

**REPORT OF THE FACILITY PLANNING
WORKING GROUP
OBJECTIVE 1.6 OF THE DMR STRATEGIC PLAN 2000 – 2004
Minority Report Prepared by Arc Massachusetts, Mass Advocates
Standing Strong (MASS) and Massachusetts Families Organizing
for Change (MFOFC)
February 27, 2002**

Summary of Minority Report

The representatives from Arc Mass, MASS and MFOFC applaud the efforts of this working group to collect and analyze source data useful for planning the future of the facilities. We saw that the data was relevant, collected from credible sources and fairly assessed in the working group meetings and those of its subcommittees. Therefore, we have no substantial objections to the process or substance of the source data included in working group report.

The report fails, however, by excluding the following:

- Certain data presented to the committee. These excluded items are identified below with asterisks (*).
- A detailed operating cost analysis for providing services from CY2002 to CY2011 for a representative group of people now living at the facilities. This operating cost analysis was discussed in various forms in the facility finance and cost subcommittee. It was also presented to the full working group as part of a summary presentation on December 20, 2001.

Further, we vigorously disagree with the recommendations as stated in the report. The working group's charter included recommendations to the DMR commissioner in three areas. All three recommendations in the report are deeply flawed.

Our report includes the excluded data and the operating cost analysis. Further, we recommend to the DMR commissioner on the three areas in the charter: facility current and future functions, appropriate number of facilities to meet capacity needs, and bed capacity.

The results from this report are compelling: We recommend that all six facilities be closed no later than CY2008, and preferably by the beginning of CY2006, with the current residents transferred to community placements.

In the following sections, we present the following:

- Our involvement with the working group
- Why the recommendations in the working group report are flawed
- The excluded data and operating cost analysis

- Five reasons why we recommend full closure of the facilities

Each of the five reasons for full closure is compelling on its own merits; one example is that facility placement is always the most restrictive placement (and therefore least appropriate placement), compared with the alternatives in the community or the home. Two other examples are excessive operating costs and capital costs for the facilities. Taking all five reasons together, the proper public policy is closure of all six facilities.

Working Group Participation by Arc Mass, MASS and MFOFC

Our representatives participated fully in the working group. One of us attended every working group meeting, and 90% of the time two or more of our participants attended. Two members served on subcommittees: Ed Bielecki on Economic Impact of Facilities on Host Communities and Donald Stewart on Facility Finance and Costs. We listened carefully to all participants at meetings, fully and vigorously stated our views, and learned substantial amounts from other participants. Our sense was that others heard and benefited from our views.

We believe that the working group meetings were a valuable and mutual learning session for all. We applaud the chair of the working group (Margaret Chow-Menzer) on the process she followed, and the even-handed way that she conducted the working group.

Why the Recommendations of the Working Group are Flawed

The charter for the working group is recommendations to the DMR commissioner in three areas: facility current and future functions, appropriate number of facilities to meet capacity needs, and bed capacity. In this section, we discuss why the report recommendations are flawed.

A. Facility current and future functions

The report summarizes in narrative and table form the current function of the facilities. We agree that the report accurately describes the current function.

For the future function, the report identifies two major populations, the current residents and future admissions. Let us take the future admissions first. We agree that the working group assumed that facilities would be available to support individuals with intensive and complex medical and behavioral needs. Looking only at future admissions, and using the data in the report, the total number of potential admissions with these needs are as follows:

	<i>FY2004</i>		<i>FY2011</i>	
	Low	High	Low	High
Short Term (6 mo or less)	25	37	25	37
Long Term	14	26	70	90

As stated in the report, we agree with the cautions in interpreting this data. But even if you accept these numbers at face value, the maximum number of facility beds needed in FY2011 is 109 [90 long term plus 37/2 (each short term placement lasts 6 months or less, so 19 beds are

needed for the short-term admissions)]. And these are the admissions for intensive and complex medical and behavioral needs.

What about the current residents? There was a strong and repeated consensus in the working group that people can be served in the community whatever their medical and behavioral needs. The only condition is that adequate funds be available for those services.* (The asterisk indicates data missing from the working group report.) By FY2011, the working group report says that the number of current residents will have declined to a range of 576 to 785. In other words, by FY2011, for every admission there are slightly more than 6 current residents.

So the question of the future function of the facilities is resolved by one's view of the current residents, as they exceed by a factor of 6 to 1, any new admissions. Can they be served in the community? The answer is a clear yes, as supported by the working group's consensus. Are they willing to be served in the community? Not according to the working group report that says the current residents are firmly opposed to community placement.

The proper recommendation to the DMR commissioner is the following. We agree with the current function of the facilities as described in the report. The future function of the facilities (if they were kept open) is to support the placement preference of 576 to 785 people, who by consensus of the working group can be served in the community. The 109 beds for new admissions might be for intensive and complex medical and behavioral needs (which can be supported in the community), but this is a small minority of the beds needed in FY2011.

Operating the facilities to meet placement preference is not appropriate public policy. There is no valid future function for the facilities. They should be closed.

B. Appropriate Number of Facilities to Meet Capacity Needs

The working group report provides two sets of data on the appropriate number of facilities to meet capacity needs. The first is table III with specific data and rankings for each of the six facilities. We agree with the data in the table. However, the table includes no data specific to the appropriate number of facilities, only to the ranking of each based on selected criteria. The reader is left to decide how many facilities are appropriate.

The second set of data is the result of written submissions (secret ballot) by the working group on members' opinion on how many facilities are appropriate to meet capacity needs. The data says that 45% (a plurality) responded with 3 or 4 facilities for capacity needs.

The result of the ballot, however, is inconsistent with the projection of the number of beds needed for future capacity. The report for the working group recommends that the number of beds in FY2011 should be in the range of 671 to 912. This range includes current residents in all six facilities. However, the working group consensus, repeatedly stated during its meetings, is that the choice of residents when their facility closes is a community placement rather than a move to another facility, in the vast majority of cases (* data excluded from the final report). The

preference for community placement is not in question, as this outcome occurred in past closings, with the Belchertown and Dever closings as examples.

For the sake of discussion, let's say that 3 of the 6 facilities are closed; which is in agreement with the secret ballot of the working group. What does that do to the number of projected beds? Instead of the range of 671 to 912 beds in FY2011, the range is now 412 to 548, simply because half of the current residents in FY2011 choose to live in the community due to half the facilities closing. (The number of beds in FY2011 with 3 facilities is closed is equal to half the current residents in FY2011 plus the 10% of current residents who stayed in the facilities when their facility closed plus the admissions. The only assumption in the calculation is the explicit estimate that 90% of residents in a closing facility choose to move to the community, consistent with past closings.)

Therefore, the working group recommendation for 671 to 912 beds in FY2011 is inconsistent with the plurality vote of 3 to 4 facilities open, simply because residents in facilities that are closing choose the community over living at another facility.

The two ways to eliminate the inconsistency is for all facilities to remain open (resulting in 671 to 912 beds in FY2011) or to cut the recommended range of number of beds to 412 to 548. The working group report is flawed in recommending that the capacity in FY2011 is 671 to 912 beds *and* implicitly recommending (no explicit recommendation is made) that 3 to 4 facilities remain open.

Given the inconsistency and the lack of explicit recommendation on the number of facilities, we do not accept that 3 to 4 facilities remain open in FY2011. Instead, we recommend full closure of all, preferably by the beginning of CY2006. Our reasoning is above in *A. Facility Current and Future Functions* and in the *Five Reasons Why We Recommend Full Closure* in the last section of this report.

C. Bed Capacity

The working group report recommends a bed capacity in FY2011 of 671 to 912 beds. This recommendation is based on a series of assumptions given in the report. We agree that using the assumptions given, the recommended bed capacity in FY2011 is accurate.

The report of the working committee includes six major assumptions for bed capacity in FY2011. We agree with three of them and disagree with three of them. By not accepting three of the assumptions, we come to a very different conclusion on bed capacity. Specifically, our conclusion is that there should be no bed capacity in the facilities in FY2011.

First, here are the three assumptions on bed capacity that we agree with (The list of assumptions is in section VII of the working group report):

- The provisions of the Olmstead ruling
- The FY2002 average yearly cost of \$182,971 for providing services in the facilities

- The FY2002 average yearly cost of \$134,247 for providing comparable services in the community. [This estimate is the result of tracking actual costs (residential, day program, transportation and health care, among others) for individuals leaving the facilities in prior years, and then correcting those costs for inflation.]

The following three assumptions on bed capacity are *not* correct in our view:

- *The policy of closed admissions to the facility since 1987 should be reversed.* We firmly believe that opening facility admissions is a step backward, counter to the national trends given in the working group report, and to the detriment of individuals and their families. Nothing has happened since 1987 to support a reversal of a closed admissions policy to the facilities; if fact, the evidence to keep the facilities admissions closed is more compelling.
- *The role of the facilities should be considered for support of individuals with intense and complex medical and behavioral needs.* In principle, you can consider the role of the facilities for individuals with these needs, but only if they are weighed against existing and proven alternatives for support in the community. Those considerations must also include cost, given DMR's charter as a public agency. Ignoring community alternatives and cost is not viable policy or procedure, so we reject this assumption.
- *Facility residents will not be involuntarily moved to a community setting.* In fact, this occurs each time a facility is closed, as in the cases of Belchertown and Dever. We firmly believe that DMR makes every effort to conduct itself in a humane and considerate way when discussing a change in services with individuals and families. Yet, in some cases, DMR, the individual and family will readily agree that no viable facility placement exists when their facility is closed. As a result, there are literally hundreds of cases where DMR has involuntarily moved individuals to a community setting. There is every reason to expect that similar future involuntary moves are possible with the closing of all facilities, with the transfers also completed in humane and considerate ways.

We recommend that the commissioner of DMR accept the first three assumptions on bed capacity, and reject the second three. Following this line of thinking, we conclude that there should be no bed capacity at the facilities in FY2011, and preferably much sooner in FY2006.

The Excluded Data and Operating Cost Analysis

Any summary report by necessity excludes data, and we respect the difficulty of choosing selected information discussed over nine months. *Our view is that certain data from the working group and the subcommittees is so central to the recommendations of the working group that it must be included in the final report. When that information was excluded from the working group report, then we have indicated it in this report with an asterisk.* The items marked with an asterisk represent our understanding of consensus views by the working group, not tangential thoughts or unconsidered information.

An operating cost analysis was prepared by the subcommittee on facility finance and costs, but just briefly mentioned in appendix 11 of the working group report. The analysis projected the total costs of providing services to a representative group at the facilities over the ten-year period

of CY2002 to CY2011 (calendar years were used because the mortality data provided to the working group was in calendar rather than fiscal years). The analysis explored nine scenarios that DMR might consider for providing services to that representative group to determine the operating cost consequences of each scenario. (An analogy for a family might be determining the costs over ten years of owning two different houses with substantially different characteristics.)

The analysis provides estimated operating costs for each scenario and collects the costs of services, regardless of where group members live. For example, in one scenario, all facilities remain open, so the costs accumulated are for each person for each year in the facility where they live. Another scenario is closure of Fernald, with the rest of the facilities remaining open. In this case, the costs remain the same as all the facilities remaining open, except for Fernald residents. For those residents, the analysis assumes that Fernald is closed over several years, so that in the early years, most of the costs accumulated by individuals at Fernald are Fernald costs. As the transfer winds down, most of the costs for former Fernald residents are community costs.

Another scenario is closing all facilities. In this case, people are moving simultaneously from all facilities to the community, again over a period of years. For this scenario, the first year is all facility costs and no community costs. After the transition is complete, all costs are community costs, since the analysis tracks costs, regardless of where people live.

There are nine scenarios selected by a representative of DMR, with the characteristics listed in appendix 11 of the working group report. All of the assumptions used in the cost analysis are listed in the last table of appendix 11, (and reproduced as Table III in the working group report), with the exception of the inflation assumption of 3 % per year (some assumption of inflation is needed for an analysis over a ten-year period).

Refinements to the operating cost analysis were added during the deliberations of the facility finance and cost subcommittee, the most important being four choices for how rapidly the transitions in the scenarios were completed. All scenarios started in CY2002, and the four choices were the following:

- Completed as fast as possible and no later than CY2004
- Completed no later than CY2004
- Completed no later than CY2005
- Completed no later than CY2007

Since the analysis is for operating cost, it does not include capital dollars that are essential to facility operation. The capital dollars are included in the body and in appendix III of the working group report. Capital dollar estimates are also discussed in the following section on *Five Reasons Why We Recommend Full Closure*.

Because operating cost is so central to the public policy for the facilities, we have included the key summary pages of the operating cost analysis. They are included in appendix A of this report, with the following pages (* operating cost summary pages are excluded from the working group report):

- The top page of the operating cost summary shows total costs over the ten-year period from CY2002 to CY2011. On this page, you see the operating cost for each of the nine scenarios over 10 years. But this page also includes the four choices on how rapidly the transition occurs. Finally, the summary page includes the annual cost of providing services for each of the scenarios in CY2008 (in CY2008 dollars). In that way, you can compare the annual operating cost of the nine scenarios after all the transitions are complete.
- The second page is a description of the nine scenarios
- The third page is the list of assumptions used for the operating cost analysis. At the top, the assumptions are in text form, and match table III of the working group report and the same table in appendix 11 of the working group report. The only addition on assumptions is inflation at 3% annually. At the bottom is the list of assumptions in table format.

The following are some conclusions from the operating cost analysis. Given the importance of cost in public policy for the facilities, you can see that it is critical that these cost projections be considered in any decision on facility planning:

- The least cost scenario is closure of all facilities. The ten-year cost for providing services for this representative group of current facility residents is \$1.645 billion, with the assumption that the transition to the community starts in CY2002 and ends by no later than the end of CY2005. If the transition is completed by the end of CY3004, the savings could be \$53 million, if the transition took an additional two years, the added cost is \$93 million. Our recommendation is closure of all facilities by the end of CY2005 (or the beginning of CY2006).
- If all facilities remain open (no closures), the ten year cost of providing services is \$514 million more than closing all facilities by the beginning of CY2006.
- The ten-year operating cost of partial closure is always higher than full closure. The least costly of the partial closure scenarios is leaving only Templeton and Glavin open. If this scenario is chosen, the ten-year operating cost is \$64 million more than full closure. This scenario simply costs more than full closure, and, in fact, is very detrimental to DMR for its service planning, if one or both of the facilities are considered for the special population of individuals with forensic involvement (see the last section on *Five Reasons We Recommend Full Closure for the Facilities*).
- The operating cost analysis shows that partial closure can result in higher costs than leaving all facilities open. This apparently counter-intuitive outcome occurs if the lower cost facilities are closed, leaving only higher cost ones operating. The two highest cost scenarios are Fernald and Monson only open and Fernald and Wretham only open (these two scenarios assume that the open facilities operate at full capacity, and the remaining people from the closing facilities are transferred to the community). The ten-year operating costs for these two scenarios are \$690 million and \$611 million respectively higher than full closure.
- After all transitions have occurred (no later than CY2008), we can then estimate the ongoing costs of each scenario. This is equivalent to jumping ahead with the clock, and finding out what the annual costs are to provide services, using each scenario. Because

3% annual inflation is included in the analysis, the annual costs of each program are in CY2008 dollars. The results shown on the first page of Appendix A of this report are the annual costs of providing services to the remaining 963 people from the representative group (the analysis includes the mortality estimates). If all facilities are closed, the annual cost is \$151 million (about \$157,300 per person in CY2008 dollars). If all facilities remain open, the annual cost in CY2008 is \$216 million (about \$224,500 per person in CY2008 dollars).

We emphasize that the operating cost analysis deals in real taxpayer money, whether state or federal (part of the DMR budget expenditures are refunded the following fiscal year by the federal government). They are real dollars because the costs are from DMR cost reports and included in table III of the working group report.

The operating cost analysis deals in huge amounts of dollars, compared with the DMR true annual expenditures (including costs in the administration and finance budget that apply to DMR). The lowest cost scenario of full closure results in a ten-year operating cost of \$1.645 billion that *exceeds* the entire DMR budget (including A&F) for a single year. In other words, the operating cost analysis deals in real and very large dollars. We believe that the operating cost analysis demands close attention as the proper choice of full closure can avoid major dollars in operating costs in the coming years.

A full Excel version of the operating cost model is available from Michael Abrahams, who is presently at the Executive Office of Health and Human Services.

Five Reasons Why We Recommend Full Closure of the Facilities

The prior sections explain our involvement with the facility planning group and why the recommendations in the working group report are flawed. We have also identified data from the working group that was excluded from the working group report, but is essential to a decision on facility planning. One data set excluded is the operating cost analysis for the facilities over the ten-year period of CY2002 to CY2011. The cost analysis is a critical part of planning for the facilities.

In this section, we explain the five reasons why all the facilities should be closed, if possible by the beginning of CY2006. We believe these reasons are the relevant ones for facility planning:

1. *An open facility bed could be filled by an individual who is placed there against his or her will.* Available facility beds are always a potential placement for someone in the community. Given their cost, the only reasonable assumption is that those beds will be filled. In spite of excellent DMR management and good will from all involved, there always remains the potential risk that someone will be placed in a facility against their will. The mis-placement could occur through error, misrepresentation by family or inability of the individual to express his or her desires.

Many self-advocates, including the two Mass Advocates Standing Strong representatives to the facility planning working group, feel very strongly that this risk, however small, is unacceptable. The most famous occurrence of mis-placement is the two women in Georgia, whose case led to the Olmstead ruling by the Supreme Court. Craig Smith, MASS self-advocate member of the facility planning working group, expressed his strong desire at a facility planning working group meeting in July 2001 that the facilities be closed, exactly for the reason of inadvertent placement in a facility.

2. In the post-Olmstead era, facilities are seen as outdated service models and no longer appropriate placements, given their restrictive institutional settings. Since the 1970s, a large number of service models for community and home supports have evolved, offering a far wider range of choices. DMR, families and individuals working together have developed pilot programs and collected data that have resulted in proven service models. The result, in our opinion, is that institutional settings like the facilities have become programmatically marginalized, except for the dollars they consume.

Further, the national data included in the facility planning working group report shows the strong national trend away from facility settings. Massachusetts is the last New England state with multiple facility campuses, and may soon be the only New England state with any facilities. It is time for us to recognize our strong financial and emotional commitment for caring, see the opportunities in community and home settings, and move with determination to close all six facilities.

3. Equal or better services to the medically fragile, behaviorally challenging and forensically involved are proven to work in settings other than the present six facilities, Fernald, Glavin, Hogan, Monson, Templeton and Wrentham. For medically fragile and behaviorally challenging individuals, the strong medical and academic resources that are available in Massachusetts community settings make community settings for these individuals the preferred choice. We are fortunate to live in a state rich in medical skills and services that are offered and consumed here by people in-state, nationally and internationally. In fact, medical services (and related services for behaviorally challenging people) are a leading export, as Massachusetts is seen as a center of excellence for these skills and services.

In an environment rich in medical and behavioral services competence, it is not appropriate public policy for DMR to perpetuate an in-house system geared only to individuals with mental retardation. Experience in many service industries shows that in-house services will invariably fall behind vibrant services in the community that must daily prove their worth and effectiveness. In summary, we see no future role for the facilities for medical or behavioral services, and recommend that the facilities be closed for this purpose.

For the forensically involved, a strong multi-disciplinary team located near an academic medical facility is a clear preference for high-intensity services. The multi-disciplinary team is not a luxury, but an essential element in identifying causes and establishing treatments for people that often have significant undiscovered medical issues.

The difficult public policy issue for forensically involved people is the high cost of services. Experience in other states (New York as one example) shows that costs approaching \$1,000 per day per person are needed for periods up to two years to appropriately address their needs (followed by suitable step-down programs). No program at the facilities comes close in medical diagnostic capability, intensive resources and strong multi-disciplinary teams.

High intensity medical and behavioral services exist in Massachusetts, and they are typically located near academic medical centers. These environments took years to develop and involve significant clinical research and graduate students. Further, program managers in these environments are not surprised by the costs involved, and actively defend their budgets based on the efficacy of their programs.

Our recommendation to DMR is to move away from attempts at facility-based in-house supports for the forensically involved that are isolated from medical centers, and consider collaborations with academic medical centers at those centers as a way to provide services, meet court-imposed constraints, and move forward the science of treating this difficult population. We believe that a team of DMR and academic medical program managers can make a strong case to the Legislature on the financial needs for the program on a year-in and year-out basis. We strongly recommend a collaborative approach to solve the difficult public policy issue of continuous adequate funding for the forensically involved.

None of the six facilities qualify for the intensive specialized programs needed by the forensically involved. Our recommendation is not to consider the facilities for this purpose.

4. The operating cost analysis shows that closing all facilities is the clear preference for operating cost reasons. Given DMR's role as fiduciary for public funds, we see that operating costs are an important issue. Further, we believe that cost savings from facility closure should be directed to strengthening the community service system for the approximately 20,000 people receiving those services. The summary of the operating cost analysis in the prior section uses assumptions agreed-to by the facilities planning working group. The summary offers several views of cost, based on nine scenarios, four different transition periods, and the annual operating cost in CY2008 after all transitions have occurred. In all cases, full closure is the lowest-operating cost choice, and for fiduciary reasons, we recommended that all facilities be closed by the beginning of CY2006.

5. Closing the facilities will avoid nearly all capital expenditures otherwise needed if the facilities remain open (Fernald and Wrentham will need some expenditures to resolve deferred maintenance issues, even if they are closed). The last major investment in the facilities was in the early 1980s. For the facilities to remain open, the working group report says that capital expenditures in the range of \$25 million to \$93 million (in February 2006 dollars) are required (*totals on capital costs not included in working group report).

Our view is that these numbers are low, and that the capital investment needed could range up to \$210 million (February 2006 dollars). The basis of this estimate is the following: We assume that the “DMR self” estimate of \$35 million total for all six facilities is mostly, if not all, accumulated deferred maintenance. In other words, these expenditures should have been made in the past 10 years or so, to properly maintain the physical plant of the facilities.

We estimated capital expenditures going forward by assuming that deferred maintenance accrues at the rate of \$3.5 million per year (\$35 million divided by 10 years), based on the DMR self estimate. Next, we assumed that eliminating the deferred maintenance plus normal capital expenditures requires pro-active spending equal to three times the rate that the deferred maintenance accrued, or \$10.5 million per year (\$3.5 million times 3). Given that nearly all facility buildings are at least 35 years old (no new construction since the 1970s), the changing requirements of building standards, the ADA, and the unforeseen (and inevitable) surprises in capital maintenance and construction, we believe that the spending rate of \$10.5 million should continue for a minimum of 20 years. Our estimate, therefore, is \$210 million (\$10.5 million times 20 years).

From a facility planning working group perspective, we recommend a capital expenditure estimate that is realistic, allows for surprises and includes some new buildings in the estimate. Keep in mind that facility buildings will be a minimum of 45-years old in FY2011, and at the end of life for commercial buildings. With that perspective, even the \$210 million estimate may be low.

The high cost and uncertainty on capital expenditures can be avoided by DMR, if the facilities are closed by the beginning of CY2006, as recommended in this report.

Respectfully submitted,

Ron Asbjornson
Massachusetts Families Organizing for Change

Edmund Bilecki
State Coordinator, Massachusetts Advocates Standing Strong

Anne Fracht
Chair, Massachusetts Advocates Standing Strong

Craig Smith
Co-Founder and Past Chair, Massachusetts Advocates Standing Strong

Donald Stewart
Immediate Past President, Arc Massachusetts

Minority Report for the Facility Planning Working Group

Appendix A

Department of Mental Retardation Operating Cost Outcomes for Nine Scenarios (CY2002 to CY2011) Summary for Four Transition Times

Scenarios Listed in Order from Highest Ten-Year Operating Cost to Lowest Ten-Year Operating Cost
All Costs Inflated at 3 Percent Annually from 2001

12/20/2001

<i>Ten-Year Operating Cost</i>					
	All Transitions ASAP and No Later than CY2004	All Transitions No Later than CY2004	All Transitions No Later than CY2005	All Transitions No Later than CY2007	
Projected Ten-Year Cost of the Lowest Cost Scenario (All Facilities Closed)	\$1,574,051,484	\$1,592,244,103	\$1,644,819,920	\$1,737,518,313	
Additional Cost of Each Scenario. Add the Number Below in Each Row to the Number Above for the Total Ten-Year Cost of Each Scenario					
Scenario 4 - Projection For Geographic Distribution (Fernald & Monson Open)	\$735,452,423	\$716,672,528	\$690,273,518	\$571,918,885	\$230,753,226
Scenario 5 - Projection For Two Large Facilities Open (Fernald & Wrentham)	\$626,603,405	\$628,034,249	\$610,639,759	\$468,154,437	\$220,498,660
Scenario 8 - Projection for Status Quo (All Facilities Open)	\$584,868,314	\$566,675,695	\$514,099,878	\$421,401,485	\$216,291,847
Scenario 6 - Projection For Two Large Facilities Open (Monson & Wrentham)	\$528,605,742	\$510,717,647	\$488,613,898	\$406,224,968	\$208,584,439
Scenario 1 - Projection For Lowest Medicaid Cost (Close Fernald)	\$527,756,654	\$509,564,035	\$468,484,502	\$387,288,749	\$209,424,844
Scenario 2 - Projection For Lowest Capital Cost (Close Fernald & Wrentham)	\$442,985,765	\$424,793,146	\$401,512,544	\$368,033,618	\$199,277,747
Scenario 7 - Projection For Geographic Distribution (Templeton & Wrentham Open)	\$256,306,207	\$241,611,617	\$231,438,877	\$192,670,708	\$179,976,180
Scenario 3 - Projection For Lowest Cost Facilities (Glavin & Templeton Open)	\$73,663,646	\$64,001,786	\$63,548,435	\$64,528,131	\$159,483,673
Scenario 9 - Projection for Lowest Operating Cost (All Facilities Closed)	\$0	\$0	\$0	\$0	\$151,476,483

**Operating Cost in CY2008
After All Transitions Have
Occurred. Shown in
CY2008 Dollars.**

**Department of Mental Retardation
Outcomes for Nine Scenarios (2002 to 2011)**

11/13/2001

	<i>Fernald</i>	<i>Glavin</i>	<i>Hogan</i>	<i>Monson</i>	<i>Templeton</i>	<i>Wrentham</i>	<i># Open</i>
Scenario 1 - Projection For Lowest Medicaid Cost (Close Fernald)	Close	Open	Open	Open	Open	Open	5
Scenario 2 - Projection For Lowest Capital Cost (Close Fernald & Wrentham)	Close	Open	Open	Open	Open	Close	4
Scenario 3 - Projection For Lowest Cost Facilities (Glavin & Templeton Open)	Close	Open	Close	Close	Open	Close	2
Scenario 4 - Projection For Geographic Distribution (Fernald & Monson Open)	Open	Close	Close	Open	Close	Close	2
Scenario 5 - Projection For Two Large Facilities Open (Fernald & Wrentham)	Open	Close	Close	Close	Close	Open	2
Scenario 6 - Projection For Two Large Facilities Open (Monson & Wrentham)	Close	Close	Close	Open	Close	Open	2
Scenario 7 - Projection For Geographic Distribution (Templeton & Wrentham Open)	Close	Close	Close	Close	Open	Open	2
Scenario 8 - Projection for Status Quo (All Facilities Open)	Open	Open	Open	Open	Open	Open	6
Scenario 9 - Projection for Lowest Operating Cost (All Facilities Closed)	Close	Close	Close	Close	Close	Close	0
Number of Scenarios that the Facility is Open	3	4	3	5	5	5	

**Department of Mental Retardation
Operating Cost Projection for Current Residents of Facilities for Ten Years (2002 - 2011)**

List of Assumptions for Operating Cost

1. Operating costs are for current residents of facilities, whether they stay at the facility or move to the community. If they move to the community, then the cost projection includes their community costs through 2011. The same mortality projections apply, whether in a facility or the community.
2. All operating costs inflate at 3 percent annually.
3. Facility per diem costs listed below are for FY 2001 and use DMR accounting. Facility costs are annualized (times 365) and corrected annually for inflation.
4. Facility annual costs are divided into a variable portion and a fixed portion as shown in the chart below. The chart is based on cost center analysis and split of A & F costs into fixed and variable based on sources of cost using Facility variable vs fixed FY02-r8 as of December 2001.
5. Average community costs are \$134,247 annually in FY2001 dollars, based on current community costs for consumers transferring to community during FY1998 and FY1999. The community costs are corrected annually for inflation.
6. For Glavin and Templeton, the per diem costs are substantially less than the average per diem cost. For these two facilities, the costs of providing services for their residents in the community are estimated to be less in the same proportion as their facility per diem costs vary from the average facility per diem cost.
7. This operating cost analysis includes no capital expenditures. However, capital expenditures are necessary and must be added to these projections for any facility remaining open for an indefinite time, and for Fernald, Monson and Wrentham even if they close.
8. If facilities close, the fixed costs continue through closure, and then drop to zero. The fixed costs for each facility are the fixed costs per consumer times the facility census as of 2002.
9. Cost projections are based on end-of-year census for each year.

Chart of Assumptions for Operating Cost

	<i>Fernald</i>	<i>Glavin</i>	<i>Hogan</i>	<i>Monson</i>	<i>Templeton</i>	<i>Wrentham</i>	<i>Non-Weighted Ave</i>
Per diem costs for FY2001	\$563.06	\$413.73	\$480.87	\$543.44	\$356.77	\$510.49	\$478
Annualized per diem costs for FY2001	\$205,518	\$151,012	\$175,516	\$198,356	\$130,221	\$186,329	\$174,492
Percent of costs that are variable	77.3%	81.4%	81.4%	80.6%	78.0%	79.9%	
FY2001 dollars that are variable	\$158,852	\$122,873	\$142,868	\$159,912	\$101,630	\$148,829	
Percent of costs that are fixed	22.7%	18.6%	18.6%	19.4%	22.0%	20.1%	
FY2001 dollars that are fixed	\$46,666	\$28,139	\$32,648	\$38,444	\$28,591	\$37,500	
Annual costs for services in the community per consumer. Includes residential, day and transportation.		\$116,182			\$100,187		\$134,247
Annual dollar inflation factor for all but construction	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3%