

Comments on the SB627 workgroup proceedings  
And Summary of Reasons to leave more Training Centers Open

Submitted by Jane Powell, President of CVTC Families and Friends

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Overview of the Meetings

The workgroup was unable to reach consensus on its specific task as required by SB627, consideration of options for expanding the number of training centers to remain open in whole or in part in the Commonwealth. After three long and argumentative meetings, early in the fourth the members who espouse the community-only ideology reported that the Commissioner had assured them that their perspective and input would be considered and that community options would be discussed as *alternatives* to training centers, counter to the purpose of the meetings as clearly identified in the legislation. Four community-only members even submitted a letter to the meeting facilitator saying that they had received such assurances. The inclusion in the workgroup of those who are strongly opposed to the workgroup's purpose rendered consensus on the group's recommendations impossible. And the exclusion of those who could have provided pertinent information, such as some major providers and representatives from various CSBs, was unfortunate. In fact, due to the strongly held opposing viewpoints of some of the workgroup members, even the wording of the factors upon which we were to judge the several suggested options was contended at length, and even now some group members, including me, are dissatisfied with the language of the final product and with the weights given to each factor.

In addition to assembling a group that was from its inception philosophically unable to reach consensus, DBHDS presented supporting documents that were seriously flawed and included false assumptions, opinions and inaccurate data, insufficient to support serious discussion of leaving more training centers open. On the contrary, one document suggested closing even the one 75-bed facility DBHDS previously planned to leave open, SEVTC.<sup>1</sup> Remarkably flawed cost analyses were inadequate to assess basic costs associated with training center operations. Different base numbers were used to compute percentages. CVTC renovation estimates included over \$2 million needed for buildings that have very recently been renovated from the ground up.<sup>2</sup> Other cost inflations in that document included a \$6 million renovation to CVTC's Regional Community Services Center which is to be moved offsite as well as millions of dollars needed to renovate unused and decertified buildings and

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<sup>1</sup> Document entitled, "Summary of Cost Analysis, SB627 Workgroup" – provided for the final meeting on October 6, 2014.

<sup>2</sup> Buildings 8, 9, 11 and 12 were estimated to need \$2,018,251 in renovations even though thorough and major renovations to those buildings were completed over the past four years, with Building 9 renovations completed as recently as this past spring. Upon completion of the current renovations to Building 10, the Lower Rapidan area of campus will be fully renovated to state-of-the-art specifications and standards. When pressed to explain why those buildings were included in projected renovation costs for CVTC, Joe Cronin of DBHDS said that in years to come the fire alarms and some other systems may need repairs, and some windows had not yet been replaced.

peripheral buildings such as pool sheds and a greenhouse, while no building repurposing for even the most obvious combined uses or other such significant efficiencies were estimated or even referenced for a future study. Significantly, five years ago DBHDS sought, and received, a \$43 million appropriation to thoroughly renovate CVTC.<sup>3</sup> **Today, with four residential buildings just renovated and another underway, and with a smaller census, DBHDS maintains that it would cost \$66 million to renovate CVTC, or about 50% more than the estimate of just five years ago which included more buildings.**

One document DBHDS provided to the workgroup claims that in most cases there is effectively no market for training center lands and buildings, yet the Department says that it is relying on the proceeds of training center land sales to fund community services. The one exception is NVTC, and even so the department claims it is of decreased per-acre value unless it is sold in its entirety rather than selling only the unused portion or sharing the land with compatible entities and enterprises.

With flawed cost estimates, overstating the costs associated with training centers and understating the costs associated with comparable community care for former training center residents<sup>4</sup>, all training center and community cost estimates provided by DBHDS are unreliable.

Since the workgroup assembled by DBHDS was unable to provide a unified group recommendation for leaving more training centers open in the Commonwealth, I submit the following facts to be considered as the legislature again takes up this issue.

## Points to Consider

### **The Case for Retaining CVTC:**

1. SB627 requires comparable medical, health, behavioral and developmental care and safety to that offered at each training center for those moved from a training center to either the community or another training center, unless comparable care is waived by the authorized representative. To be comparable, *equivalent* services must be offered, and there are some essential services that are not provided at all under the waiver and are not even under discussion for the enhanced waiver, including dentistry without cost caps (which is uncapped and provided as frequently as desirable at the training centers) and preventive physical therapy such as CVTC's residents now receive as part of their active treatment program. Thus,

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<sup>3</sup> Of that amount, \$19 million was siphoned away for community programs, and \$10-13 million remains unused.

<sup>4</sup> DBHDS cost estimates are based on serving training center individuals on the waiver at a cost of \$66,000 each, annually. Yet their own documents provided to the workgroup cite an average of &140,000 to serve 57 people recently discharged.

uncapped ICF/IID care is the only equivalent to training center care and must be offered in order to meet the comparability requirement, and new comparable ICF startups will be costly.

2. CVTC offers far and away the highest level of medical and health care available statewide, whether in the community or even in another training center. Under state law, CVTC's unique five-star nursing facility requires a physician onsite 24/7. CVTC's medical staff includes four full-time and three part-time physicians onsite as well as 167 RNs, LPNs and CNAs, with medical staff onsite at all times, in three shifts. This superior level of medical staffing and care far exceeds that of even the other training centers, let alone any existing community group homes or ICFs/IID. The reason for such superior medical staffing at CVTC is the intensive needs of its residents. CVTC has, on average, the oldest, sickest and most severely disabled census among the four training center populations, with almost every person having at least three clinical diagnoses and most needing daily medical care. The newly renovated buildings house over 100 non-ambulatory individuals all of whom are medically needy. Beyond its high level of dedicated onsite medical staff, CVTC has medical contracts with several hospitals and various specialists, and such medical contracts cost 12 to 14 times that of any other training center.<sup>5</sup>
3. The University of Minnesota did a study of HCBS waivers in 2006 for CMS, compiling data from six states. They found that when similar services were offered and when comparing similarly disabled individuals, the cost difference between ICF/IIDs and HCBS waiver homes was only 3.3%, a difference that has likely decreased in the last eight years due to increased pay and mandatory overtime pay for direct care staff and the rising cost of health care. The one exception to that finding was concerning individuals who receive daily medical care. These people were found to be more costly to serve under the waiver than in ICFs/IID, and in the intervening eight years the costs of medical care have outpaced any other costs associated with the care of the intellectually disabled. Thus the reversed cost gap for these individuals is very likely to have increased. Most residents of CVTC receive daily medical care, regardless of whether or not they live in the skilled nursing facility, and they would all receive reduced care absent the high number of experienced medical staff onsite.
4. Needs drive costs, whether individuals are served in the community or in a training center. Operational costs of providing comparable care with comparable staffing in community settings will result in comparable costs, except for those with high medical needs, in which case community care will be more costly. Capital investment at CVTC, if properly designed with repurposed buildings to serve combined functions, could approximate community capital investment needed to house and maintain former CVTC residents, considering CVTC's medical equipment and other accommodations built into its new renovations (although the state has not offered any estimates for comparable care in the community.) According to DBHDS figures, the cost of care in CVTC's nursing facility is \$898.81 per day, or \$328,065.65 annually. Comparable care in the community (which does not currently exist) in scattered four-person homes will exceed \$328,065.65 annually, far from the \$140,000 figure the Department says is

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<sup>5</sup> The Commonwealth Data Point website reveals that contracted medical services cost \$538,074 at CVTC, \$51,671 at SEVTC, \$45,525 at NVTC and \$38,366 at SWVTC. This is above and beyond the regular onsite medical staff costs and cannot be explained by regional cost differences within the state, but rather reflects the comparative levels of medical need of the different training center populations.

the average cost of serving 57 recent training center discharges. Most of CVTC's ICF residents are also medically needy and receive daily medical care, so serving them in community settings would again be more costly than serving them at CVTC.

5. CVTC's autistic and/or mentally ill behavioral residents are the hardest to place in community settings, even if the authorized representative is unopposed, because *providers don't want them*. CVTC has had far more regular admissions over the past ten years than any other training center, and most, if not all, of the recent admissions have been people with behavioral problems who were spectacularly failed by the community and who had nowhere else to go, having been evicted from group homes and even psychiatric hospitals and having exhausted all community options. CVTC still admits such individuals, and once families are finally able to admit their relatives to CVTC they are generally very relieved and pleased with the quality of care their relatives at last receive, consequently they are often unwilling to attempt community placement again. CVTC's residents with psychiatric diagnoses receive care from more supervisory direct care staff, experienced and knowledgeable in the care of such individuals, than most waiver home owners can afford to retain.
6. CVTC is the only statewide training center, with residents fairly evenly distributed across the state and coming from most of the CSBs. CVTC ARs have already made the difficult decision that families from the other training centers are potentially facing now – the choice between high quality care and close proximity. They chose superior care, and CVTC families will not choose community discharge in order to keep our people nearby. We're already travelling for visits. According to DHBDS, 191 CVTC authorized representatives have said no or absolutely not to discharge. At least 100 have submitted written statements saying that they are unalterably opposed to discharge from CVTC and do not wish to be contacted about it any more frequently than the settlement agreement requires.
7. Closing CVTC would increase the already significant challenges in providing appropriate community alternatives in some parts of the state including NoVA and the southwestern region, because CVTC residents are from those parts of the state too. Around 40 of CVTC's residents are from Northern Virginia, for example. Finding local community homes for them would increase the NoVA challenges and costs by at least 40% and likely considerably more, since CVTC people on average have more severe and more costly disabilities.
8. Considering the mandate for comparable care established by SB627, **CVTC is the one training center that legally cannot close, if services offered at each training center continue as they are today.** CVTC is centrally located and has the capacity to hold the 400 statewide who have indicated that they oppose community discharge. SEVTC is inadequate to serve that number. *If only one training center is to remain in operation, CVTC is the only fair, reasonable and legal choice.* However, each training center is treasured by the families of those who live there, and each provides well for the care of its respective residents. Thus I do not advocate closure of any training center. There are good reasons to leave each of the remaining training centers in operation and insufficient fact-based reasons to close any training center.

## The Case for Retaining the Other Training Centers in Addition to CVTC:

1. Training center operation has nothing to do with the waiver wait list, and it never did. Beyond the new waiver slots granted by the settlement agreement with DOJ, *the number of waivers approved each year depends solely on the largesse of the General Assembly, since HCBS waivers are not an entitlement like ICF/IID care*, and in lean years that number will always be meager. If training centers close, the funds formerly applied to training center operation will simply be part of the General Fund to be used as the GA sees fit each year.
2. The CMS “Final Rule” on HCBS waivers will create instability in the community HCBS system, at least until it becomes enforceable in March of 2019, and probably for some time thereafter.<sup>6</sup> Waiver recipients will have more rights and some homes will not meet new guidelines. Providers are already worried about the impact of the rule. With Final Rule upheavals coming in the near future, there is more reason than ever to retain the training center safety net.
3. While CVTC’s population is statewide, all of the other training centers serve local residents who are reluctant to relinquish regular and frequent visits to their loved ones to receive a high training center quality of care. Yet that is the choice they will face if their training centers close.
4. NVTC serves a population that lacks appropriate placement alternatives in the area, and constructing appropriate community placement options in the northern Virginia area will be very expensive. The situation in northern Virginia was dire enough to warrant a one-year delay of closure by the DBHDS Commissioner. Providers doubt they will be compensated sufficiently to invest in new residences until the new waiver is approved by CMS, predicted to be in the summer of 2016 – and then, who knows? People with complex conditions are particularly difficult to serve under the waiver in expensive NoVA, yet DBHDS discourages ICF/IID startups.
5. SWVTC serves an area with few placements at all besides sponsored residential options which have so little oversight that families consider them dangerous. There is only a nominal difference between the cost of caring for SWVTC residents in the community and caring for them at the training center.<sup>7</sup> SWVTC is reported to have a superior behavioral program that families are very reluctant to lose and valued integration opportunities including local jobs.
6. SEVTC was recently renovated to resemble the community. It is composed of fifteen houses along a three-street neighborhood. It would be the easiest training center to sell, for each house could be sold as a separate small ICF, and there are indications that that is the DBHDS ultimate plan. However, doing so would likely increase the operating costs of each, since they currently share resources. DBHDS figures indicate that SEVTC’s operating costs divided by its census equals an average cost of \$145,000 per individual annually. This is only \$5000 more than the average cost of serving former training center residents under the current waiver – the waiver that is inadequate to serve those with complex conditions. There is little or no cost incentive to close SEVTC, if the DBHDS figures are accurate.

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<sup>6</sup> The Final Rule will eliminate short-notice evictions, thus providers will be far more discriminating in choosing residents. There will likely be a flurry of group home and sponsored home evictions prior to the enforceability date in March of 2019.

<sup>7</sup> DBHDS figures indicate that the average cost of care for discharged former training center residents in the community is \$140,000 annually, and the cost of SWVTC care is \$141,000 annually. The \$140,000 average would not pertain to those with complex needs at SWVTC, and thus there is really no financial case for closing the facility.

7. Finally, consider what is happening in other states. **Georgia** provided the model for our settlement agreement with DOJ, according to Secretary Hazel. Yet two years into implementation, twice the time that Virginia has had, Georgia's plan is in disarray, people are dying, and Georgia's Independent Reviewer has twice called for a moratorium on discharges for safety reasons. Without a detailed analysis of the comparative reasons for the deaths in Georgia and Virginia, it is frightening to notice that Georgia's death rate after four years is double that of Virginia's after two, thus at least suggesting that we should slow the process to reduce the risk of harm. In **New Jersey**, which is closing some of its developmental centers for the intellectually disabled, they are jailing some of the behaviorally challenged for lack of other housing options. **Pennsylvania** has just concluded a five-year legal battle over the fate of those in its developmental centers, by working out a settlement whereby those who want to stay in their current centers can stay and those who wish to leave for community placements may leave, to everyone's satisfaction. It was a win-win resolution. I pray that Virginia will resolve our training center issues as wisely.