IN
CAPITAL EXPENDITURES FOR MENTAL RETARDATION FACILITIES:

A STATE-BY-STATE SURVEY

National Association of State Mental Retardation Program Directors, Inc.

TRENDS IN CAPITAL EXPENDITURES

FOR

MENTAL RETARDATION FACILITIES:

A STATE-BY-STATE SURVEY

June, 1980

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I. INTRODUCTION

Over the past ten years, residential services for mentally retarded and other developmentally disabled individuals have changed considerably. The model of the larger, segregated institutional facility is slowly giving way to smaller community-based alternatives. This trend toward community residential programming is the result of a variety of intersecting forces, including changing professional attitudes, increased public awareness and the gradual eradication of false stereotypes about developmentally disabled persons. In addition, new philosophies, such as normalization and the developmental model of services, as well as increased advocacy for the rights of disabled persons, have brought about a major thrust toward improving the "quality of life" for the disabled population. Finally, recent federal and state legislation, propelled by escalating consumer demands, has opened up many new avenues for financing community housing and related services.

As is frequently the case when complex, far-reaching shifts in public policy and program philosophy occur, there are numerous incongruities and evidence of possible counter trends which cloud the picture. Currently, in the area of residential services for the mentally retarded, there are a number of apparent counter trends, including reports of increased readmission rates and a downturn in community placements by some public residential institutions. Another such counter indicator is the reported increase in state capital expenditures to renovate and improve traditional public institutions for the mentally retarded. The purpose of this report is to summarize the findings of a state-by-state survey of capital outlays for the construction, renovation and modernization of facilities for mentally retarded persons. The major overarching question which this study set out to answer is: to what extent are the states, the traditional providers of residential services to mentally retarded citizens, using capital construction dollars to reconstruct and expand existing public institutions, as opposed to enhancing the development of community residential programs. In other words, are we seeing the recent trend toward community-based residential facilities undermined by widespread efforts to rebuild existing institutions.

The study was motivated by controversies in a few states over the proposed construction of new state-operated residential facilities (e.g., Virginia and Maryland) and the commitment of sizable public outlays to renovate and modernize existing state residential institutions (e.g., California and Connecticut). Cognizant of these controversies, the members and staff of the President's Committee on Mental Retardation began investigating nationwide developments to determine whether similar problems were being encountered in other states or, conversely, if these reports represented highly visible but isolated events. Recognizing the dearth of existing nationwide information and data on state capital outlay for mental retardation facilities, PCMR

decided to initiate a state-by-state survey. The major aim of the Committee was to determine the extent to which states are directing capital dollars toward community residential facilities, as opposed to rebuilding existing state institutions.

PCMR turned to the National Association of State Mental Retardation Program Directors, Inc. (NASMRPD) to conduct this study, because of: (a) the NASMRPD's staff familiarity with the issues involved; (b) the organization's access to information sources in the states; and (c) NASMRPD's past experience in conducting similar studies for PCMR.

The basic goal of the study was to obtain a well-rounded view of the capital outlay picture in the fifty states and the District of Columbia. The specific objectives of the survey included:

- to determine how states budget for capital outlays on behalf of mentally retarded citizens;
- to analyze current nationwide patterns of capital outlays for mental retardation facilities;
- to ascertain the sources of capital construction funds other than state revenue bonds and direct appropriations; and
- to uncover any problems related to state-financed capital improvement projects, as perceived by responsible state officials.

This report summarizes the results of the state-by-state survey conducted by the NASMRPD staff, beginning in December, 1978 and ending in mid-August, 1979.

II. SUMMARY OF FINDINGS

This report summarizes the findings of a state-by-state survey of capital improvement projects involving the construction, renovation or modernization of mental retardation facilities. Most of the data for the survey was gathered in the first half of 1979 through a series of in-depth interviews with state officials in forty-eight states and the District of Columbia, who were familiar with their state's capital construction plans for mental retardation facilities.

Information was collected on a variety of related areas, including: (a) the capital budgeting process; (b) actual and projected appropriations for mental retardation construction/ renovation projects in each state; (c) MR construction projects financed through sources other than the state's regular capital budget; and (d) problems related to state-financed capital construction activities, as perceived by responsible state officials. The following are among the major findings of the survey:

- Budgetary Process. Despite the similarities between the basic capital budgeting processes used by each state, signif icant differences emerged during the course of the survey, including: (a) the use of different fiscal periods (32 jurisdictions had annual budgets; 19 budgeted on a biennial basis); (b) the use of different budget formats (11 had separate capital budgets; 13 included a separate section for capital requests in the Governor's budget; 2 integrated capital requests in the regular operating budget and the remainder used some combination of the above approaches); (c) the treatment of fixed equipment in capital budget requests (34 states included such costs; 10 did not; and 6 did so only in the case of new construction projects); (d) the definition of what constitutes a "capital construction project" (about half the states used a minimum cost thres hold) ; (e) the use of revenue bonds to finance MR capital improvement projects (about half the states floated such bonds and the other half did not); and (f) the development of long range capital construction plans (most states (44) prepared such plans).

- Total Capital Outlays. Over the three fiscal years covered by the study (i.e., July 1, 1977 through June 30, 1980) the fifty responding jurisdictions reported actual and projected state appropriations for mental retardation construction/ renovation projects totaling almost one billion dollars. Actual and projected capital appropriations varied consider ably from state to state, with the top five states (CA, MI, NJ, NY and OH) accounting for over one-half (52%) of the total outlays reported for the three-year period. While the most populous states generally tended to have higher capital improvement budgets, there was no direct correlation between a state's total population and its aggregate appropriations for construction and renovation of MR facilities during the three year period.

- Types of Projects Financed. The vast preponderance of state capital appropriations during the period (82.7%) were ear marked for construction and renovation projects on the grounds of state-operated residential facilities. Thirty-three of the fifty responding jurisdictions reported that their entire FY 1977-80 capital improvement budgets would be obligated for such institutional renovation projects. Only thirteen states indicated that capital appropriations would be used to construct community residential facilities during the period, while eight states reported plans to construct community-based daytime facilities. Ohio was the clear leader in total obligations for community-based facilities (both residential and non-residential), followed by New York, Connecticut, Illinois and New Jersey.

- Per Capita Comparison. Per capita capital outlays for institutional construction/renovation projects during the reporting period, based on the relative number of residents in state-operated facilities, ranged from a high of $24,205 in Washington State to a low of $404 in Rhode Island. The national median for the three-year period was $5,460.

- Outlays for ICF/MR Compliance. Twenty-six (26) of the thirty-nine (39) jurisdictions supplying figures, estimated that three-quarters or more of their capital outlays during the three-year period would be devoted to projects aimed at bringing state-operated residential facilities into compliance with federal intermediate care facility standards, promulgated under Title XIX of the Social Security Act. The remaining 12 states said that anywhere from 17 to 62 percent of the state's capital budgets over the period would be expended on Title XlX-related renovations. Thus, it can be concluded that the need to comply with Title XIX, ICF/MR standards was the predominant factor motivating capital improvements in most states over the specified reporting period.

- Fiscal Consequences of Non-Compliance with ICF/MR Standards. Asked to estimate the fiscal fallout of failure to comply with ICF/MR standards, 35 states reported projected first year losses in federal revenues totaling $758.8 million, or just slightly less than the aggregate appropriations for institutional renovation projects over the three-year period. It seems clear that the threatened loss of federal revenues constitutes one of the primary motivations for such institu tional renovation projects.

- New Construction vs. Renovating/Modernizing Institutional Facilities. Although no formal attempt was made to separate new construction projects from the renovation of existing institutional buildings, an analysis of the data indicated that no state plans to build new state-operated institutions with the capital funds appropriated during the FY 1977-80 period. Further, no state plans to increase the total bed

capacity of their public institutional system as a result of planned renovation/modernization projects. In fact, most states anticipate moderate to sharp decreases in the total resident population of state-operated facilities over the next three to five years.

- Relationship Between Capital Appropriations and Deinstitutionalization"! A majority of respondents agreed (39 out of 50) that there is a relationship between their states[1] capital improvement and deinstitutionalization plans. Interestingly, several of the states with the largest budgets for institu tional improvements during the reporting period (both in terms of real dollars and per capita outlays) also had the most ambitious deinstitutionalization/depopulation plans. Thus, based on the available evidence, there appeared to be no direct correlation between appropriations for institutional renova tion/construction and projections of future reduction rates in existing institutional populations. In fact, in a number of states, renovations required to bring existing buildings into compliance with ICF/MR standards have resulted in reduced bed capacities, which, in turn, has caused states to accelerate the rate of placement in community-based facilities. Despite the sizable capital funds appropriated during the three year period, the aggregated data shows that: (a) the rate of reduction in the total population of public institutions over the next few years is likely to match the rate achieved over the past decade; and (b) by the mid-1980's the total number of retarded individuals in publicly-operated residential facil-ities is likely to fall under 100,000, or one-half the number in 1970.

- Capital Budgeting Problems. Among the capital budgeting problems most frequently mentioned by the respondents were: (a) resistance to capital outlays by either the Governor's budget office (13) or the state legislature (14); and (b) an inappropriate balance between institutional renovation pro jects and the construction of community-based facilities. However, on the whole, the respondents left the impression that capital budget issues are not among the highest priority problems facing state mental retardation programs.

The restricted scope of the survey and problems inherent in the methodology employed are just two of the limitations of the current study. These limitations are detailed in the next section of this report. Further details on all of the items discussed above can be found in the succeeding sections of the report.

III. METHODOLOGY

During early 1978, the Association's staff was approached by PCMR Executive Director, Fred Krause, to determine if NASMRPD would be interested in conducting a contractual study of state capital construction projects and plans affecting mentally retarded persons. After some discussion, the Association agreed to conduct the proposed study. This report contains an analysis of the information and data gathered from the 50 states and the District of Columbia through July 31, 1979.

A structured telephone interview series was selected as the most appropriate method of obtaining the objective and impressionistic information and data required. This decision was based largely on the Association's past experiences with mail questionnaires and telephone surveys.

Recognizing that states budget for and administer capital construction projects in a variety of ways, the initial step taken by the NASMRPD staff was to contact the director of mental retardation programs in each state to ascertain the name, address and telephone number of the state official best qualified to discuss current and projected capital outlay for mental retardation facilities within the particular jurisdiction. This contact person, in most instances, was either responsible for developing and/or administering the state's capital improvement budget, as it affects mental retardation projects, or had direct access to such information. After this list was completed, the contact person in each state was reached by phone to explain the objectives of the survey and elicit his or her cooperation. Next, a follow-up letter was sent to each state contact person requesting relevant materials (i.e., a copy of the state's capital budget, relevant portions of the state's current operating budget, long range capital improvement plans or other explanatory materials). Twenty-five states responded to this initial request. If a state's contact person did not respond within 30 days, a follow-up letter was sent. As a result of these follow-up letters, 14 additional states sent in background information, bringing the total number of respondents to 39.

All these preliminary steps in the survey process took place in December, 1978 - January 1979. The second phase of the survey process began in February, 1979, with a preliminary analysis of the capital budget materials received from the 39 states. The purpose of this review was to gain a sense of the types of questions which should be raised during the in-depth interview stage of the survey. Based on this review, the project staff developed a draft interview schedule which covered four issue areas—the budget process; actual and anticipated capital appropriations for mental retardation facilities; other capital improvement activities; and problems related to funding capital improvement projects.

In March, several in-depth pilot interviews were conducted to determine the effectiveness of the survey instrument. Minor modifications were made in the interview schedule as a result of these pilot interviews. In addition, the project staff decided that a copy of the interview schedule should be sent to the state contact person approximately two weeks in advance of conducting the in-depth interview.

It was felt that this approach would give the contact person an opportunity to become familiar with the format, collect his or her thoughts and seek out any necessary statistical data or programmatic information.

At this point, the project staff began conducting telephone interviews with the contact person in each state. These interviews were completed between late March and late July; they ranged in length from 30 minutes to an hour and a half. During the interview, responses were recorded on a worksheet which was returned to the contact person for verification. All reported deletions, additions and corrections were noted on a "master" worksheet for each state.

Questions were raised concerning the purposes for which state capital improvement dollars were being obligated. Specifically, state contact persons were asked to break down capital appropriations over the three-year period for the following categories of facilities: (a) state-owned and operated residential facilities; (b) state-owned and operated non-residential facilities; (c) privately-owned and operated residential facilities; and (d) privately-owned and operated non-residential facilities.

Information was obtained from most states on all four types of publicly supported projects. However, it proved almost impossible to obtain information and data on privately financed facilities and facilities constructed and renovated with funds from other public agencies (e.g., state housing finance agencies; local housing authorities; etc.). As a result, data on facilities financed through sources other than the state MR/DD agency are quite sketchy. While information collected on projects financed through such alternate sources is insufficient to support any firm, nationwide findings and conclusions, we have attempted to highlight some of the related activities currently underway in a few states which furnished data and draw several tentative generalizations.

Finally, copies of a preliminary draft of this report were shared with both the contact person and, where different, the state MR/DD director in each responding state. These individuals were asked to verify the accuracy of the data presented on his or her state and offer general comments on the treatment of the reported data. Respondents from 25 states returned suggested revisions. Four additional states reported that the data on their state was correctly reported. The reported corrections were then made in the preliminary report and the final, revised version was prepared,

It should be noted that, while this report is based largely on the responses from the in-depth telephone interviews, the Association's staff has used the original materials sent to NASMRPD by the state contact persons to verify data where questions arose and to supplement the information received over the telephone. In many instances, however, we found it difficult to make direct comparisons between states, based on their published budgets, due to differences in budgetary formats and variations in the types and extent of information included in such documents. In these instances, we have included selected vignettes to illustrate the general impressions we obtained from reviewing the material collected during the course of the survey.

IV. LIMITATIONS OF THE SURVEY

A survey of this type has certain inherent limitations. It is important that readers are aware of these limitations as they review the document.

First, survey information and data was obtained exclusively from state mental retardation officials and, as a result, does not necessarily reflect the total picture of capital construction and renovation activities underway within any given state. Although the interview schedule includes a number of questions about current and anticipated capital improvement projects which are being funded through non-public sources, as well as through public agencies other than the state MR/DD agency, in many instances the respondents either were unaware of such activities or were able to offer only incomplete, sketchy information. It is possible that the overall capital improvement picture in some states might be significantly different if we had a clear, comprehensive view of all the capital construction/renovation projects underway or planned, regardless of the source of funding.

However, to our knowledge, there is no readily available source of information concerning non-state funded projects at this time—short of a costly, time-consuming on-site review in each state. The expense of any such undertaking would have far exceeded the resources available to complete the current survey. Further, while federal, state and local housing agencies have begun to finance the construction of community residential facilities for developmentally disabled persons in several states, the dollar impact of this relatively recent, but potentially important, source of capital financing is still of limited significance. Thus, while the number and costs of such projects, no doubt, are under-reported in the current study, the inclusion of complete and accurate figures, in all probability, would not alter the overall capital construction picture greatly in the vast majority of states.

Second, in a related vein, since all of the respondents were state employees, it is quite possible that their views on subjective questions (e.g., capital improvement problems) may not reflect the viewpoints of all of the various interest groups in the state—especially on such a highly controversial question as how, where and when to commit capital construction dollars. To minimize this problem, the project staff attempted to limit the number of subjective/impressionistic questions to an absolute minimum.

Third, since each state has its own definition of what constitutes a capital improvement project and varying approaches to budgeting for them, the project staff found it extremely difficult to develop interstate comparisons which are statistically reliable. In part, this problem grows out of the varying approaches to expending capital construction dollars in the states and the lengthy time frame frequently involved in carrying out major construction projects. Some states, for example, appropriate the

total funds necessary to complete a major construction project in one year's budget and then carry unused dollars forward into future budget periods; others include only the dollars expected to be used in the particular fiscal year for a multi-year construction project. In order to partially compensate for this phenomenon, the staff requested data on capital construction appropriations in each state for a period of three fiscal years (FY 1978-80). However, we now realize that, in some instances, a more extended time frame would be necessary to gain a wholistic picture of construction/renovation trends in certain states. For example, it became clear during the survey that some states made extensive dollar commitments for capital improvements during the early or mid-1970's and, as a result, were planning only modest capital outlays during the three year period selected for study. Conversely, several states which had limited capital commitments during the earlier years of the decade were committing significant sums during the study period. The point is, if viewed from a broader historical perspective (say over a ten to fifteen year period), the comparative capital improvement commitments of these two types of states might not differ as significantly as it appears in this study.

A fourth limitation consists of inaccuracies due to the basic methodology. The majority of information was secured through telephone interviews. The accuracy of the data obtained has not been verified with any independent sources. While, as indicated above, the staff asked all respondents to review and make corrections in the recorded responses to the telephone survey questions and later sent them a preliminary copy of the report for verification, nonetheless, it is still possible that recording and transmission errors have occurred.

One final limitation is that of definitional differences. States vary in the ways they define a "capital construction project." Some include both major and minor construction/renovation projects. Others do not. Often a dollar limit is used to define projects which are labeled as capital projects in any given state, but these criteria differ from state to state. Furthermore, a state may or may not include "fixed expenditures" in its capital budget. To further complicate these definitional problems, what constitutes a "community" or "institutional" project is not always clearly discernable in the budget. If a state does budget for community facilities, the capital expenditure figures are often combined with institutional improvement/renovation projects in a manner which is difficult to account for separately. In addition, in some states small group residences built near the grounds of a state institution are deemed to be "community residences" and, in others, part of the institution's capital construction budget.

In summary, any conclusions about the policy implications of the reported data should be developed with considerable caution. Due to variations among the states (e.g., length of their respective budgetary processes; sources of capital financing; the general lack of budgetary data on facilities other than state-owned

facilities; and the definitional question), as well as the complex issues involved (e.g., the effect of capital budgets on Title XIX operating reimbursements and overall deinstitutionalization efforts), it is extremely difficult to draw valid, generalizable conclusions about the meaning of the aggregated data. In some instances, we found the only reasonable course of action was to offer suggestive interpretations of the data based on our grasp of current programmatic developments in the fifty states. Obviously, this approach is fraught with potential pitfalls, not the least of which is the unique vantage point from which the Association's staff observes current developments in the field.

V. THE CAPITAL BUDGETING PROCESS

At the outset, the project staff recognized that a basic understanding of each state's budgetary process would be an essential prerequisite to understanding the capital improvement plans of the states, as they affect mental retardation facilities. For this reason, each interview began with a series of questions concerning how the particular state went about budgeting for capital improvement projects involving mental retardation facilities.

The responses we received demonstrated that the basic process is quite similar in most states.* In general, the state agency responsible for administering mental retardation programs initiates the process by requesting an amount for specified capital improvement projects during any given fiscal period. This request, which frequently lists proposed construction/renovation projects in order of priority, is reviewed by the state budget agency (which is generally located in the Governor's office or the department of administration/finance); after modifications have been made by the budget agency, MR capital construction requests are consolidated with those of other state agencies and submitted to the legislature, usually as part of the Governor's annual/biennial budget. The legislature, in turn, is responsible for reviewing, modifying, and appropriating funds for all state capital improvement projects. Finally, in the vast majority of states (42 out of 50 + D.C.), the Governor may eliminate a legislatively approved capital construction project by exercising his item veto authority.**

Despite the basic similarities of the approaches to budgeting used in most states, there are some significant differences which emerged from the survey. First, while a majority of states (31 + D.C.) budget for capital improvements on an annual basis, 19 states maintain a biennial budget cycle (see Tables III and IV). Among the states which budget biennially, some states divide their total appropriation into two, 12-month allotments.

For the present study, capital appropriation request figures were solicited on an annual basis for fiscal years 1977-78, 1978-79 and 19 79-80. In those instances where biennium budget states broke down their appropriation request figures on an annual basis, we have reported them in this fashion. In cases where the biennium appropriation was not divided by year, we have arbitrarily divided the total into two equal amounts and assigned one-half to each fiscal year period covered in the study. Thus, for example,

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* Further details can be found in Budgetary Processes of States: A Tabular Display, National Association of State Budget Officers, Washington, D.C, December 1977.

** For additional information, see The Book of the States: 1978-79, Vol. 22, The Council of State Governments: Lexington, Kentucky, April 1978, pp. 44-45 and 142-143.

Wisconsin reported a FY 1977-79 biennium appropriation of $5.3 million for mental retardation capital improvement projects. Of this total amount, $2.7 million has been assigned to FY 1977-78 and FY 1978-79, respectively.

Second, mental retardation agencies in the 50 states prepare and submit their capital construction/renovation requests in different formats. Eleven (11) respondents indicated that their states publish a separate, capital improvement budget; thirteen (13) also indicated that capital improvement projects are included in a separate section of the Governor's operating budget, while two (2) said such requests are integrated in the Governor's operating budget, according to function, agency or activity. Most of the remaining states (2 3) employ some combination of the above approaches. Finally, in two states (Mississippi and South Carolina) a legislative (or combined legislative/executive committee/board) is responsible for developing both the operating and capital budgets, based on requests submitted by the various executive branch agencies. A state-by-state summary of capital budgeting formats is contained in Table I.

Third, the definition of what constitutes a capital construction/ renovation project varies from state to state. Over half the states (29) used a specific dollar figure in defining what constitutes a "capital construction project." The minimum cost threshold for a capital project ranged from a high of "over $50,000" in Alaska, Connecticut, Maryland, New Jersey, Oregon and Wyoming to a low of "over $2,500" in Florida. States which did not apply a dollar limit (as well as some which did) tended to define a capital construction project in terms of the useful life of the building under construction or renovation (i.e., more than five years; more than ten years; etc.). The responses of various states are summarized in Table I.

Most states (34 out of 50 respondents) include the cost of fixed equipment in their capital construction budgets. However, a few states (6) do so only in the case of new construction projects; others include all items of equipment (including fixed equipment) in their operating budgets (10 states). Table I includes an analysis of the survey responses to this question.

Thirty (30) respondents indicated that their states issue revenue bonds to finance mental retardation capital construction projects (see Table II). Of this number, only Hawaii, Illinois, New Jersey, Rhode Island, Washington and Wisconsin reported that general obligation bonds are floated to finance such projects.

For the most part, states use bond revenues to finance the construction and renovation of state-owned and operated residential facilities for the mentally retarded (see Table II). Of the 30 states using bond financing, 29 reported using bond revenues to construct state-operated residential facilities and 18 said that public daytime service facilities also are constructed/renovated

TABLE I STATE
CAPITAL BUDGETING PROCESS

STATE	BUDGET FORMAT	MINIMUM REQUIREMENT OF CAPITAL CONSTRUCTION PROJECT	FIXED EQUIPMENT INCLUDED IN CAPITAL COSTS
Alabama	A	no specific criteria	no
Alaska	C	cost over $50,000; life expectancy over 5 years	yes
Arizona	C	no specific criteria	yes
Arkansas*	C	no specific criteria	no
California	B	cost over $20,000	yes
Colorado	A	cost over $10,000	yes
Connecticut	B	cost over $50,000	no
Delaware	C	life expectancy over 10 yrs.	no
D.C.	B	NA	yes
Florida	E	cost over $2,500	yes
Georgia	B	cost over $15,000	yes
Hawaii*	B	cost over $4,000	no
Idaho	C	no specific criteria	yes
Illinois	A	cost over $5,000	yes
Indiana*	B	cost over $1,000	new const. only
Iowa*	D	no specific criteria	yes
Kansas	C	cost over $5,000	new const. only
Kentucky*	F	no specific criteria	yes
Louisiana	C	no specific criteria	yes
Maine*	B	no specific criteria	yes
Maryland	C	cost over $50,000; permanent	new const. only
Massachusetts	A	cost over $10,000	new const. only
Michigan	A	cost over $25,000	yes
Minnesota*	A	no specific criteria	yes
Mississippi	G	major repairs costing over $200,000 included	yes
Missouri	A	no specific criteria	yes
Montana*	D	only major renovation/ const. projects	yes
Nebraska	A	cost over $5,000	yes
Nevada*	A	cost over $5,000	yes
New Hampshire*	C	only major renovation/ const. projects	yes
New Jersey	C	cost over $50,000	yes
New Mexico	C	cost over $20,000	no
New York	B	only major renovation/ const. projects	yes
North Carolina*	B	no specific criteria	yes
North Dakota*	C	no specific criteria	yes
Ohio*	F	cost over $25,000; life expectancy over 25 yr.	yes
Oklahoma	A	no specific criteria	no
Oregon*	E	cost over $50,000	yes
Pennsylvania	C	cost over $25,000	no
Rhode Island	C	"long-term" life expectancy; minor repairs not included	yes
South Carolina	G	cost over $10,000	yes
South Dakota	#	no specific criteria	no
Tennessee	B	no specific criteria	no
Texas*	E	cost over $200,000	yes
Utah	C	cost over $8,000	yes
Vermont*	A	cost over $25,000	yes
Virginia*	B	cost over $10,000	yes
Washington	C	cost over $200,000**	new const. only
West Virginia	B	no specific criteria	NA
Wisconsin*	B	cost over $30,000	new const. only
Wyoming*	C	cost over $50,000	no

LEGEND: A Separate capital improvement budget
B Separate section of Governor's operating budget
C Both A and B above
D Integrated in state's regular operating budget
E A, B and D
F Both B and D
G Prepared by legislature (or joint legislative/ executive) committee/board

NOTES: NA Information not available
South Dakota capital funds are specified in special legislative appropriations for a specific purpose as needed,
* Biennial budget cycle
** Under $200,000 deemed "Capital Omnibus Appropriation* in Governor's Operating Budget

TABLE II

STATES' USE OF BOND FINANCING AND LONG RANGE PLANNING FOR CAPITAL CONSTRUCTION PROJECTS

STATE	REV. BONDS USED	TYPES OF BOND-FINANCED PROJS. STATE RES.	STATE NON-RES.	PRIVATE RES./ NON-RES.	LONG RANGE CAPITAL CONST. PLAN	YEARS PROJ.	$ NEEDS INCL.
Alabama	yes	X			yes	5	no
Alaska	yes	X	X	X	no	-	-
Arizona	no				yes	5	yes
Arkansas	yes	X			yes	5	yes
California	no				yes	5	yes
Colorado	no				yes	6	yes
Connecticut	yes	X			yes	5	yes
Delaware	yes	X			yes	6	yes
D.C.	no				yes	5-10	yes
Florida	no#				yes	5	no
Georgia	yes	X	X		yes	5	no
Hawaii*	yes	X	X	X	yes	6	no
Idaho	no				yes	10	yes
Illinois*	yes	X	X	X	yes	5	yes
Indiana	no				yes	3-5	yes
Iowa	no				yes	5	yes
Kansas	no				no	5	no
Kentucky	yes	X			yes	4	no
Louisiana	yes	X	X		NA		
Maine	no				yes	4	no
Maryland	yes	X	X		yes	5	yes
Massachusetts	yes	X	X		yes	-	-
Michigan	no	X	X		no	-	-
Minnesota	yes	X	X		yes	5	no
Mississippi	yes	X	X	X	yes	5	yes
Missouri	yes		X		yes	5	yes
Montana	no				yes	2-5	yes
Nebraska	no				yes	5	yes
Nevada	no				yes	5-10	yes
N. Hampshire	yes	X	X		yes	6	yes
New Jersey*	yes	X	X	X	yes	7	yes
New Mexico	yes	X			yes	5	no
New York	no				yes	5	no
N. Carolina	no				no	-	-
North Dakota	no				yes	2-4	no
Ohio	yes	X	X	X	yes	6	yes
Oklahoma	yes	X			yes	5	yes
Oregon	no				yes	6	yes
Pennsylvania	yes	X	X		yes	5	yes
Rhode Island*	yes	X	X	X	yes	12	yes
S. Carolina	yes	X	X		yes	5	yes
South Dakota	yes	X			no	-	-
Tennessee	no				yes	5	yes
Texas	no				no	-	-
Utah	yes	X	X		yes	5	yes
Vermont	yes	X			yes	10	yes
Virginia	yes	X			yes	4	yes
Washington*	yes	X	X		yes	6-10	no
West Virginia	no				yes	3	no
Wisconsin**	yes	X	X		yes	2	yes
Wyoming	yes	X			yes	10	yes

NOTES: * General obligation bonds
** Wisconsin uses general obligation bonds to finance its capital construction program of projects in excess of $250,000.
NA Information not available
Bonds are used to buy land for residential facilities and develop recreational parks for mentally retarded persons, but not for the construction/renovation of facilities.

with the proceeds from the sale of state bonds. However, a few states (6) finance the construction of privately-owned and operated facilities through such bond issues. Among the latter states are Alaska, Hawaii, Illinois, Mississippi, New Jersey and Ohio.

Finally, most states (44) reported that long range capital construction plans are developed and maintained, usually by the state mental retardation agency. These plans generally cover a period of from 5 to 12 years beyond the current fiscal year. In over one-half of the cases, the plans include estimates of the dollar costs of future mental retardation-related construction projects (see Table II for a state-by-state breakdown of responses). Plans in the remaining states contain only projections of future program/service needs.

VI. AN ANALYSIS OF STATE APPROPRIATIONS FOR CAPITAL CONSTRUCTION PROJECTS: FY 1977-80

A. Overview.

One of the primary aims of the present study was to determine the overall scope of mental retardation capital construction activities within the states. In developing its study plans, the NASMRPD staff recognized that budgetary data from any given fiscal year would tend to provide an incomplete and, perhaps, misleading picture of the level and types of capital construction activity within the states. At the same time, the staff was conscious of the fact that it would be extremely difficult, given the limited scope of the study, to gather reliable data from the states for other than recent fiscal periods. As a compromise, fiscal years 1977-78, 1978-79 and 1979-80 (i.e., July 1, 1977 - June 30, 1980) were selected as the study period. It was assumed that most states would have budgetary data on this three year period readily available. Even though the staff recognized that some state legislatures would not have completed action on FY 1979-80 appropriations, it was felt that such requests would be far enough advanced in the budgetary process to yield reasonably reliable estimates of each state's overall dollar commitment to mental retardation capital construction projects.

The staff's initial assumption about the state's capability of furnishing data on the selected fiscal years is borne out by the survey results. A total of 49 states (plus D.C.) furnished the requested data; of this number, 44 provided complete data on all three fiscal years.

During the three year period covered by the study, the survey respondents reported that state governments had appropriated* $993 million for mental retardation capital improvement projects.** Aggregate appropriations for all reporting states was $282 million in fiscal year 1977-78, $358 million in FY 1978-79 and $353 million in FY 1979-80. Since no comparable

* Includes FY 1979-80 request levels in states where final action had not been taken on pending money bills as of the time of the survey interview. In some instances, final FY 1979-80 appropriations figures were reported by such states when the preliminary report was sent out for review and verification.

** In instances where the state operated on a biennial budget cycle, the total biennium appropriation was divided equally between the two, 12-month periods, unless the state respondent reported a different division. This step was taken to gain a more accurate assessment of the states' relative obligations for mental retardation capital construction projects.

statistics are available on state appropriations for previous fiscal periods, it is not possible to determine whether capital outlays during the FY 1977-80 period represents a comparative increase or decrease.

An examination of figures contained in Table III makes it clear that some states have considerably more ambitious capital improvement plans than others. Indeed, actual and projected capital appropriations in the top five states (California, New Jersey, New York, Ohio and Michigan) account for over one-half (52%) of the total appropriations in the 50 reporting jurisdictions during the three year period. If figures from the five states with the sixth through the tenth highest total appropriations (Connecticut, Florida, Washington, Iowa and Massachusetts) are included, we would find that the top ten states in terms of capital outlays would account for almost three-quarters (71.5%) of all state capital appropriations for construction/renovation of mental retardation facilities.

States might be grouped roughly into the following four categories:

States with High Capital Appropriations (over $40 million)

1.	Ohio	(6)
2.	California	(1)
3.	New Jersey	(9)
4.	Michigan	(8)
5.	New York	(2)
6.	Massachusetts	(10)
7.	Washington	(22)

States with Moderate to High Capital Appropriations (between $10-40 million)

8.	Iowa	(26)
9.	Florida	(7)
10.	Connecticut	(24)
11.	Illinois	(5)
12.	Missouri	(15)
13.	Louisiana	(20)
14.	Texas	(3)
15.	Indiana	(12)
16.	Pennsylvania	(4)
17.	Minnesota	(19)
18.	South Carolina	(25)
19.	Tennessee	(17)
20.	Utah	(36)
21.	Mississippi	(31)

TABLE III
ACTUAL AND ANTICIPATED CAPITAL APPROPRIATIONS
FOR MENTAL RETARDATION FACILITIES: FY 1978-80
(in thousands of dollars)

STATE	July 1-June 30 1976-77 (FY 1977)	July 1-June30 1977-78 (FY 1978)	July 1-June30 1978-79 (FY 1979)	July 1-June30 1979-80 (FY 1980)	July 1-June 30 1980-81 (FY 1981)
Alabama		NA	NA	NA	
Alaska		80	925	350	
Arizona		897	1,856	2,111	
Arkansas		835		1,280	
California		39,000	55,686	43,812	
Colorado		85	53	8,600	
Connecticut		12,500	6,127	6,586	
Delaware		578	368	280	
D.C.		NA	1,667	2,000	
Florida		6,827	2,935	15,866	
Georgia		2,415	1,811	801	
Hawaii		680	1,038		
Idaho		728	496	198	
Illinois		12,419	5,819	6,424	
Indiana		10,053		15,500	
Iowa		11,300	7,200	8,100	
Kansas		NA	890	2,849	
Kentucky		15	9,337		
Louisiana		3,251	3,372	11,763	
Maine		1,200	650	1,280	
Maryland		731	2,439	2,203	
Massachusetts		7,085	14,500	37,950	
Michigan		18,800	47,900	7,000	
Minnesota		8,748		16,164	
Mississippi		4,470	6,039	NA	
Missouri		10,158	6,041	4,398	
Montana		230	1,250	150	
Nebraska		500	NA[a]	1,468[a]	
Nevada		1,900	0	828	
New Hampshire		226	879		
New Jersey		5,797	30,000	52,000	
New Mexico		1,126	3,656	225	
New York		22,150	18,160	24,274	
North Carolina		878	3,208	NA	
North Dakota		1,580		1,530	
Ohio		110,100		80,000	
Oklahoma		NA	2,227	3,178	
Oregon		1,431		631	
Pennsylvania		6,450	6,450	4,600	
Rhode Island		0	100	308	
South Carolina		1,447	7,430	3,980	
South Dakota		679	1,659	448	
Tennessee		5,760	5,303	NA	
Texas		11,433		13,903	
Utah		3,534	3,698	3,530	
Vermont		1,169		590[b]	
Virginia		6,992		4,445	
Washington		37,956		41,000	
West Virginia		185	4,928	107	
Wisconsin		5,347		4,373	
Wyoming		301	175		
TOTALS		$ 281,593 * (47 states)	$ 358,381 * (49 states)	$ 353,384 * (47 states)	

NOTES: NA figures not available

In instances where a state budgets on a biennium basis, one-half of the appropriated/requested amount has been included in the appropriated column. Thus, for example, $47,750,000 of the total FY 1976-78 biennium appropriation for capital improvements ($95,500,000) in Ohio has been assigned to FY 1977-78 column and, similarly, $5,027,000 of the FY 1977-79 appropriation ($10,053,000) in Indiana has been assigned to FY 1977-78 and one-half to FY 1978-79. However, some states (including Iowa, Maine, Montana, Nevada, North Carolina, Vermont) broke down their biennium appropriation on an annual basis. This **data** is so reported in the above **table.**

An injunction against any expenditure of capital construction or remodeling appropriations (including those necessary to meet Title XIX Standards) has been imposed by the U.S. District Court in Omaha, Nebraska. As such, the amount indicated are planned outlays.

Legislature appropriated capital dollars on a yearly basis in FY 1980.

States with Moderate to Low Capital Appropriations (between $5-10 million)

22.	Kentucky	(23)
23.	Virginia	(13)
24.	Colorado	(28)
25.	Wisconsin	(16)
26.	Oklahoma	(27)
27.	Maryland	(18)
28.	West Virginia	(34)
29.	Georgia	(14)
30.	New Mexico	(37)

States with Low Capital Appropriations

31.	Arizona	(29)
32.	North Carolina	(11)
33.	Kansas	(32)
34.	D.C.	(45)
35.	Maine	(38)
36.	South Dakota	(44)
37.	Nevada	(46)
38.	North Dakota	(47)
39.	Nebraska	(35)
40.	Vermont	(49)
41.	Oregon	(30)
42.	Montana	(43)
43.	Arkansas	(33)
44.	Idaho	(41)
45.	Hawaii	(40)
46.	Alaska	(50)
47.	Delaware	(48)
48.	New Hampshire	(42)
49.	Rhode Island	(39)
50.	Wyoming	(51)

(under $5 million)

Of course, this ranking is based on total actual/requested capital appropriations and, thus, does not take into account differences in population which could be expected to account for at least some of the state-by-state variations in capital outlays. For this reason, the state's relative rank in total population, as of July 1, 1978, is indicated in parentheses to the right of the name of the state (also see discussion below of comparative per capita outlays for institutional improvement projects).

B. Basic Aims.

In addition to determining the aggregate dollar value of capital improvement projects in the states during the three year period, the survey was designed to find out the types of projects which are being financed. Respondents were asked to breakdown all state-funded construction/renovation projects into the following categories: (a) *state* owned and operated *residential* facilities; (b) *state* owned and operated *non-residential* facilities; (c) *privately* owned and operated *residential* facilities; and (d) *privately* owned and operated *non-residential* facilities.

An analysis of the reported data indicates that the states planned to obligate the vast majority of capital appropriations for construction and renovation projects on the grounds of existing state-operated residential facilities. Of the

aggregate amount appropriated/requested for capital improvement projects over the three-year period ($993,358,000), 82.7 percent was earmarked for institutional construction/ renovation projects (see Table IV). All 50 reporting jurisdictions indicated that at least some portion of their capital improvement budgets over the three-year period would be devoted to institutional improvement projects. In fact, 33 of the states which furnished data, or 66 percent of the total, indicated that their entire FY 1977-80 capital improvement budgets would be obligated for such institutional improvement projects.

During the three-year period, 13 states (Arkansas, Connecticut, Illinois, Maine, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New York, Ohio, Rhode Island and Utah) reported plans to construct community-based residential facilities, with an aggregate value of $98.1 million. Forty-one percent of these actual and projected appropriations were concentrated in one state, Ohio, which maintains a unique state capital development fund. Originally authorized under a voter referendum approved in 1968, the Ohio Mental Health Facilities Improvement Fund was established to finance the construction and renovation of mental health and mental retardation facilities across the State. Capital for the Fund is furnished through the sale of state revenue bonds. Proceeds from the sale of such bonds are used to support improvements in state-operated residential facilities, to construct and renovate community-based residential facilities operated by private, non-profit organizations and to build community training centers operated by county mental retardation boards. Funds to support projects in specified areas of the state, however, are contingent on approval by the Ohio Legislature of the Governor's biennial capital budget request.

As in the case in Ohio, in 10 out of 11 remaining jurisdictions, community-based residential facilities which are being financed through state capital improvement funds will be privately owned and operated by non-profit corporations.* For example:

- The Massachusetts Department of Mental Health has requested $5 million in the Governor's FY 1979-80 budget to renovate community residential facilities operated by non-profit organizations.

- In FY 1977-78, 1978-79 and 1979-80, the New York Office of Mental Retardation and Developmental Disabilities received a total of $6.2 million to match the local/ private share of the cost of constructing community residences under its program of Capital State Aid for

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It should be noted that some states (e.g., South Dakota and Colorado) are prohibited by state law or constitution from expending tax revenues to construct or renovate non-state owned buildings.

TABLE IV
TYPES OF CAPITAL IMPROVEMENT PROJECTS OUTLINED IN STATE BUDGETS: FY 1977-80 (in thousands of dollars)

State	Total Cap. Approp. Approved FY 1978-79	Total Cap. Approp. Requested FY 1979-80	Total Cap. Approp. Approved FY 1978-79	TYPE OF PROJECTS			
				New Constr./Renov. of Existing State Res. Fac.	%	Constr. of Comm.-Based Res. Fac.	Constr. of Comm.-Based Non-Res. Fac.
Alabama	NA	NA	NA	NA	NA	0	0
Alaska	1,005	350	1,355	755	56	600	0
Arizona	2,753	2,111	4,864	4,864	100	0	0
Arkansas *	835	640	1,475	1,377	93	0	98 ***
California	94,686	43,812	138,498	138,498	100	0	0
Colorado	138	8,600	8,738	8,738	100	0	0
Connecticut	18,627	6,586	25,213	9,000	36	16,213***	0
Delaware	946	280	1,226	1,226	100	0	0
D.C.	1,667 #	2,000	3,667	3,667	89	0	0
Florida	9,762	15,866	25,628	25,628	100	0	0
Georgia	4,226	801	5,027	5,027	100	0	0
Hawaii *	859	519	1,378	1,078	78	0	300 ***
Idaho	1,224	198	1,422	1,355	95	0	67 ***
Illinois	18,238	6,424	24,662	12,762	52	11,900***	0
Indiana *	10,053	7,750	17,803	17,803	100	0	0
Iowa *	18,500	8,100	26,600	26,600	100	0	0
Kansas	890 #	2,849	3,739	3,739	100	0	0
Kentucky *	4,676	4,669	9,345	9,345	100	0	0
Louisiana	6,623	11,763	18,387	18,387	100	0	0
Maine *	1,850	1,280	3,130	2,430	78	700***	0
Maryland	3,170	2,203	5,373	3,820	94	1,553 ***	0
Massachusetts	21,585	37,950	59,535	54,535	92	5,000	0
Michigan	66,700 #	7,000	73,700	73,700	100	0	0
Minnesota *	8,748	8,082	16,830	16,225	96	605***	0
Mississippi	10,510	NA	10,510	10,510	100	0	0
Missouri	16,199	4,398	20,597	20,597	100	0	0
Montana *	1,480	150	1,630	1,450	89	180	0
Nebraska	500	1,468	1,968	1,968	100	0	0
Nevada *	1,900	828	2,728	2,728	100	0	0
New Hampshire *	553	440	992	992	100	0	0
New Jersey	35,797	52,000	87,797	77,500	88	8,300***	1,997 **
New Mexico	4,782	225	5,007	5,007	100	0	0
New York	40,310	24,274	64,584	39,382	61	12,162##	13,040 ***

State	Total Cap. Outlays Appropriated FY 1978-79	Total Cap. Outlays Requested FY 1979-80	Total Cap. Outlays Approp. & Req. FY 1978-79	TYPE OF PROJECTS			
				New Constr./Renov. of Existing State Res. Fac.	%	Constr. of Comm.-Based Res. Fac.	Constr. of Comm.-Based Non-Res. Fac.
North Carolina *	4,086	NA	4,086	4,086	100	0	0
North Dakota	1,580	765	2,345	2,345	100	0	0
Ohio *	110,100	40,000	150,100	51,250	34	40,700***	58,150**
Oklahoma	2,227 #	3,178	5,405	5,405	100	0	0
Oregon *	1,431	315	1,746	1,746	100	0	0
Pennsylvania	12,900	4,600	17,500	17,500	100	0	0
Rhode Island	100	308	408	300	74	50***	58 **
South Carolina	8,877	3,980	12,857	12,857	100	0	0
South Dakota	2,338	448	2,786	2,786	100	0	0
Tennessee	11,063	NA	11,063	11,063	100	0	0
Texas *	11,433	6,952	18,385	18,385	100	0	0
Utah	7,232	3,530	10,762	10,534	97	128***	100 ***
Vermont *	1,169	590	1,759	1,759	100	0	0
Virginia *	6,992	2,222	9,214	9,214	100	0	0
Washington *	37,956	20,500	58,456	58,456	100	0	0
West Virginia	5,113	107	5,220	5,220	100	0	0
Wisconsin *	5,347	2,186	7,533	7,533	100	0	0
Wyoming *	237	87	324	324	100	0	0
TOTALS	$639,973	$353,384	$993,358	$821,456		$98,091	$ 73,810

NOTES: NA figures not available

* State budgets for capital expenditures on a biennial basis. In instances where the bienniura covers more than the designated fiscal years (i.e., FY 1976-78 and FY 1979-81), one-half of the biennium appropriation/request figure has been included in the appropriate column.

** state owned and operated ***
privately owned and operated

\# FY 1977-78 figures unavailable: includes only FY 1978-79 appropriation

In New York, community-based residential facilities are both state and privately operated. Of the total shown ($12,162,000) $6 million will be expended for state operated facilities while 56,162,000 will be expended for privately operated facilities.

[a] Does not include anticipated capital outlays under the Division of Developmental Disabilities' recently announced plans to build 33 new conmunity residences, since construction funds are being raised through the sale of certificates of participation to private investors (see discussion on p. 65) .
Does not include construction financed through the Department of Mental Health's Alternative Intermediate Services program since capital costs are privately financed and amortized through ICF/MR reimbursements (see discussion on p. 64).

Development of Community Programs. In addition, a total of $6 million was obligated for the construction/ acquisition of community residences out of the capital budgets of state institutions during this same period.

- The Maryland Mental Retardation Administration has requested $450,000 from the State General Assembly in FY 1979-80 to cover the cost of acquiring, constructing and/or renovating privately operated group homes, each of which will be designed to accommodate eight residents and two houseparents.

Illinois offers a slight variation on this general approach. The Illinois Legislature, in the mid-1970's, authorized the construction of five Specialized Living Centers for mentally retarded residents. These 64 to 100 bed comprehensive, 24-hour care centers are owned by the State, but they are to be operated by private, non-profit organizations, under contract with the State Department of Mental Health and Developmental Disabilities.

Only eight states reported plans to construct community-based *non-residential* facilities (e.g., sheltered workshops, training centers, adult activity centers, etc.) with state funds appropriated during the PY 1977-80 period. The total estimated cost of such facilities is $73.8 million. Over three-quarters of the amount ($58.2 million, or 78.9 percent) results from Ohio appropriations, which have been earmarked for the construction of county-owned and operated training centers for mentally retarded persons. An additional 17.6 percent of this total is accounted for by the capital improvement plan of New York which will obligate $13 million for the construction of community daytime service facilities, operated by non-profit organizations, over the three year period. New York's projects will be financed through the State's program of Capital State Aid for the Development of Community Programs.

Of the eight states planning to finance the construction of community-based non-residential facilities, five indicated that these facilities would be owned and operated by private organizations (Arkansas, Hawaii, Indiana, New York and Utah), while planned facilities in the remaining three states would be owned and operated by the state mental retardation agency (Rhode Island, Ohio and New Jersey).*

c. Comparative Per Capita Appropriations.

In order to develop a clearer picture of each state's relative obligations for capital improvement projects over the three year study period, the NASMRPD staff compared the state's

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* In addition, in Utah $30,000 in reprogrammed funds was requested in FY 1979-80 for construction of a service facility at Utah State University.

aggregate appropriations for institutional construction/ renovation projects with the total population in state-operated residential facilities, as of June 30, 1978. Based on these figures, average per capita appropriations were calculated on each state over the three year period. Institutional construction/renovation appropriations were chosen as the basis for comparison (i.e., rather than total state capital outlays), both because the relative size of the resident population could be expected to influence total dollar outlays and because the vast majority of state dollar commitments, as noted above, were earmarked for such projects. The results of this analysis are contained in Table V.

We found that per capita commitments for institutional construction/renovation projects ranged from a high of $24,205 in Washington State* to a low of $404 in Rhode Island. The median per capita for all states over the three year period was $5,460.

We then categorized the states according to their relative per capita appropriations for institutional improvement projects and found the following:**

States with High Per Capita Outlays (over $10,000)

1.	Washington	(22)
2.	Iowa	(26)
3.	Nevada	(46)
4.	California	(1)
5.	Utah	(36)
6.	Michigan	(8)
7.	Massachusetts	(10)

States with Moderate to High Per Capita Outlays (between $5,000-$9,999)

8.	New Hampshire	(42)
9.	Kentucky	(23)
10.	Ohio	(6)
11.	Missouri	(15)
12.	Alaska	(50)
13.	New Mexico	(37)
14.	Indiana	(12)
15.	Colorado	(28)
16.	Mississippi	(31)
17.	Minnesota	(19)
18.	Louisiana	(20)
19.	Florida	(7)
20.	Arizona	(29)

* Note that this calculation is based on a total state institutional population, as of June 30, 1978, of 2,415. This total, along with institutional population figures from other states, was reported in Mentally Retarded People in State Operated Residential Facilities: Year Ending June 30, 1978, prepared by the Developmental Disabilities Project on Residential Services and Community Adjustment at the University of Minnesota.

** States are ranked by per capita amount within each of the four categories. The number to the right of the name of the state, in parentheses, indicates the state's national ranking in terms of total population.

TABLE V
PER CAPITA APPROPRIATIONS FOR CAPITAL IMPROVEMENTS IN STATE-OPERATED RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED, BY STATE: FY 1977-80

STATE	TOTAL OUTLAYS FOR NEW CONST./RENOVATION, STATE RES. FACILITIES FY 1977-80 #	TOTAL RES. POP. STATE-OPERATED RES. FACILITIES 6/30/78 *	AVERAGE PER CAPITA FOR 3 YR. PERIOD
	(In thousands of dollars)		
Alabama	NA	1,856	NA
Alaska	755	96	7,865
Arizona	4,864	920	5,287
Arkansas	1,377	1,775	776
California	138,498	9,674	14.317
Colorado	8,738	1,413	6,184
Connecticut	9,000	3,080	2,922
Delaware	1,226	538	2,279
D.C.	3,667	1,159	3,164
Florida	25,628	4,584	5,591
Georgia	5,027	2,644	1,901
Hawaii	1,078	475	2,269
Idaho	1,355	427	3,173
Illinois	12,762	6,361	2,006
Indiana	17,803	2,599	6,850
Iowa	26,600	1,378	19,303
Kansas	3,739	1,489	2,511
Kentucky	9,345	1,074	8,701
Louisiana	18,387	3,266	5,630
Maine	2,430	517	4,700
Maryland	3,820	3,226	1,184
Massachusetts	54,535	4,795	11,397
Michigan	73,700	5,833	12,635
Minnesota	16,225	2,855	5,683
Mississippi	10,510	1,832	5,737
Missouri	20,598	2,529	8,145
Montana	1,450	390	3,718
Nebraska	1,968	863	2,280
Nevada	2,728	146	18,685
New Hampshire	992	727	1,365
New Jersey	77,500	7,886	9,827
New Mexico	5,007	690	7,257
New York	39,382	17,747	2,219
North Carolina	4,086	3,971	1,029
North Dakota	2,345	1,093	2,145
Ohio	51,250	6,141	8,346
Oklahoma	5,405	1,956	2,763
Oregon	1,746	1,796	972
Pennsylvania	17,500	9,550	1,832
Rhode Island	300	742	404
South Carolina	12,857	3,409	3,771
South Dakota	2,786	759	3,671
Tennessee	11,061	2,456	4,504
Texas	18,385	12,213	1,505
Utah	10,534	832	12,661
Vermont	1,759	434	4,053
Virginia	9,214	4,061	2,269
Washington	58,456	2,415	24,205
West Virginia	5,220	1,093	4,776
Wisconsin	7,533	2,233	3,373
Wyoming	324	469	691
TOTALS	$821,456	150,457	$ 5,460**

NOTES: * Pop. figures taken from: Mentally Retarded People in State-Operated Residential Facilties: Year Ending June 30, 19 78, Project Report No. 4, DD Project on Residential Services and Community Adjustment, University of Minnesota, Minneapolis, Nov. 1978, p. 15 # In thousands of dollars ** The residential population figures on Alabama have been discounted in calculating this average since capital outlay figures were unavailable on this state. NA Not available

States with Moderate to Low Per Capita Outlays (between $2,001-$4,999)			States with Low Per Capita Outlays (under $2,000)		
21.	West Virginia	(34)	41.	Georgia	(14)
22.	Maine	(38)	42.	Pennsylvania	(4)
23.	Tennessee	(17)	43.	Texas	(3)
24.	Vermont	(49)	44.	New Hampshire	(42)
25.	South Carolina	(25)	45.	Maryland	(18)
26.	Montana	(43)	46.	North Carolina	(11)
27.	South Dakota	(44)	47.	Oregon	(30)
28.	Wisconsin	(16)	48.	Arkansas	(33)
29.	Idaho	(41)	49.	Wyoming	(51)
30.	D.C.	(45)	50.	Rhode Island	(39)
31.	Connecticut	(24)			
32.	North Dakota	(47)			
33.	Oklahoma	(27)			
34.	Kansas	(32)			
35.	Nebraska	(35)			
36.	Delaware	(48)			
37.	Hawaii	(40)			
38.	Virginia	(13)			
39.	New York	(2)			
40.	Illinois	(5)			

It is interesting to note the contrast between the per capita rankings of the states, as shown above, and the rankings by dollar total reported earlier. However, as pointed out earlier, care must be exercised in drawing any firm conclusions regarding the relative commitments of the states because of the narrow time frame of the reported data and other factors (see discussion below).

D. Summary.

It is clear from the data reported above that: (a) the vast majority of state capital improvement dollars are targeted on renovating and modernizing the physical plants of existing publicly-operated residential facilities for the mentally retarded; and (b) the amount of funds being obligated for this purpose varies substantially from state to state, whether we measure in terms of real dollars or per capita appropriations. However, in order to grasp the current dynamics behind public policy in this area, one must seek answers to the following fundamental questions:

- What are the primary factors which are motivating the states to renovate and modernize public residential facilities for the mentally retarded?

- Does the relatively heavy commitment in some states to capital improvements in existing public residential facilities signal a general trend toward "rebuilding" large, isolated institutions?

- How, and to what extent, are federal policies, especially Medicaid policies governing intermediate care facilities for the mentally retarded, influencing state capital expenditures on behalf of mentally retarded citizens?

These questions and other related issues are discussed in the succeeding two sections of this report.

VII. USE OF CAPITAL APPROPRIATIONS FOR TITLE XIX COMPLIANCE

One of the major policy issues which the present study set out to examine was whether existing federal standards applicable to intermediate care facilities for the mentally retarded, in effect, are inducing the states to commit large sums of money to rebuilding existing state institutions which otherwise might be used to develop community residential alternatives. To understand the current choices facing the states, one must begin by examining applicable federal Title XIX requirements, including their origins and purposes.

In 1971, Congress amended Title XIX of the Social Security Act to permit public mental retardation facilities to be certified as intermediate care providers under the federal-state Medicaid program (P.L. 92-223). In order to qualify for certification, P.L. 92-223 specified that the facility (or a distinct part thereof) would have to:

a. have as its primary purpose the provision of health and rehabilitative services to mentally retarded persons;

b. provide a program of "active treatment" for Medicaid-eligible residents;

c. meet standards prescribed by the Secretary of Health, Education, and Welfare; and

d. provide assurances that there would be no diminution of state and local support for the program.

The Department of Health, Education, and Welfare, on January 17, 1974, issued final regulations implementing this so-called ICF/MR program. Included in the Department's rules were a detailed set of operating standards, adapted from the "essential" standards of the JCAH Accreditation Council for Facilities for the Mentally Retarded. A facility was required to meet these standards in order to maintain certification as an ICF/MR provider under Title XIX of the Act.

Since 1974, some 41 states have amended their federal-state Medicaid plan to include intermediate care services for the mentally retarded as a reimbursable service under Title XIX. The latest published figures (based on FY 1977 data) indicate that reimbursements to ICF/MR facilities on behalf of Medicaid-qualified retarded persons in 39 states totaled $974 million. Although more recent data is not available, the comparable figure for the current fiscal year would easily exceed $1 billion and probably come closer to $1.5 billion.

Because the present federal ICF/MR rules require a facility to comply with complex programmatic, environmental and life safety standards in order to maintain its Title XIX certification, some observers have expressed concern that compliance-related expenditures in the states—both in terms of personnel costs and capital

improvements—is siphoning off the fiscal resources necessary to initiate community-based residential and daytime programs. In addition, they are worried that the capital construction dollars required to renovate and modernize buildings on the grounds of large, existing state institutions will lock the states into a long-term commitment to an institutional model of services—a model which many professionals now argue is outmoded and counter-productive.

For this reason, the project staff attempted to determine the proportion of each state's capital improvement budget which is directly related to ICF/MR compliance. In addition, because such renovation projects often are part of a broader state strategy for responding to the needs of retarded citizens who require out-of-home care, the staff wanted to show how decisions about such projects affect overall programmatic developments within the states. In particular, state contact persons were asked to supply figures on the fiscal consequences (i.e./ first year revenue losses) of failure to comply with federal environmental and life safety standards.

Of the 39' jurisdictions which supplied estimates of the percentage of capital expenditures directed toward compliance with ICF/MR standards, 25 indicated that three-quarters or more of their capital outlays during the three year period would be devoted to this purpose (see Table VI). In fact, respondents from 14 states reported that 90 percent or more of their states' capital expen-ditures are earmarked for renovation and modernization projects designed to bring facilities into compliance with federal ICF/MR standards. The remaining 10 states said that anywhere from 17 to 62 percent was being expended on Title XlX-related renovations.

Care must be exercised in the use of this data since: (a) in most instances the estimated percentage is based on the "best guess" of the respondent, rather than a rigorous statistical analysis of available budget data; and (b) a precise definition of what constitutes a "Title XlX-related expenditure" was not provided and, therefore, some respondents may have included types of outlays which others excluded. If more precise data were avail-able, it would not be surprising to find that the estimates pro-vided by some state respondents are off by 10 to 20 percent or more. Despite this rather wide margin of error, it seems highly unlikely that more accurate data would alter fundamentally the conclusion that the need to comply with Title XIX, ICF/MR standards is the predominant factor motivating capital improvement expendi-tures in most states over the three year period covered by the present survey.

This conclusion, however, does not provide prima facie evidence that the states have elected to rebuild existing institutions at the expense of community-based programs. First, one must examine more closely the states' motivation in obligating funds for major institutional renovation/modernization projects.

TABLE VI
STATE CAPITAL EXPENDITURES FOR TITLE XIX COMPLIANCE
IN EXISTING PUBLIC RESIDENTIAL FACILITIES
FOR THE MENTALLY RETARDED: FY 1977-80

STATE	ESTIMATED PERCENTAGE OF OUTLAYS FOR TITLE XIX COMPLIANCE (FY 1977-80)	ESTIMATED ANNUAL REVENUE LOSS FOR NON-COMPLIANCE (in thousands of dollars)
Alabama	NA	NA
Alaska	20	3,000
Arizona	*	*
Arkansas	22	14,694
California	90	12,000
Colorado	90	11,000
Connecticut	30	12,839
Delaware	80	5,100
D.C.	NA	NA
Florida	50	8,000
Georgia	NA	NA
Hawaii	NA	4,000
Idaho	90	9,000
Illinois	NA	7,000
Indiana	80	15,000
Iowa	95	16,000
Kansas	NA	NA
Kentucky	62	23,000
Louisiana	80	14,000
Maine	33	NA
Maryland	NA	NA
Massachusetts	100	60,339
Michigan	90	47,000
Minnesota	80	NA
Mississippi	NA	13,000
Missouri	75	12,000
Montana	17	NA
Nebraska	90	7,000
Nevada	0	0
New Hampshire	NA	764
New Jersey	96	42,800
New Mexico	90	3,000
New York	80	80,000
North Carolina	75	NA
North Dakota	*	*
Ohio	95	28,300
Oklahoma	NA	NA
Oregon	90	NA
Pennsylvania	95	110,000
Rhode Island	NA	NA
South Carolina	75	17,000
South Dakota	100	9,500
Tennessee	95	NA
Texas	30	64,800
Utah	90	14,000
Vermont	50	6,000
Virginia	80	5,500
Washington	86	26,300
West Virginia	35	*
Wisconsin	75	26,000
Wyoming	*	*
TOTAL	-	$ 716,949 (38 states reporting)

Does not participate in federal/state Medicaid program; West Virginia has spent capital dollars during the three-year period, however, in preparation for meeting Title XIX standards in the future.

The NASMRPD staff, based on its ongoing contacts with state program officials, began with the hypothesis that the most important factor influencing patterns of state capital outlays was the potential revenue losses which would be incurred should a state fail to complete renovations in its public residential facilities, as required under ICF/MR standards. In order to test this hypothesis, the staff asked all respondents in states with ICF/MR-certified institutions to estimate the annual revenue loss should their state fail to comply with federal standards.

As indicated in Table VI, 34 states reported projected annual revenue losses of $7 58.8 million if Title XlX-related capital improvement projects were not completed. Pennsylvania reported the largest potential loss ($110 million), followed by New York ($80 million), Texas ($64.8 million), Massachusetts ($60 million), Michigan ($47 million) and New Jersey ($42.8 million). The projected losses in the 29 remaining states ranged from $764,000 in New Hampshire to $36.3 million in Louisiana.

Once again, these estimates should be viewed as "best guesses," since it was clear that most respondents did not have data readily available to substantiate their estimates. Further, no instructions were given to the respondents on how to arrive at such an estimate; as a result, some respondents attempted to distinguish between institutional buildings which would and would not remain eligible for Title XIX certification, while others assumed that the entire state institutional system would lose certification as a result of failure to comply with the state's plan of correction. These differences in estimating techniques, no doubt, resulted in estimates with a wide margin of error.

Despite the lack of precision in the reported data, it seems quite clear that failure to comply with ICF/MR standards in Title XIX-certified state institutions would result in sizable revenue losses for many states. In fact, even those states with relatively ambitious institutional renovation budgets would recover their dollar outlays for such improvements through Title XIX reimbursements in only a two or three year period. For example, Louisiana plans to expend $18.4 million on institutional renovation projects during the FY 1977-80 period to assure continued receipt of $36.3 million annually in Title XIX reimbursements on behalf of Medicaid-eligible residents in state-operated facilities. In other words, in less than six months the funds the state "invested" in those capital improvements will be returned in the form of federal operating reimbursements. Similarly, Iowa will expend $26.6 in FY 1977-80 capital appropriations to renovate and modernize its two state institutions; if the State failed to do so, $16 million in annual Title XIX reimbursements would be sacrificed, or over half the total, one-time cost of these necessary renovations Under the circumstances, there can be little question why state policymakers view Title XlX-related capital improvements as a sound investment of state dollars.

For a variety of reasons, no attempt was made during the course of the survey to distinguish between institutional improvement projects involving new construction and those involving renovation and modernization. First, the staff felt that, because of the different ways in which states categorize capital improvement projects, it would be almost impossible to obtain accurate and reliable data. For example, some states budget for institution-wide "renovation" projects which involve both modernizing existing structures and replacing outmoded, deteriorated or non-functional buildings. Other states break down their capital improvement projects on a building-by-building basis. Second, the practical distinction between a newly constructed building and an existing structure which has undergone extensive renovation are often slight. The net effect is to put "on line" a structure with a life expectancy of 20 to 30 years, with the expectation that it will be used for the purposes for which it was designed. In practice, the decision as to whether to build or renovate comes down to the architect's assessment of the relative cost effectiveness of the two alternatives.

Although no distinction is made in the reported data between new construction and renovation projects, it is important to note that *none of the 50 jurisdictions indicated that they plan to build new public institutions with the capital monies appropriated in FY 1978-80.* * Further, as far as we could ascertain, *none of the reporting states anticipate a net increase in the bed capacity of their existing state-operated residential facilities as a result of the institutional improvement projects funded out of FY 197 7-80 appropriations*. In fact, as indicated in the succeeding section of this report, most states contemplate a net reduction in the populations of their public institutions over the next few years.

The next section of this paper will explore the relationships between state capital improvement budgets and deinstitutionalization planning within the reporting states.

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* As noted below, however, a few states do include plans to construct new public residential facilities for the mentally retarded in their long term capital improvement plans.

VIII. THE RELATIONSHIP BETWEEN CAPITAL APPROPRIATIONS AND DEINSTITUTIONALIZATION PLANS

In addition to examining the trade-off between capital appropriations and Title XIX (ICF/MR) revenues, the project staff wanted to delve into the relationship between the states' current and projected capital improvement plans and their plans to reduce the population of public residential treatment facilities. Our aim was to determine whether any correlation exists between states with heavy commitments to renovating present institutional facilities and their plans to depopulate existing state-run residential facilities. The working hypothesis which we set out to test was that states engaged in major institutional renovation activities would have less ambitious deinstitutionalization/depopulation plans.

It would be a gross over-simplification to suggest that the overall quality of residential services within a state can be measured in terms of deinstitutionalization rates, beds per one hundred thousand population, or other frequently cited indices. Nonetheless, the project staff felt it was essential to examine the states[1] capital budgets in relationship to their deinstitutionalization plans to determine if any correlations existed between these efforts. Therefore, the telephone interview schedule included several questions designed to ascertain whether such a relationship existed within the particular state, and if so, the nature of that relationship.

Of the 50 jurisdictions responding, 39 indicated that a relationship does exist between capital improvement outlays and deinstitutionalization planning in their states. Eleven respondents said that no such relationship exists in their states.

Respondents in 4 2 jurisdictions reported that their states plan to reduce the total population in public institutions over the next two to five years. The states projected population goals for public institutions are shown in Table VII. For comparative purposes, we have included in this table data previously reported in other studies on public institutional populations, as of July 1, 1970 and July 1, 1978.

Table VII demonstrates the gradual but steady decline in the population of public residential facilities which has been occurring over the past eight years. This fact has previously been reported in a number of demographic studies on state institutions.*

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* See, for example, R. Scheerenberger, Public Residential Services for the Mentally Retarded: 1976 and 1977 Editions, National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, 1976 and 1977; and K. Charlie Sakin, Demographic Studies of Residential Facilities for the Mentally Retarded: An Historical Review of Methodologies and Findings, Developmental Disabilities Project on Residential Services and Community Adjustment, University of Minnesota, 1979.

TABLE VII
PAST, PRESENT AND FUTURE POPULATION TRENDS
IN PUBLIC RESIDENTIAL FACILITIES FOR THE
MENTALLY RETARDED

STATE	TOTAL RES. POPULATION PUB. RES. FAC. 6/30/70 **	TOTAL RES. POPULATION PUB. RES. FAC 6/30/78**	EST. TOTAL RES. POPULATION PUB. RES. FAC. 6/30/79 *	TARGET POPULATION NO. *	TARGET POPULATION YEAR *
Alabama	2,204	1,856	1,500	1,400	1981
Alaska	106	96	90	40	1980
Arizona	1,136	920	630	321	1981
Arkansas	1,471	1,775	1,850	1,694	1980
California	11,483	9,674	8,000	7,620	1982
Colorado	2,278	1,413	1,460	1,106	1982
Connecticut	4,353	3,080	2,944	2,425	1985
Delaware	568	538	600	510	1979
D.C.	1,242 #	1,159	828	0	1988
Florida	6,446	4,584	4,123	2,000	1981
Georgia	1,864 #	2,644	NA	NA	NA
Hawaii	753	475	445	350	1981
Idaho	658	427	391	291	1981
Illinois	7,685	6,361	6,262	5,500	1982
Indiana	4,192	2,599	2,300	1,800	1981
Iowa	1,730	1,378	1,384	NA	NA
Kansas	2,117	1,489	1,383	900	1983
Kentucky	1,046	1,074	911	NA	NA
Louisiana	3,358	3,266	3,167	3,167	-
Maine	793	517	450	400	1980
Maryland	3,622	3,226	2,869	2,000	1990
Massachusetts	7,928	NA	4,785	1,555	1985
Michigan	11,873	5,833	5,670	3,863	1982
Minnesota	3,910	2,855	2,760	2,600	1981
Mississippi	1,861	1,832	1,880	679	1985
Missouri	2,510	2,529	2,600	NA	NA
Montana	868	390	380	300	1981
Nebraska	1,653	863	808	710	1980
Nevada	0	146	162	162	-
New Hampshire	1,167	727	605	505	1981
New Jersey	6,846	7,886	7,490	5,602	1982
New Mexico	683	690	400	NA	NA
New York	26,203	17,747	15,500	10,067	1982
N. Carolina	5,195	3,971	3,286	NA	NA
N. Dakota	1,351	867	NA	NA	NA
Ohio	11,118	6,577	6,354	4,735	1981
Oklahoma	2,194	1,956	2,100	2,100	-
Oregon	2,997	1,796	1,760	1,360	1985
Pennsylvania	11,516	9,550	7,450	5,000	1984
Rhode Island	1,136	742	715	393	1984
S. Carolina	3,874	3,409	3,500	2,950	1984
S. Dakota	1,197	759	727	455	1985
Tennessee	2,814	2,456	2,038	2,038	-
Texas	11,037	12,213	11,500	10,400	1981
Utah	922	832	830	750	1981
Vermont	627	434	340	250	1984
Virginia	3,660	4,061	3,034	2,500	1990
Washington	3,774	2,415	2,316	1,770	1986
West Virginia	461 #	1,093	510	310	1985
Wisconsin	3,670	2,233	2,200	2,096	1981
Wyoming	713	469	451	451	-
TOTALS	213,365 (50 states and D. C. reporting)	145,822 (49 states and D. C. reporting)	133,738 (48 states and D. C. reporting)	95,003	-

NOTES: NA Not available
* as reported by interviewees
** data extracted from: Mentally Retarded People in State-Operated Residential Facilities: Year Ending June 30, 1980, Project Report No. 4, DD Project on Residential Services and Community Adjustment, University of Minnesota, Minneapolis, Nov., 1978, p. 15.
\# data taken from Mental Retardation Source Book, DHEW, Office of Mental Retardation Coordination, Washington, D.C., 1972, pp. 15-16.

Of greater importance for purpose of the present study, however, Table VII also shows that, despite the sizable capital outlays committed by the states over the past few years, further reductions in institutional populations are anticipated by state officials over the next few years. Of course, the reported figures are only projections and, thus, subject to revision as time passes. How ever, should these population goals be reached, we can anticipate, on a nationwide basis, that: (a) the number of residents in state institutions will decline at approximately the same annual rate it has over the past decade; and (b) the aggregate population in state institutions will fall below the 100,000 mark by the early to mid-1980's. In other words, the total number of public insti tutional residents will have been cut roughly in half in a little over a decade.

When the respondents were asked to describe the relationship between capital improvements and deinstitutionalization plans in their states, they offered a wide range of explanations. It is difficult to categorize the responses we received to this question, except to say that most replies tended to highlight the interactive nature of the decision-making process at the state level. It was clear, for example, that in developing capital improvement plans state policymakers first must project the future demand for residential services in the state and the extent to which such demand can be addressed most appropriately through existing (or refocused) public residential treatment facilities. To arrive at realistic projections, state officials must weigh such factors as demographic shifts in the population, the functional characteristics of the known and anticipated target group for out-of-home care services, the likely capacity of local communities to program appropriately for various sub-groupings of retarded persons and the overall capacity of the state to meet the changing service demands of the population (including the appropriate phasing of future shifts in the population).

One direct link between capital budgeting and deinstitutionalization planning in states attempting to comply with ICF/MR standards was that renovations in older residential facilities usually result in a significantly reduced bed capacity, thus, generating the need for additional residential units. In other words, the maximum capacity of older institutional buildings, which have been redesigned to meet the ICF/MR minimum space requirements (i.e., a maximum of four-to-a-bedroom and the bedroom square footage requirements) is often reduced by 20 percent or more, thus, forcing the state to either add new institutional buildings or find alternative community placements for such residents. In most instances states are pursuing the latter course of action— i.e., depending on expanded community placement programs to take up the slack. For example, New Jersey's ICF/MR compliance plan calls for a 1,359 net reduction in the bed capacity of the seven state schools by July, 1982. Current plans envision the placement of some 870 of these residents into various community living alternatives, over 230 into private residential facilities and the remainder (359) into other state-operated residential facilities

While, as noted in the preceding section of this report, no state is planning to increase its total institutional population, and most are anticipating reductions, the survey data demonstrates that there are significant differences in the ways states are approaching the task of correcting environmental deficiencies in their Title XlX-certified state institutions. Many states[1] ICF/MR compliance plans rely heavily on the capability of existing institutions to place, and communities to absorb and appropriately program for, current residents who will be displaced by renovation efforts. As a result, their planned capital improvement activities often are not extensive (at least when viewed in terms of per capita outlays). For example, New York State's plan calls for vacating many existing institutional buildings in its 20 state-operated developmental centers as a result of a phased reduction in the total population from 18,166,as of July, 1977, to 10,067, as of July, 1982. As the respondent to the current survey reported "no new construction is anticipated at [New York's] Developmental Centers, and no major investments will be made in buildings planned to be phased out over the next few years."*

By contrast, the ICF/MR compliance plans of Iowa and Utah call for relatively sizable capital outlays to renovate and replace existing institutional buildings; consequently, both states anticipate only modest reductions in the bed capacity of these facilities, For example, Iowa will expend $26.6 million during the three year period to renovate facilities at the state's two existing residential schools (i.e., Glenwood State School and Hospital and Woodward State School and Hospital), or roughly $19,303 per client (based on June 30, 1978 population figures). As a result, the aggregate resident population of the two facilities are not expected to change significantly over the next few years (e.g., approximately a three percent reduction annually for both facilities).

Similarly, the State of Utah plans to expend approximately $22 million ($10.5 million of it during the three fiscal years covered by this study) to remodel and replace buildings at the Utah State Training School. When this process is completed, there will be space for 615 residents; in addition, the Mental Retardation Association of Utah, an organization representing parents of institutionalized persons, is planning to build an additional 136 units on 10 acres immediately adjacent to the Training School. As a result of these changes, the overall bed capacity of the facility is expected to be reduced from 839 to 750 over the next two years.

Obviously, the various approaches which states have elected to adopt in their efforts to comply with ICF/MR standards reflect differing philosophical viewpoints on the future residential

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* Letter from Charles Herendeen, Director of Facilities and Capital Services, New York State Office of Mental Retardation and Developmental Disabilities to Ms. Deborah Mitchell, NASMRPD Program Assistant, dated March 8, 1979.

service needs of retarded citizens in general and the role of state-operated residential facilities in particular. However, it would be a mistake to suggest that these differences can be explained simply in terms of the ideological opinions of key state policymakers. There are any number of political, economic, social and historical forces in each state which influence the development of mental retardation policies, including specific policies in the area of capital improvements. To cite just one example, New York historically has had a comparatively high rate of institutionalization. In fact, its rate per 100,000 in the general population, as of June 30, 1978, was roughly 38 percent higher than Utah and 316 percent higher than Iowa (see Table VIII). This may explain, in part, why New York has undertaken a more extensive community placement program than either Utah or Iowa.

There is one other aspect of the relationship between capital budgeting and deinstitutionalization planning which deserves attention—the potential, long-range need for new types of state-operated community residential complexes. As noted in the preceding section of this report, no state reported plans to construct new public institutions with funds appropriated during the FY 1977-80 period. However, there were several states with long-range capital projects which contemplate the construction of relatively small, community-oriented residential/daytime service complexes for multiply handicapped retarded clients (i.e., severe to profound retardation, combined with extensive physical, sensory and/or behavioral deficits). States with such long-range plans include:

- Maryland. The Governor's long-range capital improvement budget includes a proposal for the construction of two state-operated community residential centers. Capital con struction funds for these centers, each of which would con sist of seven residential units housing a total of 50 retarded persons, plus a service/administration building, would be requested in the Governor's FY 1980-81 and 1981-82 budgets.

- Virginia. In 1977, the voters approved a bond referendum which authorized $1.2 million in funds for land acquisition, site preparation and the design of two new 150-bed regional residential facilities, one in the Winchester-Harrisonburg area and the other in Fredericksburg. These "front-end" funds are included in the State's FY 1978-80 biennium budget.

- Washington. For several years the Master Plan of the Developmental Disabilities Division has included a proposal to develop 21 State Residential/Training Centers. Each SRTC was to consist of a cluster of three, 14-bed residential units plus a day training center. The residential units would be located separately in neighborhoods within 30 minutes driving time of the day training unit. However, this year the Governor struck funding for the first phase of SRTC construction from the capital budget she submitted

TABLE VIII

Population Trends in Public Residential Facilities
Per 100,000 in General Population

State	1970		1978		1979	
	Res. Pop.	Rate Per 100,000 Gen. Pop.	Res. Pop.	Rate Per 100,000 Gen. Pop.	Res. Pop.	Rate Per 100,000 Gen. Pop.
Alabama	2,204	64.0	1,856	49.6	1,500	39.8
Alaska	106	35.0	96	23.8	90	95.6
Arizona	1,136	64.0	920	39.1	630	24.5
Arkansas	1,471	76.0	1,775	81.9	1,850	83.2
California	11,483	57.5	9,674	43.4	9,000	40.2
Colorado	2,278	103.2	1,413	52.9	1,460	51.7
Connecticut	4,353	143.5	3,080	99.4	2,346	74.8
Delaware	568	103.6	538	92.3	600	100.0
D.C.	1,242	164.1	1,159	172.0	828	120.9
Florida	6,446	94.9	4,584	53.3	4,123	42.9
Georgia	1,864	40.6	2,644	52.0	NA	NA
Hawaii	753	97.8	475	53.0	445	47.3
Idaho	658	92.2	427	48.6	391	43.8
Illinois	7,685	69.1	6,361	56.6	6,262	55.6
Indiana	4,192	80.7	2,599	48.4	2,300	42.8
Iowa	1,730	61.2	1,378	47.6	1,384	47.9
Kansas	2,117	94.1	1,489	63.4	1,383	59.7
Kentucky	1,046	32.5	1,074	30.7	911	25.7
Louisiana	3,358	92.2	3,266	82.3	3,167	80.5
Maine	793	79.8	517	47.4	450	40.2
Maryland	3,622	92.3	3,226	77.9	2,869	65.9
Massachusetts	7,928	139.6	NA	NA	4,785	80.0
Michigan	11,873	133.7	5,833	63.5	5,670	61.1
Minnesota	3,910	102.8	2,855	71.2	2,760	68.6
Mississippi	1,861	83.9	1,832	76.2	1,880	77.7
Missouri	2,510	53.6	2,529	52.0	2,600	53.6
Montana	868	125.0	390	49.7	380	48.0
Nebraska	1,653	111.4	863	55.1	808	50.6
Nevada	0	0.0	146	22.1	162	24.5
New Hampshire	1,167	158.2	727	83.5	605	69.6
New Jersey	6,846	95.5	7,886	107.6	7,490	100.0
New Mexico	683	67.2	690	56.9	400	32.0
New York	26,203	143.6	17,747	100.0	15,500	86.6
North Carolina	5,195	102.2	3,971	71.2	3,286	56.8
North Dakota	1,351	218.7	867	133.0	NA	NA
Ohio	11,118	104.4	6,577	61.2	6,354	59.2
Oklahoma	2,194	85.7	1,956	67.9	2,100	73.6
Oregon	2,997	143.3	1,796	73.5	1,760	72.2
Pennsylvania	11,516	97.6	9,550	81.3	7,450	62.7
Rhode Island	1,136	119.6	742	79.4	715	74.3
South Carolina	3,874	149.5	3,409	116.8	3,500	115.7
South Dakota	1,197	179.7	759	110.0	727	105.4
Tennessee	2,814	71.7	2,456	56.4	2,038	46.7
Texas	11,037	98.6	12,213	93.8	11,500	87.2
Utah	922	87.0	832	63.7	830	62.8
Vermont	627	141.0	434	89.1	340	69.1
Virginia	3,660	78.7	4,061	78.9	3,034	56.9
Washington	3,774	110.7	2,415	64.0	2,316	63.3
West Virginia	461	26.4	1,093	58.8	510	27.7
Wisconsin	3,670	83.0	2,233	47.7	2,200	46.3
Wyoming	713	214.5	469	110.6	451	110.5
TOTALS	192,863	94.9	145,882	66.9	133,738	60.3

SOURCES:1)World Almanac and Book of Facts, Newspaper Center Assoc, Inc., New York, 1978, p. 188.
2)"Population Estimates and Projections," Current Population Reports, U.S. Dept. of Commerce, Bureau of The Census, Series P-25, No. 735, Oct. 1978, p. 4 and Series P-25, No. 790, Dec. 1978, p. 2.
3)Mentally Retarded People in State-Operated Residential Facilities: Year Ending June 30, 1978, Project Report No. 4, DD Project on Residential Services and Community Adjustment, University of Minnesota, Minneapolis, Nov. 1978, p. 15. 4) Mental Retardation Source Book, DHEW, Office of Mental Retardation Coordination, Washington, D.C, 1972, pp. 15-16.

to the Legislature. As a result, one of the key features in the Division's plan to cut the State's institutional population to 1,850 by 1983 was hanging in limbo at the time of the survey.

The proposals discussed above share one common characteristic: each has been the target of a good deal of controversy within the respective states. Critics have viewed them as unacceptable compromises with the notion of community-based programming. And yet, in different ways, in states with quite different policy-making environments and historical perspectives on the provision of residential services to retarded clients, each proposal represents an attempt to come to grips with a perceived need for continued state involvement in the operation of new facilities for severely retarded, multi-handicapped clients, if the next stage of deinstitutionalization is to occur.

Finally, we must return to the question of whether capital appropriations for institutional renovation projects are an accurate predictor of a state's future deinstitutionalization plans. An analysis of the data supplied by the 10 states with the highest *actual and projected* outlays for institutional renovation projects indicates that, of the eight states which furnished projections of future institutional populations (see Table VII): (a) three anticipate reducing their institutional populations over the next five years or so at a considerably faster rate than the national average (Nat.: -35.4%; Mass.: -208%; Florida: -106%; and New York: -54%); (b) three at approximately the same rate as the national average (N.J.: -33.7%; Ohio: -34.2%; and Wash.: -30.8%); and (c) two at a rate below the national average (Conn.: -21.4% and Calif.: -18.8%) .

If we make the same comparison in the 10 states with the highest ¦*per capita* outlays for institutional renovation projects, we find that the pattern is much the same. Two states reported anticipated population reduction rates far in excess of the national average (Mass.: -208%; Alaska: -125%). The reduction rates in three states was approximately the same as the national average (Wash.: -30.8%; Ohio: -34.2% and N.J.: -33.7%), while the remaining three states which furnished figures show a reduction rate far below the national median (Nevada: -0%; Calif.: -18.8%; and Utah: -10.7%).

The above analysis suggests that no direct correlation exists between real or per capita outlays for institutional renovation/construction projects and future population reduction rates. Instead, it appears that a variety of other factors, not directly related to capital outlays, must be taken into account in any attempt to understand the differences in the states' current deinstitutionalization/depopulation plans. Such an analysis is beyond the scope of the present report.

IX. OTHER CAPITAL IMPROVEMENT ACTIVITIES

Although the NASMRPD staff recognized from the outset that it would be difficult to obtain complete and accurate information on construction activities financed through sources other than the capital budgets of state mental retardation agencies, it was felt that survey respondents should be asked for information concerning such ancilliary construction activities since they could have a major bearing on current and future plans for providing residential and daytime services to mentally retarded citizens statewide. In particular, we were interested in determining the extent to which recent changes in federal housing policies were impacting on the development of community-based housing alternatives for mentally retarded individuals.

As we anticipated, many survey respondents were unable to furnish the Association with detailed information on the numbers, types and estimated cost of mental retardation facilities constructed with private and public financing (other than dollars appropriated through the state's regular capital budget). Because of the sketchy nature of the reported data, the NASMRPD staff elected not to include in this summary report a state-by-state breakdown of the responses. Instead, we have attempted to draw several broad, albeit highly tentative, generalizations which can be derived from the data.

Given sufficient time and resources, it would have been possible to elicit more complete data on these activities through a series of follow-up telephone interviews and/or specialized questionaires. However, such activities were beyond the scope of the current project.

A. State Housing Finance Agencies.

One series of questions raised with the respondents in the telephone interview dealt with the involvement of state housing finance agencies (SHFA's) in constructing and renovating group homes and other community housing arrangements for mentally retarded persons. Of the 50 jurisdictions answering these questions, 32 said that, to the best of their knowledge, the SHFA in their state had not developed specialized housing units for retarded individuals and had no immediate plans to do so. By contrast, respondents from 18 states reported that the SHFA either had financed community housing for developmentally disabled persons or planned to do so in the near future. A few examples will help to illustrate the types of related activities currently underway:

- Minnesota. Over the past few years, the Minnesota Housing Finance Agency has supported the construction of a total of 27 group homes for developmentally disabled persons, through a combination of state bonds •A and federal Section 8 rent subsidies (total estimated

construction costs: $4.1 million). An additional nine group homes are currently planned, at an aggregate cost of $2 million.

- Tennessee. Fourteen group homes, with a total bed capacity of 140 to 150, were financed by the Tennessee Housing Development Agency (THDA) in 1978. In 1979, ground was broken for an additional 15 homes and THDA has announced plans for 17 new community residences for the retarded, costing a total of $2 million, over the next three years. Each of these projects has been jointly planned by the THDA staff and the staff of the Tennessee Department of Mental Health and Mental Retardation, which has primary responsibility for pro viding operating funds once these facilities are opened.

- Virginia. Since initiating its specialized housing program for the mentally retarded in 1976, the Virginia Housing Finance Agency, in cooperation with the Department of Mental Health and Mental Retardation, has financed the construction of 15 group homes across the State.

- Michigan. Between 1971 and 1978, the Michigan Housing Finance Agency committed approximately $6.5 million to underwrite the construction of 24 group homes, ranging in capacity from 12 to 16 beds.

- Washington. The 1979 session of the Washington Legislature enacted a bill (H.R. 750) which authorizes the sale of $25 million in state bonds to finance the construction of state and local facilities "for the care, training and rehabilitation of persons with sen sory, physical or mental handicaps." Under the legis lation, the voters must approve a referendum before the bonds may be sold. Local communities would be permitted to use such state funds, in conjunction with HUD subsidies, to construct group homes and other residen tial facilities for the developmentally disabled.

All of the specialized housing construction programs outlined above have been initiated over the past few years. They pro-vide evidence of an emerging trend within the states toward utilizing generic state and local housing agencies as a vehicle for financing community-based living alternatives for mentally retarded persons. This impression is buttressed by the large number of requests the NASMRPD technical assistance staff has received in recent months from other states which are interested in emulating the housing finance programs initiated in Michigan, Virginia, Minnesota and a few other states. However, to date, such programs have not made a major nationwide impact on the need for residential and daytime facilities for the mentally retarded. As noted above, 32 of

the responding states reported that their SHFA has no plans for launching a specialized housing construction program for mentally retarded persons. Even in those states which have such a program underway, the number of new units constructed to date is miniscule in terms of the actual and projected need. Given the escalating construction costs involved and the growing restrictions on federal subsidies,* it seems doubtful that SHFA-financed projects will be more than a partial solution to the future demand for new community-based housing units.

B. Elderly/Handicapped Loans.

The NASMRPD staff also was interested in determining whether the federal Elderly/Handicapped Direct Loan Program, authorized under Section 202 of the Housing Act of 1959, was having a significant impact on the states' efforts to meet the community housing needs of developmentally disabled persons. Since 1974, when the program was restructured by Congress, a growing percentage of housing units have been earmarked for non-elderly housing—primarily for group homes serving developmentally disabled individuals.

Respondents from 36 states, plus the District of Columbia, reported that non-profit organizations in their states had either received or recently applied for Section 202 construction/ substantial rehabilitation loans. However, with the exception of a handful of states, the number of approved and requested 202 units in most states remains relatively small (between 8 and 100 beds). The exceptions include North Carolina (222 beds), New York (235 beds), Maryland (363 beds), Kansas (200 beds) and Massachusetts (207 beds). With the exception of Kansas, where all 200 beds are operated by UCP of Topeka, this bed capacity is spread out in group homes, with 12 or fewer beds, and apartment units, with 24 or fewer beds.

Despite the sharp increase in the number of Section 202 loans for non-elderly handicapped housing units since 1976, this federal loan program has had only a small overall impact on the community housing needs of developmentally disabled persons. Here again, it seems doubtful that states can look to the Section 202 loan program as a major source of construction funds for MR/DD community housing in the foreseeable future, given the limitations on the number of loan reservations available and the growing demand from other disability groups (especially in the area of community housing for the mentally ill and the severely physically handicapped).

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* Note, for example, that the total number of subsidy units approved by Congress under HUD's massive Section 8 program has decreased from 400,000 in FY 1978 to 265,000 in FY 1980. In addition, the percentage of units obligated for new construction has been gradually declining since the Section 8 program was initiated in 1975.

C. Intermediate Care Facilities.

Observers in some states have contended that the pressure to reduce the population of state-run institutions has resulted in a rush to build new, privately-operated congregate care facilities for mentally retarded persons. In order to gain some sense of the extent of this phenomenon nationwide, the NASMRPD staff asked respondents whether any non-profit or proprietary intermediate care facilities for the mentally retarded had been constructed (or were under construction) in their state, and if so, the number of such facilities, their rated bed capacity and intended population.

Once again, the respondents were able to supply only sketchy information. From the data furnished, it appears that larger ICF's (20 beds or more) have been constructed recently in 14 of the 4 6 reporting states. However, with the exception of two states, the total bed capacity of such larger congregate facilities was under 200 (Louisiana - 762; Utah - 400). Thus, based on the reported data, it would appear that the construction of new, "large" private ICF/MR facilities (20 to 250 beds) has occurred in only a few states.

Other states reported plans to construct small, community-based ICF/MR facilities (15 beds or less). The state with the most ambitious plans in this area was Michigan. At the time of the survey, the Michigan Department of Mental Health had opened 10 new, six to eight bed group homes under its Alternative Intermediate Services for the Mentally Retarded (AIS/MR) program. Current plans call for building 24 0 additional AIS/MR homes by July, 1982. Once opened, these homes will serve as the main placement resource for some 1,200 severely retarded persons who currently reside in state-operated residential centers.

One of the unique aspects of Michigan's AIS/MR program is that these group homes are being built, in compliance with ICF/MR physical and environmental standards, by private entrepreneurs, who, in turn, must agree to lease the completed building to the State Department of Mental Health. DMH officials then contract with qualified non-profit organizations to operate the homes, in accordance with Departmental standards. The facility's Title XIX reimbursement rate covers both the full operating costs (including the costs of out-of-home day services for the residents) and the amortized costs of constructing the building.

More recently, the Colorado Division of Developmental Disabilities has announced a $16.9 million program to build 33 new community residences across the state, which will house 276 mentally retarded individuals, plus provide about 50,000 additional square feet of program space. Capital construction costs will be financed through the sale of certificates of

participation to private investors, thus, avoiding the need for state capital appropriations. The Division will lease the new buildings from these private investors for a period of 18 years, after which ownership will revert to the State. Since these community residences will be certified as ICF/MR providers, lease expenses (including the amortized construction costs) will be built into the State's Title XIX reimbursement rate.

Current residents of the three State Home and Training Schools will be transferred to these new community residences as they become available, thus, permitting Colorado to achieve full compliance with federal staffing and environmental standards in the former facilities. State officials anticipate that construction contracts for the initial residences will be let by May 1, 1980.

D. General.

While the vast preponderance of recent and planned construction projects involved residential facilities, a few respondents reported on the construction of daytime service facilities. Respondents in both North Carolina and Montana mentioned that several sheltered workshops and adult activities centers had been built by non-profit groups with the support of loans or grant funds from either HUD (Community Development Block Grant monies), the Small Business Administration or the Farmers Home Administration. Private groups in Oregon and Tennessee also have opened activity centers and workshops without the assistance of public funding. Undoubtedly, similar developments have occurred in other states, but they were not reported during the course of the current survey.

Once again, it should be emphasized that the information summarized in this section of the survey report is based on highly fragmented data and, as a consequence, is probably incomplete. Therefore, the conclusions drawn should be treated as tentative.

X. CAPITAL BUDGETING PROBLEMS

The final section of the interview schedule focused on problems faced by state officials in budgeting for capital improvement projects. The question was intended to elicit open-ended responses; however, to stimulate the respondents[1] thinking, the following potential problem areas were used as illustrations during the telephone interview:

a. resistance to capital outlays by the Governor's Budget Office;

b. resistance to capital outlays by the Legislature; and

c. an inappropriate balance between institutional renovation projects and the construction of community-based facilities.

Of the 40 states which identified capital budgeting problems, roughly an equal number of respondents pointed to the Governor's budget office (13 responses) and the state legislature (14 responses) as the primary barrier to the appropriation of needed capital improvement funds. Thirteen respondents indicated that there was an inappropriate balance between institutional renovation projects and the development of community-based residential facilities in their states. Several pointed to the reluctance of legislators to appropriate tax funds for facilities which would be owned and operated by non-profit agencies.

The answers from the remaining respondents varied considerably from state to state. One respondent noted that the state's (Arizona)~seven percent limitation on annual increases in spending (including capital appropriations) placed a severe restriction on the amount which could be budgeted for capital improvements. Circumventing zoning restrictions and other manifestations of community resistance were cited as problems by respondents in three states (Ohio, Rhode Island and Indiana). The overall status of the state's economy and the impact of inflation on capital budgets, especially for multi-year projects, were mentioned by respondents in two other states (New Jersey and Wisconsin). Finally, two respondents (Massachusetts and Montana) pointed to the general lack of understanding among interested citizen groups of the relationship between institutional renovation projects and the development of community residential alternatives.

Despite the number and diversity of problems identified, however, one received the impression during the interviews that few states see capital budgeting as a major problem area for the state's mental retardation program. While many states have placed considerable emphasis on improved capital planning in recent years, most of the respondents did not reel off a long list of troublesome issues when asked to identify problem areas. Their responses may suggest that capital budgeting problems are viewed by state officials as simply one aspect of larger systemic barriers to progress; or, it may reflect the fact that many of the respondents were administrative/budget specialists rather than program officials. Whatever the reason, we sensed that capital budgeting is not viewed as one of the most pressing problem areas in many states.

XI. CONCLUSION

If there is a general lesson to be drawn from this analysis of state capital improvement budgets and plans, it is that extreme care must be taken in reaching any conclusions about the direction and pace of change at the state level—especially in such a volatile and emotionally charged area of policy as residential services for mentally retarded citizens. We have tried to stress throughout the report that usually one must take into account a variety of seemingly disparate factors to adequately understand the forces which are shaping the future residential service policies in any given state. Nationwide surveys of the type represented by the current study always run the risk of identifying one or two causative factors which can be used to "explain" interstate policy variations. We have attempted to avoid this trap, but it is unlikely that we have succeeded totally.

One of the major dangers inherent in the current study is that, by focusing exclusively on capital construction projects, we ignore the fact that new construction or substantial rehabilitation often is not a prerequisite for establishing mental retardation service facilities—especially community-based facilities. Indeed, the emphasis in recent years on "normalized" living and programming environments has led many program leaders to give relatively low priority to building new specialized residential facilities. Instead, the emphasis has been on locating appropriate houses in decent neighborhoods and then completing the necessary renovations to bring the home into compliance with state/local building and fire codes, licensing standards, etc.

As a result, one could spend hours deploring the lack of state commitment to the construction of community residential facilities and completely ignore the fact that: (a) according to a recent national survey, the number of community residential facilities (88 percent of which served 20 or fewer residents) more than doubled between 1973 and 1977; and (b) that there also has been sharp growth in the number of community housing units (both existing and newly constructed) made available by state and local housing agencies—a fact which often is overlooked in analysis of capital expenditures for mental retardation facilities by public agencies.

Of course, we do not intend to suggest that there is no need for the construction and renovation of additional daytime and residential facilities in the community to house programs for mentally retarded persons. In practically all states there are such needs, especially as public agencies begin to place more severely retarded and multi-handicapped clients into such community settings. However, the key question is the relative priority which should be given to capital construction projects, in view of the fact that public tax resources are insufficient to meet all the expectations and goals we have established.

Nor, do we mean to imply that the program philosophy of key state officials has little bearing on the relative priority given to the improvement of existing institutional environments, as opposed to the expansion of community living alternatives. Clearly, it does. However, it is important that we recognize that divergent viewpoints on the future of residential services in this country is the mainspring of much of the recent controversy over increased capital commitments to renovate and modernize state residential facilities. Some highly qualified observers argue that any sizable obligation of state dollars to renovate large, state-operated institutions will only prolong the day when all institutions can be closed and every retarded person can live in the community. No rate of deinstitutionalization can be rapid enough in their opinion, since institutions are, by their very nature, dehumanizing. On the other side of the question are many professionals and parents who see the rush to deinstitutionalize retarded persons as a clear signal that the public-at-large is prepared to abandon its long term commitment to caring for retarded citizens. Given this wide idealogical breach, it is not surprising that capital construction plans, with the sense of program permanency which bricks and mortar tend to engender, are an increasing point of controversy within the states.

Finally, we should say a few words about the relationship between state operating and capital budgets. Critics of sharply increased capital outlays for institutional renovation projects in some states have suggested that the state's money could be better spent by improving and expanding operating aid to community day and residential programs. That may be true, but such arguments tend to ignore the difference between a one-time outlay and a commitment which must be renewed and, given inflated costs and expectations, expanded each year. Similarly, as some of our respondents noted, it is one thing to convince legislators to provide operating funds for services run by non-profit groups but quite another to suggest that grants should be awarded to such groups to build facilities. Right or wrong, state officials and legislators, given their fiduciary responsibilities to the general taxpaying public, tend to give higher priority to the maintenance of state-owned property than to buying a building for a vendor agency over which the state can exercise only indirect control.