# Fiscal Analysis of Assembly Bill 896

California's Developmental Services System *Unification,*
Finance and Economic Issues

Prepared by

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### A Note on *Revisions* to this Document

This *note* is to help readers familiar with earlier editions of this report. The first edition was prepared May 27, 2001. Within about 10 days, two revisions were made (Edition 2). This third edition contains another set of revisions to the document. Further revisions are a possibility, if for no other reason than to reflect amendments to the bill as it moves through the legislative process. The following changes were made in the second edition:

- A few minor computational errors (tables on pages 12, 14, 18, and 21) were discovered and corrected.
- Data attributions (University of Illinois at Chicago, and University of Minnesota) were clarified, based on feedback from Charlie Lakin, who had provided information from both sources.
- Assumptions underlying projections of ordinary Medi-Cal use (excluding long-term care), outside developmental centers, were specified. (The projections, themselves, are unchanged.)

Compared with the second edition (*revised* June 8, 2001), this third edition includes (1) this explanatory *note*, (2) two summary charts covering the entire period, 2002 to 2008, including an estimate of "cost avoidance" to meet seismic, accessibility, building code, and programmatic improvements identified or recommended in the *Vanir Report,* (3) some additional narrative in the body of the report concerning the latter, and (4) some wording changes (e.g., Centers on Medicare and Medicaid Services, the new name for the federal Health Care Financing Administration (HCFA).

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# Preface

When asked by Art Bolton, Legislative Consultant to Assemblywoman Dion Aroner (Berkeley), to take on the task of analyzing the fiscal implications of Assembly Bill 896, I gladly accepted the assignment. I did so in hopes that an independent fiscal analysis would advance the cause of good lives and quality services for Californians with developmental disabilities. I believe that this analysis will stimulate thoughtful discussion of several important issues, and result in healthier, happier, more fulfilling lives.

Beyond preliminaries (Preface, Table of Contents), this report is organized as follows:

- Executive Summary;
- Fiscal Analysis of Assembly Bill 896;
- Frequently Asked Questions;
- Appendix: Generic Services and Supports; and
- Miscellaneous Materials.

I would like to thank several people for their assistance. Mary Lee Pennington served as my *liaison* with the California Department of Developmental Services (DDS). She and her colleagues generously provided requested information, and discussed several questions with me. Individuals within California's Department of Health Services (DHS) and General Service Administration (GSA) provided helpful information, as did Judy Poindexter, who worked recently on the *rate study.* The Association of Regional Center Agencies (ARCA) provided financial support, along with information, including a survey of regional centers asking about one-time, start-up costs. I very much appreciate the help provided by ARCA's Peter Tiedemann. I alone am responsible for what is said in this report. The views expressed do not necessarily reflect the views of ARCA or its members.

Several nationally recognized experts were kind enough to share data, perspectives, and ideas with me. In this regard, I would like to thank Charlie Lakin, Colleen Wieck, Gary Smith, Mary Cerreto, and Bill Copeland.

John Shea

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# Fiscal Analysis of Assembly Bill 896
## *Executive Summary*

## Introduction

Assembly Bill 896 would change the way that financial resources and responsibilities are distributed in the developmental services system. The bill would *unify* the work of California's regional centers (RCs) and developmental centers (DCs). At present, the Department of Developmental Services (DDS) directly manages a $600 million budget for services to about 3,700 individuals who live in five DCs and two smaller, state-operated facilities. Through contracts with 21 regional centers, the Department funds and monitors an additional $1.9 billion for community services and supports for about 166,000 individuals and their families.

## Development of a unified system

To make the change to a unified system, Assembly Bill 896 would:

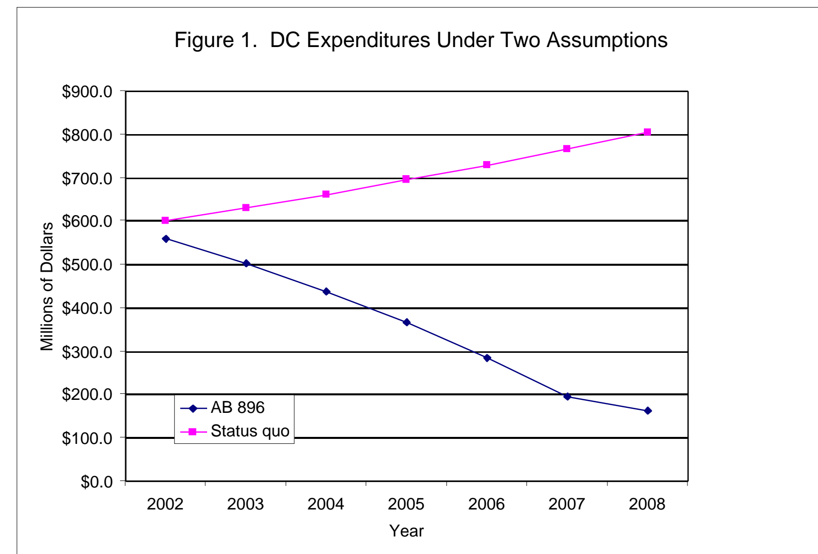
- Place the line item in the Governor's budget now called "Developmental Centers Program" under the budget heading "Community Services Program." The new line item would be called the *State Hospital Interagency Transfer Fund* (SHIFT). Working closely with DDS, the regional centers would be responsible for using these funds to meet targets in deflecting and transitioning people from DCs to the community.

- Start a *Community Augmentation and Resource Enhancement* (CARE) account, to hold any left over SHIFT or Purchase of Service funds at the end of each year. These funds would be available to regional centers to meet urgent, unmet needs.

- Develop the *Lanterman Trust Fund* (LTF) to hold resources from the sale or lease of developmental center properties no longer needed. These resources would be used to develop affordable, community housing for individuals with developmental

disabilities. This would help reduce the growth in residential service costs, and promote greater stability and service continuity in the community.

# Major findings




## What would the bill accomplish?

If AB 896 becomes law,

- community services will be strengthened by converting state developmental center overhead dollars into community direct service dollars;

- the State will avoid the expenditure of $500 million to $1.0 billion dollars from the General Fund to bring developmental centers into compliance with building, seismic, accessibility, and programmatic standards;

- the recurrent risk of losing *certification* within the ICF/MR program at DCs, and therefore federal funds, would be reduced; and

- past investments in state developmental centers (worth about half a billion dollars) will be converted into affordable housing and an improved community support system.

## Is the bill cost-neutral?

AB 896 can be *cost-neutral,* for both the federal government and the state General Fund (GF). With the possible exception of some *generic service* funding in the short-run, all of the *changes* can be funded out of the resources currently used to provide

services for individuals living at developmental centers. Indeed, under the assumptions laid out in this report, the SHIFT (or CARE) accounts will have a cumulative total (2002-08) of approximately $1 billion *left over* to meet urgent unmet needs – that is, needs beyond those assumed in this report, beyond the $500 million to $1.0 billion saved by avoiding some capital outlays at DCs.

The *Vanir Report* recommended outlays as high as $1.4 billion (in 1998). With the passage of time, with rising standards and projected increases in cost-of-construction prices, some $2.0 billion could be needed. Based on data provided by the Department of Developmental Services and a set of working assumptions (e.g., time sequence of outlays, which DCs will be closed and when, and the impact of consolidation within DCs staying open), I estimate that approximately half ($750 million to $1.0 billion) of the $1.5 to $2.0 billion in construction outlays can be avoided.

Another contingent expenditure of state funds relates to problems, including programmatic ones, that increase the risk of *decertification* under the Medicaid Intermediate Care Facilities/Mentally Retarded (ICF/MR) Program. When facilities are *certified,* federal financial participation is essentially $1 for every $1 of state GF outlays. This past year, *decertification* of DCs cost California in excess of $30 million in additional State General Funds.

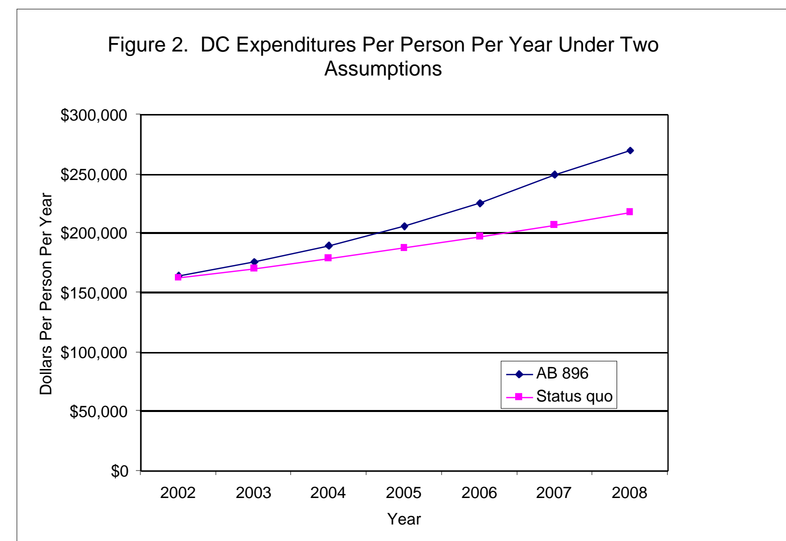
Under AB 896, a *unified* budget will be very tight in the first year, with little money available to enhance services for those who transition from developmental centers to community services. Beginning in the second year, substantial sums of money are available to enhance individualized, community services (through the SHIFT budget and/or CARE account). To be *cost-neutral*, especially in the short-run, it is critical (1) to stay close to current estimates and costs; (2) to downsize and consolidate DCs very systematically to control diseconomies of scale; and (3) to access as many Medicaid Home- and Community-Based Services (HCBS) Waiver dollars as possible. Indeed, it would be advantageous from a fiscal point of view to focus exclusively on Waiver eligible DC residents in the first year.

## Will services be available for those transitioning to the community?

This fiscal analysis assumes substantial *additional* money for one-time start-up purposes, so as to have appropriate services available in the community for individuals who leave or who would have entered developmental centers in the absence of the change in funding. The bill provides for advance payments of (SHIFT) funds to regional centers to support people who transition

from developmental centers to the community. The bill also allows regional centers to provide advance payments to providers. In addition, funds not used to pay for developmental center services can be used to start-up programs and create new services. The Department's Community Placement Plan calls for $6,000 per person to meet one-time, start-up costs, and I have assumed this will continue, growing by 5% per year. My analysis assumes $13,000 per person for this purpose, $7,000 more than currently budgeted for that purpose.

## What about *fixed* costs, and the projected increase in unit costs (per diem, or per annum) associated with downsizing?




There is sufficient funding within the SHIFT budget to cover fixed and semi-fixed costs at DCs as a consequence of serving fewer residents. If California does almost as well as twelve states that reduced the number of residents in their large, state-operated facilities by 75% between 1988 and 2000, the *backfill* cost to cover fixed and semi-fixed costs at California's DCs will be about $6.3 million in 2002, increasing to about $40 million in 2007, and staying at about that level in 2008. Over the seven years, $206.7 million will be needed to counterbalance higher *per diems* stemming from diseconomies of scale. If downsizing and consolidation is carefully planned and implemented, *all* of these funds can come out of the SHIFT budget, without any additional budget augmentation for this purpose.

## What happens to various sources of funds?

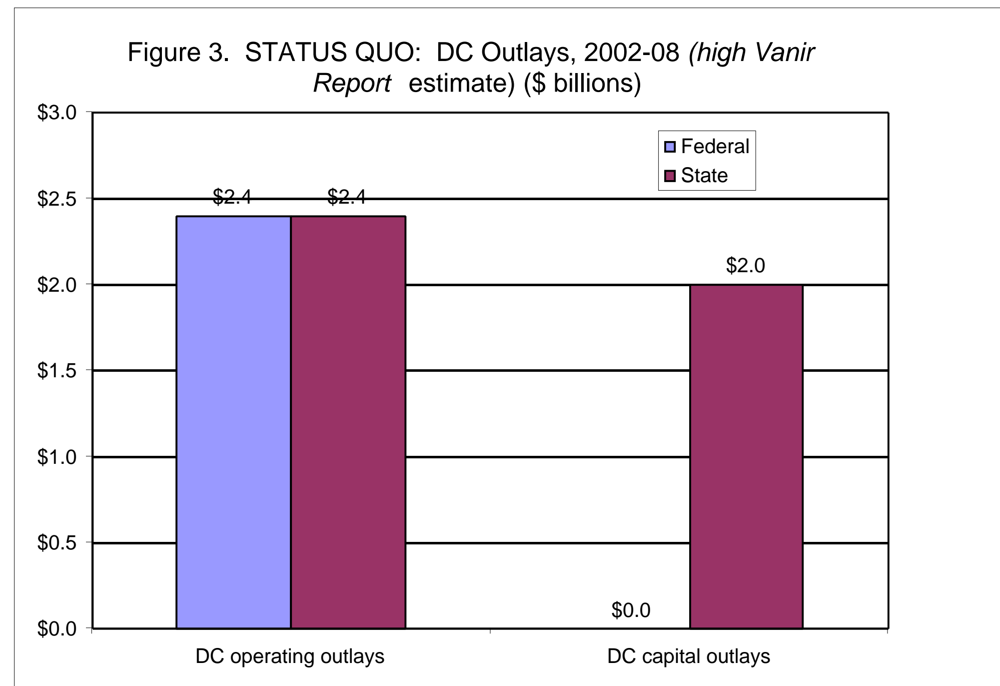
Several states have virtually eliminated the use of federal funding for developmental centers in favor of the more flexible Home and Community Based Services (HCBS) Waiver program. AB 896 is a "good deal" for federal officials, because it will reduce the total, combined federal outlay under the two major programs: ICF/MR and HCBS Waiver. Federal ICF/MR outlays at DCs will

decline. ICF/MR outlays in the community will rise, but by far less. Federal HCBS expenditures will rise, but because some individuals, services and providers are not “Waiver eligible,” the increase will be less than the *net reduction* within the ICF/MR program. In other words, with some community services being 100% state funded, the over-all federal outlay will be less than currently projected under the assumption of no change in the DC population. Because California, for a variety of reasons, has more “unmatched” State General Fund dollars within its developmental services system than any other state, nearly everyone sees the importance of working closely with federal officials to expand use of the HCBS Waiver. Finally, capital improvements called for in the *Vanir Report* could necessitate $1.5 to $2.0 billion in additional State General Fund dollars. With implementation of Assembly Bill 896, about half of this expense can be avoided.

## A summary picture or two

This report compares the *status quo* use of DCs with a reasoned *AB896 Alternative.* The *status quo* assumes fixing up all five DCs, continuing to serve 3,700 residents, and unit operating costs increasing 5% per year – a number reflective of actual experience over the past 10 to 12 years not only in California but across the Nation. In this case, an estimated $4.9 billion will be spend on operating costs, and as much as $2.0 billion on capital improvements (seismic, ADA, building code, and program). See Figure 3. Nearly two-thirds will come from the State General Fund.

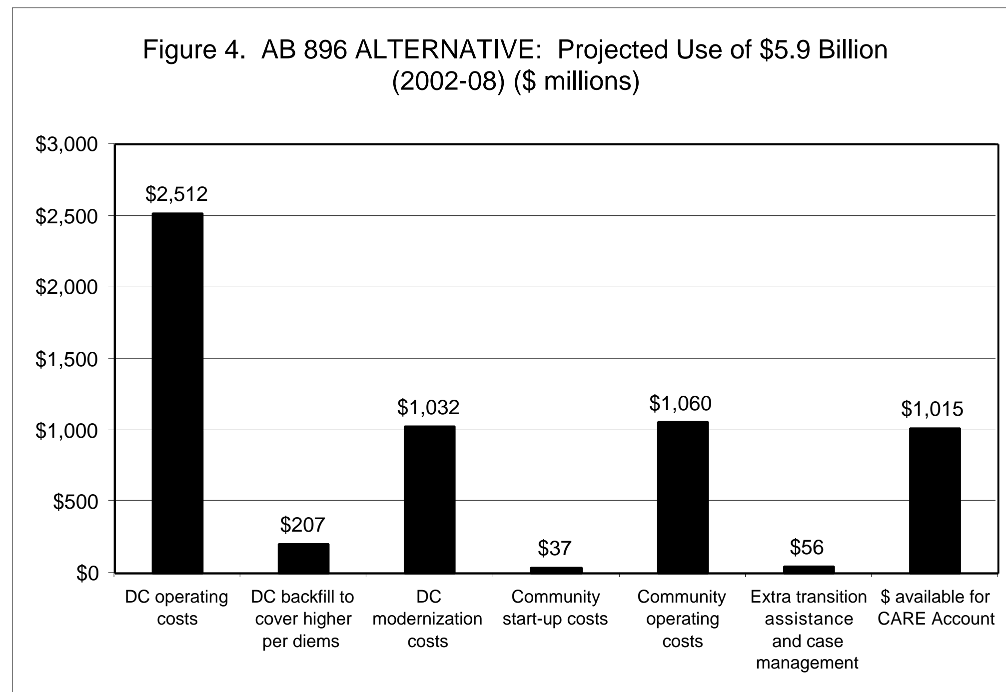
The *AB896 Alternative,* analyzed in this report, may free up nearly $2.0 billion over the period in the SHIFT budget and CARE account to augment services for those deflected from DCs, those moving from DCs to live in the community, and to



meet urgent, unmet needs of others now in the community not at great risk of institutionalization. Figure 4, below, shows how the cumulative sum of $5.9 billion would be used – given the assumptions outlined in this report. $3.8 billion would be used to meet operating and residual capital improvement expenses at DCs. Operating expenses would decline with the declining population, but as much as $1 billion of the $3.8 would be needed to make capital improvements at three DCs prior to closure and indefinitely, in the case of the other two. $1 billion would be available to cover any underestimated expenses in either locale, and to meet urgent, unmet needs in the community among those not at great risk of institutionalization. DC modernization costs, and one-time start-up costs in the community, are likely to come out of the State GF. The rest of the numbers assume federal financial participation of 50 cents on the dollar through the ICF/MR program, Targeted Case Management, and the Medicaid HCBS Waiver.

## Remainder of the report

In terms of fiscal and organizational impact, there are a number of other questions which are discussed in a Section entitled *Frequently Asked Questions,* beginning on page 27. An Appendix presents some estimates and thoughts on *generic services. Miscellaneous Materials* can be found at the end. Both items are of fundamental importance: (1) data from the twelve states that decreased their use of large, state-operated facilities; and (2) a table showing that for every person living in a DC there is a least one (and typically many) individuals living in the community.



# Fiscal Analysis of Assembly Bill 896

Assembly Bill 896 would alter the distribution of financial resources and responsibilities in a way that would *unify* the work of regional centers (RCs) and developmental centers (DCs), under the leadership of the California Department of Developmental Services (DDS). At present, DDS directly manages a $600 million budget, employing nearly 9,000 state employees who provide services to about 3,700 residents of five DCs and two smaller, state-operated facilities. (See Table 1 for some basic information about the DCs.) Through contracts with 21 regional centers, this year DDS will spend an additional $1.9 billion for community services and supports for 166,000 Californians and their families.

TABLE 1. SOME BASIC INFORMATION ABOUT THE DEVELOPMENTAL CENTERS (DCS)

| Item | Agnews | Fairview | Lanterman | Porterville | Sonoma | Total |
|---|---|---|---|---|---|---|
| Number of residents, 4/25/01 | 490 | 832 | 654 | 840 | 870 | 3,686 |
| Total budget, FY 00/01 (Mil. of $) | $95.8 | $116.0 | $98.8 | $118.6 | $133.7 | $562.9 |
| Authorized staff positions, FY 00-01 | 1,399.5 | 1,830.0 | 1,542.2 | 1,815.8 | 2,029.5 | 8,617.0 |

*Source:* Department of Developmental Services

## Major features of the bill

Assembly Bill 896 would:

- Replace the line item in the Governor's budget called "Developmental Centers Program" with a new line item within the "Community Services Program." This new line item would be called the *State Hospital Interagency Transfer Fund* (SHIFT). Working closely with DDS, regional centers would be responsible for meeting targets in deflecting and transitioning people from DCs to the community.

- Establish a *Community Augmentation and Resource Enhancement* (CARE) account, to hold any left over SHIFT or Purchase of Service funds at the end of each year. These funds would be available to regional centers to meet urgent, unmet needs.

- Establish a *Lanterman Trust Fund* (LTF) to hold resources from the sale or lease of DC properties no longer needed by people with developmental disabilities. These resources would be used to provide affordable housing in the community, thereby reducing the rate of growth in residential service costs and promoting greater stability and continuity for individuals with disabilities in the community.

Assembly Bill 896 raises several important questions from a fiscal or economic point of view, which are analyzed in this report. Key questions are:

1. What will community services cost for those <u>not</u> served in developmental centers (DCs)?

2. What one-time, start-up costs are likely to be needed, so that appropriate community services are available?

3. At the decision margin, what additional case management costs will be incurred at regional centers to serve more people in the community?

4. What resources will be needed to cover one-time *transition planning and assistance* costs associated with the net movement of individuals from DCs to the community?

5. Assuming rational, planned *downsizing* of DC programs and facilities, what will happen to unit costs (dollars per person per year)? To what extent will unit costs rise, as *fixed* (and *semi-fixed) costs* are spread over fewer residents?[1]

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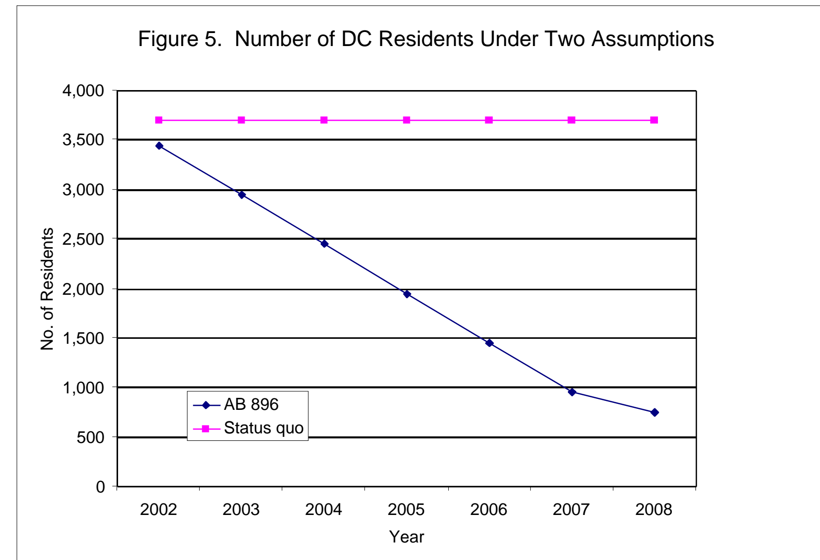
[1] By definition, *variable costs* are those costs that vary with the volume of output (e.g., units of service delivered). *Fixed costs* are those that do <u>not</u> vary with units of output. All costs, in the long-run, are *variable.* With the passage of time one can withdraw resources from existing uses and devote them to other uses. For example, if a DC were closed and the property sold (or leased for some other use), at that time previously *fixed costs* associated with physical plant become *variable.* With down-sizing, and planned, rational consolidation, many *indirect costs* (e.g., food

6. What impact would AB 896 have on capital outlays to bring existing DCs up to building code, seismic, and accessibility standards, while making some programmatic improvements?

7. What changes will occur in Medicaid funding through two major programs: (a) the Intermediate Care Facility/Mental Retardation (ICF/MR) program, and (b) the Medicaid Home and Community-Based Services (HCBS) Waiver? As a consequence, what is the likely impact on the State's General Fund?

8. What are the implications for various *generic* services and supports, including Supplemental Security Income/State Supplemental Payments (SSI/SSP), In-Home Supportive Services (IHSS), ordinary and acute health care costs covered by Medi-Cal and Medicare? Answers to this last question can be found in the appendix.

Figure 5. Number of DC Residents Under Two Assumptions




# Some simplifying assumptions

## Numbers served

AB 896 calls for movement of DC residents to the community, and deflection of some individuals who otherwise would be served in a DC. Ignoring deaths and some movement in and out of DCs despite best efforts at deflection, this analysis assumes a uniform *net shift* in services from DCs to the community of 500 per year starting in 2002 and ending with a final 200 in 2008. Starting from a

service personnel; medical records technicians) are *semi-variable,* in the sense that within a short period of time, such resources can be put to different uses. Increases in unit costs attributable to lower levels of service (output) are often called *diseconomies of scale.*

base of 3,700 residents, such an annual net shift would leave about 500 people living within one or two of the present five DCs by 2008. In the first year (2002), half the person-months of those involved in the net shift to community services (500 x 12 = 6,000), or 3,000, are assumed to be spent living within DCs, and 3,000, living elsewhere. In 2003, another 500 net shift from DC to community services is assumed, spread out over twelve months, meaning again spending (on average) half the year within DCs and half elsewhere. It is further assumed that, from one year to the next, those in the net shift from earlier years spend all of subsequent years in the community. To illustrate, the 500 individuals in the net shift in 2002 are assumed to spend *all* of 2003 in the community. The 500 net shift in 2002, plus the 500 net shift in 2003, spend *all* of 2004 in the community, and so forth.

### Living arrangements in the community

Over the seven years (2002 to 2008, inclusive), community living arrangement destinations, each and every year, are assumed to be:

- Health care facilities (HCFs)........................................................................ 30%
- Community care facilities and agencies (CCFs).......................................... 50%
- "Own home" with independent or supported living services (IL/SL)............. 12%
- Family home (living with relatives) .............................................................. 8%

Table 2, on the next page, shows "community placements" from DCs over the years the Coffelt Settlement Agreement. The pattern outlined above is roughly similar, with assumed differences related to changes in opportunities (e.g., expansion in supported living as an option), the aging of the DC population, and provisions within AB 896 itself (family self-determination).

## What will services cost in the community?

### On-going operating costs

Table 3, two pages hence, shows assumed on-going operating costs for those in the net shift to the community. One set of figures refers to a half-year (average) of community service each year for 500 individuals. The other set covers full-year costs of those in the net shift in earlier years. On-going service costs, excluding SSI/SSP for board and care and In-Home Supportive Services (IHSS), start slowly ($17.9 million in 2002), but then grow quite rapidly as more potential DC residents are assumed to

be in the community, many for full-year services. In 2008, on-going operating costs, exclusive of various generic services and supports, are projected to be $296.7 million for 3,100 individuals in that year.

TABLE 2. COMMUNITY PLACEMENTS FROM DCS, APRIL 14, 1993 – MARCH 31, 1997

| Community living arrangement | Number | | Percent |
|---|---|---|---|
| ICF/DD-H (4-6 beds) | 543 | | |
| ICF/DD-N | 363 | | |
| Other (ICF/DD, SNF, DD-H w/7-15 beds) | 47 | | |
| Sub-total, Health Care Facilities | | 953 | 40.2% |
| CCF, Level 2 | 59 | | |
| CCF, Level 3 | 356 | | |
| CCF, Level 4A-4H | 503 | | |
| CCF, Level 4I | 267 | | |
| Foster care | 15 | | |
| Sub-total, Community Care Facilities | | 1,200 | 50.7 |
| Own home (IL/SL services) | 73 | | 3.1 |
| Home of relative | 142 | | 6.0 |
| TOTAL | | 2,368 | 100.0% |

NOTE: Does not include out-of-state (N=5) and “Other” (N=106).
*Source:* RRDP Information System (1997).

The unit cost assumptions, outlined in a table footnote, are *averages.* Underneath, there will be variation around these averages. Most residents needing significant on-going health care services may be served in ICF/MR (Small) homes, consistent with the Coffelt experience. Some older persons are likely to enter Skilled Nursing Facilities. Some others will be served in quite expensive sub-acute health care facilities, where per diem charges (i.e., $ per person per day) are about $500. DDS is working with the federal Centers on Medicare and Medicaid Services (formerly, HCFA) to get their agreement to establish ten “Super Ns.” These are ICF/DD-N facilities (typically serving 6 individuals), where at present only one of three 8-hour shifts must be staffed

TABLE 3. ASSUMED ON-GOING OPERATING COSTS FOR THOSE SERVED IN THE COMMUNITY RATHER THAN IN DCS

| Item | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|
| **No. of residents in net shift to the community** | 500 | 500 | 500 | 500 | 500 | 500 | 200 |
| **Person-months of service in community** | 3,000 | 9,000 | 15,000 | 21,000 | 27,000 | 33,000 | 37,200 |
| **Person-years of service in community** | 250 | 750 | 1,250 | 1,750 | 2,250 | 2,750 | 3,100 |
| **Those in net shift in that year (1/2 year of community service, on avg):*** | | | | | | | |
| Health services facility (HSF) (30%) | $5,595,000 | $5,874,750 | $6,168,488 | $6,476,912 | $6,800,757 | $7,140,795 | $2,999,134 |
| Community care facility (CCF) (50%) | 8,391,000 | 8,810,550 | 9,251,078 | 9,713,631 | 10,199,313 | 10,709,279 | 4,497,897 |
| "Own home" with ILS/SLS (12%) | 2,430,000 | 2,551,500 | 2,679,075 | 2,813,029 | 2,953,680 | 3,101,364 | 1,302,573 |
| Family home (8%) | 1,440,000 | 1,512,000 | 1,587,600 | 1,666,980 | 1,750,329 | 1,837,845 | 771,895 |
| **Sub-total** | $17,856,000 | $18,748,800 | $19,686,240 | $20,670,552 | $21,704,080 | $22,789,284 | $9,571,499 |
| **Those in net shift in earlier years (full years of community service):*** | | | | | | | |
| Health services facility (HSF) (30%) | | $11,749,500 | $24,673,950 | $38,861,471 | $54,406,060 | $71,407,953 | $89,974,021 |
| Community care facility (CCF) (50%) | | 17,621,100 | 37,004,310 | 58,281,788 | 81,594,504 | 107,092,786 | 134,936,910 |
| "Own home" with ILS/SLS (12%) | | 5,103,000 | 10,716,300 | 16,878,173 | 23,629,442 | 31,013,642 | 39,077,189 |
| Family home w/support (8%) | | 3,024,000 | 6,350,400 | 10,001,880 | 14,002,632 | 18,378,455 | 23,156,853 |
| **Sub-total** | | $37,255,050 | $78,235,605 | $124,023,312 | $173,632,637 | $227,892,836 | $287,144,973 |
| **Total outlay ($)** | **$17,856,000** | **$56,246,400** | **$98,431,200** | **$144,693,864** | **$195,336,716** | **$250,682,119** | **$296,716,472** |
| Average outlays ($) per person-year | $71,424 | $74,995 | $78,745 | $82,682 | $86,816 | $91,157 | $95,715 |

*Figures in parenthesis refer to the assumed percentages entering each living arrangement.

NOTES: Operating costs (residential, day, transportation) in 2002, are based on the following assumptions:

- the 30% entering HCFs, 1/2 (or 15%) $180 per day and 1/2 (15%) $140 per day residential, plus $1,350 per month (day and transportation).
- the 50% entering CCFs, $5,038 - $794 (est.) SSI board and care, plus $1,350 per month (day and transportation).
- the 12% entering “own home” with ILS/SLS services, $6,750 per person-month of service, plus IHSS (not shown here).
- the 8% entering “family home”, $6,000 per person-month of service, plus IHSS (not shown here).

Operating cost per person is assumed to increase 5% per year. Operating costs in HSFs include Social Security benefits; elsewhere, the estimates exclude SSI/SSP for board and care (CCFs) and for all uses in own home or family home.

with a licensed health care professional (RN, LVN, Psychiatric Technician). “Super Ns” would have all three shifts covered by at least one health care professional. Until such pilots are approved, some regional centers – as is presently the case – will augment ICF/DD-Ns to provide the equivalent staffing. This augmentation can come out of the SHIFT budget for those deflected or moving to the community.

### One-time, start-up costs

I asked several knowledgeable people about unused capacity within the community service system. Most interviewees said that the amount and appropriateness of any unused capacity (e.g., bed vacancies) were in question. The assumptions underlying my estimates can be found in notes at the bottom of Table 4, on the next page. I assume that start-up outlays will involve residential, day, transportation, and other services, and that there will be considerable variation around an average of nearly $13,000 per person deflected or moving to the community in 2002. DDS’s existing Community Placement Plan calls for placing 210 individuals into the community in 2001-02, with start-up costs of $1,260,000 (or $6,000 per individual).[2] We have subtracted this *base* number from our estimates, and project changes in prices of 5% per year thereafter. The reasons for the assumption that unit costs will rise about 5% per year (current dollars) will be explained shortly.

## What will additional case management and *transition planning and assistance* cost?

Regional centers and DCs will experience some additional costs associated with deflections and transitions to the community, over and above on-going costs covered by purchases of service. RCs have liaison case management staff for individuals at DCs. DCs have social workers and Regional Resource Development Projects that concentrate on finding resources for those leaving DCs. Beyond these resources, Table 5, two pages hence, shows two *additional* needs that are assumed for purposes of this analysis. The first is additional RC case management and related support needed on an on-going basis. The second is the added cost of person-centered planning, checking out services, making connections with resources in the community, follow-up, comfort measures (e.g.,

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[2] Department of Developmental Services, *2001-02 May Revision.* For Legislative Review (Sacramento: DDS, Estimates Section, May 14, 2001), p. E-37.4

visits with familiar people), and making sure essential information is conveyed and understood by new caregivers. This involves the time of professionals and direct service workers at DCs, as well as the time of regional center staff, consultants and vendors working with people in the community.

TABLE 4. ASSUMED ONE-TIME START-UP COSTS FOR THOSE SERVED IN THE COMMUNITY RATHER THAN IN DCS

| Item | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|
| No. of residents in net shift to the community | 500 | 500 | 500 | 500 | 500 | 500 | 200 |
| **One-time, start-up costs per person :*** | | | | | | | |
| Health services facility (HSF) (30%) | $17,500 | $18,375 | $19,294 | $20,258 | $21,271 | $22,335 | $23,452 |
| Community care facility (CCF) (50%) | 11,250 | 11,813 | 12,403 | 13,023 | 13,674 | 14,358 | 15,076 |
| "Own home" with ILS/SLS (12%) | 10,000 | 10,500 | 11,025 | 11,576 | 12,155 | 12,763 | 13,401 |
| Family home (8%) | 10,000 | 10,500 | 11,025 | 11,576 | 12,155 | 12,763 | 13,401 |
| **One-time, start-up costs, total:*** | | | | | | | |
| Health services facility (HSF) (30%) | $2,625,000 | $2,756,250 | $2,894,063 | $3,038,766 | $3,190,704 | $3,350,239 | $1,407,100 |
| Community care facility (CCF) (50%) | 2,812,500 | 2,953,125 | 3,100,781 | 3,255,820 | 3,418,611 | 3,589,542 | 1,507,608 |
| "Own home" with ILS/SLS (12%) | 600,000 | 630,000 | 661,500 | 694,575 | 729,304 | 765,769 | 321,623 |
| Family home (8%) | 400,000 | 420,000 | 441,000 | 463,050 | 486,203 | 510,513 | 214,415 |
| **Total outlay ($), before adjustments** | **$6,437,500** | **$6,759,375** | **$7,097,344** | **$7,452,211** | **$7,824,821** | **$8,216,063** | **$3,450,746** |
| **Less: Projected start-up costs in DDS budget (210 individuals x $6,000 each, in 2002)** | 1,260,000 | 1,323,000 | 1,389,150 | 1,458,608 | 1,531,538 | 1,608,115 | 1,688,520 |
| Net, one-time, start-up costs, total | **$5,177,500** | **$5,436,375** | **$5,708,194** | **$5,993,603** | **$6,293,283** | **$6,607,948** | **$1,762,226** |

*Figures in parenthesis refer to the assumed percentages entering each living arrangement.
NOTE: Start-up costs (residential and day) in 2002, per person, are based on the following assumptions:

- 30% entering HCFs, $70,000/4 individuals = $17,500.
- 50% entering CCFs, $45,000/4 individuals = $11,250.
- 12% entering "own home" with ILS/SLS services, $10,000/1 individual = $10,000.
- 8% entering "family home", $10,000/1 individual = $10,000.

TABLE 5. ASSUMED ADDITIONAL CASE MANAGEMENT COSTS AT RCS AND TRANSITION/DEFLECTION ASSISTANCE

| Year | Additional RC Case Management | Extra transition assistance | | | Total Added RC and DC Costs |
|---|---|---|---|---|---|
| | | Regional Centers | Developmental Centers | Total | |
| 2002 | $333,333 | $2,500,000 | $2,500,000 | $5,000,000 | $5,333,333 |
| 2003 | 1,050,000 | 2,625,000 | 2,625,000 | 5,250,000 | 6,300,000 |
| 2004 | 1,837,500 | 2,756,250 | 2,756,250 | 5,512,500 | 7,350,000 |
| 2005 | 2,701,125 | 2,894,063 | 2,894,063 | 5,788,125 | 8,489,250 |
| 2006 | 3,646,519 | 3,038,766 | 3,038,766 | 6,077,531 | 9,724,050 |
| 2007 | 4,679,699 | 3,190,704 | 3,190,704 | 6,381,408 | 11,061,107 |
| 2008 | 5,539,062 | 1,340,096 | 1,340,096 | 2,680,191 | 8,219,253 |
| Total | $19,787,238 | $18,344,879 | $18,344,879 | $36,689,758 | $56,476,993 |

NOTES: Detail may not add to total due to rounding. Assumes the following, with prices increasing 5% per year:

- Additional case management of $60,000/45 individuals times full-year or half-year need, as appropriate, with such services continuing through time.
- Extra *transition planning and assistance* of $10,000 per person, with half involving RCs and half DCs. These are one-time costs associated with transition or deflection, assuming continuation of already budgeted outlays in the Community Placement Plan.

## With *downsizing*, what will happen to costs at the DCs?

This is a critically important question. If, for example, a 14.5% decline in number of residents (e.g., -500/3,450, in 2003) were accompanied by a 14.5% increase in annual per person costs, there would be *no savings* to fund services in the community. On the other hand, if a 14.5% decline in residents were accompanied by a 2.4% increase in cost per person-year attributable to "diseconomies of [small] scale," 83 percent of per person-year funding would be freed up for other uses.[3]

[3] These statements are definitional, and ignore the usual year-to-year changes in unit costs. These have averaged, both nationwide and in California, about 5% per year over the past dozen years or so. The changes in unit costs stem from several factors, including (1) changes in price

The Institute on Community Integration at the University of Minnesota has generously provided me with data showing the change from 1988 to 2000, in numbers of people served in state-operated facilities (16+ beds) in twelve states that experienced a decline in residents of at least 75% over the period. By 2000, only three of the twelve states had failed to close all of their large, state-operated institutions. The twelve states are Arkansas, Hawaii, Maine, Michigan, Minnesota, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, and West Virginia, plus the District of Columbia. The data are summarized in Table 6, on the next page. The number of residents declined every year, speeding up (in relative terms) with the passage of time. While different in sign (+ or -) for obvious reasons, the relative change in number of residents was greater than the relative change in per diems in all but two of the years. This means that estimated total outlays (per diem x 365 x number of residents) generally declined from one year to the next.[4] Removing the "outliers" in Column 11 (-4109.0 and -25.5), and calculating the average of the remaining values yields an over-all annual average value for the twelve states of 2.6, in absolute terms, in Column 11. This value indicates that, on average, a 2.6% decline in number of residents served was associated with a 1% increase in per diems.

Per diems (current dollars), as one might expect, typically increase from one year to the next. Indeed, this would have happened *even if* there had been no decrease in numbers served, because of changes in (1) prices of goods and services, (2) real earnings (an important factor in all labor intensive work), (3) service standards (or expectations), and (4) the "mix" of individuals served, generally toward individuals with greater support needs. All of these factors – plus "diseconomies of scale" -- help explain why per diems increased about 5% per year (on average), across the country, over the period 1988 to 2000.[5] In fact, across twelve states with the *slowest* declines in numbers of residents from 1987 to 1999, per diems actually increased 6.6% per year. These twelve states are Arkansas, Delaware, Florida, Georgia, Iowa, Kentucky, Mississippi, Missouri, Nebraska, Nevada, North Carolina, and Virginia. In

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levels, (2) changes in real wages (important in labor-intensive services), (3) changed (usually increased) service standards, (4) changes in the "mix" of people served, generally in the direction of people with greater service needs, and (5) diseconomies of scale.

[4] There are some anomalies in the data, including the *decrease* in the weighted average per diem across the states from 1999 to 2000. This is a consequence of Hawaii closing its last, large state-operated facility in 1999, a year when their per diem for remaining residents (in 1999) was $733.

[5] See R.W. Prouty and K.C. Lakin (Eds), *Residential services for persons with developmental disabilities: Status and trends through 1999* (Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration, 2000), p. 160; and U.S. Census Bureau, *Statistical Abstract of the United States 2000,* 120th edition (Washington, D.C.: GPO, 2000), p. 487. Prices of all goods and services increased about 4% per year from 1988 to 1999. Prices of medical care increased about 7% per year.

order to separate the effects on per diems of downsizing versus other factors, I have subtracted 5.0 percentage points from the actual percentage change in per diems each year for the twelve states that significantly reduced reliance on large, state-operated facilities. This yields *adjusted* change in per diems, likely attributable to "diseconomies of scale" or the difficulty in reducing *fixed* and *semi-fixed* costs quickly. (See Table 7, on the next page.)

TABLE 6. RECENT DOWNSIZING EXPERIENCE OF TWELVE STATES: CHANGES IN NUMBER OF RESIDENTS AND CHANGES IN PER DIEM COSTS

| | | | | **Change from Preceding Year** | | | | | | **% change in Resi-Residents/** |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Number of** | **Wt. Avg** | **Est. Total** | **Residents** | | **Wt. Avg Per Diem** | | **Total Outlays** | | **%change in Per Diem** |
| **Year** | **Residents** | **Per Diem** | **Outlays ($)** | **Number** | **Percent** | **Number** | **Percent** | **Number** | **Percent** | **(Col. 6/Col. 8)*** |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
| 1988 | 6,682 | $212.11 | $517,313,744 | | | | | | | |
| 1989 | 6,023 | 212.93 | 468,094,582 | -659 | -9.9% | $0.82 | 0.4% | -$49,219,162 | -9.5% | 25.5 |
| 1990 | 5,451 | 236.08 | 469,708,941 | -572 | -9.5% | 23.15 | 10.9% | 1,614,358 | 0.3% | 0.9 |
| 1991 | 4,069 | 270.63 | 401,937,270 | -1,382 | -25.4% | 34.55 | 14.6% | -67,771,671 | -14.4% | 1.7 |
| 1992 | 3,724 | 295.21 | 401,265,758 | -345 | -8.5% | 24.58 | 9.1% | -671,512 | -0.2% | 0.9 |
| 1993 | 3,037 | 302.67 | 335,515,665 | -687 | -18.4% | 7.47 | 2.5% | -65,750,093 | -16.4% | 7.3 |
| 1994 | 2,368 | 335.11 | 289,640,640 | -669 | -22.0% | 32.43 | 10.7% | -45,875,025 | -13.7% | 2.1 |
| 1995 | 1,824 | 354.31 | 235,884,535 | -544 | -23.0% | 19.20 | 5.7% | -53,756,105 | -18.6% | 4.0 |
| 1996 | 1,427 | 400.19 | 208,443,470 | -397 | -21.8% | 45.89 | 13.0% | -27,441,065 | -11.6% | 1.7 |
| 1997 | 1,038 | 460.57 | 174,497,740 | -389 | -27.3% | 60.38 | 15.1% | -33,945,730 | -16.3% | 1.8 |
| 1998 | 795 | 498.16 | 144,554,965 | -243 | -23.4% | 37.59 | 8.2% | -29,942,775 | -17.2% | 2.9 |
| 1999 | 532 | 498.20 | 96,741,425 | -263 | -33.1% | 0.04 | 0.0% | -47,813,540 | -33.1% | 4109.0 |
| 2000 | 377 | 448.66 | 61,737,852 | -155 | -29.1% | -49.54 | -9.9% | -35,003,573 | -36.2% | 2.9 |

Source: Institute on Community Integration, University of Minnesota.
*Expressed in absolute value, that is without regard to sign.

I have used 6.0 to project forward the likely change in annual per resident costs (per diem x 365) in California's five DCs attributable to *fixed* (and *semi-fixed)* costs in the short-run. The results, contrasting *status quo* assumptions with assumptions underlying the anticipated net shift out of DCs as a consequence of AB 896, can be found in Table 8, on the next page.

TABLE 7. RESPONSE OF PER DIEM TO CHANGES IN NUMBER OF RESIDENTS: TWELVE STATES THAT REDUCED NUMBER OF RESIDENTS IN STATE-OPERATED FACILITIES BY 75% OR MORE BETWEEN 1988 AND 2000

| | | **% change in Per Diem** | | **% change in residents/ % change in adjusted Per Diem (col. 2/col. 4)** |
|---|---|---|---|---|
| **Year** | **% change in residents from preceding year** | **Actual** | **Adjusted to reflect "diseconomies of scale" only** | |
| (1) | (2) | (3) | (4) | (5) |
| 1988 | | | | |
| 1989 | -9.9% | 0.4% | -4.6% | 2.1 |
| 1990 | -9.5% | 10.9% | 5.9% | -1.6 |
| 1991 | -25.4% | 14.6% | 9.6% | -2.6 |
| 1992 | -8.5% | 9.1% | 4.1% | -2.1 |
| 1993 | -18.4% | 2.5% | -2.5% | 7.5 |
| 1994 | -22.0% | 10.7% | 5.7% | -3.9 |
| 1995 | -23.0% | 5.7% | 0.7% | -31.5 |
| 1996 | -21.8% | 13.0% | 8.0% | -2.7 |
| 1997 | -27.3% | 15.1% | 10.1% | -2.7 |
| 1998 | -23.4% | 8.2% | 3.2% | -7.4 |
| 1999 | -33.1% | 0.0% | -5.0% | 6.6 |
| 2000 | -29.1% | -9.9% | -14.9% | 1.9 |
| Average, without regard to sign | | | | **6.0** |

*Source:* Table 6.

If this scenario were to hold, then in 2002, some $81.2 million (about half federal; half state General Fund) would be freed up within the SHIFT account to meet expenditure needs occasioned by a net shift of 500 individuals to service in the community rather than

TABLE 8. PROJECTED OPERATING COSTS AT DCS IN COMPARISON WITH *STATUS QUO* ASSUMPTIONS, 2002 TO 2008

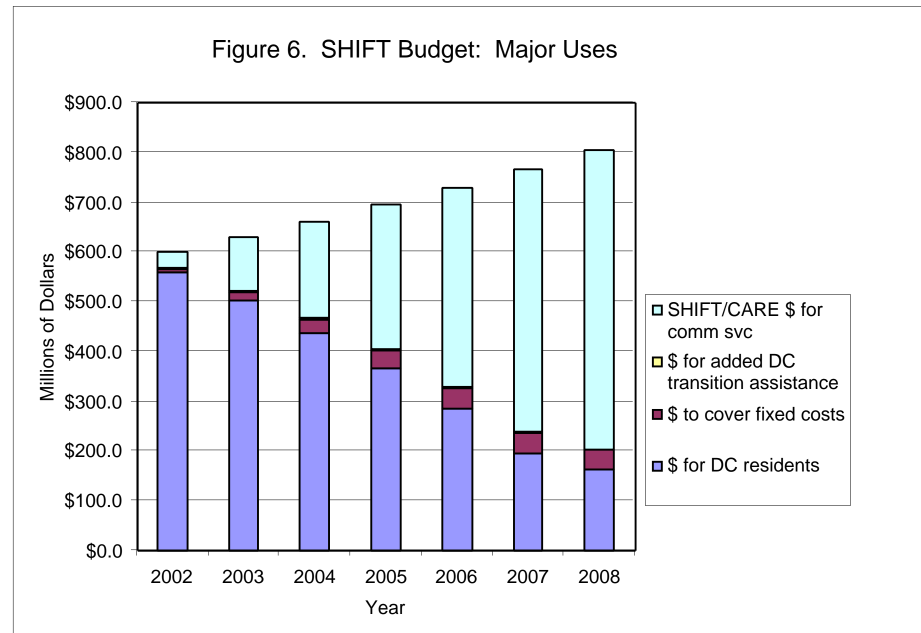
| Item | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|
| **<u>STATUS QUO</u>:** | | | | | | | |
| (1) **DC operating expenditures to serve 3,700 (mil. of $)** | **$600.2** | **$630.2** | **$661.7** | **$694.8** | **$729.5** | **$766.0** | **$804.3** |
| **<u>AB 896:</u>** | | | | | | | |
| **(2) Average number of residents** | 3,450 | 2,950 | 2,450 | 1,950 | 1,450 | 950 | 750 |
| **(3) Annual % change in Avg. No. of residents** | -6.8% | -14.5% | -16.9% | -20.4% | -25.6% | -34.5% | -21.1% |
| **(4) Assumed % change in cost per resident-year:** | | | | | | | |
| a. attributable to diseconomies of scale only | 1.1% | 2.4% | 2.8% | 3.4% | 4.3% | 5.7% | 3.5% |
| b. attributable to other factors only | * | 5.0% | 5.0% | 5.0% | 5.0% | 5.0% | 5.0% |
| Overall, combined (or total) | 1.1% | 7.4% | 7.8% | 8.4% | 9.3% | 10.7% | 8.5% |
| **(5) Projected cost per resident-year:** | | | | | | | |
| a. attributable to diseconomies of scale only | $164,043 | $168,005 | $172,751 | $178,627 | $186,261 | $196,965 | $214,243 |
| b. attributable to other factors only | 162,216* | 170,327 | 178,843 | 187,786 | 197,175 | 207,034 | 217,385 |
| Overall, combined (or total) | 164,043 | 174,245 | 187,879 | 203,664 | 222,551 | 246,469 | 280,412 |
| **(6) Total DC expenditures, ignoring diseconomies of scale only (mil of $)** | **$559.6** | **$502.5** | **$438.2** | **$366.2** | **$285.9** | **$196.7** | **$163.0** |
| **(7) Amount available in the SHIFT budget (if 1/2 state GF and 1/2 federal) to serve deflections and movers to the community (net shift)**** | **$40.6** | **$127.7** | **$223.5** | **$328.6** | **$443.6** | **$569.3** | **$641.3** |

*Budgeted costs reflect various factors impacting costs in 2002, except for diseconomies of scale.
**500 for half-year in 2002; 500 for half-year in 2003, plus 500 for full-year in 2003; and so forth.
NOTES: *Status quo* DC operating expenditures assume constant number of residents (3,700) and a projected increase in unit costs (per diem, or per annum cost for each person) of 5% per year, starting with a per annum cost of $162,216 per person in 2002.
The values in Row (4)a are calculated by dividing the numbers in Row (3) by 6.0, without regard to sign. The values in Row (4)b reflect an assumption that unit costs attributable to "factors other than diseconomies of scale" will rise by 5% per year beyond the budgeted year of 2002.

within DCs. On average, these 500 individuals would receive half-a-year of service at DCs and half-a-year in the community. Before any adjustment for "diseconomies of scale," one-half of the $81.2 million would be used at DCs (i.e., $40.6 million), and one-half in the community (i.e., $40.6 million). Of the latter $40.6 million, $6.3 million could be set aside to cover average cost increases occasioned by diseconomies of scale (fixed costs being spread over fewer units of service). This is calculated by multiplying $1,827 per person ($164,043 minus $162,216), by the reduced average number of residents (3,450).

## Projected uses of the SHIFT budget

The federal share of DC outlays is approximately 50%.[6] If a person moves into (or is deflected into) an ICF/MR facility in the community, the federal match under Medi-Cal remains 50-50. If the person is served outside of a Medi-Cal funded facility, then federal financial participation is not automatic. The main alternative federal funding source is the Medicaid Home- and Community-Based Services (HCBS) Waiver. As Table 9, on the next page, indicates, sizeable sums of money will be available in the SHIFT budget to enhance services for people in the community. (See Figure 6.) Some of this money will doubtless be used to enhance




[6] As when people live in the community, residents of DCs use other federal and state funding streams. Some children receive their education in local schools. Adult Basic Education funds are used. And, anymore, acute health care services are generally paid for with "other Medi-Cal funds," because such services are nearly always provided in community hospitals. So-called acute units at DCs are essentially small infirmaries for convalescent or follow-up care.

services for those deflected or moving from DCs. At the end of each year, unallocated SHIFT funds will be transferred to a CARE Account to meet urgent, unmet needs of others. The estimates in Table 9, will be adjusted in a subsequent section of this report to take into account the absence of HCBS Waiver coverage of some individuals and some services.

TABLE 9. PROJECTED USE OF SHIFT BUDGET FOR COMMUNITY SERVICES, ASSUMING 50% FEDERAL FINANCIAL PARTICIPATION ($ IN MIL.)

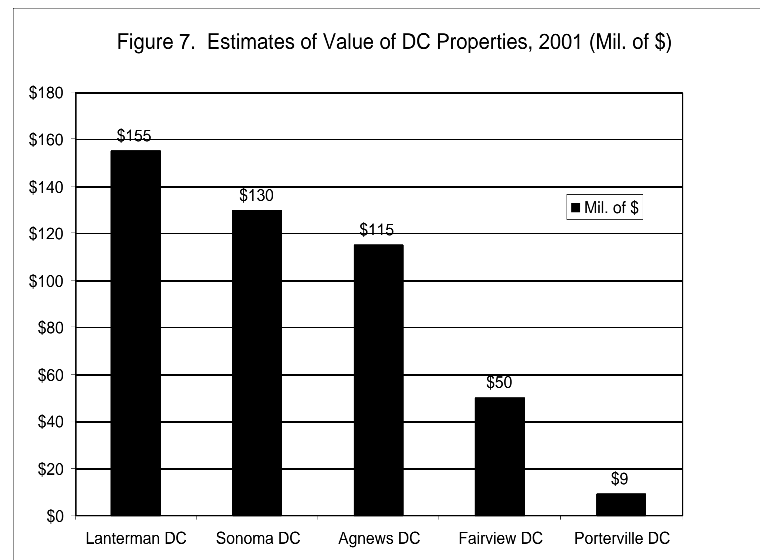
| Item | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|
| SHIFT budget *(status quo assumptions)* | $600.2 | $630.2 | $661.7 | $694.8 | $729.5 | $766.0 | $804.3 |
| *Subtract:* | | | | | | | |
| a. $ for DC services, unadjusted | 559.6 | 502.5 | 438.2 | 366.2 | 285.9 | 196.7 | 163.0 |
| b. $ to cover diseconomies of scale | 6.3 | 17.3 | 27.3 | 35.4 | 40.4 | 40.1 | 39.8 |
| c. $ for extra transition assistance from DC staff | 2.5 | 2.6 | 2.8 | 2.9 | 3.0 | 3.2 | 1.3 |
| SHIFT budget remaining for other services | $31.8 | $107.8 | $193.5 | $290.3 | $400.2 | $526.1 | $600.1 |
| *Subtract:* | | | | | | | |
| a. One-time, added start-up costs | 5.2 | 5.4 | 5.7 | 6.0 | 6.3 | 6.6 | 1.8 |
| b. Operating costs in community | 17.9 | 56.2 | 98.4 | 144.7 | 195.3 | 250.7 | 296.8 |
| d. Additional RC case mgt & transition assistance | 2.8 | 3.7 | 4.6 | 5.6 | 6.7 | 7.9 | 6.9 |
| SHIFT budget available for enhanced community services (i.e., SHIFT or CARE Account)* | $5.9 | $42.5 | $84.8 | $134.0 | $191.9 | $260.9 | $294.6 |

*Detail may not add total due to rounding. Assembly Bill 896 also provides for transfer of any end-of-year Purchase of Service (POS) funds to the CARE Account. The amount of such money varies from one year to the next. Recently, it has been about $20 million per year. These additional POS dollars are not shown in this table.

## DC lands and the Lanterman Trust Fund

AB 896 calls for closure of three of the five DCs by 2008. Here is some basic information about these properties:

Lanterman DC: 302 acres; 1,323,875 sq. ft. of improvements
Sonoma DC: 1,550 acres; 1,413,167 sq. ft. of improvements
Agnews DC: 87 acres; 662,195 sq. ft. of improvements
Fairview DC: 150 acres; 1,134,732 sq. ft. of improvements
Porterville DC: 668 acres; 1,210,742 sq. ft. of improvements




According to DDS, California's General Services Administration places the value of these properties in "highest and best use" at **$459 million**. Demolition costs are included, at $15-$20 per square foot. Estimated values for each center, allowing for demolition, can be seen in Figure 5.

Proceeds from the sale (or lease) of these properties are to be transferred to a *Lanterman Trust Fund* (LTF). If wisely invested, this fund will grow over time, while making available grant and loan funds for affordable housing and selected other purposes.[7] Some LTF funds may be used to support manufacturing facilities for adaptive equipment and places for the training of health care professionals.

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[7] Because DCs were acquired in the distant past, there are no current dollar outlays to reflect "housing services" for residents of the DCs. Reasonable estimates for imputed rent per square foot (say, $1) indicates that $68.9 million in housing and related physical plant services for DC residents is missing in the fiscal analysis, outlined earlier, because no money changes hands. This missing cost is about $18,600 per resident per year ($68.9 million divided by 3,700 residents).

In rural, low-cost areas of the State, the ratio of (1) adults living in their "own homes," with independent or supported living services, to (2) adults living in licensed settings is far higher than in areas where housing (and labor) costs are high. Where the LTF is used for affordable housing, that use should (1) lower the rate of growth in expenditures for licensed residential services in the community, where housing averages 10-15% of total costs; (2) increase the proportion of adults living in their "own homes" with support; and, perhaps most importantly, (3) increase stability and service continuity, a priority for many parents and other family members.

## Cost of DC capital improvements

In 1998, the *Vanir Report* estimated the cost of capital improvements at the five DCs, to meet accessibility (ADA), seismic safety, and building code standards -- and to make modest program improvements -- at $0.9 to $1.4 billion. Vanir recommended the lower of these numbers. DDS has kindly provided me with updated estimates (as of January 1, 2001), DC by DC, of the cost ". . . [to] fully remodel the existing client residences and training sites to bring them into full code and programmatic compliance."[8] I used the numbers provided by DDS (not given here), and assumed that the *high* Vanir estimate would be 1.4 times the lower, recommended one. In both instances, I assumed 6% per year increases in the unit cost-of-construction (prices), to reflect both price level and wage changes, and the ever rising standards in all areas (seismic safety, accessibility, building code, and program). AB 896, as amended, leaves it up the DDS which DCs are closed by which dates. Simply to get a rough idea of possible *cost avoidance* by closing three of the five DCs, I assumed Agnews would be the one closed by 2004, with Lanterman closed by 2006, and Fairview by 2008. This would leave both Porterville and Sonoma open beyond 2008. I assumed that all of the Vanir-recommended work would be completed on a schedule not given here (but available from the author, upon request) by the end of 2008. I further assumed that 25% of the otherwise scheduled capital improvements at Agnews would be completed prior to that facility being closed. I assumed that 33% of the scheduled work at Lanterman to 2006 would be completed prior to closure, and 50% of the scheduled work at Fairview prior to closure in 2008.

The actual pattern of outlays, by year, will depend on planned consolidation. As Mr. Rogers points out, if the population of a DC is declining, some buildings currently in use will not longer be in use. This will, in and of itself, save State General Fund dollars.

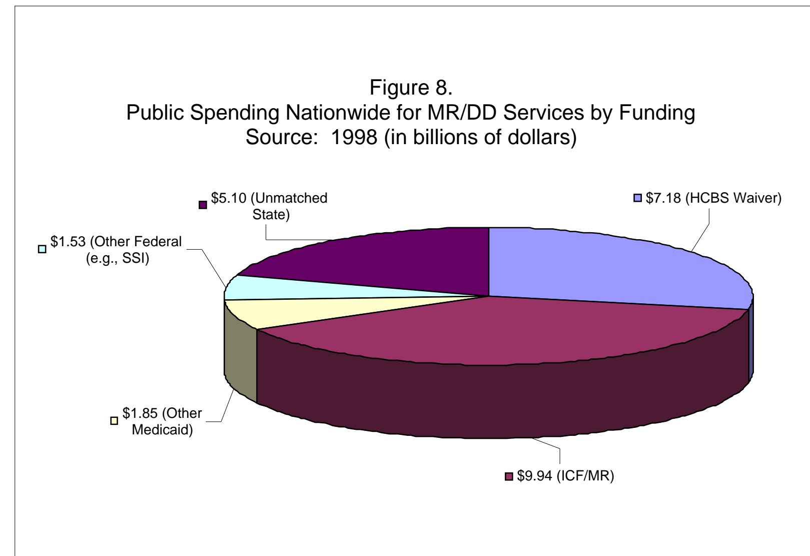
[8] E-mail message from Jim Rogers, DDS, to the author, dated June 26, 2001.

Basically, this exercise suggests that $750 million to $1.0 billion will be needed, no matter what, to improve DC facilities and meet basic expectations. If the *status quo* were pursued, anywhere from about $1.5 to $2.0 billion would be needed. The bottom-line is that consolidation of DCs will obviate the need to spend as much as $1.0 billion in State GF money on DC modernization.

# Sources of operating funds

## Background

Over the past twenty-five years, all across the country, services for individuals with developmental disabilities (MR/DD) have shifted dramatically from an institution base to a community base. In 1977, total (state, local, federal) public spending for MR/DD services nationwide amounted to about $8.8 billion. In 1998, it was $25.6 billion.[9] The sources of the $25.6 billion are shown in Figure 9. In 1998, the most recent year for which data is available, unmatched state funds were about 20% of total public spending on MR/DD services. One state, New York, had no unmatched state funds. At the opposite extreme, California had $1.06 billion in unmatched state funds, which amounted to 40% of its MR/DD outlays in 1998.[10] Indeed, California's unmatched state funds amounted to 21% of *all* unmatched state funds across the country.




[9] D. Braddock, R. Hemp, S. Parish, and M.C. Rizzolo, *The state of the states in developmental disabilities: 2000 study summary* (Chicago: University of Illinois at Chicago, Department of Disability and Human Development, 2000). Available at : http://www.uic.edu/depts/idhd/StateoftheStates/ .

[10] R. Hemp, D. Braddock, S. Parish, and G. Smith, "Leveraging Federal Funding in the States to Address *Olmstead* and Growing Waiting Lists," brief report soon to be published in the journal *Mental Retardation.*

Given its population size and wealth, California significantly underutilizes federal funds for MR/DD services. Here's another illustration. In 1999, Californians paid $91.2 billion in federal income tax. This was 12.5% of *all* federal income taxes paid of $731.1 billion. That year, California is said to have received only 4.4% of total ICF/MR and HCBS Waiver dollars for people with developmental disabilities.[11] Dividing 4.4% by 12.5% yields a *State Medicaid Benefit Ratio* of 0.35. Only one state, Nevada, was lower at 0.23. The over-all average across all the states, by definition, is 1.0. Both California and Nevada have a 50% federal cost share under the Medicaid program. Still, many other states with a 50% share had *State Medicaid Benefit Ratios* close to 1.0 or above. In this category were Connecticut (1.09), Massachusetts (1.00), Minnesota (1.56), New Hampshire (0.97), New York (2.16), Pennsylvania (1.27), and Rhode Island (1.58). The low ratio in Nevada is probably related to the fact that Nevada had only 47 individuals with developmental disabilities per 100,000 population receiving residential services in 1999, whereas the figure for California was 138 and the national average 132.

Data supplied by the Department of Developmental Services, as part of a national data collection project managed at the Institute on Community Integration, University of Minnesota, indicate that between 1990-91 and 1997-98, state expenditures for community services increased by $292 million, or 27%, from $1.1 billion in 1990-91.[12] Over the same period, federal contributions for community services in California rose by $646 million, or nearly six-fold from a low base of $114 million in the earlier year. In real dollar terms (that is, adjusting for price level changes reflected in the Consumer Price Index), state expenditures for community services in California actually decreased by 0.14%. Adding together state funds for both community and institutional services, the decline (in real dollars) was 6.7%. What is remarkable about California is how little additional state money accompanied the growth in federal funds. Nationally, over the same period, state contributions to community services increased by 59%, or twice the rate in California.

Federal HCBS Waiver funding increased dramatically in California beginning in the early 1990s. Unfortunately, the Centers on Medicare and Medicaid Services (formerly, HCFA) *froze* use of the Waiver in 1997. California's Waiver has no dollar cap, but can be used for as many as 45,000 individuals. Right now, because of the "freeze," only 28,500 are receiving Waiver-funded

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[11] See Institute on Community Integration, University of Minnesota,, *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1999,* Report #54 (Minneapolis: Institute, 2000), p. 96

[12] The unpublished data reported in this paragraph were provided to the author by Charlie Lakin, University of Minnesota.

services. Fortunately, the freeze has been lifted at 12 of California's 21 regional centers (retroactive to October 1, 1999), and 7 more should have the freeze lifted shortly, retroactive to October 1, 2000. This leaves two regional centers continuing under the freeze in the near-term.

## Federal financial participation and State General Fund

The numbers in the first row of Table 10, below, are repeated from the last row of Table 9, and assume 50-50 federal-state financial participation in *all* services in the community. Certainly, many services, including ICF/MR services in the community and extra case management and transition assistance, should generate federal funds – the latter, from Targeted Case Management dollars. But, clearly, not all other community services will fall under the HCBS Waiver. Absent borrowing and recouping start-up costs later in the rate for on-going services, most publicly funded one-time, start-up costs will come out of the State General Fund. And, if one assumes that only 80% of non-ICF/MR outlays in the community will be reimbursable under the HCBS Waiver, the numbers in row 2 of Table 10 apply. It is worth remembering, of course, that 50-50 participation in DC costs is by no means assured. From time to time, DCs are *decertified* under the ICF/MR program, and State General Fund dollars must be used to fill the gap.

TABLE 10. PROJECTED USE OF SHIFT BUDGET FOR COMMUNITY SERVICES, ASSUMING SOMEWHAT LESS THAN 50% FEDERAL FINANCIAL PARTICIPATION ($ IN MIL.)

| Item | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|
| SHIFT budget remaining for enhanced community services (SHIFT and/or CARE Account), assuming . . . | | | | | | | |
| (1) 50-50 FFP in all community outlays | $5.9 | $42.5 | $84.8 | $134.0 | $191.9 | $260.9 | $294.6 |
| (2) All one-time, start-up costs funded by GF, and 80% of non-ICF/MR costs under HCBS Waiver | 1.8 | 34.2 | 74.4 | 111.2 | 158.8 | 213.5 | 235.9 |

# Frequently Asked Questions (FAQ)

## Q1. Why is it a financially opportune time to enact AB 896?

The Legislative Analyst and others are predicting tough budget times. By enacting AB 896, one is able to strengthen community services by converting state developmental center overhead dollars into community direct service dollars. One is also able to avoid the expenditure of about a billion dollars from the state General Fund to bring DCs into compliance with seismic standards, building code, and Americans with Disabilities Act (ADA) requirements, and to reduce the recurrent risk of losing certification (and the federal matching funds) under the ICF/MR program. Finally, the bill would convert past investments in state developmental centers (worth about half a billion dollars, after demolition of buildings) into affordable housing and community infrastructure (e.g., manufacturing plants for adaptive equipment and centers for training and support of health care workers) by placing the proceeds from sale (or lease) of surplus DCs into a Lanterman Trust Fund.

## Q2. Where will the money come from to meet one-time, start-up costs?

The bill provides for advance payments of SHIFT funds to RCs, which is the present practice for purchase-of-service funds. The bill also enables RCs to provide advance payments to providers. Funds not encumbered to pay for DC services can be used to start-up programs and create new services. At the moment, there are three main sources of public funds for start-up: (1) the Department (DDS), through the budget process; (2) the Program Development Fund, managed by the California State Council on Developmental Disabilities; and (3) unencumbered positive balances in each regional center's purchase-of-service account at the end of the fiscal year. By rule, the regional center and DDS share such funds 50-50, and regional centers typically use these funds (if any) for one-time purposes. These methods, along with borrowing in anticipation of fee-for-service revenues and covering interest and depreciation costs in that way, have proven effective in providing start-up funds for programs currently serving nearly 170,000 Californians in the community system. (See pages 10-11 of this report for additional information on one-time, start-up costs.)

## Q3. How much will it cost to backfill DC fixed (and semi-fixed) costs, and from where will these funds come?

If downsizing and consolidation is carefully planned and implemented, *all* of the funds needed to cover higher *per annum* DC costs attributable to diseconomies of scale can come out of the SHIFT budget, without any additional budget augmentation for this purpose. If California does almost as well as the twelve states that reduced the number of residents in their large, state-operated facilities by 75% between 1988 and 2000, the *backfill* cost to cover fixed and semi-fixed costs at DCs will be about $6.3 million in 2002, increasing to about $40 million in 2007, and in 2008. Over the seven years, $206.7 million will be needed. (See pages 12-15 of this report for additional information. The twelve state experience can be found at the end of this document among *Miscellaneous Materials.)*

## Q4. Why does California use so few HCBS Waiver dollars?

Three reasons are usually cited. First, California got a late start, substantially expanding Waiver use with the Coffelt Settlement Agreement in the early 1990s, even though the Waiver was available as far back as 1981. Second, California may have been less creative than some states in covering individuals and services under the Waiver. Several states (e.g., Alaska, Arizona, Colorado, Michigan, New Hampshire, Oregon, Rhode Island, and Vermont) have eliminated (or virtually so) use of the ICF/MR program in favor of the more flexible HCBS Waiver program. Third, as the most populous state in the Nation, the Centers on Medicare and Medicaid Services (formerly HCFA) is reluctant to approve expansion of any Medicaid program in California without careful analysis of the impact. AB 896 is a "good deal" for federal officials. ICF/MR outlays would fall, while HCBS expenditures would rise. But, with some community services being 100% state funded, the over-all federal outlay would be less than under the *status quo* assumptions. (See pages 19-21.)

## Q5. How should *generic* services enter into the analysis?

*Generic* services, meaning either (1) expenditures outside of the California Department of Developmental Services, or (2) services available to a broader constituency than people with developmental disabilities (or closely related conditions),

should be a factor in policy discussions. Simply because of federal funding rules within the Medicaid program, the most significant fiscal impact on the State General Fund among *generic* services and supports is expanded use of SSI/SSP. (See Appendix on Generic Services and Supports.) Within the framework of AB 896, the numbers of individuals leaving DCs each year will make an almost infinitesimal impact on SSI/SSP, as well as on In-Home Supportive Services (IHSS) and ordinary Medi-Cal. Very few people would argue that people should live in one place or another based on Social Security (and Medicaid) funding rules. In general, individuals with low incomes and few assets benefit from living outside health care facilities, at least to the extent that they have more discretionary income in a community-care, licensed home (e.g., $101 or $121 per month) than in a health care facility (i.e., $35 to $45 per month).

## Q6. Will regional centers be able to handle their additional responsibilities?

Regional centers serve nearly 170,000 individuals. Shifting 500 individuals per year from Status 8 (DC resident) to Status 2 (active) is a small addition to the active case load (less than 3/10th of one percent). With additional support from the Department (DDS), there is no reason why RCs should not be able to handle their additional responsibilities. Right now, about 40% of staff at DDS headquarters are assigned to the DC side of the agency. As time goes by, staff can be reassigned to handle the complex fiscal affairs triggered by AB 896. One key informant suggested the desirability of having more accountants and bookkeepers paying close attention to changes in *per annum* costs at the DCs, within a framework (rate-setting formula) agreed to by HCFA and the California Department of Health Services. Rates should change quarterly to ease the important work of down-sizing and closing DCs, without disadvantaging those still living at DCs. As time goes by, increased attention can be paid to Quality Assurance and monitoring, and to program development, training, and technical assistance. Putting more focus and attention on these activities, many would argue, will redound to the benefit of all Californians with developmental disabilities, their families, and service providers.

## Q7. How will DC residents be assigned to regional centers? Will this have a budget impact?

Right now, residents of DCs are assigned to regional centers. Often, it makes sense for the person to live within that regional center's service area. But, there are plenty of exceptions, and the Department (DDS) has a very sensible

approach to this question. Department officials stress the importance of learning where the person wants to live, and if with others, whom? Sometimes, the living arrangement will be close to the DC, rather than back in a “home community.” Under the Coffelt Settlement Agreement, mechanisms (and understandings) were put into place to honor the preferences of each individual and his/her individual person-centered planning team. The estimates (e.g., start-up costs) used in this report are intended to provide the resources people need wherever they choose to live. Nothing in the estimates is intended to lead people to prefer one geographic locality to another.

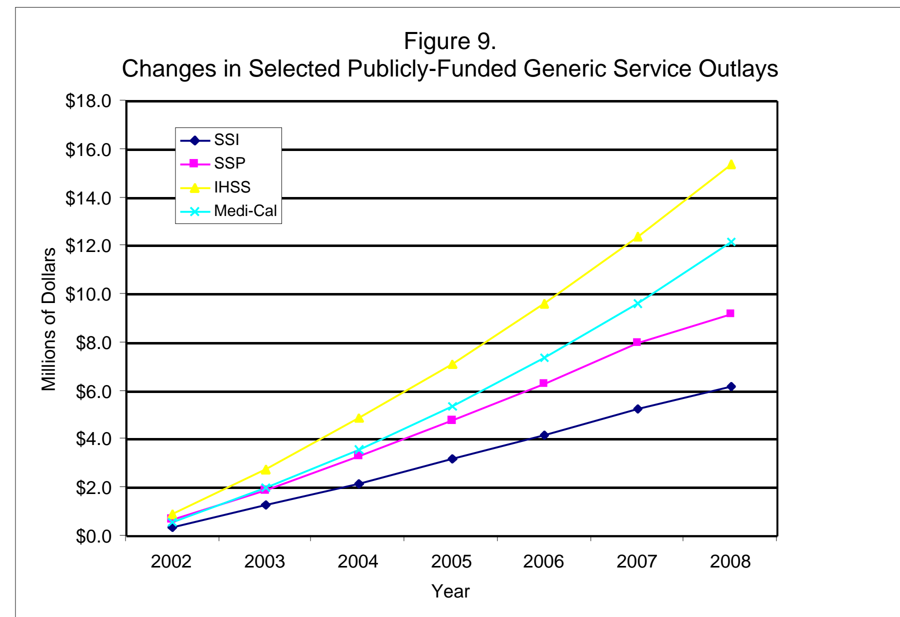
## Q8. Which DCs will be closed, and when?

As currently written, the bill calls for sale (or lease) of one DC by 2004. DDS would make the decision as to which DC to close. The bill calls for closure of two other DCs by 2008. The fate of the remaining two DCs would be determined by needs in relation to the use (or non-use) of the two remaining large institution, given other options available at that time.

## Q9. Prior to sale of DCs, what mechanisms (if any) might be used to protect these assets, and assure continued use of such resources through the Lanterman Trust Fund?

Some have suggested that the Lanterman Trust Fund be capitalized by borrowing against the ultimate sale (or lease) of certain DC properties. This could be a very promising approach and should be explored, in order to maintain the value of these assets for the Lanterman Trust and the purposes outlined in AB 896.

# Appendix:
# Generic Services and Supports




Like other citizens, people with developmental disabilities make use of publicly-funded generic services. Some of these are in the DC budget. For example, chaplains are a DC expense, whereas residents in the community use services from men and women of the cloth at ordinary churches, mosques, and synagogues, and may (or may not) contribute financially from their own funds.

Many observers would argue that decisions as to where to live (and with whom) should not depend on funding rules around Social Security benefits or In-Home Supportive Services (IHSS). IHSS is intended to help people live in their own homes, and avoid having to move to more restrictive settings. For low-income people, long-term health care facility services are funded under Medi-Cal, and if the person has at least $35 of income from some source other than SSI/SSP, this "financial assistance" to meet basic living costs will end while living in an "institution," whether a DC or a ICF/MR (Small) home. Another argument for ignoring generic service budget impacts is that 500 people a year moving away from institutions to local communities will have a small impact on such huge programs as SSI/SSP, IHSS, and regular Medi-Cal, and therefore should not overly influence thinking about the larger issues.

*Generic services* are sometimes defined as services outside the DDS budget. More often, *generic services* are thought of as those available to a broader constituency than people with developmental disabilities. Services funded through the ICF/MR program have already been analyzed. These expenditures are made through the Department of Health Services, but are not considered *generic* in the second sense of that term, because for people to access ICF/MR services they need to have a "developmentally disability." This leaves an array of publicly-funded *generic services* that deserve some attention. The main ones are (1) SSI/SSP, (2) ordinary and acute health and mental health care in the community, and (3) In-Home Supportive Services.

Not all generic services are built into the DC rate for ICF/MR services. Some DC residents use services off campus. This is true for most acute (in-patient) health care, and even schooling, where small numbers of children at DCs are transported back and forth to local schools. Vocational Rehabilitation (e.g., assessments; supported employment services prior to case closure) will, in all likelihood, be little utilized by people in the net shift to community living. Those few who may be served will take advantage of a high rate of federal participation. *Habilitation* funding, which is exclusively for people with developmental disabilities and historically state funded, can now be covered under California's HCBS Waiver.

## Supplemental Security Income/State Supplemental Payments (SSI/SSP)

Inside, as well as outside DCs, individuals living in health care facilities (1) have little access to *personal and incidental* funds ($35 - $45 per person per month) and (2) if receiving unearned income, such as Social Security Disability Insurance (SSDI), have a Share of Cost (SOC) for their otherwise, Medi-Cal funded services. Based on conversations with staff members at the Department of Developmental Services and with trust officers at a couple of the DCs, we have estimated *net changes* in SSI/SSP, associated with the movement to the community. In the case of the assumed 30% going to community HCFs, there is no *net change,* because the funding rules are essentially the same. For the other 70%, there will be a *net (positive) change* in funds from both federal (SSI) and State (SSP, State Supplemental Payment) sources. Some of the change directly benefits individuals moving to the community. Those entering CCFs, for example, are entitled (by law and rule) to $101 (or, if also receiving unearned income from SSDI or another source, $121) per month of *personal and incidental funds.* The rest ($771 this year) is for board and care. In CCFs, SSI/SSP provides a base level of support for services, whereas in "institutions," large and small, SSI/SSP goes away temporarily (if the person has unearned income) or, in the case of the person who receives SSI only, it is reduced (by rule) to $45 per month, all for *personal and incidental purposes.* The overall change in SSI/SSP is shown in Table A.1, on the next page.

TABLE A.1 ANNUAL NET CHANGE IN SSI/SSP AS CONSEQUENCE OF BEING SERVED IN THE COMMUNITY RATHER THAN IN DCS (3,200 NET REDUCTION IN DC POPULATION)

| Year | SSI (federal) | SSP (State) | Total |
|---|---|---|---|
| 2002 | $399,576 | $673,200 | $1,072,776 |
| 2003 | 1,253,712 | 1,918,890 | 3,172,602 |
| 2004 | 2,178,940 | 3,301,733 | 5,480,673 |
| 2005 | 3,158,554 | 4,765,820 | 7,924,373 |
| 2006 | 4,194,983 | 6,314,780 | 10,509,763 |
| 2007 | 5,290,755 | 7,952,388 | 13,243,144 |
| 2008 | 6,171,360 | 9,241,535 | 15,412,895 |

NOTES: Assumes that SSI/SSP increases over time 3% per year.
Assumes average of six months in the community in year left DC; subsequent years, twelve months.

The numbers (Table A.1) are based on the following estimates and assumptions, regarding the income of residents while at the DC:

- 70% receive SSDI, with an average award of $450 per month;
- 30% receive SSI/SSP, amounting to $35 (federal SSI) and $10 (State SSP) per month.

Once in the community, the current amounts of SSI and SSP depend on living arrangement. In CCFs (50% of the net shift), we assume that in 2002:

- 70% receive SSI of $530 minus $450 per month;
- 30% receive SSI of $530 per month; and
- 100% receive SSP of $342 per month.

Living in "own home" with ILS/SLS services (12%), we assume that in 2002:

- 70% receive SSI of $530 minus $450 per month;
- 30% receive SSI of $530 per month; and
- 100% receive SSP of $182 per month.

Of the eight percent assumed to be living with families, we have used the “home of another” rate, which yields for 2002:

- 70% receive no SSI, because SSDI income is greater than $353 per month;
- 30% receive SSI of $353 minus $97 per month; and
- 100% receive SSP of $192 per month.

## In-Home Supportive Services (IHSS) and ordinary health care expenses (Medicare, Medicaid)

The projections in Table A.2 assume that 20% of person-months in the community are spent in “own home” or “family home.” In addition to the regional center costs shown in Table 3, in the body of the report, I assume an average of 196 hours per person-month x $7.50 per hour, with the yearly amount increasing 5% per year, each and every year. Some people will live with one or two friends (sharing), and some families may not seek a lot of IHSS support. These are the reasons we assume an average of 196 hours rather than the maximum of 283 hours *per person* month.

TABLE A.2 ASSUMED NET CHANGE IN ORDINARY MEDI-CAL AND IN-HOME SUPPORTIVE SERVICES (IHSS) COSTS OF BEING SERVED IN THE COMMUNITY RATHER THAN IN DCS (3,200 NET REDUCTION IN DC POPULATION)

| Year | Ordinary Medi-Cal | IHSS | Total |
|---|---|---|---|
| 2002 | $625,000 | $882,000 | 1,507,000 |
| 2003 | 2,006,250 | 2,778,300 | 4,784,550 |
| 2004 | 3,577,813 | 4,862,025 | 8,439,838 |
| 2005 | 5,359,563 | 7,147,177 | 12,506,740 |
| 2006 | 7,373,228 | 9,648,689 | 17,021,917 |
| 2007 | 9,642,543 | 12,382,484 | 22,025,027 |
| 2008 | 12,193,434 | 15,365,537 | 27,558,971 |

NOTES: Assumes that Ordinary Medi-Cal is $2,500 per person-year in 2002, increasing 7% per year; assumes IHSS increases 5% per year. Assumes average of six months in the community in year left DC; subsequent years, twelve months.

Medicare is wholly federally funded, and 60% or so of DC residents have Medicare coverage, typically on a retired or deceased parent's account. As for ordinary preventive, out-patient, and acute health and mental health care, some (but not all) Medi-Cal and Medicare outlays are hidden in the DC budget. Hence the numbers in Table A.2 may (or may not) truly reflect *change* in the use of these funding streams. The Ordinary Medi-Cal figures shown in Table A.2 assume $2,500 per person per year in 2002, increasing 7% per year. The amounts shown in Table A.2 (and in Figure 9, on page 31) represent less than one-tenth of one percent of projected total outlays under these programs.

# Miscellaneous Materials

STATES THAT REDUCED THE AVERAGE DAILY POPULATION OF THEIR LARGE (16+ RESIDENTS) STATE-OPERATED FACILITIES AND SPECIAL UNITS FOR PERSONS WITH MR/DD BY 75% OR MORE BETWEEN FISCAL YEARS 1988 AND 2000

| State | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Residents | | | | | | | | | | | | |
| AK | 58 | 57 | 58 | 51 | 46 | 45 | 38 | 28 | 19 | 10 | 0 | | |
| DC | 263 | 245 | 309 | 77 | 76 | 76 | 0 | | | | | | |
| HI | 232 | 191 | 162 | 153 | 118 | 86 | 84 | 82 | 49 | 35 | 24 | 15 | 0 |
| ME | 281 | 283 | 283 | 207 | 236 | 241 | 137 | 61 | 19 | 16 | 0 | | |
| MI | 1,547 | 1,338 | 1,137 | 869 | 656 | 514 | 411 | 392 | 346 | 291 | 283 | 272 | 269 |
| MN | 1,559 | 1,443 | 1,392 | 1,264 | 1,082 | 875 | 751 | 524 | 345 | 244 | 138 | 72 | 48 |
| NH | 162 | 131 | 87 | 0 | | | | | | | | | |
| NM | 498 | 498 | 500 | 239 | 482 | 445 | 349 | 210 | 145 | 8 | 0 | | |
| OR | 1,131 | 1,021 | 838 | 659 | 597 | 527 | 489 | 442 | 429 | 373 | 350 | 173 | 60 |
| RI | 283 | 243 | 201 | 203 | 166 | 88 | 0 | | | | | | |
| VT | 190 | 183 | 180 | 170 | 135 | 31 | 0 | | | | | | |
| WV | 478 | 390 | 304 | 177 | 130 | 109 | 109 | 85 | 75 | 61 | 0 | | |
| | Average Cost ($ per day) | | | | | | | | | | | | |
| AK | 275.79 | 321.31 | 321.00 | 321.00 | 339.60 | 355.00 | 397.00 | 466.00 | 453.00 | 577.00 | | | |
| DC | 235.00 | 245.00 | 245.27 | 260.00 | 260.00 | 260.00 | | | | | | | |
| HI | 193.00 | 198.63 | 242.71 | 335.00 | 353.88 | 365.00 | 365.00 | 371.00 | 388.00 | 394.00 | 467.00 | 733.00 | |
| ME | 207.13 | 209.24 | 220.00 | 249.00 | 270.00 | 270.00 | 265.00 | 237.00 | 265.00 | 319.00 | | | |
| MI | 227.27 | 237.63 | 250.95 | 276.00 | 300.00 | 297.00 | 304.00 | 311.00 | 383.00 | 337.00 | 375.00 | 312.00 | 384.00 |
| MN | 194.95 | 191.00 | 208.15 | 233.00 | 288.00 | 288.00 | 310.00 | 324.00 | 355.00 | 541.00 | 541.00 | 615.00 | 731.00 |
| NH | 226.00 | 249.00 | 301.36 | | | | | | | | | | |
| NM | 120.31 | 122.89 | 148.25 | 148.00 | 196.00 | 208.00 | 324.00 | 288.00 | 288.00 | 288.00 | | | |
| OR | 300.00 | 235.10 | 301.33 | 374.00 | 382.00 | 389.00 | 411.00 | 462.00 | 499.00 | 519.00 | 583.00 | 772.00 | 512.68 |
| RI | 218.36 | 345.70 | 336.15 | 295.00 | 324.80 | 299.00 | | | | | | | |
| VT | 191.02 | 212.61 | 242.83 | 266.00 | 324.00 | 607.00 | | | | | | | |
| WV | 98.51 | 145.20 | 170.00 | 230.00 | 230.00 | 364.00 | 364.00 | 376.00 | 368.00 | 450.00 | | | |

Source: Charlie Lakin, Institute on Community Integration, University of Minnesota.

State of California
Department of Developmental Services
Information Systems

Thursday, October 7, 1999

Major Characteristics of Clients in Developmental Centers
Compared To
Clients in the Community

| Count Dev Center Clients | | | Count Community Clients | |
|---|---|---|---|---|
| 1,563 | 43.1% | Have Cerebral Palsy | 27,484 | 21.1% |
| 377 | 10.4% | Have Autism | 11,346 | 8.7% |
| 1,910 | 52.7% | Have Epilepsy | 29,363 | 22.5% |
| 2,504 | 69.1% | Have Major Medical Problems | 11,006 | 8.5% |
| 612 | 16.9% | Are Technology Dependent | 4,608 | 3.5% |
| 1,247 | 34.4% | Take Behavior Modifying Drugs | 12,480 | 9.6% |
| 743 | 20.5% | Have Severe Loss of Sight | 11,820 | 9.1% |
| 305 | 8.4% | Have Severe Hearing Loss | 3,597 | 2.8% |

| Count Dev Center Clients | | Have These Levels of Retardation | Count Community Clients | |
|---|---|---|---|---|
| 11 | 0.3% | Not MR | 22,318 | 17.1% |
| 393 | 10.8% | Mild | 51,663 | 39.7% |
| 264 | 7.3% | Moderate | 26,326 | 20.2% |
| 540 | 14.9% | Severe | 13,176 | 10.1% |
| 2,403 | 66.3% | Profound | 8,931 | 6.9% |
| 14 | 0.4% | Not Assessed | 7,849 | 6.0% |

*Continued on next page . . .*

| Count Dev Center Clients | | | Count Community Clients | |
|---|---|---|---|---|
| 1,554 | 42.9% | Have Severe Behavior Problems | 12,270 | 9.4% |
| 1,592 | 43.9% | Are Not Ambulatory | 27,438 | 21.1% |
| 803 | 22.1% | Do Not Understand Spoken Words | 5,506 | 4.2% |
| 1,496 | 41.3% | Are Frequently Violent | 14,500 | 11.1% |
| 956 | 26.4% | Must Be Fed | 10,986 | 8.4% |
| 2,796 | 77.1% | Need Help Toileting | 54,161 | 41.6% |
| 2,892 | 79.8% | Need Special Health Care Items | 29,997 | 23.0% |
| 2,445 | 67.5% | Are Incontinent | 43,478 | 33.4% |
| 1,619 | 44.7% | Are Self-Injurious | 17,561 | 13.5% |
| 1,508 | 41.6% | Often Destroy Property | 14,936 | 11.5% |
| 1,971 | 54.4% | Have Unacceptable Social Behavior | 27,745 | 21.3% |
| 1,402 | 38.7% | Will Run Away | 21,021 | 16.1% |

| Count Dev Center Clients | | Have Special Conditions or Behaviors | Count Community Clients | |
|---|---|---|---|---|
| 2,239 | 61.8% | None | 117,140 | 89.9% |
| 530 | 14.6% | One | 7,763 | 6.0% |
| 364 | 10.0% | Two | 3,329 | 2.6% |
| 492 | 13.6% | 3 or More | 2,031 | 1.6% |

Source: CDER Master File of Thursday, October 7, 1999.