



Fact Sheet:

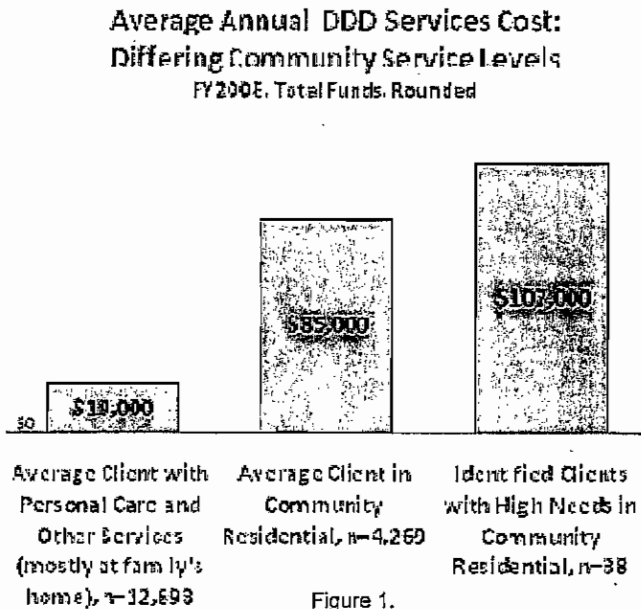
Comparing Costs for Services for Clients with Developmental Disabilities



The average cost to Washington State to serve a client in the community is 30 percent less (\$54,000 per year lower) than the cost of services in a Residential Habilitation Center, even for high needs clients and including costs outside the Division of Developmental Disabilities.

The analysis below provides a step-by-step comparison between community settings and Residential Habilitation Centers (RHCs), by carefully comparing services for clients with similar needs. It captures the known "public costs" to the State of Washington's budget (General Fund State and matching federal funds). It excludes certain costs where appropriate, and includes non-DDD costs such as medical costs. It also takes a conservative approach, by using a high community cost and a lowered RHC cost.

How much do various kinds of community-based services cost DDD?



Of the 21,000 clients of DDD who receive paid services, 95% receive home or community-based services, at varying levels. Figure 1 shows the annual DDD costs projected for three different groups of clients, whose services are primarily dictated by the clients' assessed needs and the capacity of their family to assist.¹ The first column is for about 12,900 adult and child clients, the majority of whom live with their family and all receive personal care services (assistance with activities of daily living, such as dressing, bathing, toileting, eating, moving around). In many cases a family member is paid to provide these services. A smaller number live in licensed Adult Family Homes to receive personal care.² Most also receive other DDD services, such as employment, therapies, environmental adaptations, or respite, which are also included in the cost shown. On average, DDD's service costs for these clients

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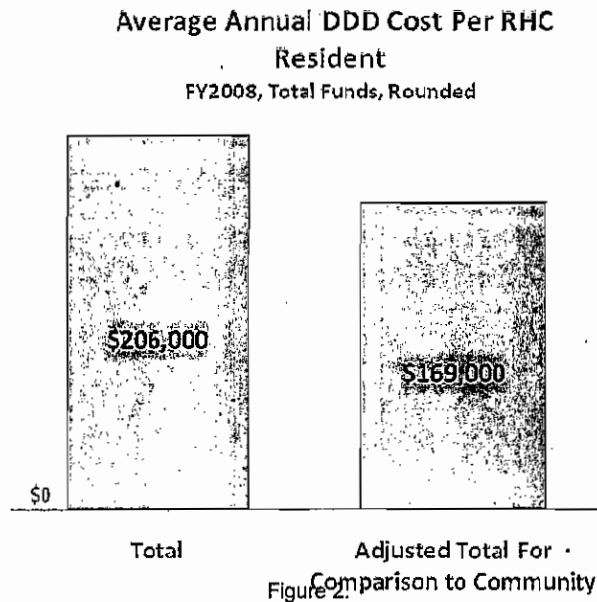
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are \$19,000 per year. The acuity level is likely lower than current RHC residents on average; however, in decades past when personal care and other supports were not available for families, institutions would have been the only option for many. Some of these clients do have acuity that is comparable to current RHC residents.³

The middle column indicates the DDD costs for 4,300 DDD community residential clients who do not live with their families and receive much more extensive supports, with an average cost of \$85,000 per year. Most clients are on a Core Home and Community-Based waiver. This means that they have been determined to be eligible for an institutional level of care, but that they have waived this right in order to live in the community with supports. These clients are supported by staff in small community residential settings, primarily contracted certified Supported Living or licensed Group Homes specifically designed for clients with developmental disabilities. Also included in the costs are other DDD services such as therapies, employment, skilled nursing, and rental assistance. The clients include many who moved out of RHCs in prior years, including about 110 clients in State Operated Living Alternatives (SOLAs), which are Supported Living settings staffed by state employees that were created when the state closed Interlake School RHC in 1994. The total community residential group is similar to institutional residents, as they have already been identified as being eligible for institutional care and have many similar service needs,⁴ but it may not be the best comparison group if the most conservative analysis is desired.

The third column represents costs for 38 clients who are a subset of the middle column, those who needed community residential services who had the highest acuity or crisis-driven needs, often due to very challenging behaviors or their family or previous setting could not continue meeting their needs. These clients are being diverted from RHC placement, or in some cases are moving out of RHCs. The Legislature appropriated specific funds to serve these clients in the community rather than in institutions, under the "Expanded Community Services proviso".⁵ For this group, in Fiscal Year (FY) 2008, the costs for the 38 clients averaged \$107,000 shown above; the range goes from about \$50,000 per year to about \$200,000 per year, so it includes some clients with very high services needs. **Because of the very high needs of the clients in this group, this is the data that can provide the most conservative comparison.** Non-DDD services costs for all clients in Figure 1 are discussed below.

How much do institutional services at a RHC cost DDD?



DDD operates five RHCs serving 970 residents, ranging in population from 50 to 370 residents. RHC residents must be eligible for an institutional level of care (either ICF/MR or skilled nursing). In addition to room and board, residents receive supports and supervision, some medical care, therapies, and either training in activities of daily living or skilled nursing care, depending on the facility. Because RHCs are state-operated, state employees do most functions, including client supervision and care, clinical work, administrative work, and support such as housekeeping, food preparation, maintenance, and grounds and physical plant. RHC expenses are averaged over all residents and are included in cost reports to the federal government.

The total annual RHC cost reported to the federal government averaged about \$206,000 per year in FY 2008, with a range of \$180,000 to \$260,000, depending on the facility. For the purpose of making a comparison to a community-based cost for a comparable service level, this cost can be lowered, see Figure 2. **"Adjusted Total" RHC costs average \$169,000 per year, ranging from about \$160,000 to \$220,000 depending on the facility.** The

adjustment shows operating costs only, removing capital costs, DSHS indirect costs, and room and board covered by client participation (Social Security and Medicare Part D). The RHC cost is also adjusted to remove a state tax charged to the RHCs but not to most community residential settings (the IMR tax). This tax adds over six percent to the cost of an RHC, and generates revenue to the state of Washington. However, since the *benefit* of the tax revenue is not counted in this analysis, and the community does not have a comparable tax, the IMR tax is removed from the "Adjusted Total" RHC cost shown. **The "Adjusted Total" RHC cost to DDD ends up being 18 percent lower (or \$37,000 less per year), for the purpose of making a fairer "apples to apples" comparison to community costs.**

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What about "other DSHS costs" for clients such as medical and dental care, or the costs of room and board?

Both community and RHC residents receive important services from other parts of DSHS, particularly Medical Assistance under the Medicaid program, as shown in Figure 3.

Medical Assistance covers primary/specialty care, hospitals, drugs, equipment and therapies if not covered by DDD, dental care, etc. For RHC residents, most of these are already covered by the RHC and show up in DDD's costs, but not all; for example, hospitalization is covered by Medical Assistance. Other services provided by DSHS and used by community clients include food and economic assistance, mental health services, long-term care, vocational rehabilitation, and small amounts for child welfare, juvenile rehabilitation, and alcohol and substance abuse. (RHC residents use little to none of these services, other than Medical.)

Room and board costs that are covered separately by the federal government are not shown for either community or RHC clients. For

community clients, most room and board is paid for with 100 percent federal funding outside of Washington State's budget. A client's Social Security check is used to assist with a clients' room and board, and some clients have federal housing vouchers. In the RHC, the facility is permitted by the federal government to keep the majority of the residents' Social Security ("client participation") to pay for the room and board inherent in RHC services. (This is why the Social Security client participation is removed in the RHC "Adjusted Total" above, otherwise the RHC cost would include room and board and the community would not, making an unfair comparison.) Community room and board costs that are not covered by federal Social Security or housing vouchers are included above in either the DDD costs or the "other DSHS" costs (these could include DDD client allowance to help cover rent and utilities, or food stamps).

What is a reasonable comparison between costs for clients with similar needs served in the community and those in RHCs?

As seen in Figure 4, the average FY 2008 DSHS services cost for community services for high needs clients totaled \$118,000, 30 percent less than the lowered "Adjusted Total" RHC cost of \$172,000.

This means that even for high needs clients, RHC services cost \$54,000 more per year per person (DSHS services, state and federal funds).

This analysis takes a conservative approach by choosing only the high needs clients as a comparison group. It adds costs for other DSHS services the clients receive shown above in Figure 3, including such items as medical, dental, food stamps, etc. This analysis also only uses those RHC costs which have comparable costs in the community, by using the "Adjusted Total" described above in Figure 2, excluding capital costs, indirect costs, IMR taxes, etc.

Average Annual "Other DSHS" (non-DDD) Services Costs for Various DDD Clients
FY2008, Total Funds, Rounded

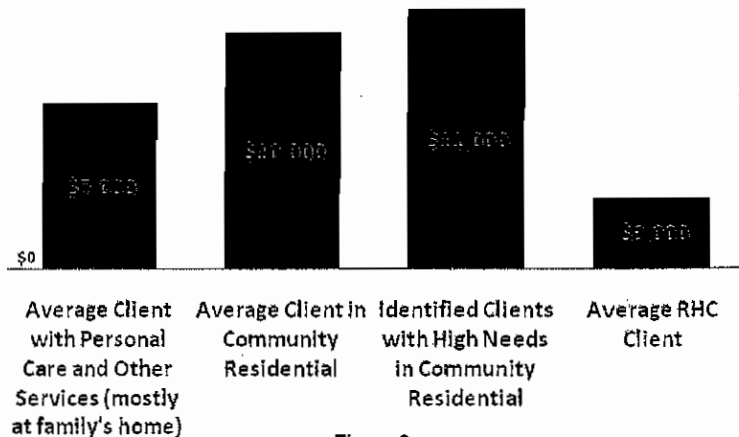


Figure 3.

Average Annual DSHS Services Cost for Clients with Similar Service Needs
FY2008, Total Funds, Rounded

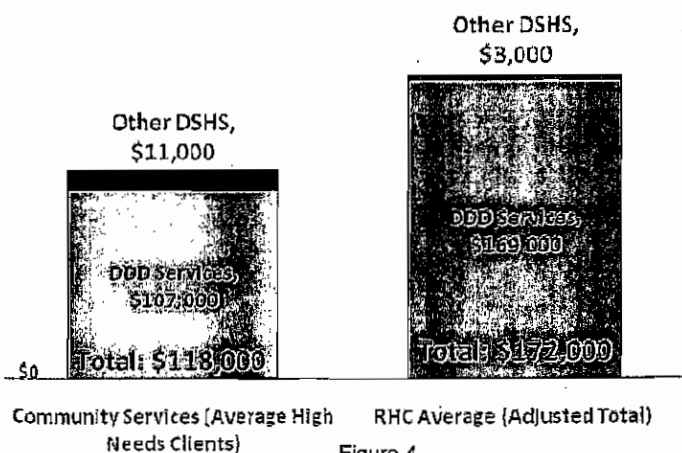


Figure 4.

It is important to remember that there are some, but few, clients with very high needs whose costs in small, community-based settings are higher than they would be in an RHC. One example of this situation is a teenager with exceptionally high behavior needs who needs two-on-one staffing, who lives in a small licensed staffed residential home specially designed for minors, near their family and local school. Another example would be a very medically fragile client whose specific needs cannot be met by nurse delegation, but only by a licensed nurse. However, the service needs for this very small group of people is factored in by averaging them into the "high needs" group above.⁶

What about the costs of State Operated Living Alternatives (SOLAs)?

Data at the same level of specificity as above for other DDD and DSHS costs is not available for SOLA residents at this time, but an estimate is provided below. The average annual cost for SOLA services in FY 2008 was \$120,000. Using the data for other community residential clients, we can add an estimate for other DDD services not included in SOLA services (\$8,000), and a similar "other DSHS" cost (\$10,000), bringing the total DSHS cost to \$138,000. **The estimated SOLA cost is 20 percent lower than the "Adjusted Total" RHC cost.** Most SOLA residents are former RHC residents who were moved when Interlake School RHC closed in 1994. Although SOLAs have higher salaries and benefits than contracted community settings, their overall personnel and fixed costs are much less than an RHC.

Why do services in community residential settings (including SOLAs) cost less per person than RHC services?

Community residential settings generally serve four or fewer clients, and have lower fixed and personnel costs than a larger facility-based setting like an RHC, with extensive grounds and physical plant needs that require resources and specialized staff. Community residential settings do not have in-house therapists and physicians like RHCs, although some nursing services are available and professional services such as medical, dental, therapies, and mental health are accessed on an as needed basis through other contracted providers (reflected in the costs above in Figure 3 for "Other DSHS"). Also, for contracted settings (as opposed to SOLAs), labor costs are lower than state employee salaries and benefits.

Can RHC costs be reduced or made efficient?

The figures shown in this analysis are from FY 2008. Since that time, responding to state budget shortfalls, the RHCs have made noticeable efficiencies, as well as some service cuts, such as closing therapy swimming pools. However, these efficiencies were largely designed to mitigate increasing costs, and the impact on the FY 2008 rates shown above will not be more than a few percent. Efficiency cuts cannot impact the health and safety of residents. The RHC facilities, although upgraded, are decades old, and were originally designed for over 4,000 residents. This means that several of the facilities have significant numbers of older buildings that are vacant, contributing to an inherent inefficiency that is hard to change. If the RHCs were designed today from scratch with efficiency in mind, they would be more modern, have fewer buildings, house fewer residents, have smaller grounds, have greater interaction with community resources, and there would be fewer total RHCs. Even keeping the current RHC structures safe and in working order will require new capital investment; efficiency redesign would require major capital investment.

Alternately, some have wondered whether it makes sense to increase the RHC population, to take advantage of empty buildings, and thereby make the RHC costs more efficient per person. This does not recognize several realities: first, it would require a very large influx of new residents to materially impact the daily rate, and currently there is very little "ready to occupy" building space, so it would cost money to reopen older structures. Secondly, adding a significant number of RHC residents might lower the daily rate but would still require new spending, likely in excess of what it would cost to serve individuals in the community, as many of these individuals have lower needs than the high needs group. Third, and although not a cost consideration, it is the most important; even though there are a small number of people interested in RHC admission for a family member, the expressed preference of most people, including those with higher needs, is to reside in small community-based settings or with their families; DDD's family support wait list and waiver request database contain thousands of such requests. Also, adding significant census to the RHCs may result in additional federal Department of Justice and *Olmstead* legal challenges.

What was not included in this analysis, and what caveats must be considered?

First, this analysis is not a scientific study; it is not a statistical analysis and cannot capture every possible cost such as those in the private sector or to entities other than the state. However, it is a reasonable analysis based on recent data that focuses on making fair comparisons that are meaningful to state budget decisions.

In addition to the exclusions described above, this cost comparison does not include the costs of licensure/certification and quality assurance for either setting, or capital and depreciation costs for either setting. The RHC capital and depreciation costs are known and considerable (they are reflected in the "Total" RHC cost.) However, since similar costs in the community are not known with accuracy, a fair comparison using capital and depreciation was not possible and the RHC

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"Adjusted Total" cost above excludes these items. In the community there may be little to no capital and depreciation costs that apply. Such costs are not factored into payments to providers. Rent paid by the client's Social Security presumably could include some allowance for capital and depreciation, and other capital costs in some cases could include the construction of new accessible housing units by the State Housing Trust Fund, local government, or non-profits.

Some other costs cannot be included in this analysis, as they are not known. These apply to both community and RHCs, including such items as local government costs for law enforcement and emergency response, and education expenses for the clients under age 21 (both children in an RHC and the community have a right to a public education, paid for with local, state, and federal funds.) While not inconsequential, these costs are likely not as high as the DSHS costs to actually provide the day-to-day care, all of which are included above. Private costs in the community such as private insurance and the value of a family's time in caring for a minor child, or the value of the housing a family provides, are also unknown, and are not included in this analysis, which focuses on "public costs."

The exclusion of certain items means that the total "real costs to society" for RHC or community services (whether to local, state, or federal taxpayers, or private costs to individuals or nonprofits) is higher than what is shown in this analysis. However, this allows a fair comparison of the majority of the services costs with recent, reliable data. These are also costs that have a direct, identifiable impact to the state budget.

What do other studies show about comparing institutional and community-based settings?

Other sources have also found that community services cost less per client on average than institutional services. A 2004 DSHS study by the Research and Data Analysis Division (RDA) did a more sophisticated analysis than the one above, but the findings are similar. RDA compared 2001-2002 total DSHS costs for specific clients while they lived in RHCs and for the same clients after they left, and found that their services cost about 30 percent less after leaving.⁷

In 2009, the Washington State Institute for Public Policy conducted a national review of research on developmental disabilities services, and found that community residential services on average cost less than institutional services for similar groups of people, even including other costs such as medical.⁸ Further, more states are downsizing or closing public institutions and expanding community services, to address both consumer demand and to respond to cost pressures.⁹

What are the implications of this analysis?

If the State wants to invest in serving more people with developmental disabilities, or in improving services, the same amount of funding in the state budget can go much farther in the community than in RHCs.

For example, based on the costs above, for \$10 Million in state and federal funds per year, the Washington could serve:

- 60 residents in an RHC; or
- 85 high needs community residential clients on a Home and Community-Based waiver; or
- 105 average community residential clients on a Home and Community-Based waiver; or
- 385 community clients with personal care in their family's home, employment, and family support services such as respite.

Most DDD services are not an entitlement, and community services provided do not meet the current demand. Unlike DSHS Long-Term Care, or Medical Assistance, much of DDD's funding allocated by the Legislature does not grow to accommodate increases in its client caseload or demand. DDD is not able to serve all of its clients with paid services, and many clients are waiting for some service or for additional services. About 1,200 clients—more than the current RHC population—have requested waiver services in the community—but specific funding for them has not been provided by the State. 7,000 people are on a wait list for the Individual and Family Support Program, which provides a small amount of annual funding per family for items such as respite care, equipment, home adaptations, and therapies. So, when making new investments, or deciding about systems reform, lower community costs can stretch the investment farther—over more clients, for improved services, or both.

Finally, when it comes to using cost comparisons, the purpose of the analysis must be kept in mind. ***This analysis is most useful for gauging the relative cost of comparable community services to RHC services, and decisions on investments of new funds.*** Actual scenarios to close RHCs would use a detailed closure model. During a closure, net costs actually increase temporarily, while adequate staff are retained at RHCs to care for remaining residents until complete closure, while simultaneously new services are opening in the community and new DDD staff are hired to facilitate safe transitions and build community resources.

Sources and Notes:

¹ Figures in chart include adult and child clients. Caseload data for community residential group is from FY 2008 forecast tracking data. Expenditure data for all groups and other caseload data are from DSHS Research and Data Analysis (RDA) Client Services Database for FY2008, queried January 2010.

² These clients may be served either on the Basic waiver, Basic Plus waiver, or with Medicaid State Plan and other services such as Individual and Family Support or employment, etc.

³ Barbara A. Lucenko, Lijian He, David Mancuso. (2010). *Assessment Findings for Persons with Developmental Disabilities Served in Institutional and Community Settings*. Olympia: Washington State Department of Social and Health Services Research and Data Analysis Division, Document No. 5.35. Found at: <http://publications.rda.dshs.wa.gov/1399/>

⁴ Ibid.

⁵ These are clients authorized to begin services in FY 2007 who had a full year of service in FY2008. The Legislature also appropriates proviso funds for "Public Safety", primarily for clients entering the "Community Protection" program. These clients are leaving or being diverted from jails, prisons, or state psychiatric hospitals, or have other public safety risks. Only about 450 such clients are currently served, with a few added each year, and their service needs are very different from either other community clients or RHC clients, so the comparison is not particularly useful for this fact sheet. Placement in RHCs (with more vulnerable clients) is generally not appropriate for the Community Protection group.

⁶ Another example is Community Protection clients, whose supervision needs are very high, to ensure public safety. As stated above, these clients do not make good candidates for RHC services, due to the need to protect the other RHC residents.

⁷ Liz Kohlenberg, Boqing Wang, Roger Calhoun. (2004). *Community Institutional Cost Comparison Example: RHC to DDD Community Care*. Olympia: Washington State Department of Social and Health Services Research and Data Analysis Division, Document No. 5.32fs. Found at: <http://publications.rda.dshs.wa.gov/1131/>

⁸ Stephanie Lee and Marna Miller. (2009). *Children and adults with developmental disabilities: Services in Washington, research evidence*. Olympia: Washington State Institute for Public Policy, Document No. 09-10-3901. Found at: <http://www.wsipp.wa.gov/rofiles/09-10-3901.pdf>

⁹ Charles Moseley. (2009). *National Association of State Directors of Developmental Disabilities Services (NASDDDS) Technical Report for December 17, 2009*. According to the NASDDDS survey, 11 states/jurisdictions have closed all of their publicly operated institutions for people with developmental disabilities. 20 states have plans to downsize, and nine states have plans to close. Of the 20 states downsizing or closing, ten states indicated this was for financial reasons.