Staff Briefing

Provision of Selected Services for Clients with Intellectual Disabilities

September 27, 2011

Legislative Program Review
& Investigations Committee

CONNECTICUT GENERAL ASSEMBLY

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

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Introduction

Study Overview

The Department of Developmental Services (DDS) operates, generally, under Title 17a, Chapter 319b of the Connecticut General Statutes. The department is responsible for the planning, development and administration of a complete, comprehensive, and integrated statewide program for persons with intellectual disabilities. The department offers an array of residential, day service, and family support programs for more than 15,000 clients with intellectual disabilities age three or older.

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

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

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

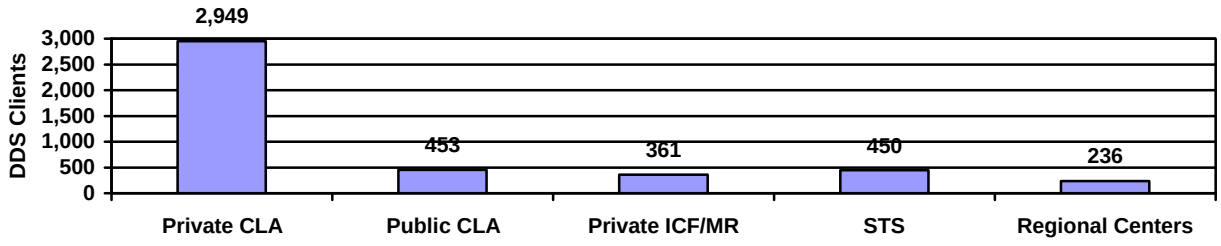
The department operates eight regional centers, five of which provide 24-hour residential services to DDS clients. The West Region includes the Southbury Training School and operates three regional centers that provide 24-hour residential services; the North Region includes the northeastern part of the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

In Connecticut, there are four types of residential settings available to DDS clients who need 24-hour care (shown in figure I-1 below for the 4,449 DDS clients receiving 24-hour residential services on June 30, 2010). The number of clients living in each type of residential setting is also shown in the figure below.

Both DDS and private providers operate intermediate care facilities for the mentally retarded (ICFs/MR). On the public side, Southbury Training School and the five 24-hour residential regional centers are ICFs/MR and there are 69 private ICFs/MR located in the community. Services delivered to clients in these types of facilities are based on a medical model with federal requirements regarding safety and sanitation, plan development, professional services, etc. Both DDS and private providers operate CLAs, otherwise know as group homes.

Private providers operate 800 CLAs compared to 70 CLAs directly staffed by DDS employees, and services are delivered in small, home-like settings. Reimbursement under the Medicaid program is different based on whether services are delivered in an ICF/MR or a CLA.

Figure I-1. Number of Clients by Type of 24-Hour Residential Setting (June 30, 2010)



Source: DDS eCAMRIS database

PRI Study Focus

Connecticut is one of 18 states that operate a dual system of public and private provision of community residential services. Of the 18 states, only New York serves more people than Connecticut in public group homes for persons with intellectual disabilities.[1] While there has been growth in residential and day services provided in the private sector in Connecticut over the last several years – mostly due to a prohibition placed on DDS from placing new clients in public settings - many believe that shift has been too gradual. The cost-effectiveness of operating a dual delivery system has been long debated, but reached a critical point in the current state fiscal crisis.

In March 2011, the PRI committee voted to undertake a thorough analysis of the costs of DDS versus private sector services, based on clients who receive 24-hour residential care, to determine whether the private sector can provide comparable services at some fraction of DDS costs. It is expected that the analysis provided by PRI staff would lead to recommendations to ensure a cost-effective, quality-driven system for Connecticut's citizens with intellectual disabilities receiving 24-hour residential care.

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

In 1978, the then-Connecticut Department of Mental Retardation was targeted in a federal class action suit, know as CARC vs. Thorne, in which the plaintiffs charged that care

[1] *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2009.* Lakin et. al., University of Minnesota, 2010.

provided to residents at Mansfield violated their civil rights. The case was settled through a consent decree that ultimately resulted in the closing of Mansfield in 1993. This produced a rapid expansion in community placements for the Mansfield population in community group homes. However, the deinstitutionalization of the state institution required that the staff who had worked at Mansfield be placed in similar state employment within a limited geographic area, per labor agreements with the state. This meant there were transfers of staff to the regional centers but also a development of public group homes in the area for former Mansfield residents and staff.

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

However, in June 2008 a federal court decision in another related case concluded that although the state had satisfied the consent decree requirements on improving care at Southbury, it had not done enough to provide residents with the information needed for them and their guardians to make informed and voluntary decisions about moving into community settings. In November 2010, the federal court issued an order for the implementation of a stipulated agreement which called for much more aggressive movement to provide individual assessments and present viable community alternatives to residents at Southbury, based on individual assessments with the ultimate decision based on the best interests of the resident. Since that time, Southbury has held a provider fair in June 2011 that was attended by many private providers and about 100 family members or guardians of STS residents.

Also, at the same time two requests for proposals (RFPs) have been issued for development of two community group homes for current Southbury residents, one for five men and the other for three women. The deadline for responses was July 22, 2011; one RFP received 10 provider responses and the other seven. While no decision has been made yet, the responses indicate that there is an interest among the private provider community in residential services for STS residents. According to STS administrators, there is also some effort to offer relocation opportunities to STS residents to already-established private homes in the community as vacancies arise.

However, even as residents voluntarily relocate from Southbury, there is the complication of the staff currently employed at that facility. Current labor agreement provisions prohibit layoffs as a result of contracting out, and also impose geographic limitations on transfers.[2] Further, as a result of the August 2011 agreement between SEBAC and the state, and

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

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 providers. Five additional such conversions are planned in the current budget, but have not yet been implemented.

Recognizing that the community integration recommendation work for Southbury residents must be aggressively pursued according to the stipulated agreement, while dealing with the restrictions that prevent any overall staffing reductions (other than normal retirements and attrition), DDS appears to be altering its policy not to develop or expand public community residential programs. At the August 2011 meeting of the State Bond Commission, $150,000 was approved to make improvements at a Hamden facility that had been a public CLA, but has not been operating for a few years. There are discussions underway to reopen that home as a public CLA. Those plans may slow down the movement to replace all public homes with private community residences; however they do provide DDS with an opportunity to redeploy current staff while abiding by state labor agreements.

Also facing the department are the more stringent requirements being placed on states in order to receive federal reimbursement. The Centers of 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.

Because of the complexity surrounding the operation of a public/private provider system that offers the same services, this briefing paper provides information and analysis on the existing funding structure, the factors that affect costs, and how those differ among public and private providers. In addition, because of the belief among some that public settings serve more difficult clients, and therefore have higher costs, PRI staff accounted for client case-mix when comparing costs of care in the four types of residential settings. Finally, the briefing paper also examines the number and types of licensing deficiency citations issued by DDS to private and public providers of service, as a proxy for quality of care provided.

During the next phase of this study, staff will continue to explore the factors that influence cost of client care among the four settings, and explore whether there are reasons for client well-being to maintain some public capacity.

Study Methodology

PRI committee staff reviewed federal and state law, national literature, and recent Connecticut-specific studies that examined the cost of client care and the rate structure used by DDS to reimburse private providers for residential and day services. Several interviews were

conducted with state agency personnel in the Departments of Developmental Services, Social Services, Administrative Services, and Public Health. PRI staff also conducted site visits of Southbury Training School, Hartford Regional Center in Newington, and a DDS-operated group home. PRI staff attended meetings, presented information about the study, and responded to questions from the two of the main nonprofit private provider advocacy groups – Connecticut Association of Nonprofit Providers and Connecticut Community Providers Association.

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

Data for Cost Comparison of Selected Residential and Day Services			
Category of Residence	***Agency/Cost Category***	***Databases***	***Aspects***
Public CLAs	DDS costs/client residential and day programs DDS staffing	• eCAMRIS • DDS cost submissions to State Comptroller • DSS Medicaid • CORE-CT	• DDS staff and costs • Client demographics and level of need • Individual client Medicaid costs
Public Regional Center ICFs/MR	DDS costs/clients residential and day	Same as above	Same as above
Private CLAs	DDS program/services residential and day DSS room and board	• DDS contracts • DSS Medicaid • DDS/DSS through contractor – Private Provider cost reports • DSS-contracted rate promulgation system • eCAMRIS	• Private staffing and costs • Private room and board costs • Client demographics and level of need • Individual client Medicaid costs
Private ICF/MR	DDS day services costs DSS all residential costs	• DSS – through contractor – private ICF/MR cost reports • DSS Medicaid • DSS-contracted rate promulgation system	Same as above
All categories	***Outcomes***	***Databases***	***Aspects***
By residence and day program	DDS DPH	• Licensing and Quality Assurance	Adding quality measures to cost and client database

Preliminary Findings

Based on the analysis, PRI committee staff presents a number of preliminary findings in this report. Staff finds the current rate-setting system is not equitable and does not pay based on client level-of-need. The system also does not meet the more stringent standards CMS is

imposing that states have a uniform rate-setting methodology and that the system offer client choice of residential setting and only pay for services used.

Many private providers are financially precarious with 36 of the 79 providers (48 percent) showing an operating loss in FY 09, and 30 of the 79 providers (38 percent) in FY 10. The Commission on Nonprofit Health and Human Services, using a number of different measures to test financial stability, concluded in its report that a large percentage of nonprofit providers are operating dangerously close to their margin and likely would not be able to maintain operations if they experienced unforeseen increases in expenses or a financially detrimental incident.

The size of private residential service provider organizations vary dramatically from several that operate only one home with only a few staff to the largest private agency that has 79 homes and more than 1,000 employees. PRI staff examined executive director compensation and found that 40 executive directors had salaries in excess of $100,000, and five had salaries over $200,000. Staff also found a few cases where "management fees" seemed high and the form required to be filed for salaries more than $100,000 was not.

With some exceptions, each client that receives DDS-funded services must have a level of need assessment (LON), a 15-page standardized assessment and screening tool administered by each client's case manager. The assessment yields a composite LON score that ranges from "1" indicating a low level of need to "8" being the highest level of need. The score is used to help teams in each region decide on the amount of resources a client should be allocated. Currently, it is used only for new DDS clients entering the system, those with a significant change in condition prompting the need for additional resources, or clients who are moving from one residence or day program to another and have portability of funds.

PRI staff compared annual average per-client costs across the four 24-hour residential settings using a weighted average to statistically maintain the same client LON regardless of setting. This allowed PRI staff to estimate how much it would have cost private providers to serve the identical case-mix of clients that lived in public CLAs, at the regional centers, and at STS during FY 10. PRI staff found that, on average, it costs about 2.5 times more to take care of the clients with the same LON in a public CLA as a private one. Similarly for public regional ICFs/MR, it costs 1.8 times more to provide residential care for the same client mix as private ICFs/MR, and twice as much at Southbury given their costs and client mix. Because the individual costs per year differ so much between the two settings, the current provision of care makes for a very costly system.

While PRI staff found that direct care staffing resources did not vary among settings on a staff-to-client ratio, it also found it difficult, for analysis purposes, to assign staff to a particular residential setting at Southbury and the regional centers because of the nature of the facilities. PRI staff also found that direct care staff in DDS residences is heavily comprised of part-time workers, making up 40 percent of employees providing direct care at STS and regional centers, and 43 percent in public CLAs.

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

Of course one should not risk quality in the interest of lowering costs. As an assessment of quality and outcomes, PRI staff examined DDS licensing data for public and private CLAs (ICFs/MR are certified by DPH and quality assurance data for these facilities will be included in the next study phase). That analysis finds the inspection data lacks any degree of severity of deficiencies that would assist in assessing overall quality of CLAs but that overall DDS had a greater than average number of deficiencies. Further, when homes that were converted from public to private CLAs are examined, fewer deficiencies are found on average after the conversion (6.4) than before (10), a finding that quality as measured by DDS inspection outcomes, does not deteriorate in a private setting and may even improve.

Briefing Organization

This report is divided into five sections. Section I profiles private providers that offer 24-hour residential care including the size of the provider (i.e., number of CLAs or ICFs/MR they operate). This section also provides some basic assessment of their revenue and financial stability.

Section II provides a demographic profile of DDS clients in 24-hour residential settings and discusses the level of need (LON) assessment instrument used by DDS to assist with resource allocation for some clients. This section also identifies clients by LON in all four types of residential settings, and compares the average cost per client while adjusting for level of need.

Section III provides a detailed comparison of direct care staffing resources in the four types of settings and compares direct care wages and benefits between public employees and direct care workers employed by private providers. It also examines some of the other staffing issues that contribute to costs, like overtime and worker compensation claims for DDS employees.

Section IV describes rate-setting and reimbursement for residential services, and Section V examines how DDS ensures quality, by comparing the number and types of licensing deficiencies issued by type of residential setting. Appendix A contains a list of the acronyms used in this report.

Section I: Rate Setting and Reimbursement

Overview

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

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

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

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

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

Table I-1. Roles of Various Agencies and Contractors in Regulation and Reimbursement of DDS Residential Programs			
Agency	***Rates/costs***	***Licensing/Quality Assurance***	***Client Information***
Department of Developmental Services	• Receives cost-reports from private providers for CLAs; • Sends cost reports to CJLC for audit of room and board costs to set prospective rates • Administers contracts w/private providers and maintains contracting database	• Licenses public and private CLAs • Conducts licensing inspections (see Section V) and maintains licensing inspection data • Quality Service Review (QSR) database (separate from licensing) that will meet the CMS requirements	• Maintains e-CAMRIS, the DDS client information system – case managers responsible for updating information
Department of Social Services	• Approves the rates for ICF/MR; the room and board rates for CLAs; and the Medicaid program "rates" for the CLAs • Submits all allowable costs to CMS for Medicaid reimbursement to the state	• Approves certificate of need for any new ICFs/MR	• Maintains Eligibility Management System that contains data on Medicaid clients • Provides income assistance checks to clients based on eligibility and monthly needs • Through HP,(the private contractor that handles Medicaid claims and payments for the State) maintains data warehouse and exchange that pays Medicaid providers and bills Medicaid
CJLC, LLC (private consultant w/DSS contract)	• Develops full rate for private ICFs/MR based on prior year costs • Develops room and board rate for room and board for private CLAs • Maintains database on private providers cost reports • Conducts desk audits of provider cost reports for room and board costs	No role	No role
Office of State Comptroller (OSC)	• DDS submits all cost information for regional centers, STS and group homes to OSC • OSC annually establishes a maximum per diem "rate" by region includes benefit costs and statewide cost allocation plan (SWCAP) • OSC sends the rates to DAS which bills Medicaid and others (see below) • Determines the benefit rate for state employees – added to the cost of public residential care – sends to DAS	No role	No role
Department of Administrative Services	• Merges costs per diem and attendance data for residential care into standard billing format • Submits the bills monthly to HP for Medicaid • Collects room and board payments from individual clients in DDS group homes	No role	No role
Office of Policy and Management	• Develops the standard purchase of service (POS) contract that DDS uses. • Develops the cost reporting standards for private providers • Conducts single state audit	No role	No role
Department of Public Health	No role	• Certifies ICFs/MR (public and private) for CMS • Conducts quality inspections of ICFs using federal standards • Maintains database of ICF/MR for certification/monitoring	• Maintains client data for quality monitoring of ICFs

As indicated in the May material distributed to the committee, there are various state agencies or contractors involved in the rate-setting, licensing, monitoring, or reimbursement processes for the residential services for the DDS clients in 24-hour care. Table I-1 indicates the roles of the various entities.

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

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

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

Rate-Setting

Private ICFs/MR. It is important to note again that the only rates that are really "set" for any of the residential services are the private ICF/MR rate and the room and board rate for the

private CLAs. Those are both established by the Department of Social Services, and are statutorily required to be based on "reasonable costs". Unlike a utility rate, where a charge (e.g., per kilowatt hour) is the same for all customers and the difference in the bills to the consumer is totally based on usage, the rates established by DSS vary considerably by provider and home, even before the utilization is calculated.

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

Private CLAs. For CLAs, the "rates" and rate-setting is even less structured. One category of rates for CLAs set by DSS is the room and board rate. There have been no overall increases (other than for emergencies) since 2009. The FY 10 room and board rate ranges from $6.78 per client per day to $96.49. The median is $43.03 and the average is $43.82. PRI staff will be examining the room and board costs and what contributes to the variation for the final report.

However, most of the costs for 24-hour residential care is for program services, or staffing. The vast majority of clients in private CLAs are Medicaid eligible and therefore their residential services are reimbursable under the federal HCBS comprehensive waiver. Currently, one of the only financial considerations CMS uses for the waiver is that the service costs overall are no more than they would be in an institutional setting.

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

In preparation for the tightening reimbursement requirements, P.A. 09-3 (Section 57) established a DDS Legislative Rate Study Advisory Committee to examine the impact of the [CMS] proposed shift to attendance-based fee-for-service reimbursement for DDS-funded programs. That committee issued a report in January 2011[4] and the report's conclusions were:

- The existing payment system is incompatible with the federal CMS requirements for HCBS waiver services.

- The current payment system does not meet *any* of the three criteria CMS requires and places the state at risk of its federal recoupment of funds and/or loss of future reimbursement.

- DDS funding history (of residential group homes) has built-in inequities among providers since the 1980s and continues under the current system. The system, which

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

is basically based on legislative appropriations to DDS and negotiated contracts with providers, has resulted in a wide disparity in funding levels for different homes and day programs and varying amounts paid for people with the same needs.

- The LON screening tool that is currently in use, if used correctly, is a valid tool to measure individual level of need (but the committee recommended a longitudinal review to test the integrity of the LON tool over time)

- The attendance factor of 90 percent -- that DDS is using as part of its system of attendance-based payment for day services for all private funded day programs effective February 1, 2010 -- may be reasonably attainable, but it is not an indication of financial viability, and should be only one factor in the overall waiver implementation.

- DDS does not have the information technology systems currently in place to effectively manage the documentation and system requirements to meet waiver assurances. While DDS has applied for funding from CMS for development of such systems, the report concludes the completion of those would be 3-5 years away.

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

Table I-3. DDS Public Per Diem Costs Established by Office of the State Comptroller

Facility	FY 09	FY 10	FY 11	FY 09 –FY 11 Change
Southbury	$997	$972	$987	1% decrease
West Regional Centers	$737	$788	$779	5.6% increase
North Regional Centers	$949	$911	$1,000	5.3% increase
South Regional Centers	$1,221	$1,223	$1,362	11.5% increase
West Region Group Homes	$710	$789	$792	11.5% increase
North Group Homes	$800	$785	$833	4.1% increase
South Group Homes	$857	$815	$844	1.5% decrease
Source: OSC Transmittals to DAS				

Reimbursement by Medicaid

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

One of the rate-setting study conclusions was that the future reimbursement of Medicaid services may be in question with the current state patchwork payment system, but thus far the state continues to receive 50 percent reimbursement for the waivered services billed by DSS. It is important to note that what is billed to Medicaid includes some of the costs for allowable services including employee benefits, allowable expenses for services provided by agencies through the statewide cost allocation plan (SWCAP), including such services as the attorney general's office review of contracts, DAS' billing and collection services, and the like.

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

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

Table I-4. Medicaid Billing for Residential Care FY 10.

Facility	Number of clients	Total billed to Medicaid	Average Medicaid billing per client
Public ICFs/MR -- includes Southbury and regional centers	684	$215,245,809	$314,687
Private ICF/MR	355	$55,929,432	$157,548
Public CLA	447	$120,039,049	$268,544
Private CLA	2,901	$354,929.324	$122,347
Total	4,387	$747,143.614	$170,309
Source: DSS Medicaid Data			

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

Other Medicaid costs. Program review staff had hoped to obtain all health care costs for the clients in the study and compare whether a type of setting might have had an impact on either the incidence or costs of the clients' other health care services. However, the data were not fully

available to do that in any meaningful way. This is because the vast majority of DDS clients are dually eligible for both Medicare and Medicaid, and wherever a service is covered by Medicare, that program is billed first. Therefore, services like inpatient hospital stays, most prescription drugs, and many outpatient services are all covered Medicare services, and neither the incidence or costs of service is available.[5]

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

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

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

Section II: DDS Client and Cost Comparison Profile

Client Demographics

DDS clients receiving 24-hour residential care can live in a variety of different settings as described in Section One. PRI staff obtained data from DDS that captures demographic and other information about clients who live in 24-hour residential care. The database contained information on 4,449 clients. This section provides a demographic snapshot of these clients as of June 30, 2010, and provides information on an assessment tool that assists in allocating resources based on a client's level of need. In addition, the cost of providing client care across the four settings is analyzed.

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

Table II-1. Client Gender by Region (N=4,445)

Region	*Female*	*Male*	*Total*
North	593	850	1,443
South	536	712	1,248
West	715	1039	1,754
Total	1,847	2,602	4,445

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

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

Table II-2. DDS Clients Residing in 24-Hour Residential Settings (N=4,445)

Age Group	*Number*	*Percent*
Age 0-20	106	2%
Age 21-44	1,386	31%
Age 45-64	2,330	53%
Age 65-74	443	10%
Age 75+	193	4%
Total	4,448	100%

Source: PRI staff analysis of DDS eCAMRIS database.

Clients by type of residence and region. Table II-3 shows the number of clients by type of residential setting and region. Seventy-four percent of clients reside in privately staffed CLAs or ICFs/MR, while the other quarter live in public CLAs, at STS, or in one of the five regional centers that provide 24-hour residential services. The North Region has the most clients at publicly-staffed CLAs, perhaps influenced by the closing of Mansfield Training School in the early 1990s and the need to quickly develop housing capacity in the community, as well as to transfer staff who had been employed at the Mansfield facility. The fewest number of clients living in publicly-staffed CLAs are in the West Region. There are only three public CLAs in that region, and a larger number of clients reside either at STS or in one of its three regional centers.

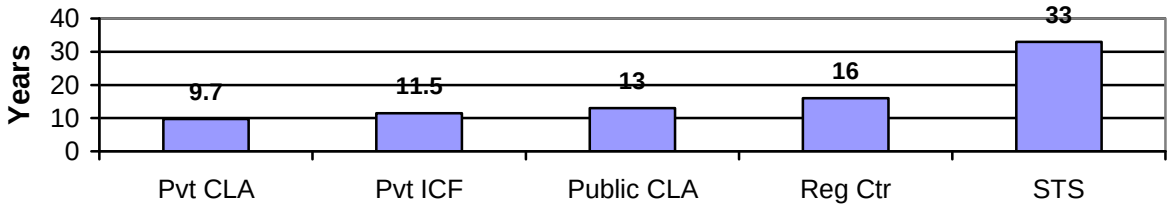
Table II-3. DDS Clients by Type of Residence and Region (N=4,445)

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

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

Length of time in residential setting. On average, the 4,449 clients receiving 24-hour residential care had resided at the facility or home for 13 years. Figure II-1 shows the average length of time that clients have lived at a specific type of residence. As the figure shows, the average number of years that clients have lived at STS is 33 years, followed by 16 years at a regional center.

Figure II-1. Average Length of Time Client Lived at Residence by Type of Residential Setting (N=4,449)

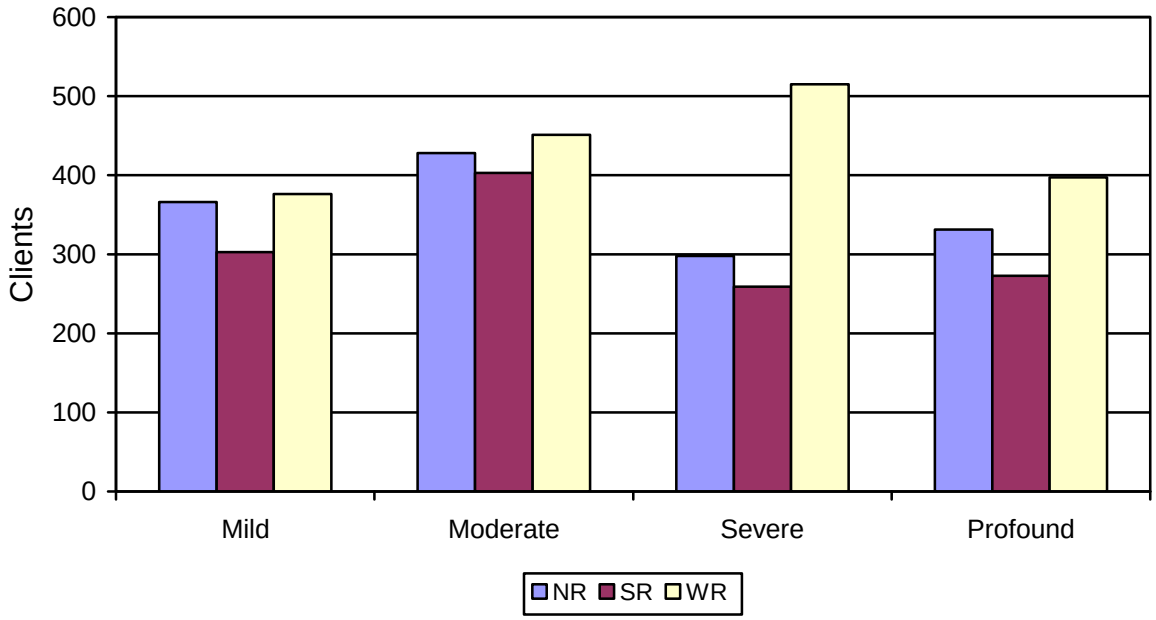


Source: DDS eCAMRIS database

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

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

Figure II-2. Level of Intellectual Disability by Region (N=4,404)



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

Table II-4. Total Number of Clients within Each Setting and Percent with Severe or Profound Diagnosis (N=4,449)					
Region	***Public CLA***	***Private CLA***	***Private ICF/MR***	***Regional Centers***	***STS***
North	232 (53%)	1,028 (37%)	106 (64%)	59 (90%)	-
South	178 (66%)	962 (37%)	77 (66%)	30 (40%)	-
West	43 (51%)	937 (32%)	178 (58%)	146 (87%)	450 (79%)
Total	453 (58%)	2,949 (35%)	361 (62%)	236 (72%)	450 (79%)
Source: PRI staff analysis of DDS eCAMRIS database					

Level of Need Assessment for DDS Clients

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

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

The LON, a web-based data application, generates a profile made up of a score in each of the areas cited above and produces two composite LON scores - one for residential services and the other for day 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. In 2009, administration of an annual LON assessment was discontinued for DDS clients residing in private ICFs/MR as part of budget reductions that eliminated public case managers for clients residing in this type of setting**.**

Residential level of need range. The Department of Developmental Services first implemented the LON in 2006, in order to better link a client's health and safety needs to the

financial services and supports that are needed. The results of a client's LON assist the regional team responsible for determining the amount of resources that should be allocated to corresponding funding limits based on level of need ranges: Minimum, Moderate, and Comprehensive (Table II-5).

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

Funding caps. In 2006, DDS adopted funding guidelines for services. Because the LON was introduced within the last five years, clients who had been receiving services prior to adoption of these funding guidelines did not have funding reallocated, regardless of their LON score. The guidelines are being used for new clients coming into the DDS system; transitioning from a home setting to a residential placement; moving from one residential placement to another; or because he or she has had a significant change in condition. For these clients, once an LON assessment is completed, the regional team uses the funding guidelines to assist in determining the resources needed to meet his or her needs.

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

Table II-6. FY 10 Funding Guidelines for Residential Services and Supports				
LON Score	***Classification***	***Reg. Team Approval***	***Reg. Director Approval***	***Reg. Director Approval for CLA***
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 teams recommendation; or

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

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

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

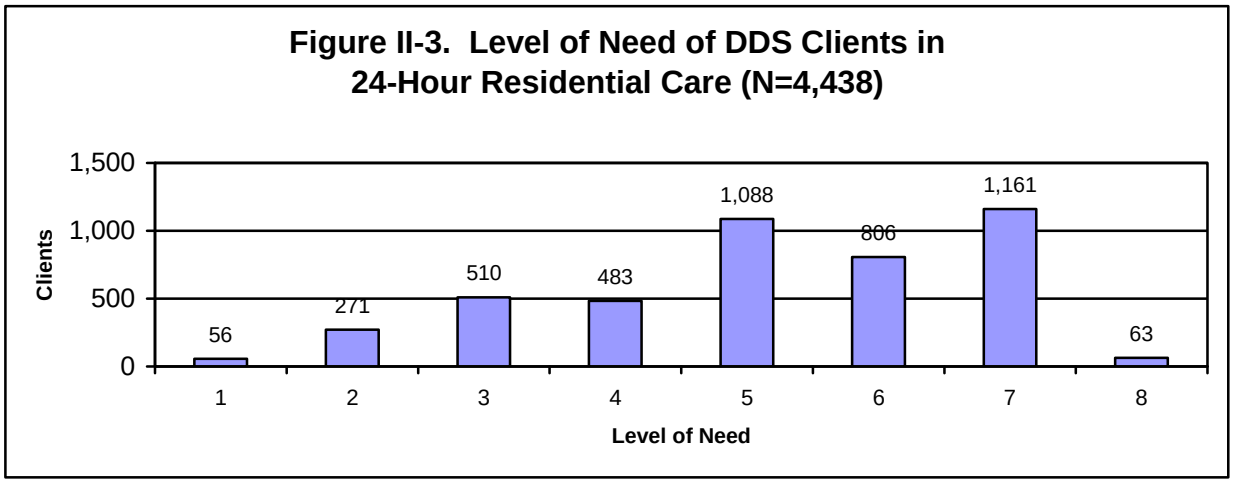
Table II-7. Fiscal Year in which Client had Latest LON Assessment (N=4,439)

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

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

It is important to note that the levels of need shown in the figure are likely not indicative of the entire DDS client population. Individuals with lower levels of need may still be receiving services from DDS but are living with family or residing in supported living arrangements that

do not require 24-hour residential services, and would not be reflected in the PRI study population.



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

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

Table II-8. Number of Clients by LON and Level of Intellectual Disability (N=4,438)

Level of Need	*Mild*	*Moderate*	*Severe*	*Profound*	*Total*
1	27	25	0	2	56
2	101	117	8	40	271
3	214	190	22	75	510
4	195	186	17	77	483
5	213	364	197	306	1,088
6	165	222	175	234	806
7	113	161	640	245	1,161
8	14	17	12	20	63
Total	1,042	1,282	1,071	999	4,438

Source: PRI staff analysis of DDS eCAMRIS database.

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

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

Table II-9. Type of Residential Setting for Clients with LON of 5 or Higher (N=3,118)

Residential Setting	*Number of Clients with LON of 5 or Greater*	*% of Total Clients in that Type of Residential Setting*
Private CLA	1,974	67%
Public CLA	339	75%
STS	332	74%
Private ICF/MR	261	72%
Regional Center	212	90%
Total	3,118	70%

Source: PRI staff anaylsis of DDS eCAMRIS database.

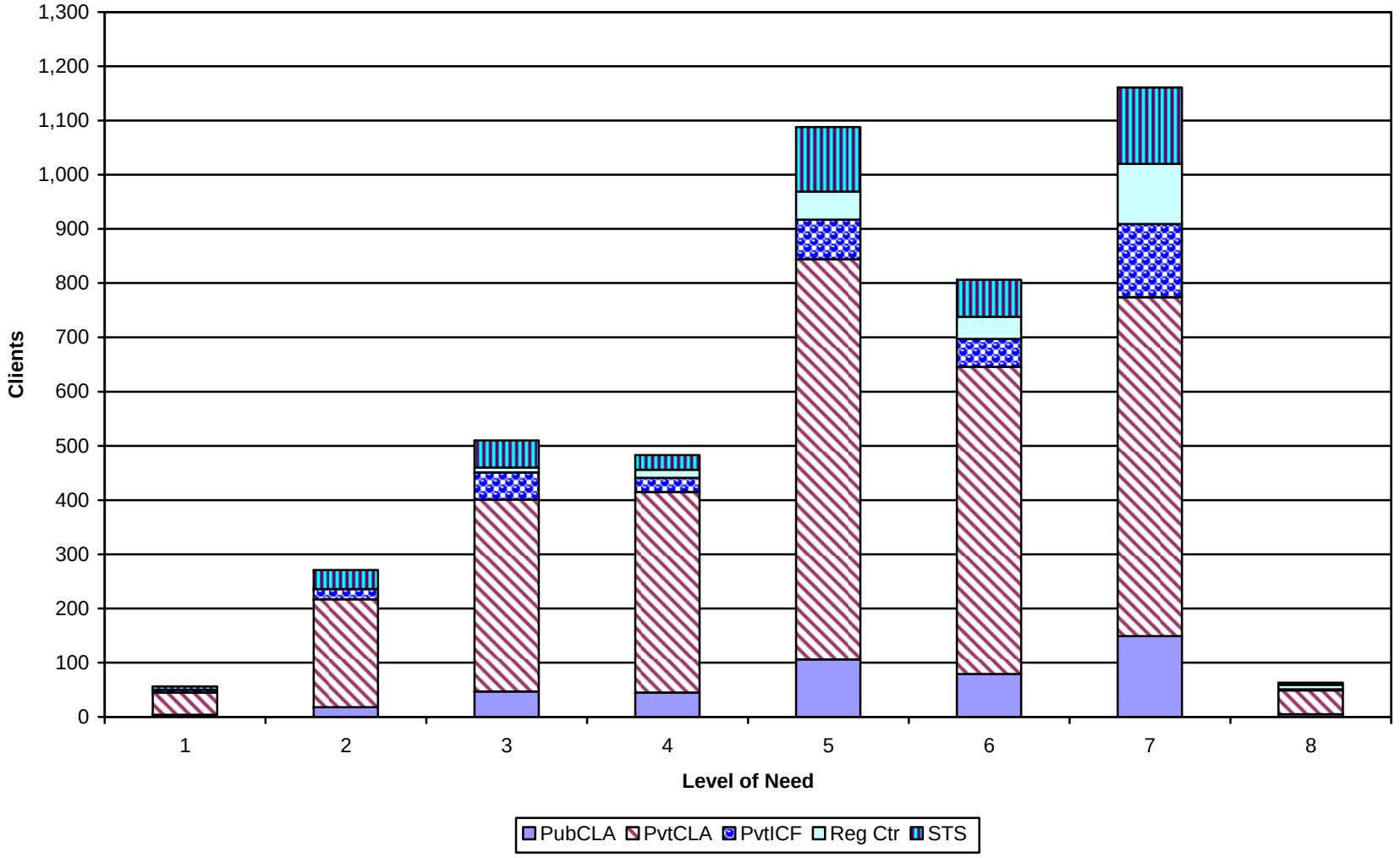
Even at the highest levels of need (7 or 8), the regional centers serve the greatest number of such clients relative to the total number of clients living in that particular residential setting, and private ICFs/MR are the second most frequent provider (Table II-10). While private CLAs serve the largest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

Table II-10. Type of Residential Setting for Clients with LON of 7 or 8 (N=1,224)

Residential Setting	*Number of Clients*	*% of Total Clients in that Type of Residence*
Private CLA	669	23%
Public CLA	154	34%
STS	145	32%
Private ICF/MR	137	38%
Regional Center	119	50%
Total	1,224	28%

Source: PRI staff analysis of DDS eCAMRIS database.

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



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

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

PRI staff examined client demographic and cost data, including levels of need across the four types of 24-hour residential settings, and presents analysis to determine whether the high cost of client care in public settings is because they provide services to clients who have higher needs. The settings reviewed include:

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

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

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

To develop comprehensive per-client cost estimates for each private CLA, PRI staff merged the prospective DDS contracted costs with an average room and board cost per-client based on the number of clients residing in each private CLA as of June 30, 2010. These two calculations together, along with any state funds for temporary supplemental services a client may receive, were then merged in order to obtain an estimated cost per-client in private CLAs for FY 10.[6] Finally, the projected cost per-client data were combined with client demographic

[6] State supplemental payments for temporary services and supports are state funds that DDS allocates for clients experiencing a temporary change in condition. Any services provided are expected to be temporary and DDS does

information and LON score, provided by DDS, in order to derive an overall profile for clients residing in private CLAs.

Private CLA cost data. Table II-11 shows minimum, maximum, and average contracted per-client residential costs for FY 10, along with projected total client costs, by funding streams. As the table shows, the most expensive costs are for the residential services and supports provided by DDS, ranging from a minimum of $8,604 for one client to a maximum of almost $500,000 annually for another.

Table II-11 Projected Annual Cost-per-Client (FY 10) and Total Cost

Funding Agency	*Minimum*	*Maximum*	*Average*	*Total*
DDS Contracted Services and Supports (N=2,875)	$8,604	$497,640	$104,444	$300,275,069
DDS Supplemental Funds (N=282)	$75	$187,954	$14,301	$4,032,825
DSS Room and Board (N=2,833)	$2,475	$35,219	$15,512	$41,039,825
Total	$17,656	$525,059	$120,120	$345,347,744

Source: PRI staff developed database from DDS eCAMRIS, DDS contracted rates, DDS supplemental funds database, and DSS room and board database. No day program costs are included in the calculations above.

PRI staff also examined DDS contracted per-client costs for residential services and supports, temporary supplemental funds, and DSS room and board rates, based on each client's level of need assessment score for FY 10. Table II-12 shows average costs ranged from almost $70,000 to provide 24-hour residential services to the 40 clients that were assessed with a "1" level of need, to slightly more than $209,000 for clients with a level of need of "8." The range in costs-per-client was great with a minimum of $17,656 for a client with level of need of "1", to a maximum of $525,059 for a client with an "8" level of need.

Table II-12. DDS Annual Contracted Cost for Private CLAs by Level of Need (N=2,875)

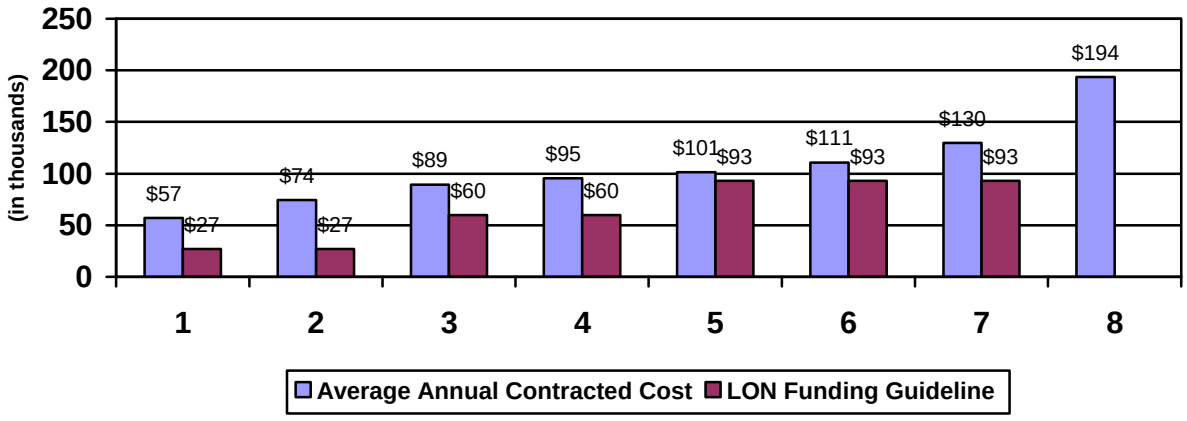
Level of Need (Residential)	*# of clients*	*Min.*	*Max*	*Average*	*Total Cost*
1	40	$17,656	$111,433	$68,994	$2,759,757
2	194	$27,696	$222,481	$86,749	$16,829,296
3	347	$29,712	$247,220	$102,781	$35,665,094
4	360	$39,177	$261,062	$109,237	$39,325,187
5	722	$26,552	$369,600	$115,348	$83,281,465
6	562	$57,000	$308,337	$125,438	$70,496,283
7	608	$60,409	$389,540	$145,074	$88,204,761
8	42	69,732	$525,059	$209,188	$8,785,900
Total	2,875			$120,121	$345,347743

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

not expect the payments will be annualized as part of a clients year-to-year expenses. There were 292 clients that received funding from DDS in FY 10 with a total amount of $4,078,253.

PRI staff examined the average contracted residential services and supports and temporary funds per-client costs at each LON, and compared them to the funding guidelines that guide the LON assessment process. The DSS room and board costs and any day program costs were excluded from the analysis since the LON funding guidelines are only for the residential services and supports needed by the client. Figure II-5 shows, in all cases, the average cost per client exceeds the maximum amount that a regional team can approve for services and supports until its authority is exceeded and the regional director or the regional UR team must make the decision about resource allocation. There are no funding maximums for clients who have a LON score of "8;" rather, an individual budget is developed by the regional Utilization Review Team.

Fig. II-5. Comparison of Average Cost to LON Funding Guidelines



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

From those cost submissions, the Department of Developmental Services each year develops a report that compares per diem client costs, annual costs per person, average level of need scores, and the number of people served across public and private DDS residential settings. Table II-13 compares the DDS average cost-per-client between public and private CLAs. To keep consistent with the costs included in the private contracted data previously presented, PRI staff deducted costs of case management and SWCAP and therefore, they are excluded from the annual and per diem cost-per-person served and total costs.[7] For public CLAs, PRI staff used the average costs-per-client calculated by DDS in its 2010 Cost Comparison Report since no client-specific data are available for DDS clients residing in publicly operated placements. Thus,

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

just based on overall averages and not adjusting for LON, it cost about two and half times as much for residential services in a public DDS-run CLA as it does in a private group home.

Table II-13. DDS Comparison of Per Client Cost		
Measures	***Public CLA***	***Private CLA***
Annual Cost per Person Served	$313,553	$124,981
Per Diem Cost	$859.05	$342,41
Average LON	5.4	5.04
People Served	453	2,932
Total Cost	$142,039,483	$366,444,350
Source: DDS FY 10 Cost Comparison Report.		

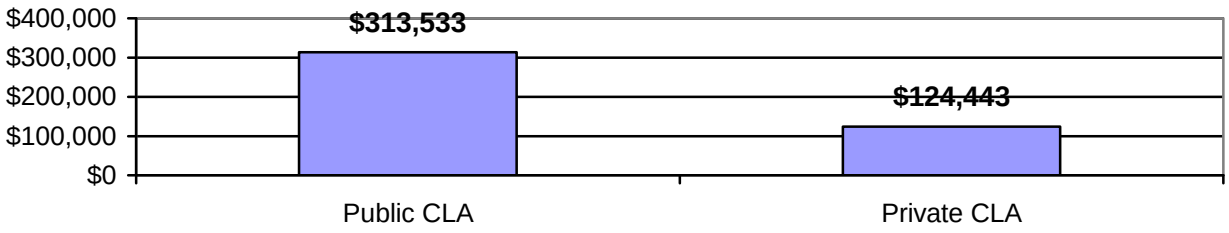
Comparisons based on client level of need. In general, a higher level of need score is associated with an overall higher cost for services, hence the development of funding guidelines based on LON. By making sure that the level of need profile is the same for the groups being compared, any cost differences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

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

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

Figure II-6 shows that it would have cost 2.5 times less for private CLAs to care for clients with the same client case mix that was at the public CLAs in FY 10. The average annual cost-per-client in a public CLA is $313,533 compared to $124,443 at a private CLA – a difference of more than $189,090 average annual cost per-client.

Figure II-6. Estimated Average Annual Cost Per Client in FY 10 Serving Public CLA Clients in Public versus Private CLAs (Adjusted for Case-Mix)



Source: PRI staff analysis, DDS reports

Private ICFs/MR. The Department of Developmental Services Cost Comparison Report also compares private and public ICFs/MR by per diem client costs, annual costs per person, average level of need scores, and the number of people served across the various DDS residential settings. Table II-14 compares the DDS average cost-per-client between private and public ICFs/MR. To keep consistent with the costs presented for public and private CLAs, case management, SWCAP, and day program costs are excluded from the total, annual and per diem cost-per-person served for the public ICFs/MR. Thus, just based on overall averages, without adjusting for, LON, it cost twice as much to provide residential services to clients living at a regional center or STS than it did for clients residing in private ICFs/MR.

Table II-14. Comparison of Public versus Private ICF/MR Client Cost.

Measures	*PRI Private ICF/MR*	*Regional Centers*	*STS*
Annual Cost per Person Served	$151,641.13	$325,835	$321,983
Per Diem Cost	415.46	$892.70	$882.15
Average LON	5.34	6.08	5.24
People Served	378	236	464
Total Cost	$57,280,049	$76,897,036	$149,400,049

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

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

Furthermore, private ICFs/MR can either operate their own day programs or negotiate with other providers to provide the day program for clients living in their facilities. Unlike the

DDS analysis contained in the Cost Comparison Report, PRI staff were unable to determine what portion of each private ICFs/MR rate that was allocated for day services, and therefore, the per-client rates in the PRI staff analysis include day costs, while the public ICFs/MR do not include day program costs.

Table II-15 shows the DSS-established prospective bundled rate for FY 10 on an annualized per-client basis by LON. The average annual prospective rate for a client residing in a private ICF/MR was $168,786.

Table II-15. DSS FY 10 Annual Per-Client Rate for Private ICF/MR by Level of Need (N=347)*

Level of Need (Residential)	*# of clients*	*Min.*	*Max*	*Average*	*Total Cost*
1	5	$101,996	$160,421	$115,417	$577,087
2	19	$101,996	$234,246	$135,016	$2,565,301
3	49	$101,996	$234,246	$146,440	$7,175,541
4	26	$109,471	$234,246	$155,862	$4,052,404
5	71	$109,471	$265,643	$168,388	$11,955,562
6	49	$117,968	$275,843	$170,531	$8,356,011
7	127	$117,968	$275,843	$186,764	$23,719,076
8	1	$167,648	$167,648	$167,648	$167,648
Total	347			$168,786	$58,568,630

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

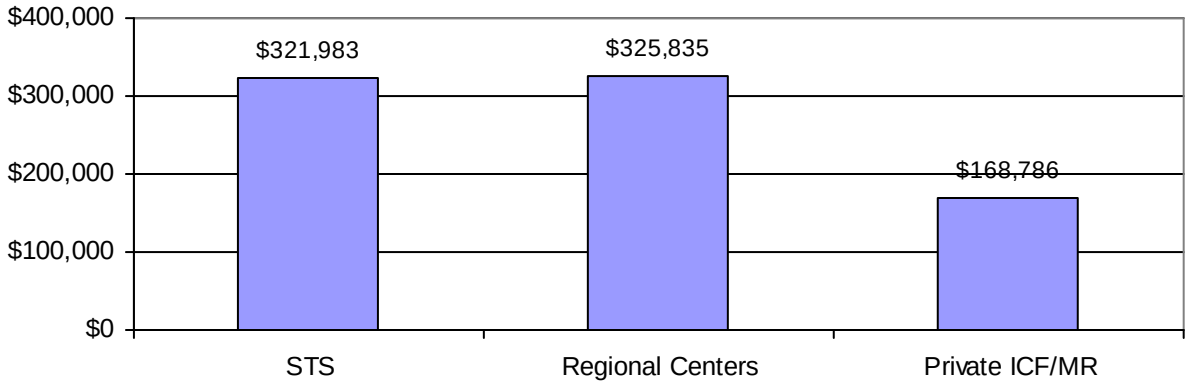
Applying the same methodology used to compare private CLAs to public CLAs, PRI staff also compared average annual cost-per-person residing at private ICFs/MR by LON and weighted it by the level of need for clients in public ICFs/MR. Since data were available for public CLAs only based on an average cost, and DDS data does not include day program costs for public ICF/MR residents, and PRI staff were unable to exclude day programs from the available data for private ICF/MR, costs are overstated for clients in private ICFs/MR. However, even given this caveat, the average private ICF/MR cost per client is much less, as shown in Figure II-7. PRI staff found, for clients in public ICFs/MR,, given the same client residential level of need:

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

- the average annual cost-per-client at STS was $321,983, almost double the cost of treatment at a private ICF/MR [and would even be higher if day

programs were included in the calculation for clients living at STS as they are for clients in private ICFs/MR]

Figure II-7. Estimated Average Annual Cost Per Client in FY 10 of Serving STS or Regional Center Clients in a Private ICF/MR (Adjusted for Case-Mix)



Source: PRI staff analysis, DDS reports

Day Programs for Clients in 24-hour Residential Care

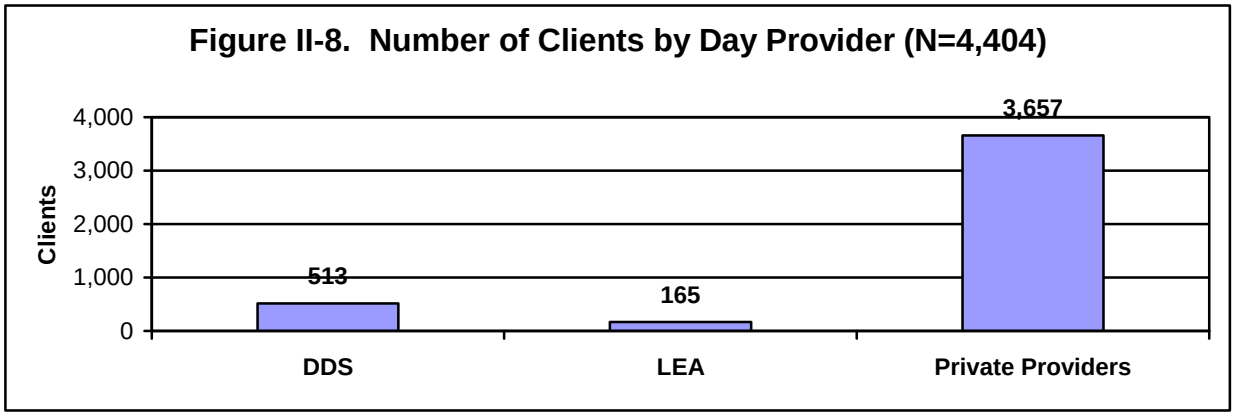
In addition to 24-hour residential care, the DDS clients that are the focus of this study also receive day program services. Day programs can be either directly provided by DDS or by a private provider. Table II-16 identifies the number of clients in each type of day program.

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

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

Figure II-8 shows the number of clients served by each type of day provider. Although DDS is the largest single provider of day services, private providers as a group, serve the greatest number of clients. Of the 513 clients served directly by DDS, 64 percent reside at STS, 16 percent at public CLAs, 11 percent at private CLAs, and the remainder come from regional centers or private ICFs/MR.

Table II-16. Day Programs for Clients in 24-Hour Residential Care (N=4,441)		
Type of Day Program	***Number of Clients N=4,411***	***Percent of Total Clients***
Client Worker	1	<1%
Day Support Options	2,603	59%
Competitive Employment	12	<1%
Group Supported Employment	1,185	27%
Individualized Day Non-Vocational Supports	61	1%
Individualized Day Vocational Supports	46	1%
Local Education Agency	165	4$
No Day Program – Refused	9	<1%
No Day Program – Medical Reasons	19	<1%
No Day Program – Program Needed	20	<1%
No Day Program – Retired	21	1%
Other Day	7	<1%
Residential School Day Program	5	<1%
Individual Supported Employment	79	2%
Sheltered Employment	178	4%
Total	4,411	100%
*38 clients missing Source: PRI staff analysis of DDS eCAMRIS database.		



DDS does produce cost comparisons exclusively for day programs; however, all DDS clients, not just the individuals in 24-hour residential settings, are included in the calculations. For example, in FY 10, 8,942 DDS clients were receiving day programs operated by private providers. The average cost of the program for these clients was $54.42 per day, while STS day programs served 326 clients for an average per diem of $101.92.

Clearly, all the clients at STS receive 24-hour residential care, while many of the DDS clients receiving day services from private providers (8,942 in FY 10 according to the DDS Cost

Comparison Report) were not part of the study population (i.e., clients receiving less than 24-hour residential services that likely have lower LON scores and therefore less expensive day programs.) Because of this, more analysis is needed to better link the clients in 24-hour residential care and the costs of their day program. PRI staff will develop information on these costs during the next phase of this study.

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

Table II-17. Funding Guidelines for Day Programs.

LON Overall Day Score or Behavior Score (whichever is higher)	***Recommended Maximum Based on 225 Days***
1	$11,286
2	$15,048
3	$18,810
4	$20,691
5	$22,572
6	$24,453
7	$26.334
8	$28,215

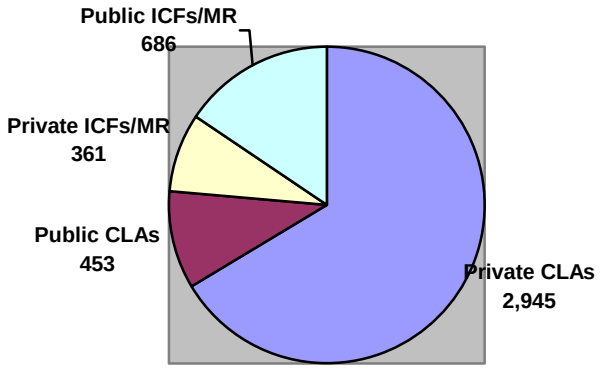
Source: DDS.

Section III: Profile of Providers

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

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

Figure III-1. Profile of Residential Programs: Clients Served By Setting



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

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

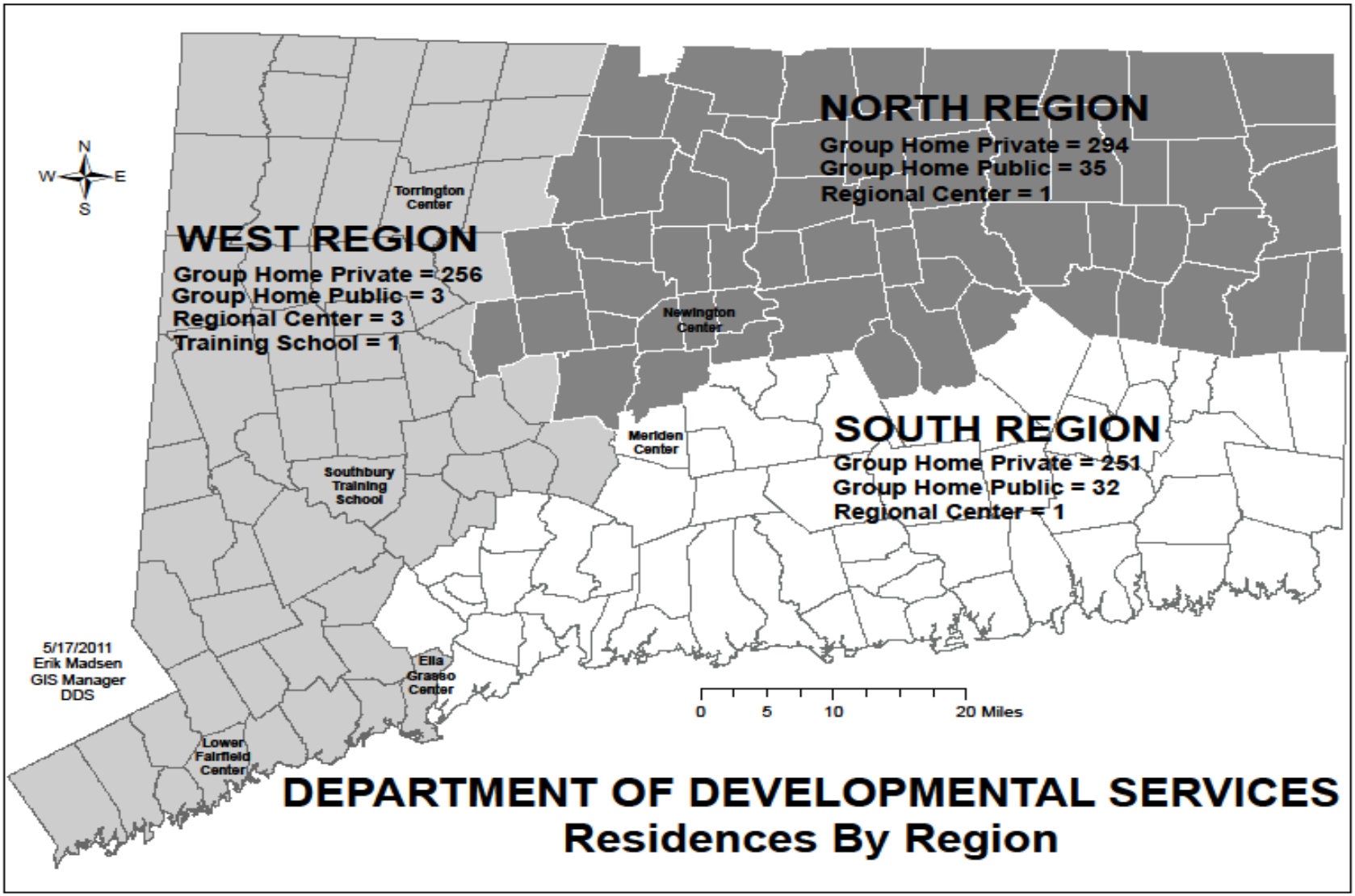

N
W
E
S
NORTH REGION
Group Home Private = 294
Group Home Public = 35
Regional Center = 1
WEST REGION
Group Home Private = 256
Group Home Public = 3
Regional Center = 3
Training School = 1
SOUTH REGION
Group Home Private = 251
Group Home Public = 32
Regional Center = 1
Torrington Center
Newington Center
Meriden Center
Southbury Training School
Ella Grasso Center
Lower Fairfield Center
5/17/2011
Erik Madsen
GIS Manager
DDS
0 5 10 20 Miles
DEPARTMENT OF DEVELOPMENTAL SERVICES
Residences By Region

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

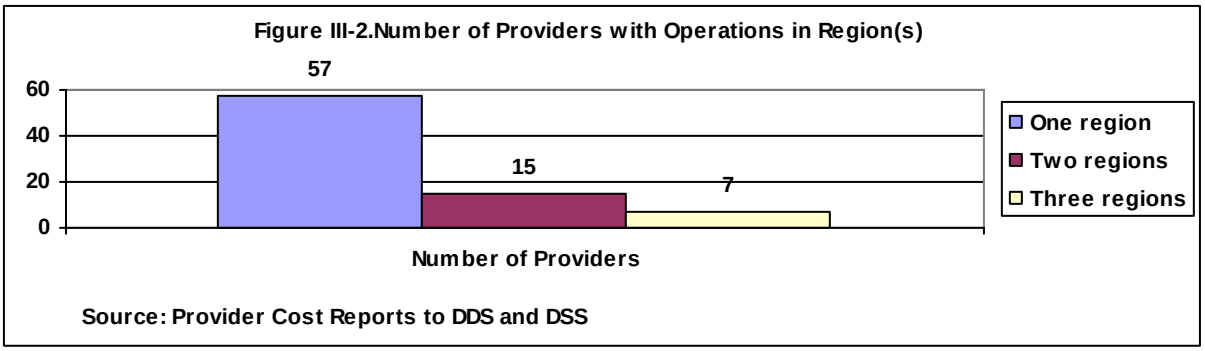
Private provider staffing. Residential programs of course require staffing whenever clients are at home. For some that is 24-hour, 7 days a week, while others may not require staffing during the day while clients are at work or other day program. Detailed analysis and comparison of staffing levels at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

Only 16 (or about 20 percent) of the private providers have unionized employees. However, because a greater number of larger providers are unionized (4 of the 8 providers with 21 or more homes), the percentage of unionized staff compared to all staff is likely to be much higher. PRI staff will obtain this information and analyze it this in greater depth for the final report.

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

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

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



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

Table III-2 Profile of DDS Residential Providers by Total Operating Revenue

Category of Revenue	Number of Providers (2009) N=79	Number of Providers (2010) N=79
Less than $1 million	6	5
$1-$5 million	24	24
$5-$10 million	21	22
$10 -$20 million	16	17
$20-$35 million	6	4
$35-$100 million	3	4
$100 million +	3	3

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

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

Table III-3. Profile of DDS Residential Providers by Net "Profit" or Loss

% profit/loss	Number of Providers (2009) N=79	Number of Providers (2010) N=79
- 5% or greater (loss)	4	3
-1 to -5% (loss)	20	10
-0 to -1% loss	12	17
0 to 1% profit	23	19
1 to 5% profit	18	26
5% or greater profit	2	4

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

As Table III-3 indicates, in terms of financial stability, the most basic measure in the cost reports (operating revenues minus operating expenses) shows that most providers barely meet expenses, and in fact, 36 of the 79 providers (46 percent) showed an operating loss in FY 09. While the fiscal environment improved slightly in FY 10, still 30 of the 79 providers showed a loss in their cost reporting. This is a very gross measure of financial stability, and does not take into account assets, reserves, or other factors that can influence a provider's fiscal strength; though the measure does seem to show on an annual basis how tight the agencies' budgets are.

Unlike nonprofit hospitals in Connecticut, which are annually assessed by the Office of Health Care Access (now part of DPH) for financial health using a variety of measures, nonprofit agencies providing human services are not regularly evaluated for this purpose. The Commission on Nonprofit Health and Human Services, in its report issued in March 2011, used a number of more complex financial tests that assessed all human service nonprofit agencies contracting with the state (not just DDS), and a more detailed discussion of these tests and findings are included in Appendix B. The commission concluded "that a large percentage of the Connecticut's nonprofit providers are in a financially precarious position, operating dangerously close to their margin and likely would not be able to maintain operations if they experienced unforeseen increases in expenses or financially detrimental incident".[8]

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

PRI staff reviewed the cost reports for 75 private CLA service providers on file at DDS, and the executive director salary results are shown in Table III-4 below. Forty of the providers (53%) included the form that is required if the director's salary exceeded $100,000 a year. In most of the cases, there were indications that the excess over the $100,000 was being paid by fundraising or a source other than the State of Connecticut. In three cases where the salaries were substantially over the threshold, other states (e.g., New York) were paying the excess. However, in several cases where there was no form filed, the agencies had large amounts paid for "management fees". Committee staff inquired of DDS and the private contractor for rate promulgation whether this type of cost reporting is allowed or not. While apparently there is no prohibition of reporting the costs this way, and the management fees are not an "allowable" cost for ultimate Medicaid reimbursement, it does appear to circumvent the statutory requirement for transparent reporting of an agency's Executive Director's salary.

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

While the salaries overall appear to be reasonable in Connecticut, with the recent New York Times articles[9] on exorbitant executive directors salaries in agencies under contract with the developmental services agency in that state, efforts should be made to ensure that providers comply with the statutorily required reporting of salaries.

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

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

Section IV: Comparison of Staffing Resources

Direct Care Staffing

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

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

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

- total number of staff in that setting – taken from CORE-CT assigned staff to location as of July 2010;
- total number of clients in that setting (this is the number of clients the e-Camris data indicates are living there as of June 30, 2010, not the number of certified beds);
- average number of full-time equivalent (FTE) staff by home or ICF;
- average direct staff-to-client ratio by home or ICF – (total number of direct care staff in that type of setting divided by the total number of clients);

The results of the comparisons are contained in Table IV-1. Since private providers submit their staffing data on an FTE basis in the filed cost reports, PRI staff calculated FTEs for public settings for comparative purposes.[10] The table results indicate that when the staffing per residential unit is measured, there are more per-unit numbers of staff assigned to the public settings --- Southbury Training School (19.2), followed by the regional centers (12.9) and the public CLAs (11.8). However, those public units also care for a greater number of clients per setting, an average of 11.3 clients in a cottage at Southbury, followed by 6.9 clients in a cottage at a regional center. The public CLAs also have more clients – 5.8 per home -- than either of the private settings – ICFs/MR (5.0) or CLAs (4.4).

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

Table IV-1. **Direct Care** Staffing Levels at Public and Private Residential Settings – FY 10					
Type of Residence	Total # of FTEs	Average Number of Staff per Home/Cottage	Total # of Clients	Average Number of Clients per Home	Average Direct Care Staff-to-Client Ratio
Public ICFs Regional Centers N+ 5 Centers 28 units	427.2	12.9	227	6.9	1.9 to 1
Private ICFs/MR N=69	713.6	10.3	359	5.2	2.0 to 1
Public CLAs N=70	828.2	11.8	410	5.8	2.0 to 1
Private CLAs N= 647	5,788	8.9	2,830	4.4	2.0 to 1
Southbury Training School N=1 facility = 40 Units	768	19.2	450	11.3	1.7 to 1
Source: PRI Staff Analysis of staffing from DDS and DSS Cost Reports; Client data from e-Camris					

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

Part-time staff. A component of the staffing data that was readily available in public (DDS) settings, but not in the private, was the number of part-time workers. The direct care staffing in DDS residences is heavily made up of part-time workers; thus while FTEs are one measure, there are actually many more *people* working in those settings than the FTE numbers would imply. For example, in the public ICFs/MR there were 427 FTEs, but 302 persons employed full time and another 202 employed part time, translating to 504 persons employed (40 percent part time). Similarly, in the public CLAs, the FTE count was 828, but the number of people employed was actually 1,047 – 592 were full time, and 455 (43 percent) were part-time. While the heavy reliance on part-time staff may assist with coverage of hours and scheduling

(PRI was unable to obtain part-time numbers for the private homes), it may add expense because of the generous benefits for state workers. [11]

Staffing Resources by Client Level of Need

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

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

Table IV-2. Direct Care Staffing Resources by Setting by Level of Need

Type of Residence	Average Client LON	Average Direct Care FTEs by setting	Number of Clients per-home/cottage
Public ICFs Regional Centers N= 5 facilities, 28 units	6.08	12.9	6.9
Private ICFs/MR N=69	5.36	10.3	5.2
Public CLAs N=71	5.42	11.8	5.8
Private CLAs N= 647	5.03	8.9	4.4
Southbury Training School N=1 facility, 40 Units	5.24	19.2	11.3

Sources of Data: Client data from e-CAMRIS, staffing data from cost reports and CORE-CT

- *Average FTE by setting:* Comparing the average client LON with the average staff per home shows that the staffing at STS is greater than all the other settings, including the public ICFs/MR, which has the highest average client LON. However, STS has more clients per home or cottage (11.3). It is worth noting again that this analysis includes only direct care staff assigned to a particular

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

home or cottage, and does not include those that work at a facility or in region generally.

Comparison of Salary Levels

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

Table IV-3. Direct Care Staffing Salaries Comparison

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

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

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

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

While the compensation level for a certain class in public service may not have a wide range, in general, longer-term public employees have more promotional opportunities to move to a higher classification level, and a higher wage, compared to private provider employees. The data to analyze length of time employed, as well as time in class are available for the public sector but not for the private providers. Another factor potentially affecting wages is whether the provider agency has unionized staff or not. Further analysis will be done in this area for the final report.

Benefits

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

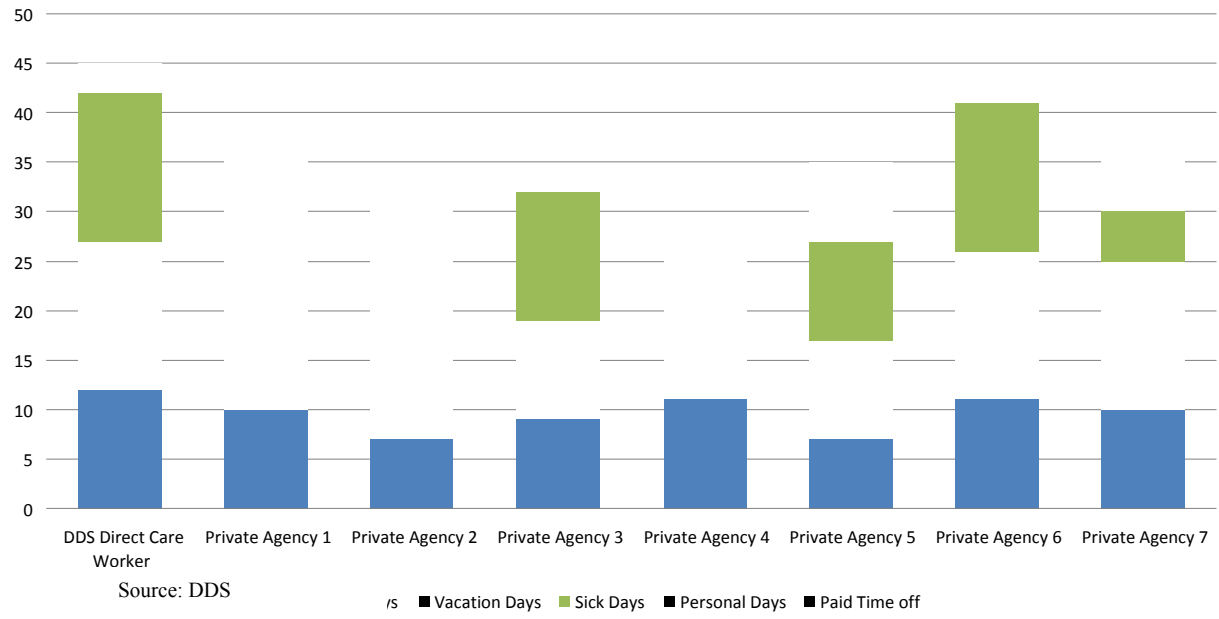
The same cost information DDS developed for per diem rates in FY 10 shows that the provider benefit costs for private CLAs was about $51.4 million, which accounted for about 27 percent of the overall $191.5 million in private provider direct care salaries. The dramatic difference in benefit costs and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

than half-time. As mentioned previously, DDS part-time employees are eligible for benefits, including health care.

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

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

Figure IV-1. Accrued Benefit Time for a Full-Time Direct Care Worker after Five Years of Service



Source: DDS

Other Costs

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

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

However, to put the reduction in overtime in context, PRI staff measured the trends in staffing and workload that might affect overtime. As a proxy for workload, PRI staff used the number of clients in DDS residential settings. This client number was compared with the number of full- and part-time staff in the department (without central office) in June of each the past four years and the results are shown in the table below. While the overtime hours have decreased about 21 percent over the five year period, clients in DDS residential facilities have decreased by almost 39 percent.

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

Table IV-4. DDS Overtime Hours, Clients and Staffing: FY 07-FY 11

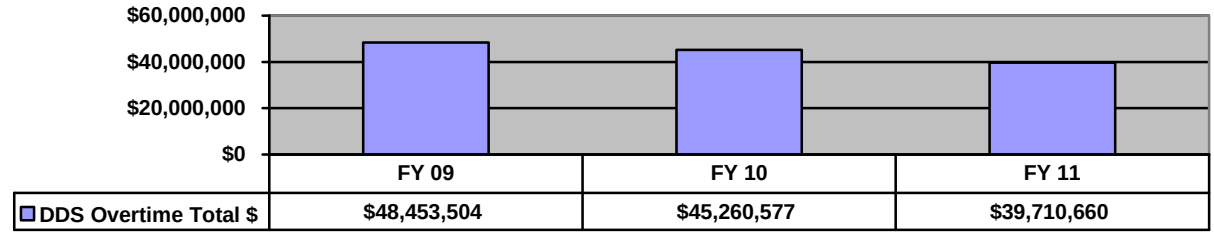
Year	FY 07	FY 08	FY 09	FY 10	FY 11	% Decrease FY 07-FY 11
OT hours	1,472,992	1,478,078	1,371,737	1,361,899	1,161,622	(21.1%)
Clients in DDS residences	1,744	1,309	1,260	1,139	1,064	(38.9%)
Staffing Full-time	3,716	3,744	3,741	3,457	3,457	(6.9%)
Staffing Part-time	1,172	1,191	1,194	1,159	1,158	(1.2%)

Sources of Data: DDS and OFA for overtime data. DDS MIR reports June 07-June 11 for client and staffing data; PRI Analysis

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

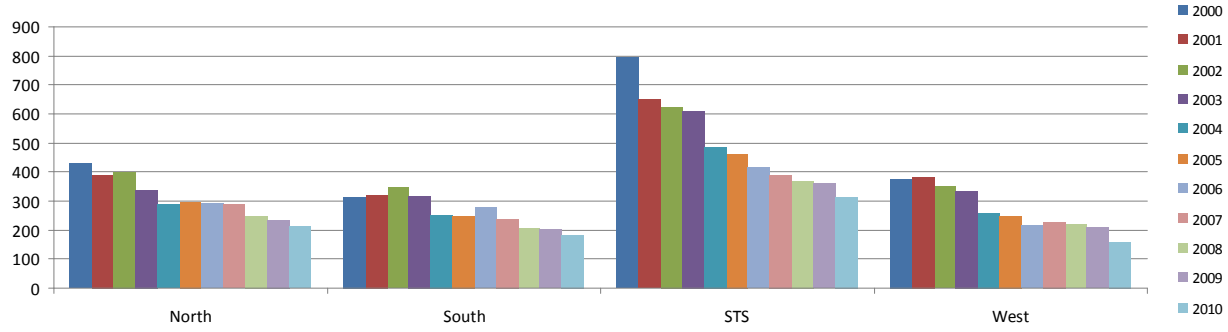
Workers' compensation costs. There are a number of reasons why overtime occurs, often to cover for regularly scheduled staff that are out for one reason or another, including those out on workers' compensation. Workers' compensation is a long-standing issue in DDS, as it is in many agencies that provide direct care or health services to clients. The figure below depicts the number of DDS workers' compensation claims by region and at Southbury from 2000 to 2010. Overall, the trend in the number of claims has been decreasing and in fact the number of new claims in FY 10 (872) is less than half the 1,918 claims filed in 2000.

Figure IV-2. DDS Overtime Costs FY 09 - FY 11



Source: DDS and OFA

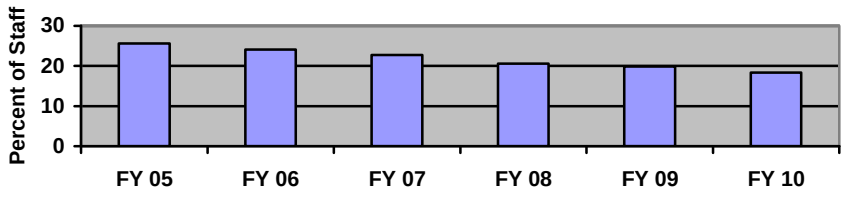
Figure IV-3. DDS Workers' Compensation Claims 2000-2010



Source: DDS

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

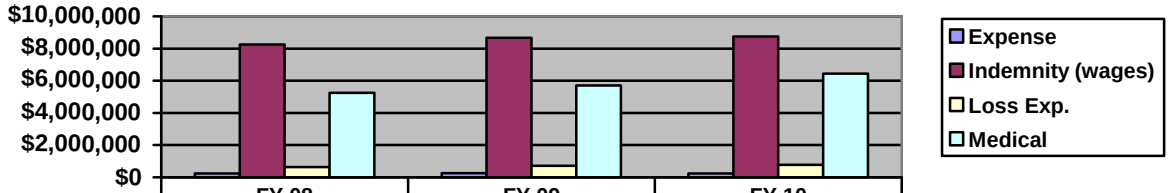
Figure IV-4. DDS New Workers' Compensation Claims as a Percent of Staff FY 05-FY 10



Sources of Data: DAS and DDS

Workers' compensation claim costs for DDS in FY 10 totaled $16.2 million, about 15 percent of the state's $110 million workers compensation costs, according to the DAS annual report on workers' compensation. (Only the Department of Correction was higher at 30 percent). DDS workers' compensation costs are depicted in the figure below. PRI staff was not able to obtain and analyze workers' compensation experience in the private provider agencies, but will attempt to do that for the final report.

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



	FY 08	FY 09	FY 10
Expense	$239,364	$265,904	$245,659
Indemnity (wages)	$8,242,572	$8,665,722	$8,746,207
Loss Exp.	$644,391	$706,465	$772,613
Medical	$5,251,011	$5,703,237	$6,437,284

Source of Data: DAS

Section V: Quality Assurance

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

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

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

Quality assurance for CLAs. An initial inspection is required before a community living arrangement can be licensed. Licensing inspections are required prior to licensure, six and 12 months after the initial licensure, and at least biennially thereafter. While licenses are renewed annually, inspections are only required at least every two years. If an inspection indicates deficiencies or problems, a "revisit" or follow-up inspection may be done. While full inspections are required at least every two years, annual inspections are conducted if a home or provider needs increased monitoring. Also, even if a full licensing inspection is not conducted annually, quality service reviews are performed of all CLAs during the interim year.[12]

The Quality Assurance Division maintains a database that includes information on each inspection, and data from that database for FY 10 were used for this analysis. While DDS also

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

"licenses" private ICF/MRs, the ultimate regulation tied to reimbursement lies with DPH. DDS conducts inspections of private ICFs and the results are contained in the database. However, PRI staff does not include the results (other than the number conducted) of the ICF/MR inspections in the following analysis for two reasons. DPH is the agency responsible for official certification and ongoing monitoring, and PRI staff has asked DPH for that data but it was not available for the issuance of this report. It will be contained in the findings and recommendations report. Secondly, DDS has no data in the database on its own ICFs/MR, so comparisons of results could not be made for the ICF/MR facilities.

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

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

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

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

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

Table V-2. Deficiencies for CLA Licensure Visits in FY 10 (N=504)

At Least 1 Deficiency within the Category	Number of CLAs with deficiencies by Category	% of CLA Visited with that deficiency
Health services	320	64%
Physical requirements	290	58%
Habilitative services	243	48%
Emergency planning	214	42%
Staff development	196	39%
Special protections	174	35%
Financial records	105	21%
Plans of correction	76	15%
Policies and procedures	43	8%
Annual license renewal	29	6%
Individual records	29	6%
Initial application	6	1%
Licensure	1	<1%
TOTAL SITE VISITS	**504**	
Average # of deficiencies per CLA	**6**	

Source: DDS Licensing Data.

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

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

Table V-3. Number of deficiencies by size of providers

Category of providers by number of homes	***Number of deficiencies***							
	0	.45-2.99	3 to 3.99	4 to 5.99	6 to 7.99	**8 to 9.99**	**10 to 12.99**	**13 +**
One home (N= 8)		1		1	1	**2**	**2**	**1**
2-5 (N= 22)	2		2	4	6	**2**	**1**	**5**
6-10 (N=18)		1	3	5	1	**6**	**2**	
11-20 (N=16)		2	3	3	5	**1**	**2**	
21-50 (N=8)		1	3	2	1		**2**	
51+ (N=1)				1				
Total Private	2	5	11	16	14	**11**	**9**	**6**
Public DDS Regions (N=3) (51+ homes)						**2**	**1**	

Source: DDS Licensing Inspection Data FY 10

Severity of deficiencies. Unfortunately, there does not seem to be a degree of severity of deficiencies that would be a tool for assessing overall quality. The regulations indicate that DDS may issue a *compliance order* if a home fails to comply with certain regulations regarding licensed capacity, increasing staff support, requiring additional staff training, or correcting specific licensing citations. However, DDS licensing staff state no provider has been issued such an order in a number of years, and order issuance is not captured on the licensing database.

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

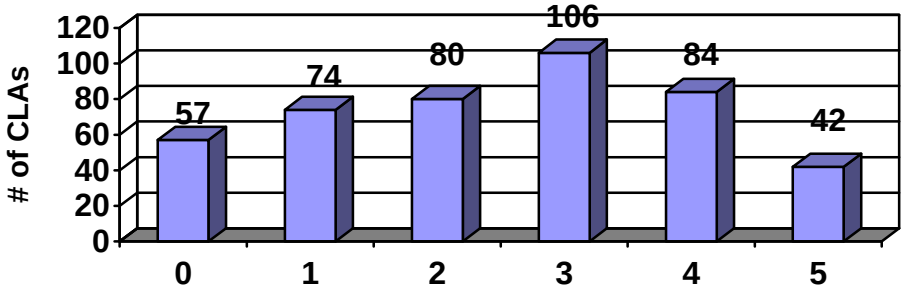
- emergency planning;
- health services;
- physical requirements;
- special protections; and
- staff development

Figure V-1 shows 57 of the 443 CLAs (13 percent of inspections) had *no* deficiencies in the more serious areas while 42 CLAs (10 percent of inspections) had at least one deficiency in *each* of the five important deficiency areas.

However, these areas cover most of the regulation categories, and once again, the lack of severity identification within the category is a shortcoming. PRI examined the citations in the health services category in greater detail and the results of that analysis are contained in

Appendix C. That analysis found the most frequent citation within the health services category was around medication administration (34 percent of inspections), followed by coordination, assessment and monitoring of medical care (31 percent of inspections).

Figure V-1. Number of "Serious" Deficiency Areas Identified in FY 10 CLA Licensure Visits



While no compliance orders have been issued recently, the department does require a plan of action for any inspection where citation of deficiencies occur. The provider must submit the plan to DDS within 15 days of receiving the summary of citation report. The department reviews the plan and if sufficient, issues the license renewal. The department may "revisit" the home to follow up on a particular plan of correction, or the department may place a home on an annual licensing inspection schedule. However, as Table V-1 indicated, only 37 inspections (8%) were an annual licensing inspection, which would be fewer than five percent of the number of CLAs.

Review of Historical Licensing Visits

PRI focused its analysis primarily on the FY 10 licensing information, as that time period is the basis of other client and cost information in the study. However, the DDS licensing database contained information on more than 7,100 inspections of CLAs that occurred between July 1995 and February 2011, and a summary analysis of that data is presented in Table V-4. The table shows the average number of deficiencies identified during the 7,761 licensing site visits occurring between July 1995 and February 2011. Overall, many more deficiencies are found during standard visits, rather than a revisit, which makes sense since revisits are often a follow-up to a plan of corrective action.

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

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

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

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

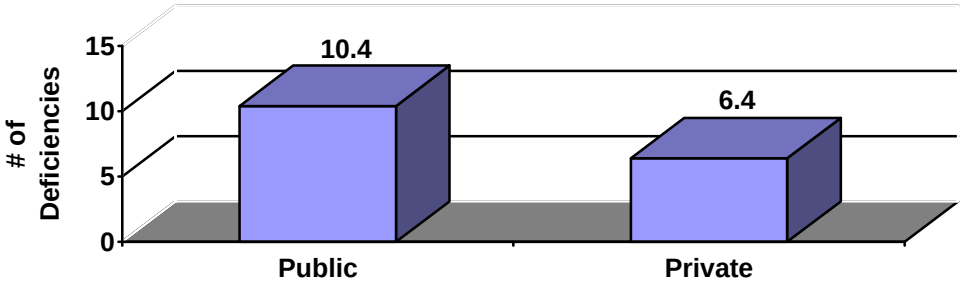
Public-to-Private CLAs. To further test the contention that public homes are treated differently than private homes, PRI examined the licensing inspection data from the 17 homes that were transferred over from DDS-run homes to private agencies. Figure V-2 contrasts the findings from the last (public) licensing visit that occurred just prior to the conversion to a

private CLA with the findings from the first licensing visit that occurred for the CLA as a private home. The results, depicted in the graph, show there were significantly more deficiencies for the CLA at the time it was a public home. In particular, when CLAs were public homes, they were more likely to have at least one deficiency in the area of staff development – 76 percent when public CLA vs. 35 percent when private CLA. The CLAs were also likely to have more of the "serious" deficiencies when they were public homes compared to when they became private homes.

Table V-5. Profile of Licensing Reviews Conducted in FY 10[1] for Public vs. Private CLAs			
	Public CLA (n=42 inspections)	**Private CLA (n=401 inspections)**	**Total (N=443)**
Type of Review			
Standard	28 (67%)	310 (77%)	338 (76%)
Revisit	13 (31%)	80 (20%)	93 (21%)
Other	1 (2%)	11 (3%)	12 (3%)
TOTAL	42 (100%)	401 (100%)	443 (100%)
Licensing Period			
Annual	3 (7%)	34 (8%)	37 (8%)
Biennial	37 (88%)	361 (90%)	398 (90%)
Other	2 (5%)	6 (2%)	8 (2%)
TOTAL	42 (100%)	34 (100%)	443 (100%)
Average Number of Deficiencies			
	10	6.4	7

[1]Type of licensing review conducted is for first visit if more than one visit occurred in FY 10.
Source: DDS.

Figure V-2. Number of Deficiencies for CLAs Converted From Public to Private Homes

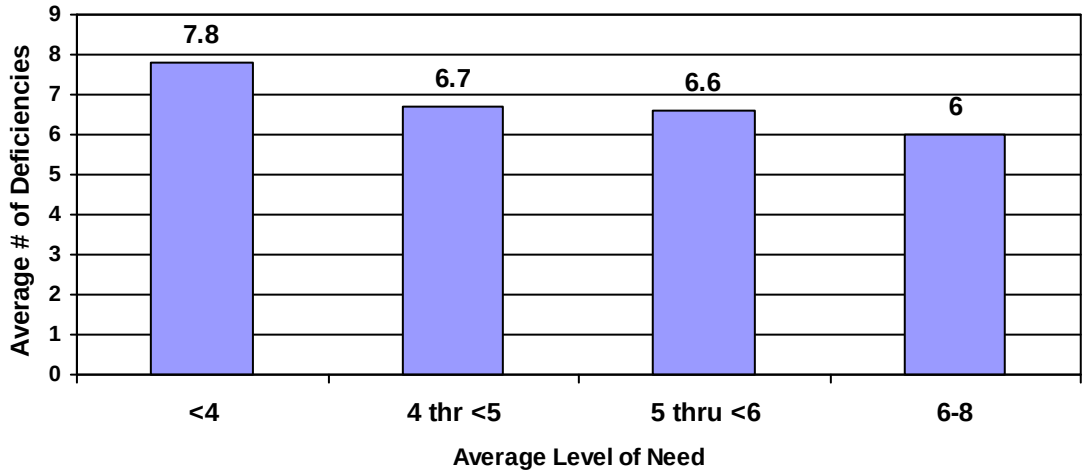


Overall, PRI staff believes the above analysis suggests that licensing inspections conducted by DDS do not "favor" public over private homes. However, apparent continued non-compliance -- indicated by historically and current higher deficiency numbers in the public homes – is a matter of concern, and may call into question the strength of follow-up enforcement of public homes. Additionally, the lower number of deficiencies post-conversion should indicate that quality does not deteriorate in a private setting and in fact may improve the residential services clients receive.

Level of Need in the CLA

PRI also analyzed the inspection data to determine whether the average level of need in a group home had a bearing on the number of deficiencies found. Interestingly, as Figure V-3 shows, the average number of deficiencies identified in a CLA actually decreased as the overall level of need (averaged for residents in the home) increased This may suggest that as the average LON increases, there are more staffing and other resources available for clients, and concomitantly, compliance with the regulations.

Figure V-3. Average Number of Deficiencies by Average Level of Need of Clients



APPENDICES

APPENDIX A

Acronyms

List of DDS Acronyms and their definitions

ABI	Acquired Brain Injury
ADA	Americans with Disabilities Act
ADD/ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
A/N	Abuse and Neglect
AO	Age Out–when a client goes from a LEA client to a DDS client at age 21
APRN	Advanced Practice Registered Nurse
APPROPS	Appropriations Committee
CAMRIS	DDS' internal client database, Connecticut Automated Mental Retardation Information System (also eCAMRIS)
CLA	Community Living Arrangement (Group Home)
CMS	Centers for Medicare and Medicaid Services (federal)
CO	Central Office of DDS
COTA	Certified Occupational Therapy Assistant
CP	Cerebral Palsy
CPAC	CT Parent Advocacy Center
CSHCN	Children with Special Health Care Needs
CTH	Community Training Home
DCF	Department of Children and Families
DD	Developmental Disabilities
DDS	Department of Developmental Services (formerly DMR)
DMHAS	Department of Mental Health and Addiction Services
DMR	Department of Mental Retardation (DDS as of 10-1-07)
DPH	Department of Public Health
DSO	Day Support Options
DSS	Department of Social Services
FSW	Family Support Workers
GH	Group Home (also CLA)
GSE	Group Supported Employment
HCBS	Home & Community Based Services-a reimbursable waiver program under Medicaid
HCFA	Health Care Finance Administration (now CMS)
HIPAA	Health Insurance Portability and Accountability Act
HRC	Human Rights Committee
HSC	Human Services Committee
ICC	Interagency Coordinating Council
ICF/MR	Intermediate Care Facility for the Mentally Retarded-A Medicaid reimbursable residential program

ID	Intellectual Disability
IDEA	Individuals with Disabilities Education Act
IDT	Interdisciplinary Team
IEP	Individualized Education Program
IFS	Individual and Family Supports
IFSP	Individualized Family Service Plan
IHS	Individualized Home Supports (Previously SL or ISHab)
IL	Independent Living
IP	Individual Plan
IPS	Individual Plan Short Form
IS	Individual Supports
ISA	Individual Support Agreement
ISHab	Individual Supports Habilitation
LD	Learning Disability
LEA	Local Education Agency-funding agency for day/education before a DDS client is 21
LON	Level of Need assessment tool-from 1 to 8 on level of severity
LPN	Licensed Practical Nurse
LTC	Long Term Care
MIR	Management Information Report
MOA	Memorandum of Agreement (between agencies or parties)
MOU	Memorandum of Understanding (between agencies or parties)
MR	Mental Retardation
NR	North Region of DDS
OBRA	Omnibus Budget Reconciliation Act of 1993 (the set of rules enacted in the federal budget act covering nursing facility placement for persons with mental retardation, e.g. OBRA nurse.)
OT	Occupational Therapy/Therapist
PAR	Programmatic Administrative Review
PATH	Parents Available To Help
PCA	Personal Care Attendant
PDD/NOS	Pervasive Developmental Disorder/Not Otherwise Specified
PECS	Picture Exchange Communication System
PHC	Public Health Committee
PMT	Physical/Psychological Management Training
PPT	Planning and Placement Team
PRAT	Planning & Resource Allocation Team
PRC	Program Review Committee
PST	Planning and Support Team
PT	Physical Therapy/Therapist
PTA	Physical Therapy Assistant
QA/QI	Quality Assurance/Quality Improvement
QM	Quality Management

QSR	Quality Service Review or Quality System Review
RC	Regional Centers-3 in West Region-1 each in South and North
SAC	Self Advocate Coordinator
SDE	State Department of Education
SEI	Supported Employment (Individual)
SERC	Special Education Resource Center
SNF	Skilled Nursing Facility
SL	Supported Living
SLA	Supported Living Arrangement
SLP	Speech & Language Pathologist
SR	South Region of DDS
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STS	Southbury Training School
TBI	Traumatic Brain Injury
URR	Utilization Resource Review
VSP	Voluntary Services Program
WR	West Region of DDS

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

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

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

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

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

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

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

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

Sources of Revenue

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

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

b) Current Revenue Funding Mix. The Workgroup fund that those with State revenues per year between $300,000 and $2.0 million had the highest percentage of Governmental Funding at 75.82%. Those with funding over $2.0 million had very similar levels of Governmental Funding 64.00% and 62.08% respectively. Another interesting similarity is that providers with under $10 million in State funds have the same exact percentage of funds coming from Philanthropy efforts at 9.5%, while those over $10 million had a much lower percentage of funds from Philanthropy, with donated funds making up only 1.7% of their overall revenues.

c) Trends in Philanthropy. The Chronicle of Philanthropy reported on October 17, 2010, that donations had dropped 11% at the nation's biggest charities during this last year. This is the worst decline in two decades, with this year's decrease being four times as great as the next largest annual decrease that was recorded in 2001 at the rate of 2.8%.

d) Possible Future Funding Mixes. There is the possibility of changing the funding mix for services, and exploring more Medicaid reimbursed services; however, this opportunity involves a number of additional administrative requirements and issues for the providers and the State that should be considered prior to switching the funding source from grant funding to Medicaid funding:

Recommendations

40. We believe it is important to have data over a period of time. It is recommended that a retrospective calculation of financial ratios included in this report be conducted from 2007 to 2010, with the audits that are on hand at the OPM to determine if the results indicate trends. It is further recommended that the financial ratios be completed on an on-going basis so trends in the private providers' financial condition can be assessed over a period of time.

41. It is recommended that a special committee of providers and State officials, chaired by the Nonprofit Liaison to the Governor, be assembled to assess and report on financial trends and unforeseen expenses and analyze provider increases and fixed costs impacting the private providers' financial position and possible solutions.

42 It is recommended that when system wide technical requirements are imposed or expected of Nonprofit providers that the State takes a lead role in assisting providers by investigating the options, initiating a bidding process to attempt to achieve savings and by providing technical assistance to providers. The current method results in a duplication of effort and costs and often results in providers having not acquired the required product. It also results in a system that makes communication with State agencies and other private providers inefficient which further burdens the system because of a lack of consistency amongst the State Agencies.

43. A cost benefit analysis should be conducted for all revenue producing initiatives including Medicaid services, waivers, and Private Non-Medical Institution. This analysis should be conducted with not only the State's costs being considered but also the costs to private providers. It is recommended that the State be cautious in its attempts to change the payer mix. If the new costs to the entire system, including both the State and the providers, are more than the State will receive in reimbursement it should be understood that this will not be a cost effective change for the State and may result in a need to continue to provide grant funding for non-reimbursable expenses. When providers do not have the investment dollars to establish the infrastructure necessary to successfully make the change in the payer mix, it results in audit findings and significant repayment of funds only further jeopardizing the providers' financial condition.

44. It is recommended that mechanisms be developed to compensate not for profit providers doing business with the state for necessary costs that occur outside the control of the provider. These necessary costs most commonly occur due to vacancies, admission delays, discharge delays, transfer delays, or unfunded continued occupancy (aka overstays)

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

APPENDIX C
Licensing Inspection Findings Concerning Health Services

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

Comments pertaining to "medication administration regulations" deficiencies included:

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

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

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