DSHS's Diversion Committee – Admission Review Team

In March -- 2004, the State of Washington under pressure from the federal Centers for Medicare and Medicaid Services, adopted an admissions policy to the state's centers that serve people with profound mental retardation and developmental disabilities. The new policy in effect reversed a *de facto* 15-year admissions moratorium.

In 2004-2005, 14 people requested RHC admission and 100% were admitted.

In 2005-2006, 22 people requested RHC admission but only 15 were admitted while 7 were denied.

In 2006-2007, 72 people requested RHC admission but only 33 were admitted while 39 were denied.

In 2007-2008, 49 people requested admission but only 30 were admitted while 19 were denied.

In 2008-2009 34 people requested admission but only 25 were admitted while 9 were denied.

In 2009-2010 25 people requested admission but only 13 were admitted while 12 were denied.

TOTAL REQUESTS: 171 (100%)

TOTAL ADMISSIONS: 102 ADMITTED (59.6%)

Total Denied: 86 were denied - 40.4% in the last 6 years who made the choice to live at one of the state's centers were denied admission.

DSHS was told to open omissions in 2004 or pay back the hundreds of millions of dollars the federal government paid to the state for DD services.

Notes for the framework:

1. Findings do not support the unqualified position that community settings are less expensive than are institutions and suggest that staffing issues play a major role in any cost difference .
2. Given the differences in the ICF/MR program and the HCBS Waiver progam, there is the potential for costs to be shiften in complex ways. For example, whereas a placement in a large ICF/MR facilitiey involves both state and federal funds, in varying proportions and at different levels across the states, not all community placements receive federal funds. Although some community-based placements are funded by both federal and state funds (e.g.,under the HCBS Waiver), other services and supports are funded solely by state funds, or are funded by complex conbinations of personal/private funds (including "entitlement" funds under Social Security) along with state funding.

3. WAIVER spending:

   Per recipient Waiver spending fails to capture actual spending on Waiver recipients because it only accounts for a portion of their expenditures. HCBS Waiver recipients typically have some of their care, most notably acute care, home health, personal care, targeted case management, and adult day care, funded from the regular Medicaid program.

4. Cost Variation: service costs also change over time - costs per resident in an institutional facility tend to rise when the most capable residents are removed and placed in community-based facilities.
5.
6. Staffing: These may be a critical variable in all service models. The average functioning level of individuals remaining in institutional facilties declined while average age increased compared to the general population served by state agencies.
7. Population differences must be considered. ACCUITY OF CARE.

Data Show in the Oregon FAIRVIEW Model: The data present some troubling facts, especially for staunch advocates of deinstitutionalization. A general conclusion can be drawn from these data that, for incividuals with challenging behaviors, residential costs within the community cost approximately the same as institutional services in Oregon,..When the staff salaries …the conclusion must be drawn that large in stitutions are, in most instances, less expensive than community residentces for these challenging populations.

8. Accurate cost comparisons must be approached from the perspective of the individual and identify the most favorable placement based on the characteristics of the person and the service setting together….The costs and expenditures are related to the needs of the person, the quality of services provided, the desired outcomes, and perceived satisfaction on the part of the individual.

ON OUTCOMES

1. Safety: Studies identified higher rates of verbal abuse and relatively greater exposure to crem among individuals who lived in dispersed community settings.
2. Studies show
    a. Difficulty in state monitoring of noninstitutional care because of their dispersed nature, an increasing problem
    b. (b) inexperience in monitoring noninstitutional care, in come states including a lack of regulations and licensing requirements
    c. © the potential impact of low provider reimbursement rates on the quality of care.
    d. As institutions increasingly provide services to people with severe and profound congnitive deficits, complex needs, challenging behaviors, and diminishing skills, concerns about quality of care may outweigh those of satisfaction.

    e. In In community settings, on the other hand, with amore heterogeneous and able population, it may be that quality of life, satisfaction, and interest in self-determination takes on more importance.

    f. Thus, the assessment of both quality of care and quality of life, although related and important in both settings, may need to be adjusted for for characteristics of the setings in which they are assessed.

3. Outcome measurement must be expanded beyond assessment of personal outcomes measures, such as choice and community involvement, to include a greater emphasis on health and safety.
4. Individuals with profound disabilities and multiple disabling conditions may benefit from measures evaluating
    a. Access to comprehensive health car services (primary, pshychiatric, and dental care as well as ancillary services, including care coordination;
    b. Rates and status of abuse/neglect reports and investigations (including victimization in the community);
    c. Mortality review

d. Access and utilization of behaviorial services; and
e. Similar direct measures.
f. Identify costs at the individual level

5. WHAT IS THE QUESTION TO BE ASKED?
6.

The question: Which is less expensive, institution or community?" is the wrong question to ask. Rather, the questions that need to be asked revolve around the individual:

What does this person need? Where is the best place toi provide for these needs? At what cost?

Research suggestions that community placements are not inherently less expensive than institutions:

1. Community services include a diversw array of service types, ranging from minimal intermittent supports to residential and day program services, whereas insitutions traditionall offer an established service package. E.g., ICF/MR –

Thus: only a part of the range of community services is comparable with the services received at a large ICF/MR.

2. The ability to shift certain community costs to programs other than those administered by a particular MR/DD state agency will lead to reduced costs within that specific governmental division or authority. However, the overall cost to society mayt not be reduced. For example:
3. 1. Medical costs within an ICF?MR are clearly part of the budget; whoever when an individual moves to a community setting, medical expenses can often be shifted to another funding sources – (e.g., the component of state government that administers Medicaid health care benefits.
4. It is possible that the disparity between community and institutional cost structures for staffing will be difficult to sustain as individuals with more complex needs are servied in community settings. It is also possible that disparity will diminish as community workers and advoctes strive to achieve parity.
5. Most recent studies show increased costs in the community.

6. Many service costs are built into the ICF/MR model. The costs incurred for supporting community infrastructure for such costs cannot simply be excluded from the cost-comparison analysis.
7. An inherently difficult fiscal problem is the inclusion of start-up and capital costs incurred in community settings compared to long-term state ownership of institutional facilties. Excluding these categories of costs is not justifiable.
8. From the cost studies reviewed in the literature: it is clear that large savings are not possible within the MR/DD field. That is, the costs of residential care, regardless of setting, involve a specific amount of resources that vary, somewhat predictably, with stffing levels, client characterists, The studies do not support he view that large cost savings are possible.

It is important to take into account the needs and values of those who use the services in making public policy decisions.