

### **Little or No Cost Savings Likely from Closing Training Centers**

Since the inception of the DBHDS plan, the Department has provided a series of cost estimates with varying assumptions for the cost of care in the Training Centers (TCs) versus the community. All of these studies conclude that TC costs would be significantly higher. This brief paper challenges these conclusions based on the premises behind the DBHDS estimates, logic, economics, experience in caring for people leaving TCs, and national studies.

**What is the relevant comparison?** The Factsheets that are relevant to the Work Group process and state decisionmaking should explain the cost of providing care in “right-sized” TCs versus providing “comparable” care in the community.

*For TCs:* The decline in the census from roughly 5,000 to about 614, with little or no change in the TC footprints or configurations, distorts the costs of retaining more TC capacity. Smaller, more efficient TCs would cost less to maintain and operate and should be the basis for comparison, rather than current costs in transition with excess land, excess staff for the discharge process and inefficient configurations.

*For the community:* SB 627 requires the Department to certify that the community option “provides a quality of care that is comparable to that provided in the resident’s current Training Center” for an enumerated list of categories. The Factsheets should identify all elements of such care and the associated costs, including the likely cost of the new waiver and the many additional community costs that are supported by public funds that are not included in the waiver (see the final subsection for more detail).

**Common sense, economics and real world experience.** Usually, common sense is a good guide to reality, and so it is here, too. For people with intensive health and safety needs, it doesn’t make sense for “comparable” care to cost less in the community, with multiple homes scattered through a wide geographic area, rather than on a centralized TC campus. Economics tells us that economies of scale, as in the TC model, would be more efficient, not more expensive.

The experience of Chimes of Maryland, a highly respected provider, confirms what common sense and economics tell us. Maryland has a more mature and flexible waiver and system of community supports than Virginia. It is not cheap. In 2012, Chimes’ annual cost per resident with highly intensive needs was nearly identical to the cost per resident at NVTC, even though Chimes does not deliver nearly as much access to nursing services. Here are some details. After the Rosewood state facility closed, Chimes established group homes to accept the remaining residents. Nurses are available on call by phone, visit each resident at least once every 45 days, offer more intensive support when needed, and meet a resident at the emergency room following a 911 call. By contrast and as required as a result of a DOJ action at NVTC, nursing ratios must be much higher than at Chimes. This higher ratio enables nurses to respond in minutes to an emergency, to supervise units daily, to treat residents as needed, and to staff an Observation Care Unit to prevent or reduce hospitalization time.

Similarly, on July 29, 2014, Community Resources opened an ICF/IID in Chantilly, Virginia, that will house some NVTC residents. The cost per resident will be the same as at NVTC.

**Cost comparisons in national research.** The author of the DOJ strategy, Sam Bagenstos, wrote that, “(A)s deinstitutionalization advocates shifted their goals from rights to services, the cost

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gap between institutional and community services narrowed . . . . [I]t is reasonable to expect that the cost gap will shrink [or reverse] as people in the community receive more services.”<sup>i</sup>

His assumption is confirmed by the work of Charles Lakin *et al.* In a 2006 Report to CMS,<sup>ii</sup> Lakin found that, after controlling for all cost factors, TC and community placements are within 3% of one another. Similarly, in a peer reviewed 2003 cost comparison study in the then-Journal Mental Retardation and its 2009 Update,<sup>iii</sup> Kevin Walsh *et al.* concluded that the research literature does not support an unqualified conclusion that supports in community settings are less expensive than those in institutions.

**The elements of a new cost comparison.** For the foreseeable future, Virginia will continue to operate at least one TC, SEVTC, while the number of people choosing TCs and policy choices may result in the continuation of others. Given the decline in census, any TCs that continue in operation will need to be “right-sized” to make them more efficient in serving a smaller population. Also, SB 627, which was enacted into law after the DBHDS first started preparing cost estimates, calls for TC residents to receive “comparable” care for health, safety and other factors in the community. Given the likely revised configuration of any new TCs and the new requirement to provide comparable care in the community, new cost estimates should reflect these new realities and compare the costs of right-sized TCs with the costs of comparable care in the community.

The DBHDS, DMAS, and CSBs should tabulate all of the many publicly supported costs contributing to community placements and compare them to a break out the essential costs of Training Center placements. The community costs should correspond to the supports for people from TCs or those requiring a comparable level of support. The tabulated community budgets should include at least the following elements:

- ID waiver charges
- Direct Medicaid fees for doctors and therapists
- Hospitalizations and convalescence
- DD Health Support Network costs such as dental
- REACH costs for crisis stabilization
- CSB supplements for such items as nursing, room and board, and day programs
- All other categories of publicly supported funding
- An estimate of the likely effect of the new waiver on each of these elements

Comparable care in the community should also include:

- Two awake staff 24 x 7 for emergency backup and evacuations
- Higher skilled certified direct care staff needed to care for those with high-intensity needs
- Improved retention to establish and sustain the intimate knowledge of their clients necessary for life-saving preventative action.

TC costs would need to be pared down to only those necessary to serve the residents; for example, the costs needed to sustain and operate appropriately configured and staffed centers and to cover hospitalizations. Other costs, such as excessive grounds and buildings, discharge planning and processing, should be eliminated.

Transitional costs for both the community and TCs should be reported separately. These include the cost of selling some land, acquiring new properties, building or refurbishment, severance

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packages for some employees, training for new employees, and all of the costs of the discharge and relocation process for current TC residents who choose to move.

With such clearly categorized estimates of cost elements available, the Work Group, the administration and the General Assembly can make more informed assessments of the budget implications for the future system of supports for people with ID and highly-intensive needs in Virginia.

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<sup>i</sup> Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 *Cardozo Law Review* 1 (2012)

<sup>ii</sup> Lakin, Doljanic, Byun, and Stancliffe, *Medicaid Home and Community-Based Services for Persons with Intellectual and Developmental Disabilities: Background and Findings from Consumer Interviews and the Medicaid Statistical Information Systems*, Final Report for Centers for Medicare & Medicaid Services, The University of Minnesota Research and Training Center on Community Living (September 2006)

<sup>iii</sup> Kevin Walsh, Theodore Kastner, Regina Gentlesk Green. *Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research*, *Mental Retardation*, Vol. 41, No. 2, 103-122 (April 2003); Kevin Walsh. *Update* (to Walsh, Kastner, Gentlesk Green comparison), *Mental Retardation* (January 2009)