-to-place clients and for those clients that the superior or federal (not probate) court directs into DDS care. This should involve about .5 percent of the 24-hour residential care population or 25 people.**
3. **DDS should reduce its overtime by at least 10 percent as recently required by the Office of Policy and Management, including through implementing those measures similar to those recommended by the Department of Children and Families in its overtime reduction report to OPM (see Appendix A).**
4. **In future contracts DDS has with private providers, the department should examine the salaries paid to direct care workers considering:**
  - **what they are paid relative to the agency's executive director's salary;**
  - **relative to wages needed for self sufficiency standards as calculated periodically by the Office of Workforce Competitiveness and the Office of Policy and Management and**

**those that may be developed by the DDS Sustainability Subcommittee; and**

- **income levels that qualify persons and families for eligibility for state Medicaid and other assistance.**

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

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

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

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

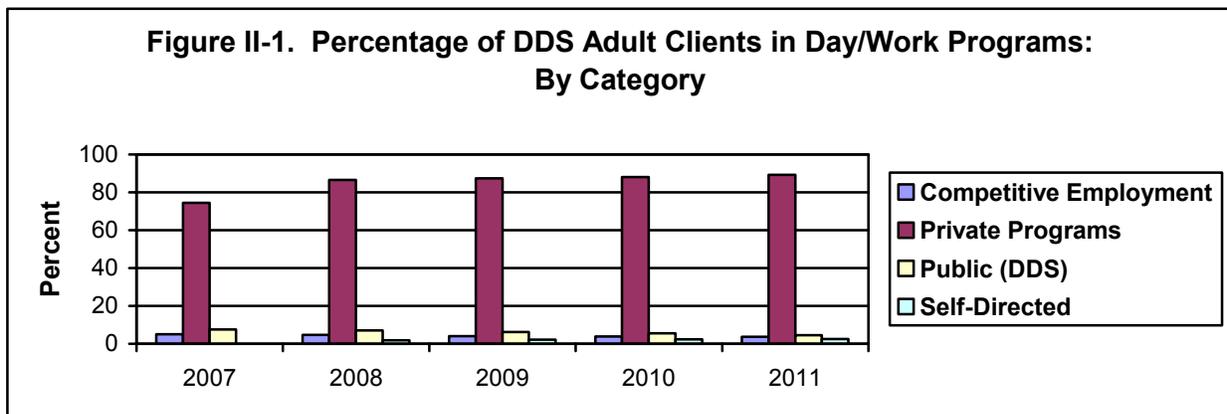
Further, as will be explained in Section III, DDS is embarking on a rate restructuring in the private sector that may take a number of years. This will alleviate many of the inequities found in the current system. However, it is important to keep in mind that much of the inequities in the system have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

## Section II: Day/Work Programs - Types and Costs

### Day/Work Programs for All DDS Clients

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

**Day/work program attendance trend.** Overall, a large majority of DDS clients participate in day or work programs that are operated by private providers and the trend is increasing. Although this section provides information on the day/work programs for the 4,436 clients that were the focus of the PRI study (i.e., receive 24-hour residential care), Figure II-1 shows there were 9,912 total DDS clients attending day/work programs and the trends in employment for all clients are shown.



The figure shows the percentage of participants in categories of day and work programs. As depicted, of the 9,912 clients receiving day/work services currently, almost 90 percent of them participate in privately operated programs, while fewer than 5 percent are in DDS programs. While difficult to detect on the graph, a trend that is of concern is that the percentage of clients who are competitively employed declined from 5.1 percent in 2007 to only 3.7 percent in 2011, perhaps a reflection of the job losses in this economic recession.<sup>10</sup>

**Types of programs.** For DDS clients in general who need and want day/work supports, there are approximately 15 different programs that provide varying degrees of assistance, and/or workplace and community involvement, depending on their client levels of need (LON).

<sup>10</sup> Competitive employment is defined as an individual who is employed and supervised directly by the employer and is paid prevailing wage. Minimal or no ongoing employment supports are provided through DDS.

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

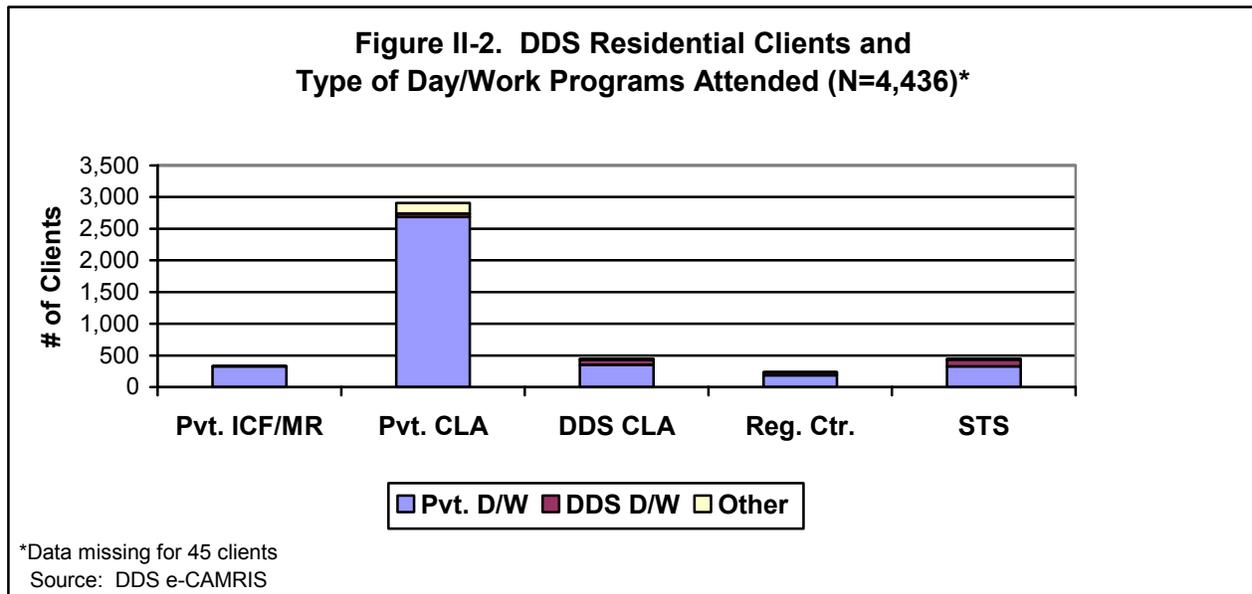
For persons who receive 24-hour residential services, PRI staff examined the day/work programs for 4,119 people for whom there was data on the specific type of day or work program they attended, and found the four most commonly used programs are:

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

**Type of day/work service provider.** Figure II-2 shows, as of June 30, 2010, the majority of residential clients, regardless of the setting in which they resided, received their day/work program from private providers. For persons living in public DDS settings, about 84 percent of the 513 clients who lived in public CLAs attended private day/work programs, with about 16 percent attending public day/work/programs. Most (79 percent) of the 236 clients residing at regional centers also attended private day/work programs. Only at STS do a majority of persons living there also receive publicly-provided day/work services—from STS itself. About 25 percent of persons living at STS attend private day/work programs off campus.

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

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



### Cost of Day/Work Programs

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

*Level of need.* As noted in the staff briefing, each client that receives DDS-funded services must have a level of need assessment. A client’s DDS case manager uses a 15-page standardized assessment and screening tool to determine each client’s level of need for supports and services. The assessment generates a profile and produces two composite LON scores - one for residential services and the other for day services. Most individual scores and the composite score range from “1” indicating a low level of need to “8” being the highest level of need. It is updated annually or upon a change in the client’s life or situation.

Currently, the funding guidelines are being used for new clients coming into the DDS system, transitioning from a home setting to a residential placement, moving from one residential placement to another, or experiencing significant changes in condition. For these clients, once an LON assessment is completed, the regional team uses the funding guidelines to assist in

determining the needed resources. Table II-2 shows the FY 10 day/work funding guidelines by LON. Further detail on the use of DDS funding guidelines in transitioning to a new rate-setting methodology is discussed in Section III.

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

Source: DDS.

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

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

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

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

<b>Table II-1. Private Day/Work Program Costs for Select DDS Clients (N=3,278)</b>	
Mean	\$23,938
Range	\$1,453 - \$134,750
Total Costs	\$78,468,836
Source: PRI staff analysis of DDS databases	

**Average private day/work costs by LON.** Table II-3 shows that, as one might expect, the average costs increase as the level of need score rises. The most dramatic growth in average costs is when clients have a LON score of “8,” with average costs of \$44,329. The table also shows the cost range at each level of need. The minimum cost range includes clients that receive day/work services on a part-time basis. The highest maximum cost for a day/work program was \$134,750 for one client with a LON score of ‘8.’

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

**Average private day/work costs by residential setting.** PRI staff examined the average cost of private day/work services by the type of residential setting the client resided in and the average LON score for that setting (shown in Table II-4). Clients who lived at Southbury Training School, but who participate in private day/work programs, on average, had the lowest day/work program costs at \$22,554 while clients living at regional centers but attending private day/work programs had the highest average cost at slightly more than \$27,000 and had the highest average LON scores of the four settings.

<b>Table II-4. Average Cost of Private Day/Work Program by Client’s Residential Setting and LON</b>			
<i>Residential Setting</i>	<i>Clients Attending Private Program</i>	<i>Average LON</i>	<i>Average Cost</i>
Private CLA	2,639	4.96	\$23,746
Public CLA	351	5.17	\$24,249
Regional Center	178	5.99	\$27,161
STS	108	5.05	\$22,554
Source: PRI staff analysis of DDS databases			

## Clients at Public and Private Day/Work Programs by LON

PRI staff also examined the level of need score for clients being served by public day/work programs and specifically examined those with a comprehensive level of need (LON score of 5 or more). As Table II-5 shows, almost 75 percent of clients served by public day/work programs had a level of need score of “5” or higher (indicating a comprehensive level of need), while 68 percent of clients served in private day/work programs had comprehensive needs. In terms of numbers though, private providers actually serve more clients who score “5” or higher on the level of need assessment – 2,210 clients attending private day/work programs versus 345 attending public programs.

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

## Cost Comparison Between Private and STS Day/Work Programs

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

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

7. **Further, the Department of Developmental Services should conduct a staffing assessment of its current staffing levels for its public day programs, using the day/work LON scores in the private programs as a guide for level of resources needed, and redeploy staff resources over those levels to other services.**
8. **As recommended for clients receiving 24-hour staffed residential services, the Department of Developmental Services should adopt a centralized utilization review process for clients exceeding the day/work program funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.**

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

### **Day/Work Program Plan Review**

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

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

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

## Section III: Cost of Care and New Rate Structure

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

### Transition to New Rate System for DDS Waiver Clients

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

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

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

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

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

Testimony was given regarding the 90 percent attendance requirement at the PRI public hearing in September 2011. In follow-up interviews with PRI staff, DDS indicated that there had been no industry standard or prior studies on which to base the 90 percent threshold, but that it

was believed achievable since most providers had attendance levels above that. Further, 10 holidays and 25 other out-of-program days are excluded from the attendance requirements.

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

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

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

- has employed several different methods of funding services and supports which has led to unequal funding among DDS private providers for the same service based on historical reasons;
- did not have a utilization-based funding system in place to meet CMS requirements;
- did not have information technology systems in place to manage to support documentation of the CMS requirements to the federal government; and
- the DDS-developed level of need (LON) assessment tool was a valid instrument to measure client LON, if used correctly.

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

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

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

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

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

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

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

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

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

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

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

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

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

### **DDS-Developed Level of Need Funding Guidelines**

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

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

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

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

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

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

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

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

Source: PRI staff analysis of DDS databases

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

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

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

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

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

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

Source: PRI staff analysis of DDS databases

**Impact on private providers.** Based on the analysis in this section, it is expected that the results of the new rate system will have significant consequences for some private providers of both residential and day/work programs. In response to the funding changes, some providers will have to reduce expenses, or add additional participants without an increase in funding. Given the tremendous variation and substantial deviation from the funding thresholds, it will probably take the full seven and a half year transition period for client’s funding authorization to match the LON-based allocation. Therefore, PRI staff finds:

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

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

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

### **Upgrading Information Technology Systems and Ensuring Accurate Client Data**

The Department of Developmental Services information technology systems are inadequate and in need of upgrades, and there needs to be more emphasis on consistency in data entry and in keeping data current. As noted in the report produced by the DDS Legislative Rate Study Advisory Committee, DDS does not have the “information technology systems in place to

effectively manage the documentation and system requirements to meet waiver assurances,” as required by CMS. The current Medicaid waiver regulations require providers to document the delivery of services in the type, scope, duration and frequency outlined in the Individual Plan. To accomplish this, the rate study committee recommended that IT systems be upgraded to provide a comprehensive database for private and public sector services and costs.

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

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

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

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

- 11. The Department of Developmental Services should remind its case managers of the importance of keeping client automated records up to date.**
- 12. The Department of Development Services should randomly audit a sample of cases in its client demographic database to ensure client information is accurate.**

An audit of this database could be conducted simply, with a list of five percent of clients in each region with demographic information attached generated by the central office and sent to

each the regional office. Each region could conduct a quick review, correct any inaccurate information and report the number and percent of clients with incorrect information back to the central office. If the number of clients with inaccurate information exceeds a certain percentage, the central office could determine if a more widespread audit is needed.

Another area where there appeared to be inconsistency in reporting by DDS was in CORE-CT, the state's automated personnel system, from which PRI staff obtained some of the DDS staffing information. For one region, locations for position classes were assigned by generic office (e.g., West Region, administration building) while another region inputted the position class location by program within the region (e.g. South Region, Early Connections). This made it difficult to compare staffing levels and assignment by region. Since the CORE-CT system is the state's only personnel system from which to obtain and analyze staffing information, it is important that data be entered with some degree of consistency.



## Section IV: Quality Assurance

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### Focus on Licensing Inspections

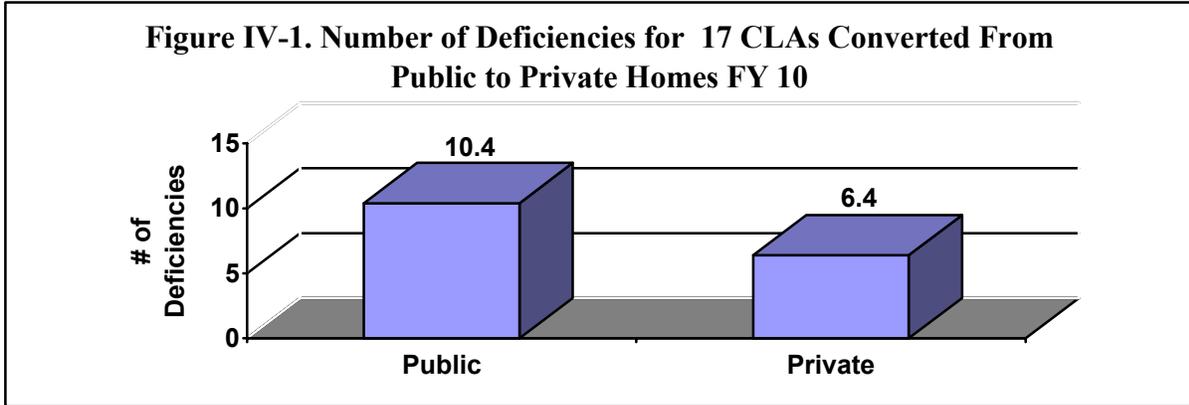
In discussions with agency staff, advocates and others, there does not appear to be consensus around a set of quality measures that one could easily use to rate or assess quality. Program review staff focused primarily on the number and areas of deficiencies found in licensing and certification inspections and, to the extent possible, the provision of preventative health and dental care to clients with intellectually disabilities in 24-hour residential settings.

All 24-hour residential care facilities are regulated. The Department of Developmental Services licenses and inspects all community living arrangements, whether public or private, using state regulations adopted in the early 1990s. Inspections are conducted every two years. The state Department of Public Health inspects and certifies Intermediate Care Facilities for Mentally Retarded, (ICF/MR) under federal regulations issued by the Centers for Medicare and Medicaid Services (CMS). (As noted in Section I, regulations are proposed to change the name to ICFs for Intellectually Disabled (ICF/ID). The CMS certification is necessary for federal Medicaid reimbursement.

The September briefing report contained information on the inspection results and deficiencies cited for the community living arrangements. *In that report, PRI staff found that on average there were 10 deficiencies per public group home for the 42 inspections conducted in FY 10, while there was an average of 6.4 deficiencies cited in the private CLAs based on 401 inspections in FY 10.* While this finding appeared to contradict the concerns raised by private providers that inspections of public homes tend to overlook deficiencies, it does not lessen another concern that deficiencies are not corrected in public homes. The committee asked staff to examine this matter further.

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

The September briefing report also compared inspection results on homes that had been public but now are privately run. Seventeen homes were converted from public to private after the Retirement Incentive Program in 2009. *For those homes that were converted, the number of all deficiencies found was higher in the homes when they were public than when they were private as shown in Figure IV-1 below.*



At the September briefing, the committee asked that staff further analyze what types of deficiencies were found in the 17 CLAs pre- and post-conversion. Table IV-1 below shows the total number of deficiencies found by category when the homes were public and after the conversion to private. The analysis provided in the table shows that:

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

Category of Deficiency	Number of deficiencies Pre-conversion (public)	Number of deficiencies post-conversion (private)	Percent decrease after conversion
Plans of correction	5	3	40%
Physical Plant/facility	33	23	30%
Emergency planning	16	13	19%
Staff Development	54	18	67%
Special protections	23	12	48%
Individual records	2	0	100%
Facilitative Services	19	15	21%
Financial records	6	4	33%
Health Services	20	12	40%
<b>Total</b>	<b>178</b>	<b>100</b>	<b>44%</b>

Source: DDS Licensing Inspection Data

The highest number of deficiencies for the public homes was in the area of staff development, which would include documentation that direct care staff have had training some time in the past two years in such areas as emergency procedures, communicable disease control, and signs and symptoms of diseases and illnesses. A total of 54 such deficiencies were found in the last licensing inspections before the conversions, while after the conversions to private only 18 staff development deficiencies were found, a 67 percent drop.

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

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

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

**ICFs/MR.** There are 382 beds in 69 private ICFs, operated by 14 different providers in various communities. While the facilities vary in size, all can accommodate at least four people (they cannot have fewer and be certified as ICF), and most have between four and six clients.

Altogether, the DDS ICFs provide care for about 680 people. For certification and inspection purposes, there are 30 certified public ICFs operated by DDS at five regional centers and Southbury; none is located in the community. On average, then, the public ICFs have about 22 people per residence compared to 5.5 per home in private ICFs. Further, the private ICFs are located in the community while the public facilities, by and large, are on campus-like settings.

The state Department of Public Health annually certifies all ICFs/MR (public and private), a necessary designation in order to receive federal reimbursement. The briefing materials provided to the committee in September contained quality assurance information taken from DDS licensing inspection data for CLAs only. PRI did not have the DPH inspection results on ICFs/MR at that time. Since then, PRI has obtained information for those facilities, and the results are analyzed below.

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

<b>Table IV-2. Deficiencies by Facility for ICFs/MR: FY 10</b>			
<i>Type</i>	<i>Total deficiencies</i>	<i>Average per facility</i>	<i>Range</i>
Private ICFs N=65	195	3.0	0 – 16
Public ICFs N=30	127	4.2	1 – 18

Source: DPH Survey Data for FY 10

Sixty-five of the 69 private ICFs/MR were inspected during FY 10 (four were not inspected during the period that covered the state fiscal year), and all 30 of the public facilities were inspected. On average there were 1.2 fewer deficiencies found in the private ICFs/MR than in the public facilities. There was an average of three deficiencies for each private facility inspected, and 14 of the 65 homes had no deficiencies. The public facilities had an average of 4.2 citations and no public facility had a deficiency-free inspection.

In addition, three facilities with many deficiencies were surveyed twice during the period reported. Two of these were public and one was a private. *As with the CLAs, program review staff finds that, based on the average number of deficiencies found, the quality of the private ICFs is somewhat higher than the public ICFs.*

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

*Therefore, based on this analysis and information in the September briefing report, program review staff finds:*

- *a lower average number of total deficiencies in private ICFs;*
- *many fewer citations of more serious “conditions of concern” in private ICFs;*
- *fewer people per private home than the public ICFs;*
- *public ICFs/MR are located at campus facilities, and not in the community;*  
*and*
- *on average, residential care is provided less expensively at private ICFs.*

*From the results of both the ICF/MR certification surveys and the results of the DDS licensing inspections, program review staff finds that the quality of residential care is not lower in private settings, even though less expensive on average. Further, if assessed narrowly on the basis of deficiencies cited, the care in the private settings is better. These findings all support a transition to a private residential system for DDS clients, as recommended in Section I.*

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

**Health Services**

A particular concern around quality for clients with intellectual disabilities is the provision of health and dental care. Often, DDS consumers have special medical and dental needs, and may also have anxieties and fears of medical and dental procedures. This, coupled with low Medicaid rates, presents difficulties in locating providers who will treat Medicaid DDS clients. As noted in the briefing, program review staff had hoped to compare health services provided to DDS clients in the various residential settings. However staff was unable to do so because it could not access comprehensive health care information for the DDS clients. The vast majority of DDS clients are dually eligible for Medicare and Medicaid; the covered services dually eligible clients might receive under each program are shown in Table IV-3.

<b>Table IV-3. Covered Services by Program for Dually Eligible Clients</b>	
<b><i>Medicare (100% federal reimbursement)</i></b>	<b><i>Medicaid (50% federal reimbursement)</i></b>
Acute care (hospital) services	Medicare cost-sharing (premiums and deductibles)
Outpatient, physician, and other supplier services	Transportation to medical appointments
Skilled nursing facility services (typically following hospital stay and with other limitations)	Nursing home care
Home health care	Home health not covered by Medicare
Dialysis	Optional services such as dental and personal care
Prescription drugs	A portion of prescription drugs
Durable medical equipment	Durable medical equipment not covered by Medicare
Source: Department of Social Services Presentation to Medicaid Management of Care Council, Oct. 2011	

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

**Dental care.** As shown in the table, one service that is not a Medicare service is dental care. Connecticut is one of only 11 states that offer comprehensive dental care to adults as a Medicaid option. However, the difficulty is in locating dental providers that will accept

Medicaid clients at the Medicaid payment rates offered -- typically about half of the commercial insurance reimbursement levels.

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

Because of the issue surrounding access to dental care, the Department of Developmental Service has a staff person who serves as dental coordinator for the agency's clients. The role of the coordinator is to "educate, communicate, collaborate, and facilitate access to dental services for the consumers of DDS". By working closely with consumers, their families, guardians, case managers, nurses and dental care providers, the department tries to make certain that each individual receives the dental care they need. In order to ensure access, the department operates four dental clinics to serve DDS clients. Table IV-4 summarizes information regarding the clinics.

<b>Table IV-4. DDS Dental Clinics</b>		
<i>Location</i>	<i>Staff</i>	<i>Consumers Served by Type of Residential Setting</i>
Norwich	1 Full time Dentist 1 Full-time Hygienist	<b>760</b> 565 – Living in Private 195 – from Public settings
Southbury at STS	1 Full-time Dental Director (dentist) 1 Part-time Dentist 1 Full-time Dental Hygienist 2 Full-time dental Assistants	<b>1,002</b> 420 Southbury residents 71 – other Public settings 511 – from private settings
Ella Grasso Clinic (Stratford)	1 Full-time Dental Hygienist 1 Part-time dental assistant 1 dentist on contract 1 day per week	<b>614</b> 84 from public settings 530 from private settings
Norwalk Dental Clinic at Lower Fairfield Regional Ctr	1 Part-Time Dental hygienist 1 Dentist on contract 1 day per week	<b>306</b> 285 Regional Center residents 21 – from private settings
Source: DDS		

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

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

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

Program review staff believes there should be some method of systematically ensuring that clients with intellectual disabilities are receiving appropriate preventive health care. Because electronic records are still in development, and Connecticut does not have Medicaid managed care for its aged, blind, and disabled population, another practice should be employed for Medicaid clients with intellectual disabilities. Program review staff had considered recommending that the Department of Developmental Services and the Department of Social Services develop a memorandum of understanding where data on encounters for the relevant screenings and other preventive care for DDS Medicaid clients could be shared. However, as shown in Table IV-3 above, Medicaid is not the primary payer for most outpatient services so the shared data would be of limited use in assessing what services the dually eligible clients have received.

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

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

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

delivery, coordination and management of primary, preventive, acute, and behavioral health integrated with long-term services and supports under one program.”<sup>11</sup>

The plan recognizes the need for better linkages of use of Medicaid and Medicare, with the “development of an integrated database of all relevant Medicare and Medicaid data [as] the anticipated deliverable”.<sup>12</sup> DSS will start the project in 2012 with the elderly (65 and over) dually eligible population and then expand it to other dually eligible clients. Thus, comprehensive health encounter data for DDS clients as a result of the Integrated Care Organization initiative may not be available for at least another year. While this delay is an issue, it is probably more beneficial for DDS staff to be involved with assisting with the planning and data linkage efforts as part of the overall grant than for the department to develop its own tracking system for DDS clients.

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

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

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

### **CMS Quality Assurance Requirements**

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

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<sup>11</sup> [Former] DSS Commissioner Starkowski’s application letter to CMS, February 1, 2011

<sup>12</sup> DSS application to CMS

At the same time, though, two key national associations that represent state agencies responsible for implementing the CMS waiver services are protesting the new quality assurance measures as overly burdensome. In a January 11, 2011 letter to CMS, the executive directors of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the National Association of States United for Aging and Disabilities (NASUAD) wrote that:

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

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



# **Appendices**



## **DCF Overtime Reduction Plan**

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

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

### **DCF's Overall Plan for all Locations**

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

Overtime is only allowed for essential and emergency purposes.

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

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

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

### **Overtime Plan specific to Area Office Operations**

**A standard system and workflow for Area Office overtime is being put in place (see attached). The Area Office system will make individual managers accountable for the use**

**of overtime within their unit. Reporting will be provided on a monthly basis to top office administrators and the individual managers.**

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

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

### **Overtime in 24/7 Operations**

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

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

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

# Appendix B

## Preventative Health Guidelines



STATE OF CONNECTICUT  
Department of Developmental Services

Minimum Preventive Care Guidelines For Persons With Intellectual/Developmental Disabilities

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



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

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

## Letter to the Centers for Medicare and Medicaid Services

**NASDDDS**

 **NASUAD**

January 19, 2011

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

Dear Ms. Edwards,

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

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

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

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

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

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

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

#### **Performance Measures and Compliance**

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

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

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

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

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

#### **Remediation at the Individual Level**

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

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

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

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

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

#### **Data Collection and State Resources**

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

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

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

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

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

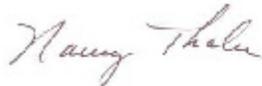
### **In Summation**

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

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

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

Sincerely,



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