



## Deinstitutionalization Toolkit: **COSTS – inDETAIL**

This section of the Deinstitutionalization Toolkit includes the supportive detail on the subject of Costs. The research and detailed information are intended to provide background for the Deinstitutionalization Toolkit:

➤ **COSTS – inBRIEF**

### **The Costs of Deinstitutionalization**

#### ***Comparing the Costs of Institution Versus Community-Based Services***

In 2009 (the most recent year for which data are available), the average annual expenditure for state institutions was \$188,318, compared to an average of \$42,486 for Medicaid-funded home and community-based services.

However, these figures oversimplify the relative cost of institutions versus community-based care and should not be used to indicate how much a state may save by closing an institution.

This section discusses the inherent complexities of comparing the cost of institutional and community-based services, including the following:

1. Variability within and among states
2. Heterogeneous populations
3. Complex funding

In an article widely distributed by opponents of deinstitutionalization, Walsh et al. (2003) reviewed studies and argued that each is flawed because it does not address these inherent complexities. However, a number of studies and state cost estimates do address these issues and consistently find that although community-based services may be more expensive for a small number of individuals, overall, closing an institution yields cost savings (Stancliffe and Lakin, 2005).



### ***Cost Variation within and among States***

Estimating the cost savings from closing a particular institution based on national averages can be problematic because the cost of services (both institutional and community-based) varies widely across states.

In table 1, for example, Lakin et al. (2010) report that the average cost of care in large state institutions ranged from a low of \$104,025 per year in Arkansas to a high of \$375,000 in Tennessee, while the average Home and Community-Based Services (HCBS) Waiver cost ranged from \$21,789 in Mississippi to \$107,453 in Delaware.

Variations in the cost of institutions may be based on characteristics of the users, the cost of staff, staff levels, and ratios, as well as other factors. Variations in the cost of HCBS Waiver services may be based on the characteristics of the individuals with intellectual disabilities and developmental disabilities (ID/DD), the types of services and supports offered in the waiver, the type of residential options available, and other factors.

For example, the per capita HCBS Waiver figure includes people living with their families as well as people receiving both residential and day services from paid providers. Since providing care to people living with their families is usually less costly than providing residential services in the community, such as congregate living or shared housing, a state with a higher proportion of people living with their families will have lower average HCBS Waiver costs. However, this type of variation in HCBS Waiver costs underestimates the cost of providing community care to former institution residents, who will usually transition to residential services.



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**Table 1. Average Annual Cost of State Institutions Compared to HCBS Waiver Services by State, 2009**

<b>State</b>	<b>State Institutions*</b>	<b>Home and Community-based Waiver Services**</b>
Alabama	\$195,275	\$49,859
Alaska		\$64,017
Arizona	\$151,840	\$26,805
Arkansas	\$104,025	\$34,469
California	\$255,865	\$22,809
Colorado	\$211,700	\$41,472
Connecticut	\$336,530	\$63,394
Delaware	\$311,345	\$107,453
District of Columbia		\$92,190
Florida	\$147,460	\$29,215
Georgia	\$172,280	\$28,901
Hawaii		\$41,441
Idaho	\$292,730	\$30,196
Illinois	\$144,175	\$32,264
Indiana	\$196,370	\$45,389
Iowa	\$217,175	\$23,147
Kansas	\$148,920	\$36,224
Kentucky	\$250,755	\$48,831
Louisiana	\$172,645	\$50,665
Maine		\$72,821
Maryland	\$170,090	\$48,305
Massachusetts	\$246,375	\$56,241
Michigan		\$44,865
Minnesota	\$330,690	\$66,158
Mississippi	\$116,070	\$21,789
Missouri	\$159,505	\$48,765
Montana	\$251,850	\$36,022
Nebraska	\$221,920	\$44,304
Nevada	\$182,865	\$45,941
New Hampshire		\$40,370
New Jersey	\$250,025	\$54,142
New Mexico		\$71,517
New York	\$337,625	\$69,752



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**Table 1. Average Annual Cost of State Institutions Compared to HCBS Waiver Services by State, 2009 (continued)**

State	State Institutions*	Home and Community-based Waiver Services**
North Carolina	\$175,565	\$45,697
North Dakota	\$187,610	\$22,467
Ohio	\$152,935	\$44,208
Oklahoma	\$191,625	\$52,099
Oregon		\$40,295
Pennsylvania	\$220,095	\$44,062
Rhode Island		\$74,206
South Carolina	\$113,150	\$38,228
South Dakota	\$167,170	\$31,297
Tennessee	\$375,950	\$75,411
Texas	\$145,270	\$39,125
Utah	\$168,995	\$33,329
Vermont		\$54,151
Virginia	\$181,040	\$57,570
Washington	\$207,685	\$35,822
West Virginia		\$60,839
Wisconsin	\$255,865	\$39,989
Wyoming	\$235,425	\$46,002
US Total	\$196,735	\$43,395

Sources: \*Lakin et al. (2010); \*\*HCBS per service recipient extracted from <http://rtc.umn.edu/risp/build/index.asp>

***Heterogeneous Populations and Case Mix***

Individuals with complex needs can be effectively served in community settings in a cost-efficient manner. However, when we compare the costs of institutional versus community settings, we need to recognize that the cost of providing services to individuals with more complex behavioral and medical needs is higher than for those with more independent functional skills. In addition, compared to people with ID/DD living in the community, a higher proportion of people in institutions have complex medical or psychological needs. This disparity increases throughout the process of deinstitutionalization as the residents of institutions with the least complex disabilities often transition before those with more complex or coexisting disabilities.



As a result, the state cannot simply look at the average cost of care in the community to determine the cost of care for institution residents when they are discharged. The cost estimator must adjust for this difference in case mix. The Costs: in**DEPTH** section includes cost estimates from three states (Kansas, Maryland, and Massachusetts) that took different approaches to making this adjustment. To access the costs estimates of these states, see the next part of Section 6 of the Deinstitutionalization Toolkit:

➤ COSTS – in**DEPTH**

**Kansas:** Kansas groups people with ID/DD into five tiers based on the severity of their disability. The state pays providers a daily rate for day services and a daily rate for residential services based on the tier of each of their clients, regardless of the specific services provided. The state based the cost estimate on the assumption that the majority of the residents of the Kansas Neurological Institute would be in the highest tier.

**Maryland:** Maryland conducted individual assessments to identify the services and supports, including residential, day, employment, and technology, required to meet each individual's needs. Using this list of services, the state was able to estimate the cost for each individual (Maryland Department of Health and Mental Hygiene. 2008). This cost estimate is unique because it highlights the fact that for some individuals the cost of community care is higher than the average cost in the institution. Overall, however, the state saves money by closing the institution.

**Massachusetts:** Massachusetts has recently closed another institution and has estimates for the cost of providing community care to its former residents. The state based its estimates of the costs associated with closing additional institutions on the assumption that the residents of those institutions had similar needs to those at Fernald State School (Massachusetts Executive Office of Health and Human Services and Department of [Mental Retardation], 2009).

### ***Complex Funding***

The Medicaid Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) program covers most of the costs associated with institutional care. However, a variety of funds are combined to cover the costs of community-based care. While Medicaid



covers certain services under the HCBS Waiver, other services and supports are funded solely by state funds, or by combinations of funds from the federal Department of Housing and Urban Development, the Social Security Administration, mental health block grants, and other funding streams. This complicates the cost comparisons.

For example, Medicaid HCBS Waivers cover the cost of services provided in a community-based residential setting but do not cover room and board. In most cases, residents pay a large portion of their Social Security Disability Insurance income or Supplemental Security Income to cover the cost of housing. Additional funding may come from state or federal housing funds and other state funds.

Even when comparing the costs of institutional and community-based care, including all funding streams, researchers find community care is less costly. For example, Lakin et al. (2008) used data from the National Core Indicators project and Medicaid cost data to study the relative cost of HCBS and ICF/DD. The findings indicated that HCBS Waiver services, including other Medicaid services (medical, prescription drugs, social services, personal care, etc.) were substantially less costly than ICF/DD services. The differences were evident not only in overall average expenditures but also in virtually all comparisons for individuals with similar characteristics.

From the state's perspective, some of these other funding streams are not important. Legislators are likely to be concerned only with costs borne by the state. It is important, however, to recognize these other sources of funding when talking about whether the resources available are adequate to meet individuals' needs.

### ***The Reason Community-Based Care Is Less Expensive***

Community-based services include a diverse array of service types, ranging from minimal intermittent supports to residential and day program services, whereas institutions traditionally offer an established service package (e.g., ICF/DD services). Thus, only a part of the range of community services is comparable with the services received in a large ICF/DD.

People who oppose deinstitutionalization argue that a cost comparison must look at what the same services provided in the institution would cost in the community (Walsh, 2003). However, this approach is not productive. When a person is being discharged





from an institution, it is not necessary to replicate what the institution provided. Because institutions provide an established set of services, they may be providing services the person does not want or need, and fail to provide things the person may require to live more independently in the community. However, the plan should encompass everything the person must have in order to be healthy and safe in the community.

Cost-effectiveness is possible for three basic reasons:

1. Despite the level of need exhibited by people currently living in institutions, states have had great success (as measured by independent means) providing effective care in the community without some of the clinical services and physical plant features required by regulation in the institutions (Gettings, 2003).
2. Once person-centered planning is fully developed, states are finding that a significant number of people with developmental disabilities and their families or guardians begin to request less intense levels of specialized care over time than typically is provided in institutions (Gettings, 2003).
3. One of the major costs of providing services and a major component of the cost differential between institutional and community-based care as well as the variation across states is staffing level and cost of staff. As highlighted in many studies over time, from the Pennhurst study (Conroy and Bradley, 1985) to more recent studies (Stancliffe and Lakin, 2005), there are significant differences in salary and benefit levels between institution and community-based services because generally, public employees are unionized and have richer compensation packages than community-based staff. Advocates need to be aware of this disparity. The low pay and benefits for the direct care workforce in the community often lead to high turnover rates and vacancies.

### ***Deinstitutionalization—The Transition Costs***

The state covers the operational cost of state-owned facilities regardless of the number of residents. The per capita cost of care that is often cited is calculated by dividing the facility's budget by the number of residents. It is not possible or necessary to assign a cost to each individual. This is in sharp contrast to community-based care, in which the state pays for each additional service user.



As a result, discharging one resident from the institution does not yield per capita cost savings. Many of the cost savings occur only when the institution is completely closed. However, adding people to the community adds a cost.

Thus, during the closure process, states should anticipate some temporary “dual costs” of community-based care and maintaining the physical infrastructure and adequate staff until all residents are moved to the community. Other transition costs may include programs to support and assist institution employees (staff training and placement activities), staff early retirement bonuses, leave balances, costs of closing down the physical plant, and funding needed to help expand the community network.

Additional resources are available on the topic area of costs in the deinstitutionalization toolkit. These are external documents that may be accessed for a more in**DEPTH** review of the topic area.

➤ COSTS – in**DEPTH**

## References

- Conroy, J. W., and V. J. Bradley. (1985). The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis. U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. Accessed August 30, 2011. <http://aspe.hhs.gov/daltcp/reports/5yrpenn.pdf>
- Gettings, R. M., R. Cooper, and M. Chmura. (2003). Financing Services to Individuals with Developmental Disabilities in the State of Illinois. National Association of State Directors of Developmental Disabilities Services, Inc. Accessed January 25, 2011. <http://www.state.il.us/agency/icdd/communicating/publications.htm>
- Kansas Facilities Closure and Realignment Commission Meeting. (2009). *Discussion on Rehabilitation Center for the Blind and Visually Impaired, Kansas Neurological Institute and Parsons State Hospital*. Topeka, KS, October 26, 2009.
- Lakin, K. C., R. Doljanac, S. Y. Byun, R. J. Stancliffe, S. Taub, and G. Chiri (2008). Factors Associated With Expenditures for Medicaid Home and Community Based Services (HCBS) and Intermediate Care Facilities for Persons With [Mental Retardation]





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(ICF/MR) Services for Persons With Intellectual and Developmental Disabilities. *Intellectual and Developmental Disabilities* 46(3):200–14.

Lakin, K. C., S. Larson, P. Salmi, and A. Webster. (2010). Residential Services for Persons with Developmental Disabilities: Status and Trends through 2009. Research and Training Center on Community Living. Institute on Community Integration/UCEDD, College of Education and Human Development, University of Minnesota. Accessed July 21, 2011. <http://rtc.umn.edu/docs/risp2009.pdf>

Maryland Department of Health and Mental Hygiene. (2008). Memo to Martin O'Malley, Governor; Thomas M. Middleton, Chairman Senate Finance Committee and Peter A. Hammen, Chairman House Health and Government Operations. RE: HB 970 – Rosewood Center – Plan for Services to Residents. Accessed August 30, 2011. [http://www.dhmh.state.md.us/dda\\_md/Developments/HB970Report.pdf](http://www.dhmh.state.md.us/dda_md/Developments/HB970Report.pdf)

Massachusetts Executive Office of Health and Human Services and Department of [Mental Retardation]. (2009). DMR Community Services Expansion and Facilities Restructuring Plan, revised March 9, 2009. <http://www.mass.gov/eohhs/docs/dmr/facilities-restructuring-plan.pdf>

Stancliffe, R. J., K. C. Lakin, J. R. Shea, R. W. Prouty, and K. Coucouvanis. (2005). The Economics of Deinstitutionalization. Chapter 13 in R. J. Stancliffe and K. C. Lakin, eds. *Costs and Outcomes of Community Services for People with Intellectual Disabilities*. Baltimore, MD: Brookes Publishing.

Walsh, K. K., T. A. Kastner, and R. G. Green. (2003). Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research. *[Mental Retardation]* 41(2):103–22.