A Study of the Department of Health's Administration of Contracts for Purchases of Service for Persons With Developmental Disabilities

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

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Foreword

This report was prepared in response to Senate Concurrent Resolution No. 157, Senate Draft 1 of the Regular Session of 1992. The resolution requested the State Auditor to study the contract policies and administrative processes of the Department of Health in providing services to persons with developmental disabilities.

We wish to express our appreciation for the cooperation and assistance extended to us by the officials and staff of the Department of Health and others whom we contacted during the course of our study.

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State Auditor

Table of Contents

List of Figures

List of Tables

Chapter 1
Introduction

Developmental disabilities are chronic conditions that substantially limit a person's ability to function in daily activities. Depending on their severity, conditions such as autism, mental retardation, and combined impairments of vision and hearing can be developmental disabilities.

Several state agencies in Hawaii, including the Department of Health, serve persons with developmental disabilities. The department is responsible for developing a comprehensive system of services in coordination with other agencies. Within this system, the department has a program of services that it offers directly or through contracts with private providers.

In 1992 the Legislature passed Senate Concurrent Resolution No. 157, Senate Draft 1, requesting the State Auditor to study the department's contract policies and administrative processes for providing services to persons with developmental disabilities.

The resolution notes disparities in funding levels among private providers. It asks the State Auditor to evaluate current purchase of service contracts including those of the department's Developmental Disabilities Division and Zero-to-Three Hawaii Project. The State Auditor is to consider the funding needed to support quality services; the use of "unit cost"; the mix of direct services and contracted services; and the funding methods of other states.

Objectives of the Study

Our study had the following objectives:

1. Examine the Department of Health's current program of services for persons with developmental disabilities.

2. Assess the department's process for administering purchase of service contracts for these services.

Scope and Methodology

To accomplish the objectives of the study, we reviewed the laws and literature on services to persons with developmental disabilities. We examined the Department of Health's documents and files including those of the Community Services for Developmental Disabilities Branch,

the Waimano Training School and Hospital Branch, and the Children with Special Needs Branch. We reviewed purchase of service contracts and related materials.

We interviewed personnel from the Department of Health, the State Planning Council on Developmental Disabilities, the Commission on Persons with Disabilities, and private service providers. We contacted other states for information about trends in service delivery and funding.

Our work was performed from May 1992 through November 1992 in accordance with generally accepted government auditing standards, except that we did not test the data supplied by the department.

Chapter 2
Current Program of Services

This chapter describes the Department of Health's authority for serving persons with developmental disabilities, trends in serving these people, and the services provided.

Statutory Basis for Services

State and federal statutes serve as the framework for the Department of Health's program for persons with developmental disabilities.

State statutes

Chapters 333E and 333F, Hawaii Revised Statutes, define developmental disability as a severe, chronic disability that reflects a mental or physical impairment or combination of impairments, manifests itself before age 22, and is likely to continue indefinitely. By law, persons with developmental disabilities are limited in three or more of the following: self-care, receptive and expressive language, learning, mobility, self-direction, the capacity for independent living, and economic self-sufficiency. They need an individually planned, coordinated sequence of services over an extended period of time.[1]

Chapter 333F, enacted in 1987, requires the department to develop and administer a comprehensive system of programs and services for persons with developmental disabilities within the limits of state or federal resources available for this purpose. The system must include community services. The law authorizes the department to use existing community resources, coordinate with services provided under other laws, and fund specific services when no other resources are available. The final decision on services is left to the department.

The law also contains a bill of rights for persons with developmental disabilities. They must receive the least restrictive, appropriate services as close as possible to their home community.

Federal statutes

The federal Developmentally Disabled Assistance and Bill of Rights Act states that persons with developmental disabilities have a right to appropriate treatment and rehabilitation. These services help persons reach their developmental potential in the environment that is least restrictive of their personal liberty. The states and the federal government are responsible for ensuring that public funds go only to programs that meet individual needs and that satisfy certain federal standards.[2]

Under the Individuals with Disabilities Education Act, states may obtain grants to help them develop statewide, comprehensive, coordinated, multidisciplinary, interagency systems to provide early intervention services for developmentally delayed infants and toddlers and their families. Grantees must meet certain requirements set forth in the law.[3]

Other federal laws include the Fair Housing Amendments Act of 1988 and the Americans with Disabilities Act of 1990. The Fair Housing Amendments Act prohibits discrimination and helps people with disabilities to find living accommodations including group homes and other community residences.[4] The Americans with Disabilities Act protects them from discrimination in the areas of employment, public accommodations, transportation, and telecommunications.[5]

Trends in Services

Government's approach to serving persons with developmental disabilities has moved over the years from institution-based care to community-based care. Authorities have developed a "residential continuum" in which clients who meet certain criteria are moved step-by-step from group homes to transitional homes and to their own apartments, gaining independence with each move.

The latest approach favors "supported living"—allowing clients to decide where and how to live and to draw from an array of community services. This approach is due to growing concern that the residential continuum approach is lock-step, facility-based, and disregards the unique interests and preferences of individual clients.

The National Conference of State Legislatures (NCSL) reports a shift toward a service delivery system that allows persons with developmental disabilities to maintain relationships with family and friends, participate in community life, and make choices about their future. Increasingly, states are moving away from a provider-driven service system to one that empowers families to choose services that meet their needs and the needs of their family member with disabilities.[6] NCSL says the emphasis is on supporting people in natural settings including:

- Children with disabilities growing up in a home with their family, instead of in an institution;
- Children with disabilities going to a neighborhood day care center or home, instead of to a segregated program;
- Children with disabilities attending regular preschool and neighborhood school classes, rather than being isolated in a special class;

- Children and adults with disabilities participating in community activities with family and friends, rather than being isolated with others who have disabilities; and

- Persons with disabilities working side by side with persons without disabilities in a competitive job, rather than being segregated in sheltered workshops.[7]

How the states decide to structure services will determine how they structure funding. Funding is also affected by tighter state budgets, increased demand for services, pressure from advocacy groups, and increased litigation. These factors make it important to increase funding efficiency and program effectiveness.[8]

Hawaii's State Planning Council on Developmental Disabilities reports that Hawaii has followed national trends. According to the council, all state and private agencies can expect to be in a "state of disequilibrium" for a few years as efforts are made to implement an "individualized, comprehensive, consumer-driven, community-based philosophy of supports to persons with developmental disabilities."[9]

Services Under the Department of Health

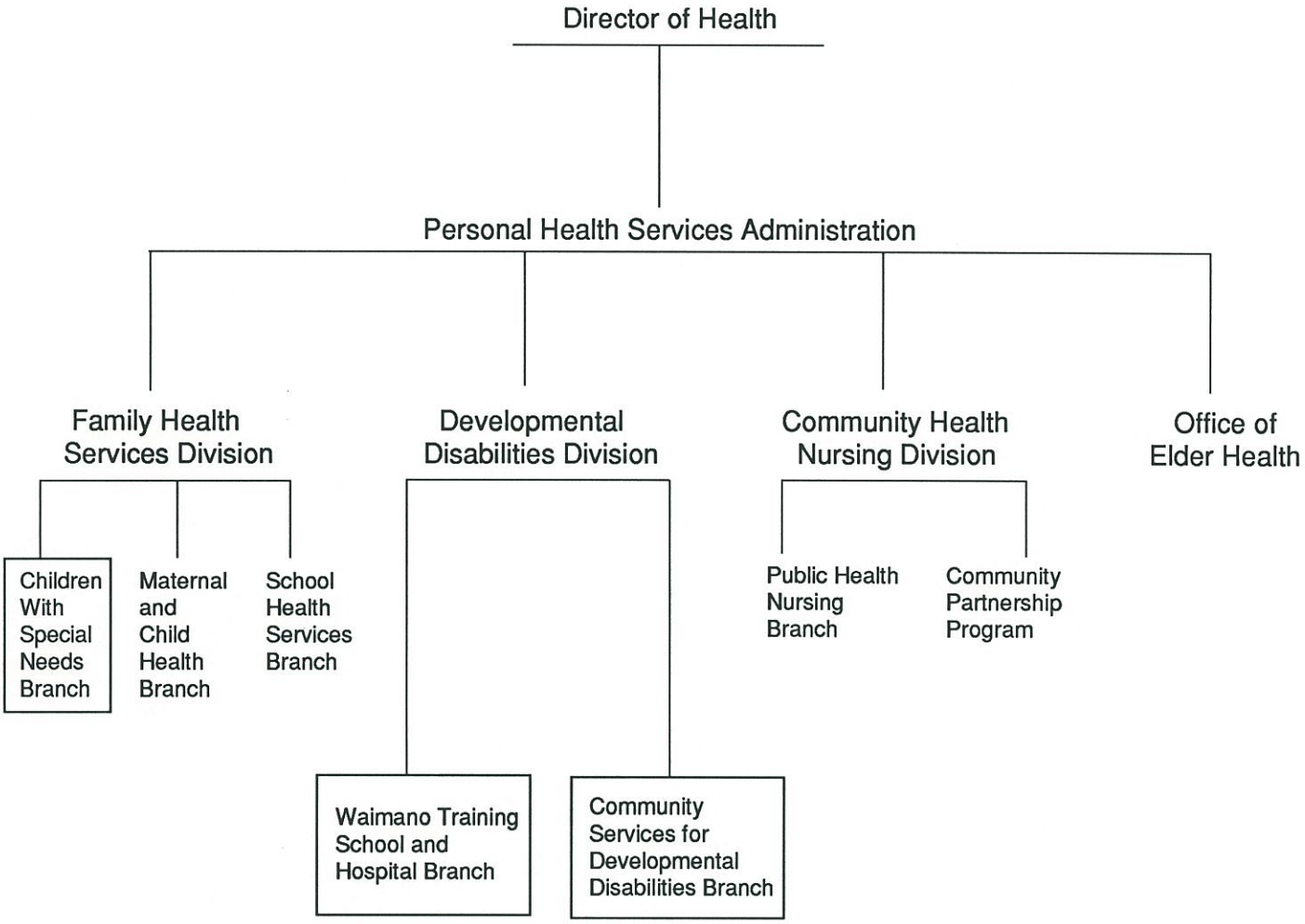
The nature and extent of developmental disabilities differ widely. Instead of a standard set of services, each person needs a range of services to meet his or her individual needs.[10] The department seeks to offer this array through various approaches, and funding for these services has been increasing.

Three branches of the health department provide services: (1) the Waimano Training School and Hospital Branch, (2) the Community Services for Developmental Disabilities Branch (both within the Developmental Disabilities Division), and (3) the Children with Special Needs Branch (within the Family Health Services Division). All three branches come under the department's Personal Health Services Administration. Figure 2.1 shows the organization of services. Two advisory groups, the State Planning Council on Developmental Disabilities and the Commission on Persons with Disabilities, have input.

Waimano branch

The Waimano Training School and Hospital Branch of the department's Developmental Disabilities Division provides 24-hour hospital inpatient care. The branch also has adult day activities to prepare some of its clients to live in the community.

FIGURE 2.1
Department of Health
Organization of Services to
Persons With Developmental Disabilities



= Branches serving persons with developmental disabilities.

Community services branch

The Community Services for Developmental Disabilities Branch provides a range of residential arrangements and support services for persons who are able to live in the community. A central intake system determines eligibility for services and provides information and referrals. Clients are given diagnostic evaluations and case management to ensure access to appropriate services.

Special needs branch

The Children with Special Needs Branch is responsible for medical, surgical and other corrective services for children up to age 21 who have special needs. As of July 1, 1992, infant development programs that were in the community services branch were transferred to the Zero-to-Three Hawaii Project administered by the Special Needs Branch. The infant development programs seek to decrease the prevalence and severity of symptoms experienced by children from birth to three years who are developmentally delayed. Under Chapter 321, Part XXVIII, HRS, the department has responsibility for early intervention programs for infants and toddlers who are developmentally delayed (in one or more key areas such as language, vision, or self-help skills) or who are at risk of developmental problems (because of such factors as fetal alcohol syndrome or child abuse). The Zero-to-Three Hawaii Project was serving both the developmentally delayed group and the at risk group; the community services branch also was serving the developmentally delayed group.

To avoid fragmenting services for infants and toddlers between branches located in two divisions, the department put all of these services under the Zero-to-Three Hawaii Project. The project has its own intake and referral system and case coordinators but diagnostic services are provided by the community services branch.

Related agencies

Under state and federal laws, the State Planning Council on Developmental Disabilities must plan, monitor, advocate for, and report on services. The council consists of 25 members representing state agencies, community service providers, persons with developmental disabilities, their parents or guardians, and advocates. It is administratively attached to the health department and has its own full-time executive director. The council is required to coordinate the departments that serve persons with developmental disabilities including the health department, the Department of Education, and the Department of Human Services.

The Commission on Persons with Disabilities, also administratively attached to the health department, serves as a central clearinghouse for information and provides research, advice, and advocacy for all persons with disabilities, including those having developmental disabilities. It

has 15 members including persons with disabilities, their parents or guardians, and representatives of state agencies. The commission also has its own full-time executive director.

Service mechanisms

Services for persons with developmental disabilities may be operated by the health department itself or by private providers under purchase of service contracts with the department. Table 2.1 identifies the types of services offered, whether they were operated by the department or private providers, and the number of clients served in FY1991-92. Table 2.2 identifies the purchase of service providers and their activities for that year.

Table 2.1 suggests that about 12,000 persons with developmental disabilities were served but the number is actually about one-quarter of this. A major reason is that our table counts some clients more than once. For example, the same client may have been counted for going through central intake, receiving case management, and entering one or more service programs.

Purchase of service process

Under Chapter 42, HRS (which has since been replaced), the department began the purchase of service process by soliciting proposals. The department evaluated each proposal and recommended some of them for funding as part of its annual budget submission to the governor. Following review and revisions by the governor, recommendations were included in the executive budget which the governor submitted to the Legislature. Providers could also submit proposals directly to the Legislature.

The Legislature decided which proposals it would fund and for how much. Like other appropriations, these were subject to the state's allotment system administered by the Department of Budget and Finance. The department then executed a contract with each provider and payments to the provider began.

Act 335, Session Laws 1991, repealed Chapter 42 and replaced it with Chapter 42D. Beginning with the 1993-95 biennium, the Legislature will normally appropriate funds for purchases of service to agencies in a lump sum without naming the specific provider. The executive branch will determine the funding for specific providers. The act allows the departments to solicit and review proposals after the Legislature makes funding available rather than before.

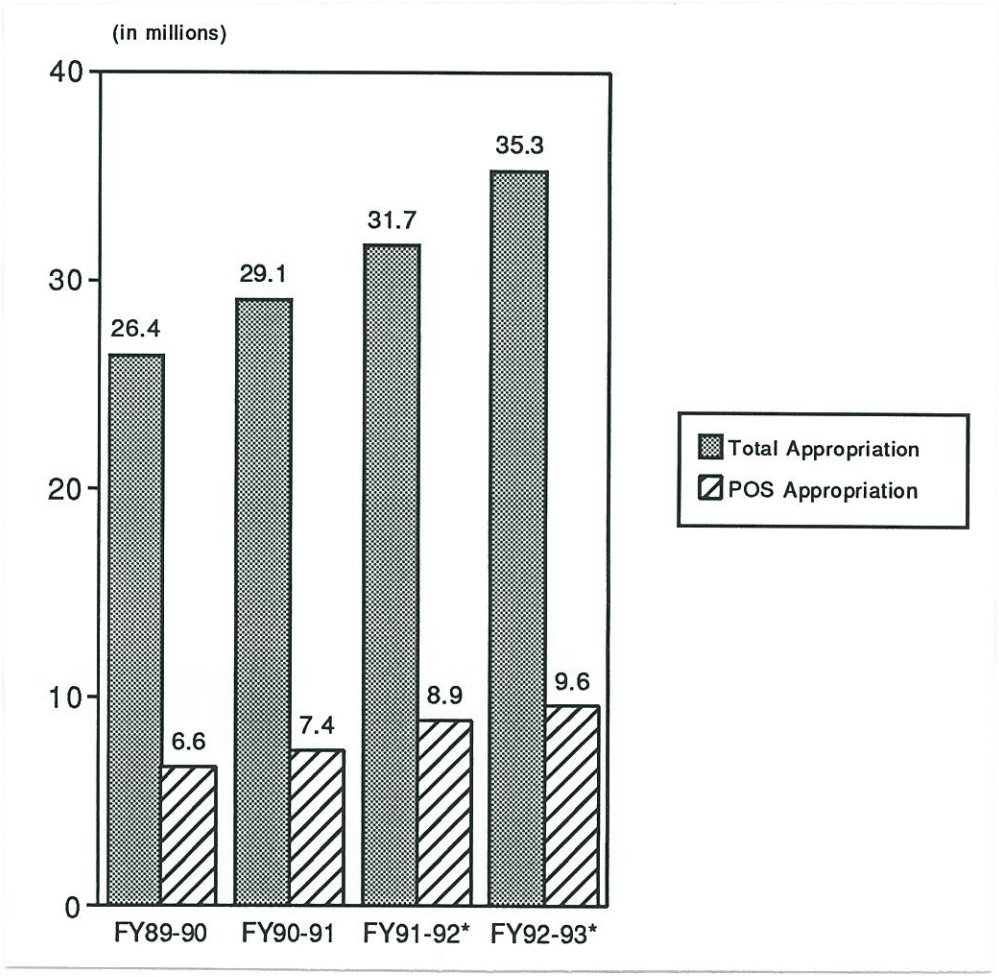
In its report on the bill which became Act 335, the Senate Committee on Ways and Means reported that the Chapter 42 process had been controversial because some of the proposals that were solicited,

reviewed, and recommended by agencies for funding were not included in the final budget while others that were not recommended by agencies were included. Allowing the solicitation and review of proposals after funding is available was intended to eliminate these inefficiencies.[11]

Funding levels

For FY1989-90 the Legislature appropriated about $26.4 million to the department for services to persons with developmental disabilities. About $6.6 million of this was for purchases of service. Appropriations rose to at least $35.3 million for FY1992-93, of which $9.6 million was for purchases of service. Figure 2.2 shows trends in funding.

FIGURE 2.2
Department of Health
Developmental Disabilities
Appropriations, FY1989-90 to FY1992-93



Source: Executive Operating Budget Worksheets and Purchase of Service (POS) and Grant-In Aid Appropriations

*Due to data limitations the totals for FY1991-92 and FY 1992-93 do not include all infant and child development appropriations.

TABLE 2.1
Department of Health Services Provided
FY 1991-92[1]

Types of Service	Description	Number of Clients Served	
		Purchase of Service	State Operated
Adult Day Program	Provides training towards the highest level of independence possible, primarily in the areas of self-care, mobility, communication, personal/social skills, use of leisure time, transportation, home management, vocational training, and supportive employment.	627 (13 contracts)`	102
Adult Functional Skills/ Basic Education Training	Health department offers input into curriculum for Department of Education courses including: basic money management, personal grooming, personal management, and social skills. Classes may be integrated with those of the non-disabled community.		96
Case Management	Assists persons in gaining access to needed social, medical, educational, and other services.	67 (1 contract)	1,300
Central Intake	Intake and Children's Services Section serves as the entry point for services. Determines eligibility and provides information and referrals.		4,200
Consolidated Purchase of Service	Provides flexible support services tailored to meet individualized needs of persons in order to promote integration into the community. Includes services, supplies, and equipment which are not available through other resources.	37 (3 contracts)	
Day Treatment[2]	Provides training to adults towards the highest level of independence possible, primarily in the areas of making choices, self-care, mobility, communication, personal/social skills, and use of leisure time. Clients are more severely impaired than those served in adult day programs; services are more intense.	4 (1 contract)	
Diagnostics	Provides comprehensive diagnostic evaluations needed to plan for care following intake. Interdisciplinary teams provide functional and support services to clients in the community.		1,461
Early Intervention[3]	Provides a range of services which include intake/referral, social services, parent education, infant stimulation, child development, special education, physical therapy, occupational therapy, speech therapy, and psychological assessments.	1,010 (6 contracts)	508

TABLE 2.1 (continued)
Department of Health Services Provided
FY 1991-92[1]

Types of Service	Description	Number of Clients Served	
		Purchase of Service	State Operated
Home and Community Based Services Waiver Programs (H& CBS)	Federal Title XIX match waiver programs which include case management, adult day health, respite, habilitation, and personal care to clients living in the community. The purpose of these programs is to move clients out of and divert them from entering institutions. Health department and Department of Human Services work together to provide services.		178
Homemaker Services	Provides in-home care ranging from housekeeping to training parents in the care of children with developmental disabilities. Assists families on the island of Hawaii.		8
Residential	Provides services which include foster care, group homes, domiciliary homes, and intermediate care facilities for the mentally retarded with the purpose of maximizing the potential of the client and supporting the family's effort to care for the person with a developmental disability at home. Twenty-four hour residential care and treatment is available at Waimano Training School and Hospital, an extended care facility that combines skilled nursing care and intermediate care.	24 (4 contracts)	412
Respite	Provides temporary relief and assistance to families and caregivers through services for the person with disabilities which include short-term out-of-the-home placements, center-based recreational activities, sitter services, and camps.	242 (4 contracts)	278
Training for Care Providers	Provides training of foster parents and purchase of service providers by department staff.		1,080
	Totals[4]	**2,011 (32 contracts)**	**9,623**

Source: Department of Health Staff; Purchase of Service Contracts

1. Excludes services provided under Title XIX.
2. Some clients receive day treatment under other types of programs.
3. Clients are developmentally delayed and at-risk infants, not all of whom have developmental disabilities.
4. Totals reflect duplication because clients may receive more than one type of service.

TABLE 2.2
Department of Health
Services Operated by Purchase of Service Providers
FY1991-92

Provider	Service	No. of Clients Served
OAHU		
Association for Retarded Citizens of Hawaii	Adult Day Program	115
Autistic Vocational Education Center	Adult Day Program	20
Easter Seal Society of Hawaii	Infant Stimulation & Child Development Respite	*165 108
Goodwill Industries of Honolulu	Adult Day Program	100
Kapiolani Medical Center Mobile Team	Infant Stimulation & Child Development	20
Lanakila Rehabilitation Center	Adult Day Program	119
Opportunities for the Retarded	Adult Day Program	65
Research Center of Hawaii	Group Home	8
Special Education Center of Oahu	Day Program	10
United Cerebral Palsy Association of Hawaii	Case Management Infant Stimulation & Child Development	68 20
University Affiliated Program	Consolidated Purchase of Service	15
Waianae Coast Day Care Center	Infant Stimulation & Child Development	60
Winners at Work	Adult Day Program	45
HAWAII		
Brantley Center	Adult Day Program	14
Easter Seal Society of Hawaii	Infant Stimulation & Child Development	*
Hilo Association for Retarded Citizens	Adult Day Program Group Home Respite	35 12 55
Kona Association for Retarded Citizens	Adult Day Program Consolidated Purchase of Service Day Treatment Group Home	23 8 4 4

TABLE 2.2 (continued)
Department of Health
Services Operated by Purchase of Service Providers
FY1991-92

Provider	Service	No. of Clients Served
KAUAI		
Kauai Association for Retarded Citizens	Adult Day Program	10
	Consolidated Purchase of Service	8
	Respite	37
Easter Seal Society of Hawaii	Infant Stimulation & Child Development	*
LANAI		
Imua Rehab	Infant Stimulation & Child Development	**
Maui Association for Retarded Citizens	Adult Day Program	***
MAUI		
Easter Seal Society of Hawaii	Respite	32
Imua Rehab	Infant Stimulation & Child Development	**115
Ka Lima O Maui	Adult Day Program	11
Maui Association for Retarded Citizens	Adult Day Program	***12
	Group Home	5
MOLOKAI		
Imua Rehab	Infant Stimulation & Child Development	**

Sources: Department of Health staff; purchase of service contracts.

* Oahu number includes clients served by Easter Seal Society of Hawaii on the islands of Oahu, Hawaii, and Kauai.

** Maui number includes clients served by Imua Rehab on Lanai and Molokai.

*** Maui number includes clients served by Maui Association for Retarded Citizens on Lanai.

Chapter 3

Assessment of Contract Administration

In this chapter we examine the Department of Health's administration of purchase of service contracts with private providers that serve people with developmental disabilities. We discuss contract funding, timeliness, monitoring, and other matters needing attention.

Summary of Findings

1. The Department of Health's approach to funding private providers of services to persons with developmental disabilities appears arbitrary.
2. The department is not executing and implementing purchase of service contracts in a timely manner.
3. The three branches are inconsistent in their monitoring of contracts.
4. The department needs to develop better estimates on the number of persons with developmental disabilities and improve its consolidated purchase of service program.

Funding Appears Arbitrary

The department's funding for each purchase of service contract seems arbitrary. Contract amounts are based not on expected costs but on across-the-board inflationary increases for each provider based on the previous contract amount. The current method of funding weakens the purchase of service process and should be replaced with an approach that identifies reasonable costs.

Contract disparities common

Contract amounts vary widely among providers offering similar programs to similar numbers of clients. In FY1990-91, for example, a provider serving 35 clients in an adult day program received $192,372. A second provider serving 38 clients in the same program received $295,958, and a third serving 40 clients received only $110,793.

For a day treatment program, one provider serving 12 clients received a contract for $66,531. Another provider serving 14 clients received $102,538. The contract for a group home serving 7 clients was $42,998; another contract for a group home serving 8 clients was $186,762. Table 3.1 illustrates these and other differences.

TABLE 3.1
Department of Health
Unit Costs, Purchase of Service Contracts
FY1990-91

Provider	Service	Department of Health Clients	Contract Amount	Department of Health Unit Costs
Winners at Work	Adult Day	38	$295,958	$7,788.37
Goodwill Industries of Honolulu	Adult Day	40	$110,793	$2,769.83
Maui Association for Retarded Citizens	Adult Day	14	$64,575	$4,612.50
Goodwill Industries of Honolulu	Adult Day	60	$295,958	$4,932.63
Association for Retarded Citizens Hawaii	Adult Day	167	$875,143	$5,240.38
Hilo Association for Retarded Citizens	Adult Day	35	$192,372	$5,496.34
Lanakila Rehabilitation Center	Adult Day	108	$641,225	$5,937.27
Kona Association for Retarded Citizens	Adult Day	23	$137,828	$5,992.52
Easter Seal Society of Hawaii	Adult Day	11	$66,531	$6,048.27
Kauai Association for Retarded Citizens	Adult Day	10	$62,612	$6,261.20
Brantley Center	Adult Day	21	$136,346	$6,492.67
Ka Lima O Maui	Adult Day	11	$85,583	$7,780.27
Opportunities for the Retarded	Adult Day	65	$512,308	$7,881.66
Autistic Vocational Education Center	Adult Day	20	$221,260	$11,063.00
United Cerebral Palsy	Case Management	68	$21,712	$319.29
Easter Seal Society of Hawaii	Day Treatment	12	$66,531	$5,544.25
Association for Retarded Citizens Hawaii	Day Treatment	14	$102,538	$7,324.14
Kona Association for Retarded Citizens	Day Treatment	4	$39,936	$9,984.00
United Cerebral Palsy Association Hawaii	Group Home	7	$42,998	$6,142.57
Easter Seal Society of Hawaii	Group Home	27	$326,128	$12,078.81
Hilo Association for Retarded Citizens	Group Home	16	$202,826	$12,676.63
Association for Retarded Citizens Hawaii	Group Home	22	$343,238	$15,601.73
Maui Association for Retarded Citizens	Group Home	5	$93,692	$18,738.40
Research Center of Hawaii	Group Home	8	$186,762	$23,345.25
Hilo Association for Retarded Citizens	Respite	55	$24,518	$445.78
Easter Seal Society of Hawaii	Respite	32	$16,351	$510.97
Easter Seal Society of Hawaii	Respite	150	$138,414	$922.76
Kauai Association for Retarded Citizens	Respite	57	$77,077	$1,352.23
Easter Seal Society of Hawaii	Infant Development	109	$243,245	$2,231.61
Imua Rehab	Infant Development	115	$175,864	$1,529.25
United Cerebral Palsy Association Hawaii	Infant Development	15	$28,054	$1,870.27
Waianae Parent Child Development Ctr.	Infant Development	55	$175,128	$3,184.15
Special Education Center of Oahu	Day Program	20	$200,593	$10,029.65

Note: The infant development programs have been transferred from the Community Services for Developmental Disabilities Branch to the Zero-to-Three Hawaii Project in the Children With Special Needs Branch.

Source: Department of Health Unit Cost Computation FY1990-91; purchase of service contracts.

Automatic increases

The arbitrariness in the contract amounts stems largely from the department's lack of knowledge of what it costs to provide the services. The department has not determined the true costs of services and how they compare among providers. Providers are given great latitude in how they report costs. For example, some providers report costs for utilities and others do not.

With some exceptions, the department generally recommends that providers be allowed an across-the-board increase for inflation. For FY1992-93 the department recommended an increase of about 3 percent for most providers. The department informs providers in advance about what amount they can expect to receive, and providers gear their proposed budget to this amount.

Providers report in interviews that disparities are based primarily on history. Providers who came under contract many years ago have been held to a smaller contract amount base while new providers can start with a higher contract amount. The base directly affects the amount of inflationary increase a provider receives.

"Unit cost" not helpful

The department's limited analysis of costs is illustrated by its use of "unit cost." The Community Services for Developmental Disabilities Branch calculates two "unit costs" for each purchase of service contract. It develops a "program unit cost" by dividing the provider's total reported operating cost by the total number of clients served by the provider, regardless of the number served under the contract. It also calculates a "Department of Health (DOH) unit cost" by dividing the contract amount by the number of clients to be served under the contract. But it apparently makes little use of the two sets of figures.

As Table 3.1 shows, unit costs vary widely. For example, depending on the provider, the DOH unit cost per client in an adult day program ranges from $2,769.83 to $11,063.00. The DOH unit cost per client in a group home ranges from $6,142.57 to $23,345.25. The DOH unit cost per client for respite care ranges from $445.78 to $1,352.23. Finally, the DOH unit cost per client in an infant development program ranges from $1,529.25 to $3,184.15.

The department's calculation of unit costs is meaningless. It is based on shaky data, its purpose is unclear, and the branch does not seem to use this information to make decisions. The Zero-to-Three Hawaii Project in the Children with Special Needs Branch does not bother to calculate unit costs.

Purchase of service system weakened

The department's lack of information on what the services it purchases should cost will compromise its ability to implement Chapter 42D, HRS, the new statute governing purchases of service. Chapter 42D uses lump

sum appropriations for purchases of service rather than the provider-specific appropriations under Chapter 42. Unless the department develops a funding approach based on some knowledge of costs, it will have no rational basis for its request from the Legislature and for allocating funds equitably among providers.

Providers have expressed concern about disparities in contract amounts. The current approach undermines competition, cost containment, innovation, and quality. It offers no incentives for providers to use better and more innovative approaches. Established providers know that they will receive an automatic increase each year with the same services.

Alternatives available

Other states have faced the challenge of reforming their funding approach by establishing cost ranges, incentives, individualized payment mechanisms, unit billing, or vouchers. The states report benefits such as cost savings, efficiency, more clients served, and expedited third-party reimbursements. These approaches are based on systematic analysis aimed at identifying reasonable costs.

Cost ranges

California law requires its Department of Developmental Services to establish an equitable system of payment to ensure that providers can meet clients' needs and provide quality services. Cost ranges (or "windows") were established for day programs. The cost range is similar for programs that offer similar types of service and that have a similar staff to client ratio.

A range of costs is allowed for each service category. Providers whose costs remain within the range can receive increases. Providers whose costs exceed the range are not reimbursed for the excess and may be cut back to the allowable range. The amounts cut are reallocated to providers whose costs are at the low end of the range.

Incentives

The Arizona system of reimbursing providers is designed to foster quality in services. Providers receive a base rate for services with additional payments if the program is nationally accredited or meets other criteria.

Nevada triples its per capita reimbursement for providers of supported employment who place clients in community work instead of sheltered workshops for the first quarterly reimbursement period. After six months, the provider is reimbursed only enough to provide case management services for the client.

Individualized payment

For supported living arrangements, North Dakota writes a contract for each client and pays the provider a flat rate per client that would maintain the client in an apartment or family home. Part of the rate reflects "service costs" that are determined by the number of staff hours required to help the client live independently. (These costs are reimbursable through Medicaid.) The other part of the rate covers room and board costs that exceed any income the client might have. (These costs are not reimbursable from Medicaid.)

Unit billing

Massachusetts funds early intervention services by paying providers a set fee for each unit of a particular service delivered. Through a cost analysis the state classified all early intervention services into one-hour units of service in the following categories: home visit, assessment, screening, center-based individual service, center-based child-focused group, and center-based parent-focused group. The services provided are based on individual needs as determined by an individualized family service plan.

Vouchers

Rhode Island has a voucher program that encourages clients to identify and purchase the services they need. The emphasis is on obtaining services that increase their independence.

Reform efforts on hold

The department is aware that its funding approach is arbitrary. It has tried to develop a payment system based on a service rate, but it abandoned its efforts when it could not reach a consensus with providers.

The Developmental Disabilities Division met with representatives of the private provider community to consider a payment system modeled on California's cost range. However, the department and providers could not agree on what should be considered in calculating the allowable range. Providers who anticipated being outside the allowable range felt they would be unfairly denied inflationary increases.

The division apparently has not pursued the effort. We believe the department must persist in developing a better payment system even if it cannot obtain consensus among providers.

Contracts and Payments Are Often Delayed

The department does not execute its purchase of service contracts in a timely manner. Contracts are not in place until well after the beginning of the contract year. Providers are paid weeks or even months after they begin providing services. To correct this problem, the department must correct its cumbersome contracting process.

Extent of delays

The contracts typically cover a fiscal year—July 1 through June 30—and pay the provider in advance in four quarterly installments. We found many delays in executing contracts and making payments. Of 23 contracts we examined from several fiscal years, only two were executed prior to and one on the contract's effective date of July 1. The rest were executed from 10 to 313 days late. The average delay was 72 days.

Some providers received their first payment very soon after the contract was executed. But other providers were not paid until several additional weeks had passed. Under the contract that was executed 313 days after the effective date, the first payment was not made until almost three weeks after contract execution. This provider received no money until 11 months after the effective date of the contract.

This practice of delaying contract execution until after services begin is not sound contracting practice. Contracts establish the nature, scope, and extent of services; the compensation and method of payment; indemnification of the State; and other rights and obligations of the parties. Without a contract, both parties are at legal and financial risk.

Provider concerns

Almost half of the providers we talked to said delays in executing contracts and making payments are a problem.

Delays in payments—whether the result of untimely contract execution or some other factor—reduce the provider's cash flow and could interfere with client services. The impact may be magnified because payments on the new contract tend to occur at the same time that providers are waiting for their final payment on the previous contract. (Normally one-twelfth of the total contract amount is withheld pending settlement of that year's account.)

Providers reported many hardships resulting from delays. One drew from personal savings to pay bills; others took out loans. In still another case, the provider's governing board considered halting services but decided their clients might regress if they took this step.

Cumbersome procedures

Providers attribute contract and payment delays to deficiencies at the department including short staffing, disorganization, unclear or inconsistent instructions to providers, and carelessness resulting in lost documents. One provider said that the department's accountants are sometimes in the field doing fiscal monitoring at the very time they are needed to process payments.

Even if everything goes smoothly, contract procedures take time. The draft contract may be in place but it cannot move forward until the department's administrative services officer gives formal notice of the appropriated amount, usually two weeks after the close of the legislative session (early May). After the appropriation is announced, providers are often required to revise and resubmit budgets to match appropriations. Multiple reviews and approvals of contracts and payments, both within and outside the department, are then required.

There may be additional delays if problems crop up. For example, contracts for FY1992-93 were held up because of anticipated budget cuts. Providers may also submit paperwork late or fill out forms incorrectly.

Department-level action needed

Improvements are needed at the departmental level. A financial audit of the department being conducted concurrently with this study found delays in contract execution throughout the department. The financial audit concluded that the department needs to take steps to ensure that contracts are in place before services are to be provided.[1]

The community services branch reports that it has tried to speed up the contracting process by developing boilerplate contracts for each type of provider program and by following up with the administrative services office two weeks after paperwork is sent there. In addition, the branch reports that it has set up a tracking system in which the secretary records all documents entering and leaving the office. Some providers report improvements. These are steps in the right direction, but consistent action is needed for all units in the department.

Monitoring Is Inconsistent

Chapter 42, HRS required the department to monitor each purchase of service agreement to ensure compliance with the chapter and with the public purpose and legislative intent of the purchase of service agreement. The new Chapter 42D will have even more stringent monitoring requirements.

We found that monitoring is inconsistent among the three branches serving persons with developmental disabilities. Because of this

inconsistency, the department lacks sufficient information on whether its contractors are in compliance. Without consistent, comparable data, it lacks information on which to base decisions about purchases of service. Providers are also confused because some of them have purchase of service contracts with more than one of the three branches. They are uncertain about what they must do to comply.

Monitoring objectives vary

The three branches differ in their monitoring objectives. Only the Community Services for Developmental Disabilities Branch includes in its monitoring objectives a system for ensuring compliance with Chapter 42 and the purchase of service contract. The branch has a checklist that allows monitors to check for compliance with each statutory requirement and contract stipulation. Two monitors visit each program site annually and complete the checklist. Program quality, contract compliance, and client satisfaction are monitored by completing the checklist.

The monitoring by the Waimano Training School and Hospital Branch focuses on whether needed services are being provided, whether the active treatment requirement is being met, and whether regulations for services are being complied with. The focus is on patients' progress which is monitored quarterly by members of interdisciplinary teams and monthly by a case coordinator. But we found no evidence of monitoring to ensure compliance with Chapter 42 and the contract terms.

The monitoring objectives of the Zero-to-Three Hawaii Project in the Children with Special Needs Branch are to ensure that the provider's program meets federal requirements, achieves quality of services, meets health and safety standards, and includes the client's family in program planning and implementation. The monitoring team includes a project staff member, a member of the University Affiliated Program, and the parent of a child receiving services. The team works together in evaluating programs through site visits.

Uniform guidelines needed

To improve the monitoring process, the department should develop policies and procedures for monitoring. These should be flexible enough to accommodate differences among the branches, but should require a core of compliance monitoring. At a minimum, the three branches should be required to use a checklist similar to that currently used by the community services branch.

Other Matters Need Attention

The program for persons with developmental disabilities is in transition. The department is attempting to move from a facility-based approach, in which clients follow a prescribed path, to a client-based approach, in which clients and their families have more say. It also is moving from

provider-specific legislative appropriations for purchases of service to lump sum legislative appropriations under Chapter 42D.

To make these major changes, the department should have a clearer idea of whom it is serving and how to structure and fund services. The following matters need attention in addition to those already discussed.

Varying population estimates

We found the department's data on persons with developmental disabilities in Hawaii to be unreliable. Estimates on the numbers of these persons vary widely, making it difficult to assess the extent to which services are needed or are being provided.

The Developmental Disabilities Division estimates that 10,967 persons in Hawaii will have developmental disabilities or mental retardation in 1993 and 11,030 persons in 1994.[2] These estimates are based on two other estimates. The division applied a national prevalence estimate that 1.5 percent of the population is developmentally disabled to Hawaii's zero-to-two population. The division applied the State Planning Council on Developmental Disabilities prevalence rate estimate of 0.9 percent to the population three and older. The division then added the estimates for the age groups to arrive at the 10,967 figure.

But the State Planning Council on Developmental Disabilities estimates that there are between 10,373 and 20,016 people in Hawaii with developmental disabilities. It based the lower figure on information about the number of persons with developmental disabilities served by the Department of Education. It reached the higher figure by applying another prevalence rate, 1.8 percent, to Hawaii's population. The council is aware that the discrepancy in estimates exists and that it needs to research and determine the best method of calculating the number of persons with developmental disabilities in Hawaii.

A more precise estimate would provide a baseline to help policymakers determine whether services are being provided to all who need them. The department's own figures show that the department is serving at most about 3,300 people with developmental disabilities. This is far short of the low-end estimate of about 10,000 persons needing services, and the gap is even wider if the estimate of 20,000 is accepted.

The Developmental Disabilities Division has some theories but no hard data on the size of the gap and the reasons for it. Possible explanations may include the following: some families do not see their family member as a person with disabilities or in need of outside services; some families arrange for services through other departments or without state assistance; people do not know about available services; and transportation to services is not readily available.

Consolidated purchase of service troublesome

The division recently initiated a contract for consolidated purchase of service (CPOS). This new approach is intended to fill gaps in services identified by clients and their families or other representatives. Clients are referred to providers who may provide service to clients or train them on how to obtain the services. The department does not state the specific services in the contract. The contract only specifies the number of clients to be served. This initiative is a well-intentioned means of moving to client-based services. But there have been some problems.

The CPOS contract has stipulations that require the provider's project to be flexible, consumer-driven, and highly individualized. Clients identify and prioritize the services they need. The provider then coordinates, supervises, and supports these services. Services may be needed for transportation, recreation, medical and dental needs, development of social skills and personal adjustment, or personal attendants. Providers receive payments in advance in quarterly installments based on client participation and expenditures.

The department does not have sufficient knowledge for this initiative to work. For CPOS to succeed, the department should know in advance what clients the provider will serve, what services will be provided, and what the services should cost. The department currently lacks this knowledge. Moreover, the department has not clearly informed providers of how CPOS is supposed to work.

We could not determine how the department arrived at the funding amount for CPOS providers. For example, providers who would each be serving 20 clients were funded between $88,032 and $103,990 for the same contract period. Providers developed initial budget proposals, but the department insisted that each provider revise its budget proposal to coincide with a pre-set funding level for each as determined by the department. The department set the funding levels by comparing the providers' budgets and staffing ratios. Staffing ratio is one aspect of costs but may not be an appropriate method of comparing budgets of highly individualized, flexible programs.

Challenges for the department

We do not underestimate the challenge of identifying reasonable costs in the face of significant changes in service. The department needs a new approach, reliable data, and a commitment to making the change.

Rhode Island's voucher initiative has made some progress but apparently it has been limited by resistance from traditional forces. Ohio established a funding system for a supported living program that allows consumer choice in the selection of a provider. It is reported that providers initially were discontented with the system but have now taken

on the responsibility of marketing themselves. Another issue is whether there are likely to be enough providers in Hawaii to allow for real competition.

For major change to occur, the department will have to devote the necessary resources and time. To develop its unit billing system for early intervention, the Massachusetts Department of Public Health performed a time-motion study in which 800 service staff kept time sheets in 15-minute blocks and worked closely with the Massachusetts Rate Setting Commission.

Increased analysis of costs could have benefits in addition to improving purchases of service. It could help the department determine more systematically which services should be operated by private providers and which should be operated directly by the department. Without sound cost data, this determination is difficult.

Recommendations

1. The Legislature should consider requiring the Department of Health to develop a payment system for purchases of service for persons with developmental disabilities based on identifying reasonable, equitable, and appropriate costs.

2. The director of health should ensure that the Developmental Disabilities Division and the Family Health Services Division take the necessary steps to execute all purchase of service contracts in advance of their effective date and to ensure prompt payment following contract execution.

3. The director of health should develop uniform departmental policies and procedures for contract monitoring.

4. The department's Personal Health Services Administration should work with the Developmental Disabilities Division, the Family Health Services Division, and the State Planning Council on Developmental Disabilities to identify the target population, and to clarify the consolidated purchase of service program.

Notes

Chapter 2

1. Sections 333E-2 and 333F-1, Hawaii Revised Statutes.
2. Public Law 101-496.
3. Public Law 99-457, Part H, Handicapped Infants and Toddlers.
4. Public Law 100-430.
5. Public Law 101-336.
6. Barbara Wright and Martha P. King, *Americans with Developmental Disabilities: Policy Directions for the States,* National Conference of State Legislatures (NCSL), Task Force on Developmental Disabilities, Denver, Colorado, February 1991, pp. i, ix, 8.
7. Ibid., p. ix.
8. Ibid., pp. x, xi, 22; Barbara Wright, *What Legislators Need to Know About Mental Retardation and Developmental Disabilities,* NCSL, Health and Mental Health Program, Denver, Colorado, February 1990, pp. 2-3.
9. State Planning Council on Developmental Disabilities, *Choices and Changes: The 1992-1994 Hawaii State Plan for Services for Persons with Developmental Disabilities,* Honolulu, 1991, p. 4.
10. *What Legislators Need to Know,* p. 4.
11. Senate Standing Committee Report No. 767 on Senate Bill No. 1379, Regular Session of 1991.

Chapter 3

1. Hawaii, The Auditor, *Financial Audit of the Department of Health,* Report No. 92-30, Honolulu, December 1992, p. 6.
2. Hawaii, Department of Health, Developmental Disabilities Division, *A Plan for Services for Persons with Developmental Disabilities, and/or Mental Retardation,* Honolulu, 1990, p. VI-1.

Responses of the Affected Agencies

Comments on Agency Responses

We transmitted a draft of this report to the Department of Health, the State Planning Council on Developmental Disabilities, and the Commission on Persons with Disabilities on December 8, 1992. A copy of the transmittal letter to the department is included as Attachment 1. A similar letter was sent to the council and to the commission. The responses from the department, the council, and the commission are included as Attachments 2, 3, and 4 respectively.

The Department of Health did not respond specifically to our recommendations but made many comments on the related findings. The department acknowledges that there is empirical proof of lack of consistency, parity, and acceptable standards and unit costs for funding contracts with providers. The department attributes these problems to (1) the lack of standards for services, (2) no decision on which services are to be provided by the department and which by the providers, and (3) the inability to develop unit costs because of resistance by providers. The department offers to work with an objective observer who has the necessary expertise and resources, such as the State Auditor or a contractor, to develop a better payment system. It agrees with our finding that contracts and payments are often delayed and that the department's contracting process is cumbersome.

The State Planning Council on Developmental Disabilities responded to our recommendation that the Legislature consider requiring the department to develop a payment system based on identifying reasonable, equitable, and appropriate unit costs by saying that the department cannot do this without assistance from an unbiased, experienced source. The council also says that providers should be paid on time. It believes that the department's Developmental Disabilities Division can do more to ensure timeliness but lacks a comprehensive planning process needed to put all the pieces of the picture together, including CPOS. The council says it will follow up on the issue of population estimates.

The Commission on Persons with Disabilities says that our report is not faulty in its content but that we should have given more guidance to the Department of Health by recommending a cost calculation method which would appear to be equitable in determining unit costs.

We are concerned that the three agencies responsible for the state's program for persons with developmental disabilities perceive that the Department of Health lacks the ability to correct certain problems

identified in our report, particularly the lack of an appropriate payment system, and that the State Auditor should play a stronger role. We believe that the department *has to assume* the duty and obligation to make the necessary changes using our findings and recommendations as a guide.

All three agencies suggested some technical clarifications and corrections in our draft. We incorporated some of these in our report.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

December 8, 1992

The Honorable John C. Lewin, M.D., Director
Department of Health
Director's Office
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Lewin:

Enclosed are three copies, numbered 6 through 8, of our draft report, *A Study of the Department of Health's Administration of Contracts for Purchases of Service for Persons With Developmental Disabilities.* We ask that you telephone us by Friday, December 11, 1992, on whether you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Friday, December 18, 1992.

The Governor, presiding officers of the two houses of the Legislature, the Chairpersons of the State Planning Council on Developmental Disabilities and the Commission on Persons with Disabilities have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa

Marion M. Higa
State Auditor

Enclosures

ATTACHMENT 2

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: DDD

December 18, 1992

TO: The Honorable Marion M. Higa
State Auditor

FROM: John C. Lewin, M.D.
Director of Health

SUBJECT: Your Draft Report on POS Contracts for Persons with Developmental Disabilities, 12/8/92

Thank you for the opportunity to comment on your draft report. Purchase of Service (POS) matters, especially as they apply to Consolidated POS contracts under the new Chapter 42D, pose a formidable opportunity and challenge to the entire State. Your assistance on this portion relating to developmental disabilities is most welcomed.

By way of background, Senate Concurrent Resolution 157, Senate Draft 1, directed the Legislative Auditor to consider the following in its evaluation of DOH contracts and administrative processes:

1. Funding level needed for quality of service.
2. Adequacy of current funding levels.
3. Definition of unit cost and method to determine appropriate unit cost.
4. Which programs should the State provide and which should be provided by private nonprofit providers.

The Department appreciates your efforts to address these concerns, and has the following comments.

1. Funding level needed for quality of service.

   Before funding levels can be set, standards should be set for service elements of programs. Substantive differences should be acknowledged between those needing more care or services, such as the behaviorally

challenging and medically fragile, and those needing less care or services such as higher-functioning ambulatory clients. Staff costs for the same type of program would differ markedly. Various services, such as diagnostics, should specify what type of staff support is needed and at what costs (salary times time allowed). If necessary, different costs should be calculated for different quality levels for the same type of service (routine diagnostic, one involving psychiatric evaluation, etc.).

2. Adequacy of funding level.

It would appear that first, some decision should be made as to who does what: what programs will the State handle, and which will the providers handle. If service standards are set so that sub-unit costs can be computed, we would have the fiscal building blocks to develop unit costs for individualized Consolidated POS contracts covering a wide range of combinations.

3. Unit cost: definition and methodology.

As stated by providers and covered in your report, the Department has attempted to develop workable unit costs with the providers but has not been able to come up with something acceptable to the providers and to the Department itself, for that matter. Given the resistance from the providers, the Developmental Disabilities Division is not a likely candidate to do further work on unit costs for DD POS contracts. Who will (can) do this task? It should be someone detached and objective who has the expertise and resources. It could be done by your office or contracted out. If it is the latter, funds will be needed to hire a firm.

Three other points are noted:

a. Historically, the past "informal" way of determining unit cost (dividing "program" cost by number of clients") should be discouraged since it compares apples and oranges. It lumps different service levels and types which share the same program label (note earlier discussion about behaviorally challenging, medically fragile, and higher-functioning, low-maintenance clients).

b. As you noted, earlier POS programs with relatively low unit costs only get nominal across-the-board escalation increases. Under the present setup they will never close the gap between them and newer POS programs with higher unit costs.

c. Lobbying and legislative intervention will continue as a normal and realistic way of political life. Providers will obtain additional funding not subject to the same scrutiny and unit costs, which will affect overall unit costs, parity and consistency. If providers accept standards and new unit costs, they will be less likely to find it necessary to lobby for additional funds.

4. Who (State or providers) provides which programs?

Guidelines need to be set and some decision reached first on who should do what. To the extent that service standards, guidelines and unit costs are put in place, we can reduce inequities, inconsistencies, disparities, and the unavoidable impact of legislative intercession and provider lobbying for additional funds. It is hoped that you will comment on how to divide this program workload, taking into account the best and most exportable features of different states' practices. Presently the State is the provider of last resort.

5. Additional detailed comments and corrections.

Attached is a more detailed list of comments and corrections.

Attachment

Additional Department of Health Comments
on Legislative Auditor's Report
on Developmental Disabilities POS Contracts
December 18, 1992

1. Page 1, Introduction, last paragraph: Suggest inclusion of all four items mentioned in SCR 157 SD 1.

2. Page 1, Objectives of Study: Expand accordingly.

3. Page 9, Funding levels: Doesn't address question about desired level and what would be adequate. Suggest that prerequisite work is required: setting service standards and unit costs, developing guidelines and procedures, and dividing program workload between providers and State.

4. Pp. 10-11, Table 2.1: What are your conclusions or comments about who (State or provider) should provide which programs? Note: DOH is provider of last resort now, and must be ready to handle a provider's clients on short notice when provider is unwilling or deemed unable to care for client.

   Central Intake and Diagnostic figures, p. 10: We are confirming these figures and will call Melanie Chinen early next week (week of 12/21) with our findings.

5. Pp. 12-13, Table 2.2, Corrections

Page 12:	From	To
Oahu		
Association for Retarded Citizens of Hawaii		
Adult Day Program	115	142
Group Home		4
Goodwill Industries Adult Day Program	100	105
Hawaii		
Hilo ARC Adult Day Program	35	38
Kona ARC		
Consolidated POS	8	4
Group Home (delete)	4	(delete)
Page 13		
Kauai ARC Adult Day Program	40	20

5. Page 15, Summary of Findings

   a. P. 15, Item 1: "The Department of Health's approach to funding private providers of services to persons with developmental disabilities is arbitrary."

   Concur on empirical proof of lack of consistency, parity, and acceptable standards and unit costs, but this does not mean that the department is therefore willfully acting arbitrarily. Note your comments on historical quirk favoring higher-costing latter day programs and across-the-board escalation increases. Also, RFP time frames are

typically short for analysis and recommendations on proposals.

b. Concur with general findings as far as they go, but suggest that report scope be expanded to cover more fully items addressed in SCR 175, SD1.

6. Page 15, "Funding Appears Arbitrary; contract disparities common."

See above. Absent standards, providers prefer their own "standards" vs. a common standard or unit cost. Some opt for more comprehensive services (higher staffing ratio) than others and have higher unit costs. Salary schedules from provider-to-provider differ, unlike State employees. While we do not disagree that disparities are common, it is requested that the contributing factors be cited.

7. Page 17, Automatic increases, "The arbitrariness in the contract amounts stems largely from the department's lack of knowledge of what it costs to provide the services."

Lack of service standards is the main factor, not lack of knowledge. There is lack of consensus on service standards and a unit cost, or acceptable range of unit costs.

8. Page 17, "Unit Costs Not Helpful." Concur. Question is, who will set unit costs, Legislative Auditor or someone else contracted to do it?

9. Page 17, "Purchase of system weakened." Concur. Again, the emphasis should be on lack of standards and unit cost, not "lack of information." The lack of information is symptomatic of the lack of standards and unit costs. Ch. 42D presents a formidable challenge unless the issues cited by SCR 157, SD1 are addressed and resolved.

10. Page 19, "Reform efforts on hold: We believe the department must persist in developing a better payment system if it cannot obtain consensus among providers."

We were hopeful that the Legislative Auditor's report would address more fully the issues raised by the Legislature. We are willing to work with you or a contract firm, and believe that provider participation would make it easier for them to concur and comply with the standards, unit costs, procedures and policies that will be developed.

11. Pp. 20-21, "Contracts and Payments...delays...provider concerns...cumbersome procedures." Concur.

12. Page 21, "Department-level action needed.

We were deferring to your report findings, recommendations and corrective actions. Will you opt to work on this further, or will you recommend that funds be provided to contract with a firm to do the job?

13. Page 22, "Monitoring objectives vary." On monitoring by Waimano: "...we found no evidence of monitoring to ensure compliance with Chapter 42 and the contract terms."

Do not concur. Waimano monitored for Chapter 42 compliance with its one POS contract with the Special Education Center of Hawaii (SECOH). See attached memos from Director of Health to SECOH dated 6/21/91, 10/29/91 and 6/8/92. The FY91-93 contract was awarded consistent with Chapter 42 and State accounting procedures; the 1991 memos cite specific contract monitoring findings; Waimano conducted a fiscal review in June, 1992 for FY91; and a follow-up review is scheduled for January, 1993.

14. Page 23, Varying Population Estimates.

True, there are conflicting data including varying population estimates (different percentages used to determine number of those with developmental disabilities out of the total population). Rather than labor over a more precise figure (is it closer to 10,000 or 20,000?), it would appear to be more pragmatic to use more tangible indices such as number of clients on waitlists, and length of time on waitlists. A more precise population figure would mainly be useful in deciding if the department should initiate a more forceful outreach program to identify clients which we are presently not staffed to serve. By contrast, the waitlist information would bear immediately on handling clients that are already identified.

15. Page 24, "Consolidated purchase of service troublesome."

This is a formidable challenge (and opportunity) requiring immediate resolution of the issues raised or implicit in SCR 157, SD 1. The new "lump-sum" method of allocating funds for service allows providers (and the department) to determine the best direction to take in delivering services. We request more time for beta-testing and debugging since it has only recently been initiated and Chapter 42D is silent on logistical and coordination matters.

16. Page 25, Recommendations: Which of the states' features cited would you recommend that we deploy here, and why?

DLS - 26

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File: DDD

June 21, 1991

Ms. Mary F. Jossem
Chief Administrative Officer
Special Education Center of Hawaii
708 Palekaua Street
Honolulu, Hawaii 96816

Dear Ms. Jossem:

Re: Salary Increases for FY 90-91 Relating to the Contracts with Department of Health, Waimano Training School and Hospital

Your request for salary increases relating to the H&CBS II and the ICF/MR contracts have been reviewed. Salary increases stated in your letter has been approved effective September 1, 1990 with the provision that total expenditures do not exceed actual services rendered multiplied by the service rates.

As provided for in our pending agreement, we will recommend to DHS approval on the H&CBS I and II contracts.

Very truly yours,

JOHN C. LEWIN, M.D.
Director of Health

Bus-45

October 29, 1991

Ms. Mary F. Jossem
Chief Administrative Officer
Special Education Center of Hawaii
708 Palekaua
Honolulu, Hawaii 96816

Dear Ms. Jossem:

Thank you for your letter of October 17, 1991 regarding the status of [redacted] and [redacted] who are sisters employed under an ICF/MR contract with Waimano Training School and Hospital. Based on the information presented in your letter regarding their duties and lines of supervision, I am granting an exception to the prohibition of hiring two or more members of a family under contract by a private organization as provided for by HRS 42-3(1), Conditions for grants, subsidies, or purchase of service agreement.

Thank you for your continuing support in servicing the needs of Hawaii's developmentally disabled population.

Very truly yours,

JOHN C. LEWIN, M.D.
Director of Health

FILE COPY

JOHN WAIHEE
GOVERNOR OF HAWAII

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES DIVISION
741-A SUNSET AVENUE
HONOLULU, HAWAII 96816

In reply, please refer to:
File:

June 8, 1992

Ms. Mary F. Jossem
Chief Administrative Officer
Special Education Center of Hawaii
708 Palekaua Street
Honolulu, HI 96816

Dear Ms. Jossem:

Thank you for the cooperation extended to my Fiscal staff who performed our internal review of your contracts for fiscal year 1991. The review was performed in compliance with the DOH and DHS regulations and covered your contracts for the HCBS I, HCBS II, HCBS III, and ICF/MR programs.

A copy of the final finding and recommendations of the review are provided on the attachments. We will be disallowing the items identified on the attachment to determine your final adjusted expenditure amounts for FY 91. Should you disagree with these adjusted expenditures, please notify us in writing with supporting documents by Wednesday, June 17, 1992. Unfortunately, the short time limit is due to the fiscal year closing.

Sincerely,

Stanley C. Yee
Chief

SCY:MA:au
Encls

STATE OF HAWAII
STATE PLANNING COUNCIL
ON DEVELOPMENTAL DISABILITIES
FIVE WATERFRONT PLAZA
500 ALA MOANA BOULEVARD, SUITE 200
HONOLULU, HAWAII 96813
TELEPHONE: 548-8482

December 18, 1992

Marion M. Higa, State Auditor
Office of the Auditor
State of Hawaii
Kekuanoa Building
465 King Street, Room 500
Honolulu, Hawaii 96813

Re: "A Study of the Department of Health's Administration of Contracts for Purchases of Service for Persons with Developmental Disabilities."

Dear Marion:

We appreciate the effort that went into this report and the opportunity to comment. We agree with many of the findings and have comments on several of the points: unit cost; private versus public services; what private providers need; timeliness of contracts; planning for more flexible services; and population estimates.

Unit Cost. We supported the resolution in order that the unit cost issue be clarified and a method be determined for calculating fair and appropriate unit cost. This we feel was left unanswered. The first recommendation (p. 25) begs the question: it asks the Legislature to "consider requiring the Department of Health to develop a payment system.....based on identifying reasonable, equitable, and appropriate costs." Suggesting how this might be accomplished, as we saw it, was your primary task. We do not think the Department of Health can, without assistance from an unbiased, experienced source, accomplish this.

Public versus Private. The Resolution also called for you to address the "programs that will or should be provided by the Department of Health as opposed to private nonprofit agencies.." We did not see this addressed at all except to show (Table 2.1, p.10) that both the State and private providers are providing services. (You do note on page 15 that contract amounts vary widely among private providers offering similar services, but do not address differences between State and private providers.)

Noting Figure 2.2 (p. 9), it appears that nonprofit agencies which provide a large part of the "hands-on" services, receive a disproportionately small share of the allotted funds. As deinstitutionalization of Waimano Training School and Hospital continues, the State will need to decide who should provide necessary services. We had hoped that the Auditor would have provided some direction in addressing this question.

Essential for Private Providers. If the State decides that private providers should deliver all direct services--as several Department of Health officials have stated--efforts **must** be made to assure that purchase of service providers are strengthened. They must receive an equitable, fair sum for their services; contracts and payments must be completed in a timely, efficient manner.

Timeliness of Contracts. The issue of timeliness of contract completion and payment has been a concern of the Council for several years. The problem is complex and not solely that of the Developmental Disabilities Division. It is our belief, however, that the Division could and should do more to assure that contracts and payments are timely.

Planning and Providing for More Flexible Services. We support the inclusion of your comments (p. 5) noting that Hawaii is following national trends in attempting to provide services that are more individualized, consumer-driven, and community-based. In order to be successful in doing this, it is critical that there be a thorough understanding of not only the philosophy behind these kinds of services, but of a funding structure that is workable. Currently the Developmental Disabilities (DD) Division is lacking the comprehensive planning process that would enable them to put the disparate pieces together into a workable whole. The Consolidated Purchase of Service (CPOS) process is a case in point. The concept behind this new approach is good and the Council endorses it. However, as you note (p. 24), the implementation has been "troublesome." We believe it should be pursued with all players--DD Division, private providers providing the services, the required advisory groups, and others such as Council representatives--working together to see that a structure is developed that will allow it to succeed. The current purchase of service procedures are hampering the current projects.

Population Estimates. Also needed, as you note, are more reliable estimates of the population potentially needing services--now and for the future. This is a difficult question. The Council has looked into ways of establishing that prevalence rate of developmental disabilities in the state of Hawaii. The cost would be high to conduct an independent, statistically significant study. We, therefore, rely on a national prevalence rate. However, there

are State offices that make prevalence estimates on various matters, and it is a possibility that a few questions about disabilities could be attached to a current survey. The Council will follow up on this issue.

There are a few technical details that need clarification.

1. The State Planning Council on Developmental Disabilities is not an advisory body (pages 5 and 7). Federal and State law makes it clear that it is a decision-making body.

2. On page 6, Figure 2.1: Clarify that the branches that are outlined are those that provide disability services through contracts as well as directly. The others provide services although not through the contract process.

3. The tables on pages 10, 11, 12, 13, and 16 are somewhat confusing. We suggest making it clear to the reader that these are for different years and thus not easily comparable.

We hope the comments are useful and our suggestions taken in consideration. If there are any questions, please call Jean Moore or Diana Tizard at the Council office.

Sincerely,

Margaret B. Proffitt

Margaret B. Proffitt
Chair

MBP/JM:pt

ATTACHMENT 4

COMMISSION ON PERSONS WITH DISABILITIES

Five Waterfront Plaza, Suite 210, 500 Ala Moana Blvd., Honolulu, HI 96813, Ph. ~~548-7606 (V/TDD)~~
586-8121 (V/TDD)
586-8129 (FAX)

December 17, 1992

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OFC. OF THE AUDITOR
STATE OF HAWAII

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 South King Street
Room 500
Honolulu, HI 96813

Dear Ms. Higa,

Regarding: Draft Report "A Study of the Department of Health's Administration of Contracts for Purchases of Service for Persons with Developmental Disabilities"

The following represents staff technical comments on the preliminary draft report, *A Study of the Department of Health's Administration of Contracts for Purchases of Service for Persons with Developmental Disabilities.* The comments represent a technical analysis of the report by our staff and are not to be construed as a policy/position statement of our Board.

Our comments fall generally into two (2) categories: those reflecting technical corrections to factual statements and those reflecting the broader goals/objectives of the report.

Comments regarding technical corrections to factual statements

The following pages and sections contain terms, phrases or legal references which are incomplete or incorrect. The attached copy #9 of the Auditor's Report is a marked-up copy reflecting these changes and other minor editorial comments.

1. Page 4 - **Federal statutes**

   - Replace "Education of Handicapped Act" with "Individuals with Disabilities Education Act." The Education of the Handicapped Act was recently amended to reflect this name change.

   - Remove second sentence of the second paragraph, "...helps people with disabilities to find living accommodations including group homes and other community residences." Recommend the following replacement statement. The Fair Housing Amendments Act... "prohibits discrimination towards persons with disabilities in the sale, rental and financing of dwellings, or in the provision of services and facilities connected with those dwellings." There are provisions within the Fair Housing Amendments Act to find group or community housing for people with disabilities.

   - Insert "government services" after employment in last sentence of the second paragraph.

2. Page 23 - **Varying populations and trends**

- Paragraph 2 uses two projected figures in estimating the prevalence of persons with developmental disabilities in Hawaii. The figures are 10,967 and 10,907. This maybe a typographic error.

Comments regarding the goals & objectives of the report

A more significant concern about the report relates to the goals and objectives of the report. S.C.R. 157, S.D. 1, requested the State Auditor to study the department's contract policies and administrative processes for providing services to persons with developmental disabilities. Specifically, the resolution asked that the study determine:

(1) The levels of funding necessary for quality services;
(2) The adequacy of current funding levels;
(3) The method for appropriate unit cost;
(4) The programs that will or should be provided by the Department of Health as opposed to private, nonprofit agencies.

The study did not address the objectives of the resolution, except, to a partial degree for objective (2). The conclusions of the study appear to merely validate the premises which were stated in the resolution itself; furthermore, the recommendations appear to ask the Department of Health to correct the deficiencies which are noted in the conclusion (and the resolution) without giving specific guidance as to how this should be accomplished. The report, while not faulty in its content, is not particularly useful in resolving the issues surrounding the purchase of service system for persons with developmental disabilities.

The fundamental issue in the resolution revolves around the calculation of unit costs which are used as a basis for the purchase of service contracts; a secondary issue is the administration of those contracts (regardless of the dollar value of the contract). The conclusion that the Department of Health does not have a method for accurately calculating unit costs is a restatement of the problem. The Legislative Auditor's Report needs to recommend a cost calculation method which would appear to be equitable in determining unit costs. There are a significant number of cost:benefit analyses nationwide which attempt to standardize unit costs, the results yielding significant variations in the per person costs of providing various type of care. Differences in cost can be attributable to variations in staffing patterns, use of specialized care (e.g. therapy), the costs of resources (e.g. mortgages of residential homes), longevity of staff in the various agencies, economies of scale, age of the clients, stability of the program and its ability to obtain other funds, the severity of the disability of clients served, even in apparently similar programs, or some combination thereof.

The large variations in costs, which are reflected in Table 3.1, have enormous implications for public policy and cost reimbursement. The "unit costs" which are noted in the same table should be more accurately termed "average per client reimbursement rate" because they do not reflect anything other than a mathematical calculation of the contract amount divided by the number of clients served, an amount that the Department has negotiated or decided to give to a specific provider. A true "unit cost", if calculated upon a base cost, adjusted for variables such as those listed in the aforementioned paragraph, would drive the contract amount, rather than be derived from it.

As it now stands, if the State is to accept the premise that "unit costs" will be no more accurate in the foreseeable future than what is presently available (i.e. an average reimbursement rate), then the extent to which the rates differ should trigger an administrative decision to adjust the contracts.

(a) If the rate differential reflects solely the differences in the efficiency with which different contractors provide the same services at the supposedly same level quality of care, then either 1) the less efficient providers should be required to adopt procedures and practices of the more efficient providers or 2) fiscal resources should be transferred from the less efficient providers to the more efficient providers.

(b) If the rate differential reflects the costs of resources (e.g. staff salaries, mortgage payments, etc.), then either 1) providers will need to subsidize the difference for higher costs above a baseline contract cost, or 2) the contract rate must be adjusted per some acceptable formula which takes into account those factors up front and is applied equitably to all providers.

(c) If the rate differential reflects differing quality of care issues and training methods, acknowledged by the providers themselves to be different among the programs, then the reimbursement rate must openly acknowledge that philosophical difference (and bias).

The purpose of determining "unit costs" is to determine an equitable rate of reimbursement for supposedly like services. As an extension of that premise, monies would be shifted to those agencies which are able to best provide the service for the reimbursable rate. It should be noted that IF the analyses is performed for the latter reason, then including the state-provided similar services in the cost comparison would help answer the question of whether monies should be shifted from state-operated programs to private, non-profit programs. In addition, the analysis would provide a more accurate estimate of the total level of funding necessary to provide a comprehensive array of services to the developmentally disabled population (by multiplying a truer "unit cost" times the number of clients in need of a service). Unfortunately, this report does not give the state sufficient guidance to move clearly in that direction.

Sincerely,

Francine Wai Lee

FRANCINE WAI LEE
Executive Director

Enclosures