REPORT TO

UTAH STATE LEGISLATURE

Report No. 98-07

A Review
of the
Costs and Services for Individuals
with Developmental Disabilities

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Review of the Costs and Services for Individuals with Developmental Disabilities

This report compares the costs and services for individuals with mental retardation and developmental disabilities (MR/DD) who require a high level of care in three programs:

1. Home and Community Based Services (HCBS) group homes and apartments
2. Utah State Developmental Center (USDC)
3. Private Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Because resources are limited and needs are great, difficult decisions must be made about how to best balance costs incurred with services provided. The purpose of this report is to provide decision makers reliable information to help them evaluate the difficult policy alternatives. The report has two main conclusions.

- The average cost of high need individuals is greatest at the USDC and least at ICFs/MR. While the cost in the HCBS program is between the other two, average cost comparisons need careful analysis.

- The Division of Services for People with Disabilities (DSPD) should develop a more effective monitoring system to provide assurances that individuals' needs are being met and that the state receives full value for dollars spent.

Excessive costs deny services to others. Although expenditures for MR/DD services have increased in recent years, DSPD has a long list of individuals waiting for services that it cannot afford to supply. Unless better ways to control costs are found, the state either needs to significantly increase MR/DD funding or accept the continuing existence of a lengthy waiting list of individuals who need services. Our cost and service information can help the Legislature to make more informed decisions when considering policies about the services that can reasonably be provided with limited funds.

Cost Comparisons Require Careful Analysis. We compared the costs of serving an individual in the HCBS program to the USDC and to privately-owned ICFs/MR. Our estimates include the cost for the full array of services received regardless of the funding source. We found that in fiscal year 1997:

- The average cost of former USDC residents in the HCBS program was 10 percent less than that of USDC residents ($ 83,785 per year vs. $92,766).

- The average cost of former ICF/MR residents in the HCBS program was 25 percent more than that of ICF/MR residents ($57,901 per year vs. $46,355).

However, average cost data should be interpreted with caution so that erroneous conclusions

are not reached. Average costs do not necessarily indicate the likely cost of placing one more individual in a program or the likely savings for serving one less individual. Because of fixed and transitional costs, USDC's average costs have increased as the institution's population has decreased. In fact, transfers from the USDC to the HCBS program appear to increase total costs although average costs appear to indicate otherwise. In addition, service differences may affect the comparability of costs. ICF/MR providers are paid a flat rate per person regardless of each individual's disability that may incorporate a lower staffing level and larger facility size into their rates than that provided in HCBS group homes.

In addition to estimating program costs, we also were asked to review some specific issues related to the *Lisa P.* Settlement Agreement. Under the 1993 agreement, Utah committed to transferring USDC residents into less restrictive placements when appropriate. Many individuals have transferred from the USDC to the HCBS program. We were asked: (1) if the funds followed individuals who transferred from the USDC to the HCBS program; and, (2) if the proportion of costs paid by the state changed significantly because of the transfer. First, we found that $59,000 per person per year was transferred from the USDC budget to the HCBS region where the individual moved. However, both programs realized a shortfall and, as a result, required additional appropriations. Second, while total costs may have increased, the state's proportional share of costs does not appear to have significantly changed.

Care Comparisons Indicate DSPD Needs to Develop Compliance Monitoring Program. We were also asked to review the delivery of services in the three program settings. While we compared service delivery to requirements, it was beyond our audit scope to assess the relative quality of life experienced by residents in each setting. We found the following:

- Our case file review shows similar results for all three programs: all individuals received required health care but some did not receive the full complement of training and prescriptive therapies specified in their individual plans. A person's functioning level may deteriorate without adequate training and therapy.

- Effective monitoring in the HCBS program is important. First, we found that there is little monitoring of whether providers deliver the required staffing levels that clients need and for which the state pays. Second, the number of high service level individuals is growing not only from new clients but also by the reclassification of existing clients.

- Philosophical changes at DSPD has led to some uncertainty about support coordinators' role. With the emphasis on an individual's quality of life, cost control and the monitoring of service delivery have become less important.

To help control costs and ensure that individuals receive services and staffing that they need and that the state is paying for, we recommend that DSPD develop a more effective monitoring program by clarifying responsibilities and communicating them to staff. We also recommend that the Division of Health Care Financing review its monitoring procedures to insure that ICF/MR residents receive consistent training throughout the year.

Chapter I
Introduction

The state faces a variety of challenges in meeting the needs of Utah's citizens with mental retardation and other developmental disabilities (MR/DD). Because resources are limited and needs are great, difficult decisions must be made about how to best balance costs incurred with services provided. Excessive costs deny services to others. The purpose of this report is to provide decision makers reliable information to help them evaluate the difficult policy alternatives.

This report compares the costs and services for individuals with mental retardation and related developmental disabilities who require a high level of care in three residential programs:

- Home and Community Based Services (HCBS) group homes and apartments
- Utah State Developmental Center (USDC)
- Private Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

In recent years, the Division of Services for People with Disabilities (DSPD) has increased the number of individuals served in the HCBS program while USDC has decreased its residents, and the ICF/MR population has remained level. Many individuals could be served in any of the three programs. However, a number of organizational and philosophical differences among the programs make it difficult to get comparative data. In fact, efforts to compare programs tend to lead to controversy and acrimony.

This report is mostly informational rather than evaluative. We focused on estimating the costs of serving an individual who requires a full complement of services in each of the three programs. Our cost information is presented in Chapter II and includes the historical expenditures for health care, therapies, training, and room and board for people who reside outside of their family home. We did not attempt to evaluate the quality of life realized by individuals in the three programs or to compare the cost effectiveness of each program's services. While we did not evaluate the quality of care given by service providers in each setting, we did review consumer files to assess whether prescribed services were delivered. Prescribed services include health, therapy and training objectives outlined in each individual's plan. Since insufficient oversight jeopardizes efforts to reduce costs, we recommend that the DSPD improve its contract monitoring program. Services information is presented in Chapter III.

Costs for Individuals with MR/DD Vary Based on Needed Services

Individuals with mental retardation and related developmental disabilities (MR/DD) vary in levels and types of disabilities as do the intensity of services and therefore the costs necessary to assist them in achieving their maximum potential. An individual's level of mental retardation and developmental disability, severity of behavioral or neurological conditions, and degree of physical and functional impairments play a role in determining the variety and intensity of services required. The type and amount of services required also depends on a person's needs. Therefore,

a person with minimal disabilities may need few services while people with severe disabilities may require a vast array of services to assist them in achieving their own potential and in remaining safe, healthy and productive within the limits of their disabilities. Individuals with more severe disabilities typically require more intensive, and therefore, costlier services.

The **Utah Code** describes people with developmental disabilities as individuals with

> a severe, chronic disability that meets all of the following conditions:
>
> (1) is attributable to cerebral palsy; epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
> (2) is manifest before the person reaches age 22;
> (3) is likely to continue indefinitely; and
> (4) results in substantial functional impairments in three or more of the specified areas of major life activity. (**Utah Code** 62A-5-101(4)).

The major life activities include self-care, understanding and use of language, learning, mobility, self-direction (e.g., decision making, goal orientation, exercising civil rights, etc.), and capacity for independent living.

Anyone meeting the statutory definition of a person with a developmental disability is eligible for an array of services to ameliorate the debilitating effects of disabling conditions and promote growth and development. Since Utah's MR/DD population includes people with a wide range of mental retardation and medical needs, a variety of services is needed to assist them in achieving "their maximum potential through increased independence, productivity, and integration into the community" (**Utah Code** 26-21.13.5).

State statutes require that developmentally disabled persons be provided with residential services that, if feasible, resemble home-like settings to enable them to achieve their maximum potential in a community-integrated setting.

Utah Serves Individuals With MR/DD in Three Program Settings

Individuals with all types and levels of disabilities are provided residential services in the following three program settings:

- **DSPD Home and Community Based Services (HCBS) Programs** include an array of services for persons with disabilities and their families throughout the state. Through its four regional offices, DSPD contracts with over 50 private providers for services in consumers' homes, in day programs, or in 24-hour residential settings outside of the

family home. Residential living options include group homes where five or fewer individuals reside and supervised apartments with three or fewer residents. Other services provided in the community include professional parent homes, supported living arrangements, host homes, supported employment, day training, family support, and respite care. While 2,647 individuals receive at least one of the services, 1,089 receive a full complement of services since they reside in group homes or apartments.

- **Utah State Developmental Center (USDC)** is a state-owned facility operated by DSPD and certified as an ICF/MR. It provides residential and specialized services to individuals with multiple, severe disabilities who require either continuous medical care or interventions for behaviors that present a danger to themselves or to others. Services at USDC are considered transitional and are designed to help individuals return to home or community-based services when possible. USDC sometimes provides services for the disabled community not residing at the center. The resident population has declined from 666 in 1986 to fewer than 270 residents in 1998.

- **Intermediate Care Facilities for the Mentally Retarded (ICF/MR)** are privately owned facilities located in the community that are administered by the Department of Health, Division of Health Care Financing (DHCF). Approximately 560 people presently reside in 13 ICFs/MR which range in size from 12 to 85 beds. By state statute, future licenses will be for small facilities that serve 15 or fewer individuals. However, there is currently a moratorium preventing any new ICF/MR providers.

The majority of consumers served by these programs are financed via the federal-state Medicaid program. Authorized under Title XIX of the federal **Social Security Act**, Medicaid pays medical bills for persons with mental retardation who have low incomes or cannot afford the cost of health care and who meet the program's eligibility requirements. As an alternative to institutional care, Utah was given an HCBS waiver that allows the use of Medicaid funds for an array of home and community-based assistance services that would not normally be reimbursed with Medicaid funds. Utah's Medicaid waiver requires that community-based services be "cost neutral" in that costs can not be more to provide services in the community than in an institution. Utah is currently responsible for funding approximately 27 percent of total Medicaid expenditures.

Services Are More Often Provided in Small Community Settings

Several important changes in the MR/DD residential services system have taken place. Nationally, there has been a movement away from providing residential services in large facilities to small community-based residential settings. These settings are less restrictive and less isolated environments and also may be less costly for many people who do not require the full array of services that are provided in large institutional settings. Not only is the population in large state-operated facilities shrinking, but overall, the states' role as a residential service provider has diminished. Utah's MR/DD residential services system has undergone similar changes.

National Trends - The settings in which services to individuals with MR/DD are provided have changed. Figure I shows that nationally there is a movement away from providing services in larger facilities of 16 or more people to smaller facilities of 15 or less. In fact, by 1996 over 70 percent lived in smaller community residential settings, and 53 percent of these lived in settings of 6 or fewer people.

Figure I
National Trends
Move Away From Large Facilities

	1977	1996
Residents of Large Facilities (16 or more beds)	83.7%	29.5%
Residents of Small Facilities (15 or fewer beds)	16.3%	70.5%

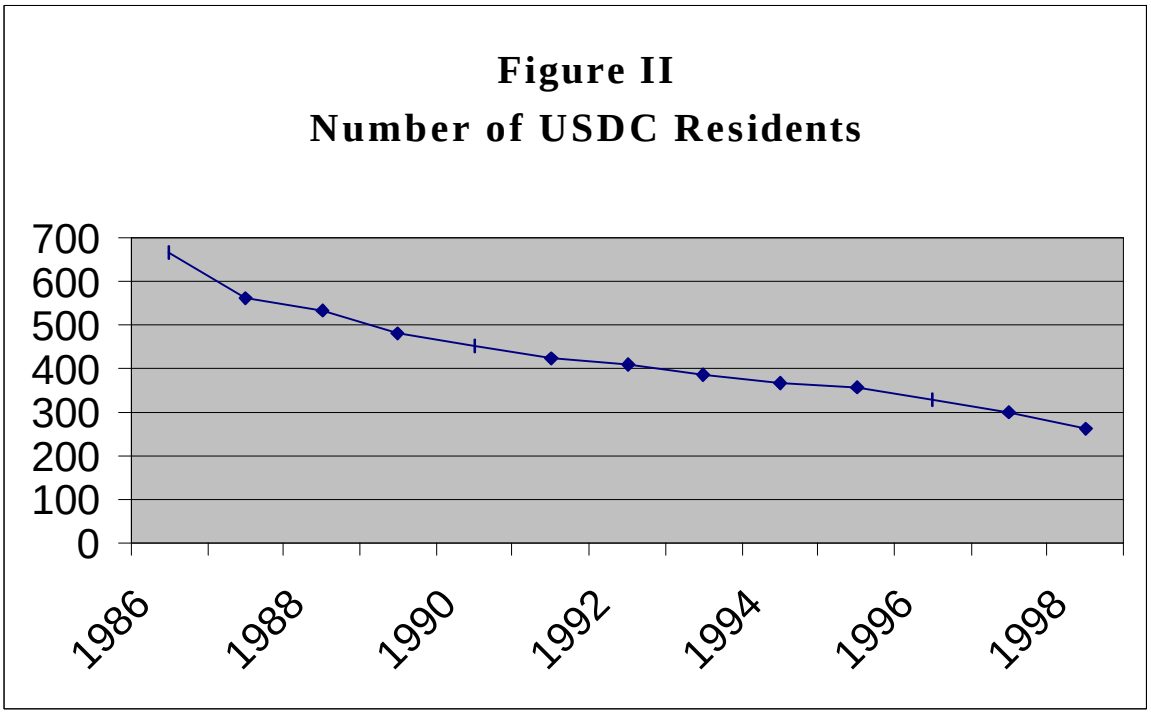
Source: Residential Services for Persons With Developmental Disabilities: Status and Trends Through 1996, College of Education & Human Development, University of Minnesota

Across the country, states have reduced their use of large state-operated institutions. In the period between 1980 and 1996, more than half the states reduced the average daily populations of large state-operated MR/DD facilities by 50 percent or more. States continue to close large state-operated facilities. Between 1992 and 1996, 59 large state-operated MR/DD facilities were closed. In fact, several states -- Maine, New Hampshire, Vermont, Rhode Island and the District of Columbia -- closed all their large state MR/DD facilities.

The depopulation of large state-operated facilities has reduced the states' role as a residential service providers. In 1977, 62.9 percent of all consumers lived in state operated residential settings. The states' role as residential providers have shrunk to such an extent that by 1996 only 21.4 percent of all residential service consumers lived in state-operated facilities.

Changes in Utah's System - Similar changes have taken place in Utah's MR/DD residential services system. For example, as Figure II shows, the population of Utah's sole state-operated MR/DD facility, the USDC, is shrinking, thereby diminishing its role as a

residential service provider. In 1986, 666 individuals with MR/DD resided at the USDC while at present, 262 individuals reside there.



In recent years, the *Lisa P.* Settlement Agreement contributed to the speed with which the USDC population diminished. Under the 1993 settlement agreement, Utah committed to the placement of USDC residents into "appropriate, less restrictive placements" and were charged to "determine each year the number to be placed based upon the individual assessed needs of the individuals." In addition, the state is to "take reasonable steps to assure that class members shall be placed in settings consistent with their needs within 2 years after the completion of their individual evaluations."

Utah adopted the philosophy that persons with mental retardation and developmental disabilities be afforded services in the least restrictive and most enabling environment which meets the individual's needs and promotes their independence and productivity. To this end, the state and DSPD supports placing people with MR/DD into community living alternatives where they live in much the same way as people without disabilities. The division is now moving towards living alternatives that include fewer residents than the established group home concept. Instead of group homes where 6 to 8 people reside, DSPD now advocates placing individuals into smaller group homes or apartments of 3 or fewer individuals in order to provide living situations more akin to those of unrelated adults without disabilities.

Reliable Information May Help Legislators Develop Policies That Balance Cost and Services

Reliable information may help legislators as they address the policy challenges of balancing the demand for services with available resources. Although expenditures for MR/DD services have increased in recent years, DSPD has a long list of individuals waiting for services that it cannot afford to supply. Unless better ways to control costs are found, the state either needs to significantly increase MR/DD funding or accept the continuing existence of a lengthy waiting list of individuals who need services.

Legislators must weigh a number of competing objectives as it makes policy choices. The state wants to provide all individuals with MR/DD the services they need. In addition, state policy is that individuals should be allowed to participate in decisions about their care and that services should be provided in the least restrictive setting possible. At the same time, the costs of serving an individual already in the system must be controlled so that an individual from the waiting list can be served. Controlling costs also protects taxpayers' resources.

The Legislature has been concerned for some time about balancing competing objectives. For example, in 1994 the Legislature directed the Division of Health Care Financing and DSPD to report on implementing a "combined funding stream" for ICFs/MR and HCBS services that would not result in increased costs to the state and also give service recipients "freedom of choice to determine the setting in which they receive services." These same issues were addressed again in 1998 in H.B. 372 **Portability of Funding for Health and Human Services** which requires the same divisions "to identify alternatives for increasing the portability of state and federal funding to persons with disabilities." Their report is to include an estimate of the costs of moving individuals to the services or facilities of their choice.

Despite legislators' need for reliable data about costs and services, this data has been difficult to obtain. In fact, much of the cost information we initially received seemed confusing and contradictory. While this report does not attempt to answer the difficult policy questions facing the state, it does attempt to provide comparable cost data for the HCBS, USDC, and ICF/MR programs. Reliable information about costs and services in each of the settings may help the Legislature make more informed decisions on the choice of services that can be provided with limited funds.

Audit Scope and Objectives

Our audit objective was to compare the costs and delivery of prescribed services to individuals with MR/DD in each of Utah's three residential program settings. Our audit consisted of reviewing costs for residents in each of the three program settings and compiling relevant costs for two groups of individuals residing in HCBS residential settings; a case file review of prescribed services for a selected sample of individuals with comparable disability levels served in the three program settings; and interviews with family members, support coordinators, Qualified Mental Retardation Professionals (QMRP), guardians, and service provider representatives associated with these individuals.

Although DSPD offers many in-home services to people with disabilities, we limited our evaluations to out-of-home residential programs including group homes and apartments. We did not attempt to compare or evaluate the cost effectiveness of each agency's services, nor did we attempt to evaluate the quality of care given by service providers in each setting.

Our cost and service information in each of the program settings can help the Legislature to make more informed decisions when considering policies about the services that can reasonably be provided with limited funds. Specifically, our audit objectives were to:

1. Estimate the cost of serving selected individuals residing in HCBS group homes and apartments and compare with the costs for residents of USDC and private ICFs/MR.

2. For *Lisa P.* transfers from the USDC to HCBS programs:
   a. Determine if funds followed individuals who transferred between programs,
   b. Determine if the proportion of costs paid by the state changed.

3. Review delivery of prescribed services to individuals in the alternate program settings.

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Chapter II
Cost Comparisons Require Careful Analysis

This chapter provides information on the costs of serving an individual in the Home and Community Based Services (HCBS) program compared to either the Utah State Developmental Center (USDC) or privately-owned intermediate care facilities for the mentally retarded (ICFs/MR). Our estimates include the cost for the full array of services received regardless of the funding source. We found that in fiscal year 1997:

- The average cost of former USDC residents in the HCBS program was 10 percent less than that of USDC residents.

- The average cost of former ICF/MR residents in the HCBS program was 25 percent more than that of ICF/MR residents.

However, average cost data should be interpreted with caution. For example, USDC average costs have increased recently because USDC has not yet been able to reduce costs as its population has declined. A single year analysis may also include capital improvement costs. Thus, average costs do not necessarily indicate the likely cost of placing one more individual in a program or the likely savings for serving one less individual. In addition, cost information does not address issues of program effectiveness.

The difficulty of determining the cost of serving an individual in an HCBS program compared to the USDC and ICFs/MR has led to conflicting claims about the costs associated with each program. Utah legislators have been presented with numerous cost estimates associated with serving the MR/DD population by groups who favor one setting over another. We were asked to collect reliable cost information because such information is important for making public policy decisions and allocating scarce resources.

We also evaluated the budget effects of recent transfers from the state institution to community programs under the *Lisa P.* settlement agreement. We found that:

- Although $59,000 per person per year was transferred from the USDC to an HCBS region with each transfer, both programs suffered budget shortfalls as a result.

- The proportion of state funding does not appear to have changed significantly.

The state's costs increase when an individual transfers from the USDC to the HCBS programs even though average cost data appear to indicate otherwise. This increase is because USDC has not reduced its costs by the $59,000 transfer amount. Additionally, costs for HCBS providers exceeded the $59,000 that followed people transferred into the community.

Concerns With Comparing Costs

We were cautioned that it would be difficult to compare the cost of serving consumers in the HCBS program with those of the USDC and ICFs/MR. Some people felt any comparison of costs between programs would be akin to comparing "apples to oranges." Concerns that were cited include:

1) Individual cost information is not always available.
2) Comprehensiveness of services provided varies.
3) Costs relevant to disability intensity is unknown for some individuals.
4) Philosophical approaches lead to intrinsic differences.

As discussed below, these concerns raise important issues that need to be considered. We believe our methodology addressed the first three concerns. The fourth concern, costs should not be compared because of intrinsic differences, did not directly affect our work. We simply accumulated costs. In our view, legislators need the most complete and comparable cost information available as they make policy decisions and we were not charged to evaluate philosophical approaches to the care of individuals with MR/DD.

1. **Individual Cost Information for USDC and ICF/MR Residents Is Not Available.** Neither the USDC nor ICFs/MR could provide cost data by individual consumer. The USDC receives an appropriation sufficient to operate the entire center. The center provides the services needed by each resident but does not track the costs by individual. Similarly, ICFs/MR are paid a set rate ranging from $98 to $118 per day for each resident regardless of disability level. Consequently, there is no need for individualized cost data. We addressed this concern by collecting all of the cost information for a sample of HCBS consumers and averaging those costs. Therefore, we had an average to compare to an average.

2. **USDC Incurs Costs for Services That HCBS and ICF/MR Programs Do Not Track.** Each program incurs a different set of costs. Consequently, service components that are used by one program in calculating the cost of serving an individual may not be included in the other programs' cost calculations. For example, while USDC costs are all-inclusive, medical expenses are not included when ICF/MR costs are calculated. Individuals still incur these costs; they are just not funded through that particular program. Instead, individuals use their Medicaid card to directly pay the doctor or pharmacist for their services. Similarly, HCBS cost calculations do not include medical expenses and room and board expenses. We addressed this concern by including costs that may not be calculated by one program but are still incurred by another agency. For example, we acquired medical costs from the Division of Health Care Financing to include in our HCBS cost calculations.

3. **Costs Relevant to Disability Intensity Is Unknown for USDC and ICF/MR Individuals.** Since individuals with severe disabilities typically require more intensive and therefore costlier services, it is important to compare costs for people with similar needs. While HCBS programs establish fees based on individual disability levels and service needs, USDC and ICF/MR programs do not. Instead, costs are averaged across all individuals regardless of their disability levels. Since all costs are averaged together, it was unknown if costs for one person are more than for another based on their disability level. In answering this concern, we could not match individuals by disability level because programs do not have a common disability measure. Therefore, we compared costs of HCBS group home residents who had transferred from USDC or ICFs/MR to average costs of individuals presently residing in those program settings. Although we can not be sure if people who transferred are representative of the people that still reside in the USDC and ICF/MR programs in terms of their disability, we believe they indicate costs for people with similar disabilities in alternate settings.

4. **Philosophical Differences Make Program Services Fundamentally Different.** According to advocates, the fundamental philosophy behind the delivery of HCBS services in each program makes it unique, and therefore not comparable. We were told that HCBS services focus on community integration and family environment, and are intrinsically different from the medically oriented services provided by USDC and ICFs/MR. We did not attempt to evaluate the quality of life realized by individuals in the three programs or to compare the cost effectiveness of each program's unique type of service. Instead, we obtained cost information incurred by individuals in each program regardless if the services are unique to that program.

HCBS Costs Calculated for Two Samples

Because we could not directly compare costs of all individuals in each program, we selected samples of HCBS group home residents for comparisons to the costs of USDC and ICF/MR residents. As discussed above, selecting individuals from each program by matching their established disability level was not possible because programs do not have a common disability measure. We evaluated the costs of two groups of individuals that moved from either the USDC or ICF/MR programs into HCBS group homes or apartments. These groups included:

(1) 51 former USDC residents who moved to HCBS programs, and
(2) 24 former ICF/MR residents who moved to HCBS programs.

While we did not select a random sample, each of these individuals resided in a group home or apartment all of fiscal year 1997 and received a full complement of services similar to

those received when they resided at the USDC or an ICF/MR. The service components, which could be paid for from a variety of sources, are:

- Residential habilitation
- Day services (including day training, supported employment, and skills development)
- Transportation
- Housing assistance
- Medical (including premiums and fee for service payments)
- Case management and administrative services
- Rent and food

The appendices of this report give more detail of our methodology. Appendix A describes service components, the details of our sample selection process, and the source of our cost information. We collected fiscal year 1997 cost information for each service component from DSPD and from each person's Medicaid Claim History obtained from the Division of Health Care Financing (DHCF) for our sample individuals. We estimated rent and food and some administrative costs because this information was not available by individual resident. Appendices B and C list each sample resident's fiscal year 1997 costs by service component.

Costs of Former USDC Residents in HCBS Program

We found that the costs of former USDC residents in the HCBS program were less than the average cost of residents at the USDC. However, careful analysis of cost comparisons is needed. Because of fixed and transition costs, USDC's average costs have increased as the institution's population has decreased. While the average USDC costs are easily determined, directly comparing them to our sample residents' costs may be misleading.

HCBS Costs Were Less than USDC Average Costs

We estimated the total costs of serving a sample of 51 individuals who moved from the USDC to the HCBS residential programs. As described in Appendix A, we included all transfers since 1993 for whom we could obtain complete fiscal year 1997 cost data. Most of the individuals in our sample moved from the state institution to a community program in accord with the *Lisa P.* settlement agreement mentioned in Chapter I.

Since this sample of individuals consisted entirely of former USDC residents, we reviewed the state institution's costs for comparison. We found that for fiscal year 1997, the average cost for our sample of HCBS residents was 10 percent less than the average cost for USDC residents.

Former USDC Residents Cost Was $83,785 in the HCBS Program. The following figure shows that the average costs for our sample of 51 former USDC residents who resided in HCBS group homes for all of fiscal year 1997 was $229.55 per day or $83,785 annually. Appendix B shows the cost of each service component for each person in our sample. The appendix also shows the service level for each person. Classified as individuals with severe MR/DD, they were all rated as service Level 5, the highest cost service level.

Figure III
Fiscal Year 1997 Group Home Costs
Sample of Former USDC Residents

Service Component	Average Daily Cost	Average Annual Cost
Residential Habilitation	$ 158.50	$ 57,852
Day Services	29.97	10,938
Transportation	3.05	1,116
Housing Assistance	.25	91
Medical	19.32	7,052
Case Management/Administrative	5.58	2,036
Rent & Food	12.88	4,700
TOTAL	$ 229.55	$ 83,785

Some costs shown in Figure III were included even though they are not paid through the HCBS program. Medical costs are paid through the Medicaid program without involving DSPD's budget. Rent and food are directly paid by each resident, generally with their Supplemental Security Income (SSI). Also, while most day services costs are paid through HCBS, a couple of individuals received Skills Development services that were directly paid by Medicaid to the school district. Although these costs were not paid through HCBS, we included them to make the data more comparable to USDC costs. At the USDC, the costs of all the services shown in Figure III are part of the institution's costs.

USDC Residents' Average Cost Was $92,766. As shown in Figure IV, the average costs for all USDC residents in fiscal year 1997 was $254 per day or $92,766 annually. While USDC costs include all of the services shown in Figure III, detailed information on costs by individual is not available. Without individual data, we simply determined average cost based on total expenditures divided by number of residents. These costs are about $9,000 greater than the

HCBS costs of former institutional residents shown in Figure III.

Figure IV
Average USDC Costs

	FISCAL YEAR					
	1992	**1993**	**1994**	**1995**	**1996**	**1997**
Number of Residents	411	385	368	357	329	301
Daily Cost per Resident	$186	$187	$205	$212	$237	$254
Annual Cost per Resident	$67,715	$68,425	$74,973	$77,198	$86,420	$92,766
Expenditures (millions)	$27.8	$26.3	$27.6	$27.6	$28.4	$27.9

USDC Expenditures Were Not Reduced in Proportion to Population

Average USDC costs have increased in recent years because there has not been a proportionate reduction in expenditures with the decline in residents. The comparison of average costs seems to indicate potential savings by moving individuals from the USDC to HCBS programs. However, because of the nature of USDC's costs, the opposite may be true. As Figure IV shows, because there has not been a reduction in expenditures in proportion to the population decline, average costs have risen steadily. This average cost increase highlights the importance of carefully interpreting average cost data. Some issues that should be considered include USDC's fixed costs, transitional costs and the comparability of residents.

- **Fixed Costs Issue.** USDC's average cost includes both fixed costs that are unaffected by the institution's population and variable costs that change with the population. In 1995, USDC estimated that about 20 percent of its expenditures were fixed or semi-fixed costs, and the remaining 80 percent were variable. Applying that same percentage to USDC's fiscal year 1997 costs indicates that about $74,213 (80% of $92,766) are variable. Theoretically, using this estimate, USDC's costs may decline by about $74,000 when a resident is discharged. This amount is 13 percent less than the average cost of an HCBS resident shown in Figure III.

- **Transitional Costs Issue.** It is impossible for the USDC to simultaneously adjust its number of staff and other expenditures when residents are discharged. This adjustment period causes transitional or semi-fixed costs. Unlike fixed costs that continue indefinitely, transitional costs are due to variable cost components that continue temporarily. We believe the population decrease experienced by the USDC has led to

transitional costs. For example, in fiscal year 1998, the USDC budget was adjusted to include another $449,100 for the *Lisa P.* shortfall, discussed later in this chapter.

- **Comparability of Residents Issue.** We believe it is fair to compare the costs of individuals who transferred from the USDC with the costs of those that remained. All of our sample individuals (shown in Appendix A) have extensive needs as reflected in their HCBS residential service Level 5 classification. In fact, a few individuals returned to the USDC after initially being transferred to an HCBS program because the USDC could better meet their needs. Those individuals remaining in the USDC also have extensive needs.

In summary, USDC average costs are somewhat greater than HCBS average costs for similar individuals. However, USDC costs include some fixed and transitional costs that affect the amount of funds needed when individuals transfer between programs. The state budget effect of an individual who transferred from the USDC to an HCBS program is discussed in more detail later in this chapter.

Costs of Former ICF/MR Residents in HCBS Program

We found that the costs of former ICF/MR residents in the HCBS program exceeded the average cost of ICF/MR residents. However, careful analysis of cost comparisons is needed. Differences between HCBS and ICF/MR services may affect the comparability of costs.

HCBS Costs Were More than ICF/MR Costs

We estimated the total costs of serving a sample of 24 individuals who moved from the ICFs/MR to the HCBS residential programs. This sample includes most recent transfers. Generally, few individuals are able to move from an ICF/MR to an HCBS program because of funding restrictions. In recent years, most of the people who moved were in response to a 1994-95 initiative allowing individuals the choice of moving between programs. We collected our cost information using the same methodology as the prior sample.

Since this sample of individuals was all former ICF/MR residents, we reviewed those facilities' costs for comparison. We found that for fiscal year 1997, the average cost for HCBS residents was 25 percent more than the cost for ICF/MR residents.

Former ICF/MR Residents Cost Was $57,901 in HCBS Program. Figure V shows that the average fiscal year 1997 costs for our sample of 24 former ICF/MR residents who resided in HCBS group homes and apartments for all of that year was $158.63 per day or $57,901 annually. Appendix C shows the cost of each service component for each person in our sample.

Figure V
Fiscal Year 1997 Group Home Costs
Sample of Former ICF/MR Residents

Service Component	Average Daily Cost	Average Annual Cost
Residential Habilitation	$ 93.95	$ 34,292
Day Services	23.52	8,587
Transportation	2.52	920
Housing Assistance	.78	284
Medical	19.74	7,204
Case Management/Administrative	5.24	1,914
Rent & Food	12.88	4,700
TOTAL	$ 158.63	$ 57,901

Just as was discussed earlier with Figure III, some costs were included for this sample even though they are not paid through the HCBS program. Neither medical costs nor rent and food are paid through the HCBS program. We included these costs for our comparisons with ICF/MR average costs. Except for medical costs, all costs listed in Figure V are paid through the ICF/MR program and are included as part of their basic rate.

Although we accumulated the costs shown in Figures III and V similarly, the total costs are quite different. HCBS costs for former ICF/MR residents were 31 percent less than those of former USDC residents. Most of the lower costs result because habilitation services are less costly ($93.95) for these individuals than for individuals in the first sample ($158.50). Our first sample of former USDC residents is all classified as severely disabled and requiring individualized habilitation rates (service Level 5) whereas in this sample only 12 of the 24 were so classified. People with more severe disabilities incur more costs because their daily habilitation rate is individualized to include services that include extra staffing and services from medical or behavior professionals.

ICF/MR Residents' Average Cost Was $46,355. As shown in Figure VI, the average costs for all ICF/MR residents in fiscal year 1997 was $107 per day or $39,055 annually. The average costs increase to $46,355 when, for our comparisons, we included an estimate of the medical costs each resident incurs.

Rates for the thirteen privately owned ICFs/MR range from $98 to $118 per day. Each facility receives the same rate for each of their residents regardless of the intensity of their disability. Much like the USDC, we were unable to obtain cost information that was individualized and could not determine if costs for one person are more than for another.

Figure VI
Fiscal Year 1997
Average ICF/MR Costs

Service Component	Average Daily Costs	Average Annual Costs
Average ICF/MR per Person Rate	$ 107	$ 39,055
Medical	20	7,300
TOTAL	$ 127	$ 46,355

In fiscal year 1997, an average of 574 people resided in ICFs/MR, and total expenditures were $19.1 million. Daily costs averaged $107 per person or $39,055 annually. While providers pay for residents' day training and some medical costs from this amount, their prescriptions, doctor and hospital expenses are paid with each individual's Medicaid card. Consequently, we included another $20 per person for medical costs outside of the facility. We estimated medical costs would be similar to the people included in our sample and tested this estimate by averaging costs for seven individuals who presently reside in ICFs/MR. For our comparisons, we estimated the average fiscal year 1997 costs for each person residing in an ICF/MR was about $127 per day or $46,355 annually.

Differences May Affect Cost

Daily costs appear to be about $30 less for ICF/MR residents than for our sample of HCBS group home residents who formerly resided in an ICF/MR. However, as discussed earlier, average cost comparisons should be interpreted carefully. Some issues that should be considered include the different services provided and the comparability of residents.

- **Difference in Services Issue -** While we did not attempt to evaluate the cost effectiveness of each program, we believe lower costs are a consequence of program

differences. ICF/MR providers are paid a flat rate per person regardless of each individual's disability while group home providers are paid a fee for service based directly on the person's disability and individual service needs. ICF/MR averages may incorporate a lower staffing level and larger facility size into their rates than that provided in group homes.

- **Comparability of Residents Issue -** We believe it is fair to compare the costs of individuals who transferred from an ICF/MR with the costs of those that remained. First, if they had remained at an ICF/MR, providers would have been reimbursed at the flat rate for our sample individuals. Second, as shown in Appendix C, half of our sample were classified as HCBS residential service Level 5. According to data furnished by an ICF/MR provider representative, their Inventory for Client and Agency Planning (ICAP) evaluations indicate that about half of their facilities' residents require extensive care and supervision similar to HCBS Level 5 individuals.

- **Limits on New ICFs/MR Issue -** While ICF/MR costs appear relatively low, it may not be possible to achieve savings by expanding the ICF/MR system. Currently, the state has a moratorium preventing new ICF/MR providers. In addition, any new ICFs/MR would have to meet current state licensing requirements including a limit of 15 or fewer beds. Most existing ICFs/MR are larger than 16 beds. Smaller facilities may lead to higher rates because providers could lose some of their economies of scale.

In conclusion, our calculations indicate that for fiscal year1997, USDC average costs exceeded the costs for former USDC residents who resided in HCBS group homes or apartments. Further, the average costs for ICF/MR residents were less than those of former residents who resided in HCBS group homes and apartments. However, our cost information should be cautiously interpreted, and policy decisions should incorporate other related concerns. For example, a better quality of life is not necessarily supported by the least costly alternative. In addition, these average cost comparisons do not indicate the total public dollar expenditures required when an individual moves from one program to another.

Lisa P. Outplacement Had Significant Budget Effects

In addition to estimating program costs, we also were asked to review some specific issues related to the *Lisa P.* Settlement Agreement. Specifically, we were asked to answer two questions about the transfer of individuals from the state institution to the community program:

- Did funds follow individuals from the USDC to the HCBS program?
- Did the proportion of costs paid by the state change significantly?

First, we found that $59,000 per person, per year was transferred from the USDC budget to the HCBS region where the individual moved. However, both programs realized a shortfall in relation to *Lisa P.* transfers and, as a result, required additional appropriations. Second, while total costs may have increased, the state's proportional share of cost does not appear to have significantly changed.

Funds Were Transferred but Shortfalls Resulted in Both Programs

Additional appropriations were needed by both the USDC and HCBS programs following the transfer of institutional residents and funds to community programs under the *Lisa P.* Settlement Agreement. Based on its costs, the Division of Services for People with Disabilities (DSPD) determined the amount of funds that could be transferred from the USDC to HCBS regional programs with each individual. However, funds transferred from the USDC fell short of the amount needed to fully pay for the transferred persons HCBS program services. In addition, USDC realized a shortfall from the transfers because it was not yet able to reduce its staffing levels during a transitional period.

The state's costs increase when an individual transfers from the USDC to the HCBS programs even though average cost data appear to indicate otherwise. This increase is because USDC has not reduced its costs by the $59,000 transfer amount; and, because costs for HCBS providers exceeded the $59,000 that followed individuals who transferred into the community.

In 1995, DSPD determined that $59,000 per person per year should be transferred from USDC to HCBS regional budgets with each individual. The amount was based on an estimate of fixed and variable costs at the USDC. About 20 percent of its $26.3 million expenditures were identified as fixed costs that would remain even as the number of residents declined. The other 80 percent of the USDC expenditures ($21.2 million) was classified as variable costs, a portion of which could be eliminated as residents moved from the institution. Since the resident population was 362 at that time, average per person costs were abut $73,000. DSPD determined that $59,000 per person per year could be transferred with each person who moved from USDC to HCBS programs.

Since fiscal year 1996, funds have followed individuals as they moved from the state institution to community programs. Funds, prorated by the number of days the individual resided in the community, were transferred between programs by amending the budgets of both the USDC and the regions where the people presently reside. As a result of the transfers, USDC's budget authorization will decrease and DSPD regional budgets will increase by about $6 million ($1.7 million/ General Funds) to cover the costs of individuals who have moved into the community to date. Still, both the USDC and the DSPD regions requested an increase in their respective fiscal year 1998 budgets since they realized budget shortfalls as a result of the outplacement.

Fund Transfers Have Not Fully Covered HCBS Program Costs. *Lisa P.* outplacement created a shortfall in funding because the actual costs of serving individuals in HCBS programs exceeded the amount transferred from the USDC to cover those costs. DSPD received an additional appropriation based on the shortfall. In addition, individuals on the waiting list may not have been brought into the system because regions used some of their budgeted funds to cover the shortfall.

DSPD regions realized a budget shortfall because the $59,000 per person being transferred from the USDC was considerably less than the average costs actually incurred by HCBS programs. After a year of experience with *Lisa P.* transfers, DSPD estimated average annual costs for residents in the Central region at $73,700 and $68,000 for the three remaining regions. That estimate is consistent with the transferred $59,000 since only variable costs were transferred. It is also consistent with our estimate of $83,800 since medical, skills development and rent and food are not HCBS region costs.

In fiscal year 1998, the Legislature amended DSPD's budget and provided an additional $728,000 appropriation to DSPD. That amount was designed to provide an additional $14,000 for each of the 52 additional people that DSPD anticipated would transfer into the community (52 x $14,000 = $728,000). Funds are transferred to the respective regions once the individual's actual costs are determined and the region submits a request for the funds. Along with the $59,000 already received, the $14,000 brought the total amount available for regional costs to $73,000 per person per year.

When we inquired about funding the initial shortfall, we were told that the regions absorbed any differences by not filling vacancies. Since the regions were required to accept *Lisa P.* individuals and the funds transferred were inadequate, they used funds that may otherwise have been used to provide services to those on the waiting list.

Fund Transfers Caused USDC Budget Shortfalls. Although the $59,000 transfer was too little to meet HCBS needs, it was too much to take from the USDC budget. The USDC required an additional $449,100 to cover costs it anticipated it would incur as clients left the center. The additional costs stem from the USDC's inability "to meet the reductions in staff in a timely enough manner in order to reduce their budget to save the sufficient funds necessary to send out with the individual."

It is not clear whether the additional amounts are transitional costs or more permanent. Transitional costs are due to temporary inefficiencies caused by the difficulty of reducing staffing and other variable costs immediately when a resident is transferred. However, we also were told that although USDC has fewer residents, only those with the most difficult behavioral and/or medical challenges -- the higher cost residents -- have remained. If the additional costs result from the changing character of USDC's population, they may be permanent. Nevertheless, USDC administrators told us they will reduce staffing levels as additional people move into community group homes or apartments.

In conclusion, $59,000 has followed each *Lisa P.* individual who transferred from the state institution to community programs. However, the transfers led to budget shortfalls in both programs. DSPD's fiscal year 1998 budget was amended to include an additional $1,177,100 appropriation ($323,500 General Funds) to cover shortfalls resulting from *Lisa P.* outplacements. Of this amount, DSPD was authorized $728,000 to cover excess group home costs at its regions, and the USDC received $449,100 to cover its costs during a transitional period.

Ratio of State Funds Has Not Significantly Shifted

While the transfer of USDC residents to HCBS group homes under the *Lisa P.* Settlement Agreement required additional funds, we believe the ratio of state versus federal funds has not significantly shifted. Even though we found some shifts due to Medicaid reimbursement policies regarding a specific program service component, the ratio of costs have not shifted significantly because Medicaid reimburses USDC for the same services even when overall costs increase.

Lower Federal Participation Could Increase State Participation. The federal Medicaid program funds MR/DD services and administrative costs for eligible individuals on a federal/state cost sharing basis. Eligible services and direct administration are funded by approximately 73 percent federal and 27 percent state funds. Indirect administration is reimbursed at a reduced federal participation of 50 percent. Of course, no federal funding is provided for non-eligible costs. Possible reasons that *Lisa P.* transfers could increase the state share of costs is if previously eligible costs became ineligible or were reimbursed at a lower federal participation rate. As Figure VII shows, most service components are reimbursed at the same rate. However, room and board, housing assistance, and case management/ administration are service components that are either no longer eligible or have less federal participation.

Figure VII Federal/State Participation for Service Components	
Service Component	**Federal/State Participation**
Residential Habilitation	No Shift
Day Services	No Shift
Transportation	No Shift
Medical	No Shift
Rent & Food	Possible Shift
Housing Assistance	Shift-100% State Funds
Case Management/Administrative	Possible Shift

Room and Board - Room and board is one service component that could cause the state to pay a greater share because it qualifies for Medicaid reimbursement in one program and not in the other. Residents' room and board are covered by Medicaid at the USDC while it is not covered in group homes. However, group home residents retain their SSI funds to pay rent and food costs, while USDC residents do not.

At USDC, all but a small amount of residents' SSI is paid to USDC, and Medicaid reduces its payment by this amount when it cost settles at year end. Since Medicaid pays more by way of a cost settlement if there has not been an SSI deduction, the net result is neutral. In the end, federal funds pay for room and board costs at the USDC either through SSI or Medicaid. SSI from group home residents is used to pay for rent, food and other personal expenses. Consequently, while their SSI is not paid into state coffers, the private sector receives these federal funds, and state funds are not used.

Housing Assistance - While group home residents use their SSI to pay for rent and expenses, if it is insufficient, state funds are used to supplement their rent. At this point, we do not believe there has been a significant shift in the state share of costs because our sample of transferred individuals has received little assistance. Less than one-fourth of the residents in our sample received housing assistance, and then it was very minimal. However, in the future, the proportion of state funds may increase if rental fees increase and more residents request assistance.

Indirect Administrative Costs - Some administrative costs could be paid at a different rate due to *Lisa P.* transfers. At the USDC all administrative costs are paid at the full federal participation rate of 73 percent. In HCBS regions, case management and some additional administrative costs are paid at the same 73 percent rate. However, in its reimbursement request,

DSPD includes other regional costs as indirect administration that are payable at the lower 50 percent rate. Lower federal participation increases the required state participation.

We do not believe there has been a significant shift in the state share of costs due to *Lisa P.* transfers. Most costs, including habilitation, day services, medical, transportation, and case management are paid at the same 73 percent in either program. While the state share of two items (room and board and indirect administrative costs) could be changed, the difference does not appear to be significant.

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Chapter III
Care Comparisons Indicate DSPD Needs to Develop Compliance Monitoring Program

Along with estimating program costs, we were also asked to review the delivery of services in the Home and Community Based Services (HCBS) program compared to the Utah State Developmental Center (USDC) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) settings. While we compared service delivery to requirements in each of the three residential settings, it was beyond our audit scope to assess the relative quality of life experienced by residents in each setting. Our file review did not show significant differences in the three programs' delivery of required services; providers in all three programs did not always implement each aspect of some individual's training and prescriptive therapy programs. However, our review indicates that the Division of Services for People with Disabilities (DSPD) needs to improve its monitoring of HCBS providers. We believe that an effective monitoring system would provide assurances that each client's training programs and therapies are taking place according to their individual plan requirements and that the state is receiving full value for dollars spent.

Our work was initiated in part by concerns that individuals transferred from the USDC to HCBS programs were not receiving services they had received while at the USDC. Consequently, we tested the delivery of medical care, training, and prescriptive therapies at the USDC, several HCBS providers and, for comparative purposes, privately-owned ICFs/MR. Discussions of our case file reviews with DSPD support coordinators and their supervisors led us to a general assessment of the HCBS provider monitoring program. The materials we reviewed showed the following:

- All three programs were similar in that case files indicated
  (1) All clients received required health care.
  (2) Consistent administration of training and therapy programs could not be confirmed.

- An effective HCBS compliance monitoring program is important because
  (1) Some clients may not be receiving the staffing level and supervision the state is paying for, and
  (2) Service levels of existing clients are increasing to more costly levels and appropriate oversight can prevent unwarranted increases.

- DSPD should clarify monitoring responsibilities and ensure that staff understand them. Also, the Division of Health Care Financing should review its monitoring procedures to insure that ICF/MR residents receive consistent training throughout the year.

Case File Reviews Show Similar Results for All Programs

Our case file review indicates that while people in all three programs received required health care, some did not receive the full complement of training and prescriptive therapies specified in their individual plans. We reviewed case files of a sample of individuals with severe disabilities who had been served at both the USDC and in HCBS programs as well as individuals in private ICFs/MR with comparable disability levels. Specifically, we reviewed each person's individual program plan and activity sheets to identify the service efforts a provider was expected to deliver. We also examined raw data collection sheets, which record the delivery of services, to substantiate whether each person received the full complement of interventions and services specified in their individual program plan.

We also examined DSPD Compliance Monitoring Reports and Department of Health Annual Surveys of ICFs/MR. In addition, we interviewed providers, support coordinators, Qualified Mental Retardation Professionals (QMRP), guardians and family members.

Time constraints and the detailed nature of the case files limited our sample size to 12 people who had been served by both the USDC and HCBS programs and 8 people served in ICFs/MR. Consequently, we caution that our results may not provide information that is statistically valid. Still, the longitudinal nature of our review provided enough data to indicate that some problems may exist in the delivery of services. Our review of case files shows that

- Clients received annual physical and dental examinations and other health related services when necessary.

- Training and prescriptive therapy programs were inconsistently administered in that some were either not implemented or failed to meet frequency requirements stated in their individual plans.

Individual Program Plans Establish Care Expectations

HCBS providers are required by Utah Administrative Rule, R539-3-2(A), and ICFs/MR by Federal regulation 42 CFR 483.440 (c)(4), to develop individual plans detailing the array of services necessary to meet each person's needs. Individual plans and training objectives are based on professional assessments identifying each person's unique strengths, needs and preferences. Thus, individual program plans and activity sheets detail the training methods and schedules, the type of data, and data collection frequencies that a provider must use in its effort to meet plan objectives.

Data on efforts by both HCBS providers and ICFs/MR to implement individual program plans are collected on the following categories:

- **Service Objectives -** are provided as a matter of course in caring for the individual.

Typically, these objectives deal with the receipt of health care services and medications.

- **Training Objectives -** are the specific training protocols and procedures identified by the individual plan team as required for this individual.

- **Prescriptive Therapies -** are designed to address behavioral and physical difficulties.

In addition, program participants also work on informal objectives---training to maintain or improve certain skills---but no data are collected on these objectives. The lack of data regarding informal objectives training limited the scope of our efforts to determine whether HCBS providers were: 1) providing or obtaining minimum required health care services; and 2) providing the full complement of formal training and prescriptive therapies identified in each person's individual plan.

Individuals Receive the Minimum Required Health Care Services

Our case file review indicates that individuals residing in HCBS programs, ICFs/MR and the USDC not only received or obtained annual physical and dental examinations, but were also seen by physicians, specialists and dentists as needed. However, it should be noted that interviews with parents, guardians and providers indicated that it is sometimes difficult to obtain appropriate health care services in a timely manner in the community.

HCBS Providers Are Able to Obtain Required Health Services. According to **Utah Administrative Rule** R539-6-10(A) & (B)(1)(b), providers must either provide or obtain routine and acute medical, dental or other health related services as well as annual physical and dental examinations. All HCBS case files contained evidence that, in addition to annual physical and dental examinations, individuals received additional health care services when necessary. For example, we found evidence that an HCBS client, in addition to obtaining an annual physical examination, was seen by a physician an additional 8 times over a 10 month period. Furthermore, his records indicated that he again saw his dentist 3 months after his annual dental exam.

USDC and Private ICFs/MR Also Obtained Required Health Services. Our case file review of the USDC and ICFs/MR yielded similar results with regard to the provision or procurement of health care services. ICFs/MR are required by Federal regulation 42 CFR 483.460(a)(3) to "provide or obtain preventive and general medical care as well as annual physical examinations of each client." Federal regulation 42 CFR 483.460(e)(1) & (f)(2) imposes a similar obligation with regard to dental care.

All files we examined contained evidence that individuals residing at the USDC or ICFs/MR received annual dental and physical examinations, and received specialist care when necessary. For example, an ICF/MR client's records showed the receipt of annual dental and physical examinations, an additional 3 visits to a physician and 2 visits to a psychiatrist over a 5 month period. Similarly, a USDC client's records revealed that after the annual dental and physical

examinations were done, they were seen by the psychology department.

Inconsistent Administration of Formal Training and Prescriptive Therapy Programs

Some clients may not have received the full complement of training and prescriptive therapies outlined in their individual plans. A person's functioning level may deteriorate without adequate training and therapy. The records we reviewed indicated that programs were administered inconsistently in all three settings. While some of the training and prescriptive therapy programs were being run at a high rate, pockets of inferiority existed. Some of the individual programs were not implemented, and others failed to meet individual plan-imposed frequency requirements by a wide margin.

We wish to note that the lack of data in the case files does not necessarily mean that required training and therapies did not occur. Still, the lack of data regarding services is a matter of concern because it raises the possibility that 1) clients may not be involved in planned activities and are sitting around; 2) conclusions made regarding a person's progress may not be valid because the routine execution of program training and therapies is recognized as critical to retaining skills that promote independence and a greater quality of life; and, 3) the state may not be receiving full value for dollars spent.

Inconsistent Administration of Habilitation Services by HCBS Providers. According to our case file review, 3 of the 12 HCBS clients had training programs that were run at less than 70 percent of the minimum frequency requirements in their respective plans. In the case of one person, we found no evidence that an exercise objective was implemented. Their file also indicated that training for them to "remain on task" and to "decrease inappropriate behaviors" was run at a rate of 60 percent and 65 percent respectively. Another person's records indicated that training to increase "adaptive skills" and "communication" were run at less than a 20 percent rate. The case file of another person showed that training on the objectives of "increasing social roles" and "finding new interests" occurred only 30 percent of the time.

Even clients whose training and prescriptive therapies were run at a high rate overall had individual programs that were either not implemented or were run at low rates. For example, a client who received 94 percent of required training overall, received only 38 percent of the minimum training required for the "increase independence" objective. A client with an overall rate of 86 percent had 2 objectives for which the they received only 60 percent of the minimum training required.

Inconsistent Administration of Treatment Programs by USDC. We found similar inconsistencies in the administration of training and therapy programs at the USDC. We found that 4 of the 12 USDC clients had programs that were run at less than 70 percent frequency overall. The records for one of the individuals in this group indicated that training for 4 formal objectives occurred at less than a 30 percent rate. According to the file, training for their objective to "complete meal routine" occurred at a 26 percent rate while training for 3 other objectives was carried out at rates below 20 percent.

Another person's records revealed that training programs for 2 of 4 formal objectives were conducted at less than 50 percent of the frequency imposed by the individual plan. Training for the "use of public transportation" and the "reduction of inappropriate behaviors" objectives were only run at 42 percent and 33 percent respectively. Additionally, we found no records to indicate that training for the person's "self-medication" objective was ever implemented. Surprisingly, we found one instance where the person's file contained no records. This seems to indicate that none of the programs designed to address his 3 formal objectives had been implemented.

Inconsistent Administration of Habilitative Treatment Programs by ICFs/MR. The ICFs/MR case file review also revealed flaws in the implementation and administration of their habilitative treatment programs. The records of ICFs/MR clients differ from those of HCBS and the USDC clients because they indicate that overall, training and prescriptive therapy programs were run at a rate above 85 percent. Still, the program data sheets indicated that individual programs were either not being implemented, or the high training rates were the result of periods of intensive training compensating for periods when no training took place.

For example, we found no evidence in each of the files of two people to indicate that training for individual formal objectives had taken place. Another person's records indicated that while training for other objectives was running at a very high rate, physical therapy was taking place only 32 percent of the time.

Program data sheets showed several cases where individual programs were being conducted in an inconsistent manner with periods of intensive training compensating for periods when training occurred below the stated frequency requirements. For example, a person's records indicated that their physical therapy program was being run 75 percent of the time. However, the data sheets indicated that the program was run below the minimum frequency requirement for 4 months and not at all for 1 month. Another person's files indicated that the training program for "cleaning and organizing" was being run at a rate almost 3.5 times greater than the minimum frequency requirement. However, the data sheets indicated that in the 9 months that the program was in place, all training took place during a 4 month period. No data were collected for 5 months.

Annual monitoring surveys conducted by the Utah Division of Health Systems Improvements during the period 8/19/97 to 7/16/98 provide collateral support for the contention that some ICF/MR clients are not receiving the full complement of treatment programs outlined in their individual plans. Five of the 14 ICFs/MR received deficiency statements for failing to meet

Medicaid standards related to the implementation and administration of treatment programs. For example, one facility was cited for failing to run its treatment program properly. Another was cited for the inconsistent implementation of behavioral management plans designed to address inappropriate behaviors.

Effective Monitoring Is Important

As we discussed the results of our case file reviews with support coordinators and their supervisors, they raised additional monitoring issues. Some DSPD staff expressed concern about whether all providers were providing the staffing level for which they were paid. We found that there is little monitoring of the delivery of required staffing levels. In addition, some DSPD staff expressed concern about the increasing dominance of high service level clients in the HCBS program. We found that the number of high service level clients is growing not only from new clients but by the reclassification of existing clients as well. We believe that careful scrutiny of client level and rate classification changes by DSPD is important to make sure these changes are justified.

DSPD classifies individuals who receive residential services into five service levels depending on their needs. Their needs are assessed using a nationally accepted instrument, the **Inventory for Client and Agency Planning** (ICAP). The ICAP assesses individuals on both a service scale and an adaptive behavior scale. DSPD considers both of the ICAP scales to determine which of five residential service levels an individual needs. Level 5 individuals have the greatest needs and are the most costly. Service providers are reimbursed at a set rate for Level 1 through Level 4 clients. However, providers are reimbursed at an individualized rate for each Level 5 individual depending on their unique needs. Level 5 reimbursement rates are based on specified staffing ratios that the provider promises to maintain.

Level 5 Worksheets Specify Staffing Requirements for Some HCBS Clients

Level 5 Worksheets establish the number of professional consultants and the habilitation staff ratios that an HCBS provider must contractually commit to in order to manage and supervise a person with profound MR/DD. However, it should be noted that Level 5 Worksheets are prepared for severely disabled individuals in HCBS programs only. Worksheets are not prepared for residential service Levels 1 through 4 clients. Further, the USDC and ICF/MR providers are not required to prepare Level 5 Worksheets for any of their clients.

Some HCBS Providers May Not Deliver Promised Staffing

Interviews and compliance monitoring reports suggest that HCBS programs may be having difficulties meeting Level 5 Worksheet staff ratio requirements. A provider's inability to fulfill the ratio requirements suggests that the state is not getting full value for monies spent since staffing ratios play a critical role in determining the rates that DSPD pays HCBS providers. Additionally, inadequate staffing raises concerns about the ability of providers to consistently administer training and prescriptive therapy programs.

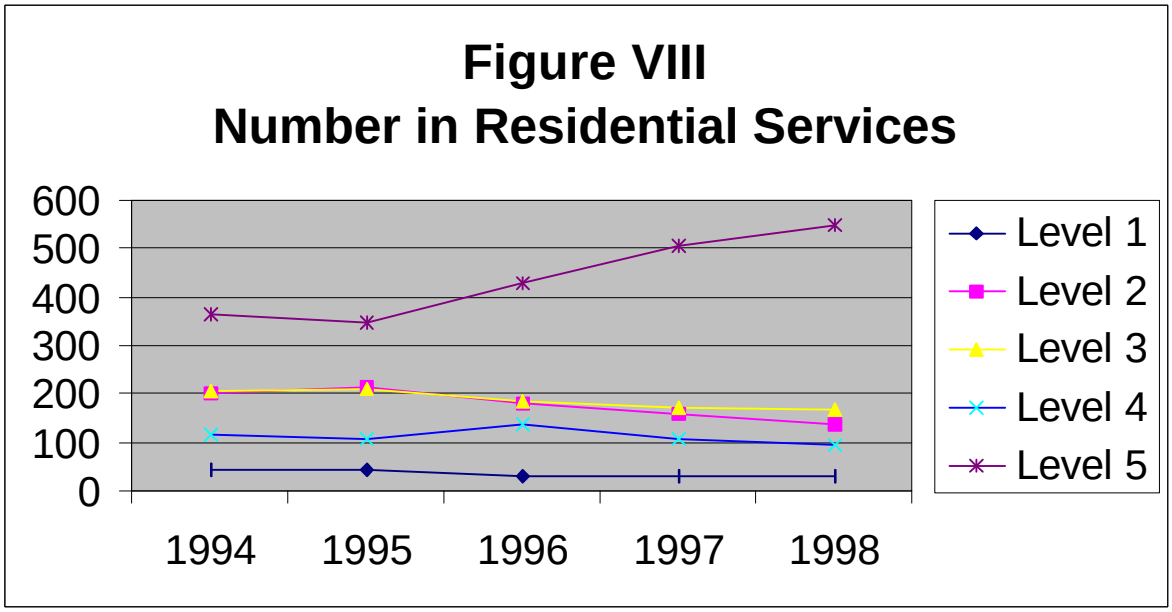
Interviews with DSPD staff and provider personnel suggested that some HCBS providers were unable to meet required staff to client ratios. Staff shortages and a high turnover in personnel appear to be a problem for all MR/DD service providers. A contract analyst declared that in the course of conducting compliance audits, she found that Level 5 Worksheet staffing requirements were not being met. Additionally, during an interview, a provider employee explained that a 1.5 month gap in a person's raw program data was the result of the turmoil caused by the departure of the program coordinator and most of the staff.

We used Central Region Compliance Monitoring Reports to corroborate whether HCBS providers were meeting Residential Level 5 Worksheet requirements. We found concerns about staffing raised in four of the seven audit reports. These contract monitoring audits (known as Attachment F audits) used to be conducted routinely but are now done on an as- needed basis. One audit we reviewed found that the staffing pattern specified on the Level 5 worksheet was not being delivered and that the provider had been "unable to provide all of the 1:1 hours for this client." Another report recommended that additional staff be provided in the morning and that staffing patterns be examined for appropriateness. In responding to an audit, one provider admitted to difficulties in hiring adequate and appropriate staff.

HCBS Service Levels Tend to Creep Up

Another concern raised by division staff was increasing dominance of Level 5 clients in the program. We found that the increase of Level 5 clients was caused not only by new entrants into the system but by reclassification of existing clients as well. Since higher service levels based on ICAP classifications are costlier, we believe that level creep affects DSPD's ability to serve individuals on the waiting list. Therefore, careful review of reclassifications is important.

Level 5 individuals, who require a great deal of supports and therefore the most expensive to care for, dominate placement in residential services slots. As shown in the following figure, the number of Level 5 individuals receiving residential services has increased over the last five years from 363 or 27.5 percent of those receiving residential services in fiscal year 1994 to 549 or 56 percent of those receiving residential services in fiscal year 1998. Because Level 5 individuals are the most costly, the budgetary dominance of these individuals is even greater.



Some HCBS staff told us that with Level 5 individuals consuming so many resources, it is becoming more difficult for people with less severe disabilities to get any services. Some people expressed concern that the HCBS system is becoming driven by the need to provide emergency care to people with critical needs. The entry of individuals into the HCBS system from the waiting list is determined by their critical need score. The ICAP score is a significant element of the critical need score, and most new entrants into the system receive Level 5 services.

A second factor contributing to the growth in the number of Level 5 individuals is the reclassification of lower service levels. Some staff told us that people go up in service level, but nobody comes down. We tested this assertion by reviewing Central Region residential services rate adjustments. We found that no person experienced a decline in either service level or rate classification. In fiscal year 1998, the service level of 16 individuals rose (*e.g.,* from an R3A to R5B). Twelve others experienced increases in their rate classifications within the same service level (*e.g.*, changing from R5A to R5B). Thus far in fiscal year 1999, the service level of 27 individuals has increased and one has decreased. The rise in service level and rate classifications without offsetting reductions indicate that individuals within the HCBS program tend to become more costly over time.

Since service level depends on ICAP scores, service level inflation could indicate that individuals tend to develop greater needs in the HCBS program. More likely, service levels creep up as a method of increasing payments to providers so they can provide more services to clients. Providing additional services to existing clients may be important, but doing so leaves less funding to serve individuals on the waiting list. Careful scrutiny of rate increases is important to make sure each change is justified.

DSPD Should Clarify Monitoring Responsibilities

We believe that DSPD needs to strengthen its oversight of HCBS habilitation services delivery. The inconsistent administration of training and prescriptive therapy programs, questions about the delivery of required staffing levels, and concerns about rising service levels all point to the need for an effective monitoring process. The follow three factors appear to have contributed to weakening DSPD's oversight efforts:

- Changes in DSPD's philosophical approach has led to confusion about the importance of formal training for clients and the monitoring of training programs.

- DSPD's primary oversight mechanism, the Quality Enhancement Survey, does not focus on the actual delivery of habilitation services.

- Support coordinators may lack the necessary independence to avoid conflicts of interest.

Changes in Philosophy Have led to Confusion About the Importance of Client Training

Philosophical changes resulted in confusion regarding the importance of habilitation program objectives, client training and data collection. DSPD's change to person-centered planning and the accompanying focus on quality of life resulted in a shift away from monitoring treatment programs to monitoring personal outcomes---the major expectations that people have in their lives. Instead of emphasizing compliance with program processes as the criteria for successful delivery of services, DSPD's new paradigm focuses on the client's perception of whether or not an outcome has been achieved. While we believe that personal outcomes and normalization are laudable goals, we also believe that DSPD must also monitor staffing levels and the process involved in the delivery of services.

The change in philosophy apparently had a major impact on both the monitoring of training programs and enforcement of standards. Support coordinators became unsure about the importance of training and whether training requirements should be enforced. According to a regional supervisor, the change led to the belief among support coordinators that the responsibility of monitoring clients' training programs had been lifted from them and, therefore, they no longer had to methodically check training programs.

Interviews with support coordinators also show that program monitoring has become less important. Support coordinators indicated that an overall assessment of clients' quality of life took precedence over insuring that the training outlined in the plans took place. A support coordinator stated that there were more important things going on in a person's life than training. Another indicated that the lack of data regarding training objectives was of no consequence.

Similar comments were made about the impact that the change in philosophy has had on HCBS providers. A support coordinator commented that some providers forgot about the

importance of developing skills. An individual stated that the adoption of person-centered planning led providers to believe that training programs were no longer important and, hence, did not have to be implemented as before. This belief was, according to another supervisor, reinforced by the fact that the methodical monitoring of training and therapy programs designed to implement plan objectives was no longer taking place.

To summarize, DSPD's paradigm shift appears to have diminished the importance that support coordinators attach to habilitation services monitoring. Thus, support coordinators interviewed were not concerned about the low training rates revealed by our case file review. As one support coordinator put it: "Support coordinators are moving away from documenting progress. They are focusing more on quality of life issues." Another stated that "if the home is in good shape and the clients seem happy, their needs are being met."

Primary Oversight Mechanism Does not Focus on Delivery of Habilitation Services

DSPD's primary oversight mechanism, the Quality Enhancement Survey, focuses on client outcomes rather than on whether providers are delivering contracted services. Quality Enhancement Surveys are conducted annually for 10 percent of the clients each provider serves. Surveys focus on 25 personal outcomes measures identified by The Council on Quality and Leadership in Supports for People with Disabilities in order to evaluate quality of life and to assist HCBS providers to more effectively help clients achieve their personal outcome goals. The survey is not designed to directly monitor the actual implementation and delivery of training services and therapies or compliance with staffing requirements.

In fact, one region found Quality Enhancement Survey results were suspect because staffing, behavioral plan implementation, as well as health and safety issues arose with regard to providers who received fair Quality Enhancement Survey ratings. Consequently, the region revived, on an as-needed basis, Attachment F audits which specifically monitor provider compliance with requirements like staffing ratio and plan implementation.

However, compliance audits are seldom performed by DSPD regions because of instructions from the state office not to routinely conduct them. Rather, such audits are done only on an as-needed basis---when complaints about a particular HCBS provider surface. Contract analysts from one region said that they had never conducted an Attachment F audit during their tenure with DSPD. An analyst from another region stated that although Attachment F audits had once been conducted on a routine basis, she had not performed one in the last few years. Additionally, staff from two regions claimed that their respective regional offices received instructions not to go forward with plans to institute routine Attachment F review programs on 10 percent of HCBS providers.

Support Coordinators May Lack Necessary Independence to Avoid Conflicts of Interest

DSPD support coordinators are responsible for ensuring that their clients gain access to "needed assessment, medical, social, educational and other service needs." Therefore, one of the principal roles of the DSPD support coordinator is to be an advocate for their client, ensuring access to and the continued availability of services. However, support coordinators are also responsible for "monitoring the provision of services..."

A potential conflict of interest exists in that support coordinators are placed in a position of cultivating amicable relations with providers to obtain the supports and services for their client, and to become adversarial when services are not being delivered according to the person's individual plan. Further, the duty to ensure access to needed services may place them in the position of agreeing to upward changes in ICAP disability scores, service levels, or rate classifications in order to obtain more funds for the care of their clients. The support coordinator's conflicting roles point to the need for careful scrutiny of level and rate classification increases to make sure each change is justified.

In conclusion, while we found providers in all three programs did not always implement each aspect of some individual's training and prescriptive therapy programs, we do not believe HCBS programs deliver fewer services. In the process of refocusing its efforts towards outcome-based monitoring, DSPD has overlooked monitoring provider contract compliance to insure that the state receives full value for dollars spent or to insure training programs and prescriptive therapy programs are taking place according to plan requirements. As one parent put it, formal training programs and prescriptive therapies ensure that clients are "engaging in activities, not just sitting around."

Recommendations:

1. We recommend that the Division of Services to People with Disabilities take the following steps to insure that individuals receive services and staffing that have been prescribed and that the state is paying for.

    a. Develop a monitoring program designed to focus directly on the delivery of training and therapy to individuals who reside in HCBS programs and the agreed upon staffing levels.

    b. Clarify and communicate to staff the role they play in both services delivery monitoring and cost control.

    c. Provide the necessary staff training to allow them to fulfill their roles.

2. We recommend that Division of Health Care Financing review its monitoring procedures to insure that individuals receive consistent training throughout the year.

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Appendices

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Appendix A

Methodology for Calculating Group Home Costs

Sample Selection Process

We selected samples of individuals presently residing in group homes or supervised apartments that formerly resided in either the Utah State Developmental Center (USDC) or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Instead of matching individuals and tracking costs in both programs, we controlled differences in the severity of disability classifications by sampling only individuals that moved from one program into another. A "matched set" analysis was impractical because disability classifications vary between programs.

1. The former USDC resident sample was selected by obtaining a master list of every individual who moved out of the USDC since 1993. We eliminated individuals from the sample who:

a. did not move to group homes/apartments,
b. were re-admitted to the USDC,
c. did not reside in the community for all of fiscal year 1997, or
d. for whom we could not obtain complete cost information.

2. The former ICF/MR resident sample was selected by obtaining a list of individuals who moved in 1994-95 in response to a legislative initiative. The Division of Services for People with Disabilities (DSPD) provided the list, but because they did not maintain a complete master list of names, our sample may include a few individuals who may not have actually been in response to that initiative. We eliminated one person from the sample because their cost information was incomplete.

Sources of Information

All cost information is not kept by one agency. Most costs were obtained from DSPD Pay-History files. We matched much of these costs to each person's Medicaid Claim History Detail Report obtained from Division of Health Care Financing (DHCF). The following summarizes the steps used to collect cost information for each person:

1. Obtained most cost information from DSPD Pay-History files.
    a. Searched the file by our sample resident name and account number.
    b. Totaled expenditures for July 1996 thru June 1997 for each service component.

Service components included residential habilitation, day-training, supported employment,

transportation, and housing assistance. Medicaid paid all components except housing assistance. Components obtained from DHCF that DSPD did not have included medical costs, case management and skills development. Component descriptions are included in the next section.

2. Obtained each resident's Medicaid Claim History Detail Report from DHCF by date of service.

    a. Totaled each person's Medicaid paid amount for waiver services.
    b. Compared waiver payments to DSPD record to verify costs.
    c. Totaled Medicaid and Medicare payments.

3. Obtained premium amounts paid for HMO and Mental Health services for each resident for fiscal year 1997 from DHCF.

4. Allocated or estimated two service components–administration and rent and food–because the information was not kept on an individual basis. These costs were included for comparison purposes because the other two programs' average cost information includes these costs.

    a. **Administration** - Cost allocations were based on a portion of each region's service delivery expenditures. The following table is an example of one region's allocation.

ADMINISTRATION ALLOCATION Example of Calculations for Northern Region	
Total Service Delivery Administration (Northern Region) Less Case Management Portion Administrative Portion	$2,053,052 -1,676,466 **376,586**
Administrative Portion Divided by Number of People(FPE*) Served in All HCBS Programs Administrative Costs Per FPE (376,586 ÷ 1534.7 = 254.38)	$376,586 ÷1,534.7 **$245.38**
Annual Administrative Costs Per FPE Per FPE Costs Times 3 Programs * (3 x 245.38 = 736.14)	 **$736.14**
Note: This number is expressed in Full Program Equivalents (FPE). Group home residents are counted as an FPE in a minimum of three different programs - Residential, Day Services, and Transportation- therefore Annual Costs per FPE were multiplied by three.	

    b. **Rent and Food** - Estimated costs are based on DSPD recommendations that of the

$494 maximum SSI most residents receive, a minimum of $130 be contributed towards food costs and $102 as personal funds with the remaining $262 as the recipient's share of rent. We did not include any income the individual may have contributed.

Service Components

1. **Residential habilitation** includes the supervision and direct care services necessary for a person to live in the community. Services include 24-hour supervision, medical care, behavior training, and living support and training. The variety and extent of these services vary based on the needs of each individual. A team that includes family members, providers, and agency support coordinators uses disability measures and personal association with the individual to develop the method and level of supervision each person requires. Services are designed to "facilitate the recipients independence and promote integration into the community by increasing their ability to acquire, retain and/or improve skills critical to independent living skills development or maintenance."

2. **Day-Services** include habilitation services or employment opportunities outside of the individual's residence. While most residents attend a day-training facility each weekday, others work or attend classes. A few individuals do not attend day programs because they have retired or because they have medical or behavior difficulties. Day services include day training, supported employment, and skills development classes.

    - ***Day training*** activities are habilitation services designed to maximize an individual's functioning level and assist them in acquiring, retaining, and/or improving self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Group home and ICF/MR residents often receive services from the same providers.

    - ***Supported employment*** services include a job coach to give ongoing support and on the job training to assist some individuals to work in a competitive work setting. Services are available only to individuals who had previously resided in an institution. The amount of support generally decreases or ends as a person becomes more proficient.

    - ***Skills Development*** services are provided by school districts to assist formerly institutionalized individuals to acquire specialized skills. Medicaid directly pays the school districts for these services and these costs are not included in the DSPD budget.

3. **Transportation Services** are provided to assist individuals in getting from their homes to day programs, jobs, and other activities.

4. **Housing Assistance** is financial assistance given to some residents to help pay their expected living expenses. Funds come entirely from the state.

5. **Medical Costs** include premiums for HMOs and mental health care for some residents and payments for medical needs not covered by the person's HMO.

    - ***HMO and Mental Health Premiums*** are paid by DOH for non-institutionalized individuals residing in Davis, Weber, Salt Lake and Utah counties.

    - ***Medicaid & Medicare*** payments to pharmacists, dentists, hospitals and physicians for services not covered by a person's HMO. While the state does not share in the Medicare costs, we included these costs for our comparisons because USDC average costs incorporate all expenditures regardless of funding source.

6. **Case Management** costs are paid by Medicaid to Division of Human Services for the time spent by support coordinators assigned to assist each individual in accessing services and in assuring they receive appropriate care.

7. **Administrative** costs include each region's service delivery costs. Service delivery includes in-take and eligibility evaluations and support personnel. In addition to the case management costs, we allocated a portion of service delivery cost for each resident. We excluded state office administrative costs.

8. **Rent and Food** - While room and board are provided at USDC and ICFs/MR, group home residents pay for their own rent and food costs. Most individuals qualify for Supplemental Security Income (SSI) benefits which they contribute to expected living expenses. At their former institutional residence, their SSI helped to pay for their services.

Appendix B

Fiscal Year 1997 Group Home/Apartment Costs
Sample of Former USDC Residents

	Service Level	Residential Habilitation	Day Training Support Emp Skill Developmt	Transp	Housing Assist	Medical Premiums	Medical	Case Mgmt	Admin DSPD(1)	Rent & Food(2)	TOTAL
1	R5B,C	60,777	5,777	827		4,749	1,640	1,338	480	4,700	80,288
2	R5B	58,742	11,567	1,618	762	4,006	1,484	1,537	480	4,700	84,896
3	R5B	54,569	4,508	1,523	399	4,250	7,343	1,323	480	4,700	79,095
4	R5B	48,389	12,393	1,734	376	2,113	560	1,456	480	4,700	72,202
5	R5B	67,688	-	1,581		4,501	2,375	1,205	480	4,700	82,529
6	R4A,5B	31,061	6,963	1,489		4,082	2,172	1,262	740	4,700	52,469
7	R5C	79,119	11,615	1,862	468	988	3,305	2,264	480	4,700	104,801
8	R5B	47,013	12,393	1,734		5,132	221	1,523	480	4,700	73,196
9	R5B	54,130	11,345	1,646			1,803	1,030	810	4,700	75,464
10	R5B	68,292	11,518	1,766		3,681	236	1,774	480	4,700	92,446
11	R5C	75,811	13,580	1,706		3,717	2,188	1,762	480	4,700	103,943
12	R5C	120,002	-			3,605	4,609	1,624	480	4,700	135,020
13	R5B	60,157	10,300			4,835	8,889	1,301	480	4,700	90,661
14	R5B	51,940	11,372	1,743		4,749	5,483	1,733	480	4,700	82,201
15	R5C	67,384	16,917		14	3,966	876	1,077	740	4,700	95,673
16	R5B	53,536	6,888	1,673		4,204	3,343	1,994	480	4,700	76,818
17	R5B	59,551	11,372			3,216	5,479	656	740	4,700	85,714
18	R5B	50,123	11,548	1,691		-	7,349	1,030	810	4,700	77,251
19	R5B	52,716	12,393	1,734	314	2,113	4,362	1,653	480	4,700	80,465
20	R5A,C	47,000	12,587			4,666	5,177	1,222	480	4,700	75,833
21	R5B	59,203	11,664	760		3,594	417	1,456	480	4,700	82,274
22	R5A,C	45,245	15,906	1,758		4,707	5,546	1,059	480	4,700	79,401
23	R5B	66,335	15,300	1,691		3,898	3,970	1,024	480	4,700	97,398
24	R5A,C	43,617	12,587			4,918	5,306	894	480	4,700	72,503
25	R5B	52,790	4,424	136		3,350	347	1,210	480	4,700	67,437
26	R5B,C	76,913	15,704	1,736		4,707	2,080	1,878	480	4,700	108,199
27	R5A,C	44,174	12,587			1,553	3,325	1,158	480	4,700	67,977
28	R5B	54,276	7,056	1,700		3,730	5,899	2,032	480	4,700	79,872
29	R5B,C	78,364	7,400	831		3,500	7,201	1,980	480	4,700	104,457
30	R5A,C	47,624	16,041	1,773		3,681	1,656	892	480	4,700	76,847
31	R5B	46,757	12,393	1,734		2,113	596	1,695	480	4,700	70,469
32	R5A,B	46,256	13,995	1,758		4,060	10,995	1,524	480	4,700	83,768
33	R5B	56,714	8,930			3,905	1,372	4,163	740	4,700	80,523
34	R5B	48,620	3,444			3,080	179	1,343	480	4,700	61,846
35	R5B	44,977	11,713	1,639		1,987	26,395	1,894	810	4,700	94,114
36	R5B	45,956	12,101	1,693	312	2,113	163	1,470	480	4,700	68,989
37	R5B	49,932	10,060	1,605		4,501	1,812	1,433	480	4,700	74,524
38	R5C	102,218	16,311		316	4,308	1,979	2,221	740	4,700	132,793
39	R5B	45,953	9,722	1,333		2,314	2,392	706	740	4,700	67,861
40	R5A	43,617	12,587			3,558	1,568	819	480	4,700	67,330
41	R5B	52,774	4,956	1,632	429	4,250	4,311	1,286	740	4,700	75,077
42	R5B	43,540	10,888	1,496		3,998	898	799	740	4,700	67,059
43	R5B,C	71,928	12,557			3,681	798	1,636	480	4,700	95,779
44	R5B	50,042	11,761	1,646		4,501	1,890	1,064	480	4,700	76,084
45	R5B,C	74,569	18,351	1,788		3,681	4,048	1,912	480	4,700	109,530
46	R5B	58,061	6,464	836	621	4,006	5,418	2,234	480	4,700	82,818
47	R5B	50,123	11,157	1,795			4,387	433	810	4,700	73,406
48	R5B	50,123	13,936	1,751		4,749	133	1,865	480	4,700	77,736
49	R5B	38,066	10,694	1,482		3,384	5,914	565	740	4,700	65,545
50	R5B,C	78,482	16,143		388	3,987	894	2,198	740	4,700	107,532
51	R5C	75,190	15,974		252	4,308	188	1,555	740	4,700	102,907
Total		2,950,432	557,845	56,900	4,651	178,697	180,973	75,162	28,660	239,700	4,273,019
Avg 51 clients		57,852	10,938	1,116	91	3,504	3,548	1,474	562	4,700	83,785
Avg/Day (365)		158.50	29.97	3.06	0.25	9.60	9.72	4.04	1.54	12.88	229.55

1Administration costs were allocated based on each region's service delivery averaged across all service categories.

2 Estimated $4700 annual rent and food were estimated based on federal SSI and does not include any income the client may have contributed.

APPENDIX C

Fiscal Year 1997 Group Home/Apartment Costs
Sample of Former ICF/MR Residents

	Service Level	Residential Habilitation	Day Training Support Emp Skill Developmt	Transp	Housing Assist	Medical Premiums	Medical	Case Mgmt	Admin DSPD(1)	Rent & Food(2)	TOTAL
1	R5B	50,766	11,470	1,758		4,835	1,536	1,300	480	4,700	76,846
2	R5B	52,795	11,421	1,751		4,835	2,374	1,256	480	4,700	79,612
3	R5B	41,387	11,858			4,707	6,316	1,879	740	4,700	71,586
4	R4A,5A	23,961	7,560	1,632		4,835	604	901	480	4,700	44,674
5	R5B	64,861	12,199		686	5,332	11	841	480	4,700	89,110
6	R4A	21,998	11,470	1,758	1,331	5,125	644	591	480	4,700	48,096
7	R2A	14,589	6,171	1,646		4,498	2,468	1,048	480	4,700	35,598
8	R4A	24,874	3,337	490	20	4,204	13	1,089	740	4,700	39,467
9	R4A	25,342	-	564	170	2,740	6,952	1,316	480	4,700	42,265
10	R5B	40,747	11,664			4,138	3,324	3,437	740	4,700	68,749
11	R5B,C	71,870	8,459		686	4,707	3,985	539	480	4,700	95,427
12	R5B	33,472	11,567			4,020	562	2,089	740	4,700	57,149
13	R4C, 5A	27,366	5,208	1,378	2,904	4,835	8,766	1,115	480	4,700	56,752
14	R2A	14,710	5,916	1,728		4,835	1,680	879	480	4,700	34,928
15	R5B	43,873	11,858			3,216	12,778	2,011	740	4,700	79,176
16	R4C	26,501	2,184	378	20	4,204	282	2,053	740	4,700	41,063
17	R2A	14,145	-			2,108	3,297	328	480	4,700	25,057
18	R4B	26,499	6,504			5,135	2,621	982	480	4,700	46,921
19	R5B	40,240	22,461	1,578		1,987	4,351	1,890	480	4,700	77,687
20	R5A,C	39,669	-	1,661		4,835	2,430	1,223	480	4,700	54,998
21	R5A	33,573	16,762	1,617		4,835	6	1,618	480	4,700	63,591
22	R3A	17,833	7,340	1,706		3,749	31	777	740	4,700	36,875
23	R3B	22,823	7,088	1,676	273	4,877	2,481	848	480	4,700	45,245
24	R5B,C	49,104	13,601	755	717	2,757	4,040	2,587	480	4,700	78,741
Total		822,996	206,097	22,075	6,809	101,349	71,551	32,596	13,340	112,800	1,389,613
Avg 24 clients		34,292	8,587	920	284	4,223	2,981	1,358	556	4,700	57,901
Avg/Day (365)		93.95	23.53	2.52	0.78	11.57	8.17	3.72	1.52	12.88	158.63

1Administration costs were allocated based on each region's service delivery averaged across all service categories.

2 Estimated $4700 annual rent and food were estimated based on federal SSI and does not include any income the client may have contributed.

Agency Response