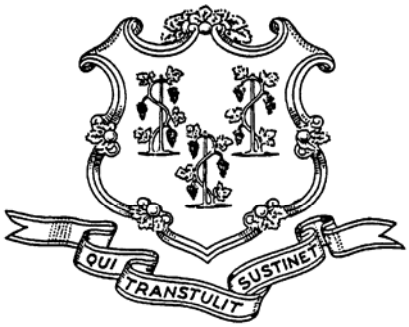
Feasibility of a Medicaid Home and Community Based Services Waiver for Persons with Serious Mental Illness



Report to the Governor and General Assembly
State of Connecticut

MARCH 2006

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Executive Summary

During the 2005 legislative session the Connecticut General Assembly passed PA 05-280 (HB 7000) *"An Act Concerning Social Services and Public Health Budget Implementation Provisions."* Section 85 of the act called for the Commissioners of Social Services and Mental Health and Addiction Services to jointly convene a Taskforce to study the feasibility of obtaining a Medicaid Home and Community-Based Services Waiver for adults with serious mental illness being discharged or diverted from nursing home care. Such a waiver would allow the state to provide non-traditional Medicaid services to better support individuals in the community and would enable these services to become reimbursable under Medicaid.

It is important to recognize that this study occurs within a larger context involving federal law and a landmark ruling from the U.S. Supreme Court. In June 1999, the Supreme Court held in *Olmstead v. L.C.& E.W.*, that unnecessary segregation of individuals with disabilities in institutions may constitute a violation of their rights under the Americans with Disabilities Act.

In 2004, Connecticut had an estimated total population of 3.5 million.[1] As of June 30, 2005, there were approximately 27,000 people living in the state's 247 licensed nursing homes, or an overall occupancy rate of 91 percent.[2] About 3,000 current nursing home residents have serious mental illness. During 2005, among the 39,000 people screened for nursing home placement, about 1,300 had serious mental illness.[3] About 34 percent of the 1,300 were age 54 and younger. Slightly more than 10 percent of the new arrivals (139 people with serious mental illness) being admitted to nursing homes that year were judged to have a "high diversion potential," meaning they probably could have avoided nursing home care and been placed in the community, if the right services were available to address their needs. Also, among the 3,000 people with serious mental illness currently residing in Connecticut nursing homes, approximately 420 are estimated to have a high discharge potential. The consensus among subject matter experts participating on the study Taskforce is that these estimates of persons with high division and high discharge potential are conservative. However, in the absence of a rigorous, ongoing resident review process these figures are difficult to verify.

Federal regulations permit the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid requirements and include as "medical assistance" a variety of home and community based services (excluding room and board) provided to individuals with serious mental illness who would otherwise require nursing home care. If granted, the so-called "1915 (c) Waiver" would enable Medicaid to cover the cost of "habilitation services" designed to assist individuals in acquiring, retaining, and

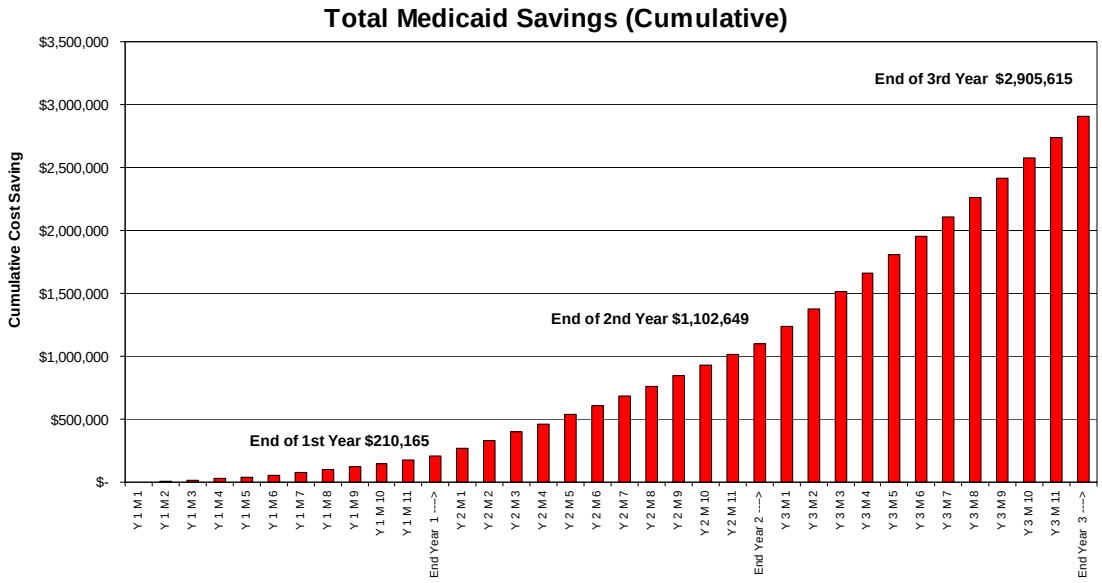
[1] Source: U.S. Census Bureau
[2] Source: Connecticut Department of Public Health (as of 6-3-05).
[3] Source: DMHAS – OBRA (Nursing Home) Resident Evaluation Unit. The remaining numbers cited in this paragraph also are from the OBRA Unit.

improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. In order to meet federal requirements for a waiver, Connecticut must demonstrate that alternative community services for persons served under the waiver would cost no more than Medicaid-covered institutional care.

In this study, cost neutrality is assessed using actual clinical profiles of five people currently residing in Connecticut nursing homes.[4] Each clinical profile contains a description of the individual's community service needs and the estimated cost of those services, compared to the cost of their nursing home placement.

A fiscal analysis found that the Medicaid cost neutrality requirement was met. Compared with the net cost of their nursing home stay, all five people profiled had lower Medicaid costs for each of the three years following discharge from the nursing home.

In order to calculate an estimate of Medicaid savings for each year of the waiver, a "phase-in" model was developed. The model assumes that 72 new people will be covered under the waiver per year, at a rate of 6 people per month, or a total of 216 people during the three-year waiver period. We used the average monthly, per person, savings for the each of the three years of the waiver as the basis for the cost analysis for persons covered during that year. This yielded a conservative estimate of savings. The analysis revealed Medicaid savings of $210,165 in Year 1 of the HCBS waiver, $892,485 in Year 2, and $1,802,966 in Year 3. The figure below shows cumulative savings for each month totaling $2,905,615 by the end of Year 3 of the wavier.



[4] Fictitious names were substituted on each profile. However, all other information, including institutional cost data is accurate.

The study Taskforce strongly recommends that the legislature direct the Department of Social Services and the Department of Mental Health and Addiction Service to collaborate in developing and implementing a Home and Community Based Services waiver for adults with serious mental illness. The legislature also should consider developing a mechanism to assess the needs of people with serious mental illness in nursing homes on an ongoing basis and for identifying those who might be suitable for discharge.

In order to implement and manage the proposed Medicaid waiver, the State of Connecticut would incur certain costs, some of which would be partially reimbursable through Medicaid, but others, such as community housing supplements for people discharged from nursing homes, would not. These costs are described in the report sections entitled Other Feasibility Related Issues (pages 21-22), Conclusion and Recommendation (page 23), and in APPENDIX C (page 32-33).

Introduction

During the 2005 legislative session the Connecticut General Assembly passed PA 05-280 (HB 7000), *"An Act Concerning Social Services and Public Health Budget Implementation Provisions."* Section 85 of the act called for the Commissioner of Social Services, and the Commissioner of Mental Health and Addiction Services to jointly convene a Taskforce to study the feasibility of obtaining a Medicaid Home and Community-Based Services Waiver for adults with severe and persistent psychiatric disabilities being discharged or diverted from nursing home care. Such a waiver would allow the state to provide non-traditional Medicaid services to better support individuals in the community and would enable these services to become reimbursable under Medicaid. The present study is submitted in fulfillment of the aforementioned legislative requirement.

It is important to recognize that this study occurs within a larger context involving federal law and a landmark ruling from the U.S. Supreme Court. In June 1999, the Supreme Court held in *Olmstead v. L.C.& E.W.*, that unnecessary segregation of individuals with disabilities in institutions may constitute a violation of their rights under the Americans with Disabilities Act. The court found that states must make "reasonable modifications" in their programs to foster community integration of institutionalized persons, provided that such changes do not require a "fundamental alteration" in programs. As a result of the decision, most states, including Connecticut have developed "Olmstead" plans to identify and resolve barriers to community integration.

For some people with serious mental illness, a nursing home may be the most appropriate treatment setting to meet their needs. These individuals should not be denied nursing home care. Consider, for example, a person with well-stabilized bipolar disorder who stays in a nursing home temporarily while recovering from hip replacement surgery.

The problem arises when nursing homes become the placement of "last-resort" for people with serious mental illness who could be effectively supported in other community settings. This situation is perhaps most egregious when a young person with serious mental illness, who has few physical health problems, is placed indefinitely with frail elderly adults in a nursing home, and is receiving little or no psychiatric rehabilitation. This is not a good solution for anyone involved. Connecticut can and must do better.

Background

Mental illness is one of the most significant public health problems in the nation. In his landmark 1999 report, U.S. Surgeon General, David Satcher, M.D., concluded that one in five Americans experiences mental illness during the course of a single year. Approximately 15 percent of these individuals also have a co-occurring substance use

disorder. However, less than one third receive any form of treatment. Finally, many also have other physical health problems.

Based on findings from carefully controlled epidemiological studies,[5] Dr. Satcher reported that more than one in twenty Americans has serious mental illness. This includes disorders like schizophrenia, bipolar disorder, major depressive disorder, and other seriously disabling psychiatric conditions. Extrapolating these figures to Connecticut, we can estimate that, during any given year, over 175,000 state residents have serious mental illness.

Not only can these disorders cause significant cognitive and functional impairments, but also they are highly stigmatized in our society. As a result, people with serious mental illness often have difficultly adjusting to community life and are confronted by significant barriers in their attempts to find and retain suitable employment, and safe, affordable housing. In addition, because serious mental illness is often a persistent condition, punctuated by acute episodes, people with these disorders often exhaust their personal or family financial resources and insurance benefits, and must rely upon government supported services.

While these are significant challenges, there is reason for optimism and hope. Longitudinal research, and the personal experiences of thousands of professionals and people with mental illness have shown that recovery from mental illness is possible.

Until the 1970's, the prevailing view among most health professionals was that severe psychiatric disabilities, such as schizophrenia, worsened as the disease progressed, eventually causing permanent deficits in most functional capacities. This conclusion was based on observations of long-term psychiatric patients who were held, sometimes for decades, in custodial settings that fostered nearly total dependence and eliminated volitional choice. However, the stereotype of poor prognosis began to change as former hospital patients were discharged to community settings with adequate treatment and support services.

Despite predictions that they were incapable of living outside the hospital, many former patients exceeded the expectations of professionals. With appropriate rehabilitation, medications, and support, they were able to adapt successfully to community life (DeSisto et al, 1995a, 1995b). A twenty-five-year follow-up study of patients discharged from Vermont psychiatric hospitals found that "One half to two thirds had achieved considerable improvement or recovered in contrast to statements … that predicted a poor outcome for schizophrenic patients" (Harding et al, 1987). Although a wide variety of outcomes were reported, former patients with the most positive outcomes were those who had obtained the community services that they needed.

[5] Such as the National Co-morbidity Survey

The concept of recovery from mental illness is not synonymous with "cure." It is based on the idea that with the right combination of treatments and supports, people can learn to manage their illnesses. As recovery progresses, the individual becomes more independent and better adjusted to community life while simultaneously reducing reliance on the mental health system. Thus, movement toward recovery produces a greater sense of hope, empowerment, self-determination and self-satisfaction. Individuals who achieve stability and a sense of recovery often become excellent role models for others who are learning to grapple with psychiatric disabilities.

In 2004, Connecticut had an estimated population of 3.5 million residents, with a slightly older age distribution than the national average.[6] The state has 247 licensed nursing homes, and a total bed capacity of 29,800, or about one nursing home bed for every 16 persons aged 65 years or older. As of June 30, 2005, approximately 27,000 of these beds were filled, yielding an overall occupancy rate of 91 percent.[7] Data from the Department of Mental and Addiction Services (DMHAS) indicate that about 3,000 current nursing home residents have serious mental illness. Anecdotal information and data from evaluations performed prior to nursing home admissions suggest that some of these individuals might be better served in non-institutional community settings.

In Connecticut, the Department of Public Health (DPH) has cognizance over nursing home operations. DPH inspects, licenses, and regulates all nursing homes in the state.

As the state Medicaid Authority, the Department of Social Services (DSS) is responsible for setting nursing home rates. In addition, significant changes affecting nursing homes, contained within the federal Omnibus Budget Reconciliation Act (OBRA) of 1987, conferred responsibility for the Pre-Admission Screening and Resident Review (PAS-RR) program to DSS. Under PAS-RR, all persons being considered for nursing home admission must first be screened to determine whether or not they have serious mental illness or mental retardation and whether they meet eligibility criteria for a nursing home level of care. This initial screening is called the PAS Level I Screening. If a mental health problem is detected during the Level I Screening, a second assessment is performed (called the PAS Level II Evaluation) to verify that a mental illness is present, to assess its seriousness, and to determine whether nursing home placement is appropriate for the individual.

OBRA-1987 conferred responsibility for PAS Level II Evaluations to the mental health authority in each state, i.e., DMHAS in Connecticut. The law also gave DMHAS responsibility for Change in Condition Evaluations for nursing home residents with serious mental illness who have experienced a significant change in their mental or physical condition. These assessments are performed to determine whether the individual should remain in the nursing home. Finally, federal law requires that both PAS Level II Evaluations and Change in Condition (CIC) Evaluations be conducted by a third party

[6] Source: U.S. Census Bureau
[7] Source: Connecticut Department of Public Health (as of 6-3-05).

under contract with the *state mental health authority* (SMHA), and not directly by the SMHA. In Connecticut, DMHAS contracts with Advanced Behavioral Health, Inc., to perform these evaluations. Thus, although approximately 11 percent of Connecticut nursing home residents have serious mental illness, with the exception of its limited role in contracting for and overseeing the PAS Level II and Resident Review/Change in Condition Evaluations, DMHAS has no other statutory control over nursing home operations.

The Challenge

This study is the result of a growing recognition that some people with serious mental illness currently residing in Connecticut nursing homes could live successfully in community settings, with the right combination of treatments and supports.

Figure 1 reveals that during FY 05, approximately 39,000 people were screened for nursing home admission (i.e., received PAS Level I Screenings). Thirteen hundred (1,300) of these individuals were found to have serious mental illness (based on findings from PAS Level II Evaluations).[8] One hundred and thirty nine (139) of the new arrivals with serious mental illness that year were judged to have a "high diversion potential," meaning they probably could have avoided nursing home care and been placed in the community, if the right services were available to address their needs.[9] Figure 1 also shows that among 3,000 people with serious mental illness currently residing in Connecticut nursing homes, approximately 420 are estimated to have a high discharge potential.[10,11] The consensus among subject matter experts participating on the study Taskforce is that these estimates of persons with high division and high discharge potential are conservative. However, in the absence of a rigorous, ongoing resident review process these figures are difficult to verify.

Additionally, Taskforce members expressed considerable concern about the absence of any external mechanism designed to monitor the status of people with serious mental illness in Connecticut nursing homes, particularly since some of these individuals are currently being held on locked "behavioral health units." The capability to conduct this type of monitoring was lost when Connecticut chose to terminate the Annual Resident Review program in 1996. Presently, in the absence of ongoing monitoring, there is no

[8] 1,300 of 39,000 screenings, or 3.3 percent of all screenings performed in FY05 identified persons with serious mental illness.
[9] 139 of the 1,300 persons with serious mental illness, or 10.7 percent, were identified has having a high diversion potential.
[10] Source: Clinical assessments conducted as part of PAS Level II Evaluations performed for DMHAS by Advanced Behavioral Health, Inc.
[11] 420 people currently residing in nursing homes, or about 1.5 percent of the total nursing home population in Connecticut, are believed to have a high discharge potential. This is an estimate based on initial evaluations conducted during the process of nursing home placement.

means for determining whether a nursing home resident with serious mental illness might have improved to a point where he/she could be discharged. Taskforce members were concerned that in the absence of such information, people who could be discharged might be languishing in nursing homes. There was strong sentiment in the Taskforce that the State of Connecticut should develop a mechanism to assess the needs of people with serious mental illness in nursing homes on an ongoing basis and for identifying those who might be suitable for discharge.

Lastly, the Taskforce was concerned about the growing number of younger adults with mental illness being served in Connecticut nursing homes. The mixing of younger adults and frail elderly in these facilities was seen as potentially contributing to problems for both groups. Since recovery-oriented care is care provided in the least restrictive environment, the Taskforce made it clear that nursing homes should not be used merely as a "housing option." Similarly, the duration of nursing home care should not be extended beyond a period justified by an individual's medical condition and functional impairments.

A Solution

Federal regulations, set forth in Section 1915 (c) of the Social Security Act, permit the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid requirements and include as "medical assistance" a variety of home and community based services (excluding room and board) provided to individuals with "chronic mental illness" who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR). If granted, the so-called "1915 (c) Waiver" would enable Medicaid to cover the cost of "habilitation services" designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

In order to meet federal requirements for a waiver the applicant must demonstrate that alternative community services for persons served under the waiver would cost no more than Medicaid-covered institutional care. The present study provides a preliminary test of his "cost neutrality" condition. In addition, other factors are discussed that might influence the feasibility of obtaining and implementing a 1915 (c) waiver pilot program in Connecticut.

In this study, cost neutrality is assessed using actual clinical profiles of five people currently residing in Connecticut nursing homes.[12] These individuals were selected because they represent many other people with serious mental illness currently being

[12] Fictitious names were substituted on each profile. However, all other information, including institutional cost data is accurate.

considered for nursing home admission, or presently living in nursing homes, who could be diverted from admission, or discharged from these homes, if community services were available to meet their needs. Each clinical profile contains a description of the individual's community service needs and the estimated cost of those services, compared to the cost of their nursing home placement. The cost of community care was calculated separately for each person profiled using a Menu of Services developed by a clinical and administrative subgroup of Taskforce members. The Menu contains a description of each service type and its associated *per unit* or *per diem* costs, as applicable. In creating the Menu, some service definitions were taken from existing Medicaid waivers developed in Connecticut or in other states for similar service populations. Other service definitions that address the unique needs of people with serious mental illness were developed specifically for this study.

Description of Connecticut's Target Population

The study Taskforce recommends that in order to be eligible for participation in a proposed Home and Community Based Services (HCBS) Waiver, individuals must:

1. Be Eligible for Medicaid.
2. Be At-Risk for Institutional Care (i.e., in a Nursing Facility, Intermediate Care Facility/Mentally Retarded, or a Chronic Disease Hospital).[13]
3. Have a Serious Mental Illness (see Appendix A).
4. Have Manageable Medical, Physical, or Sensory Condition(s) – If the individual has a co-occurring medical, physical, or sensory condition, it must be manageable within a community setting with health education, medication management, home health services or other supports (such as transportation to medical appointments), environmental modifications, specialized medical equipment, and psychiatrically and medically informed rehabilitation. The cost of managing the condition in the community will also be considered.
5. Have High Diversion or Discharge Potential – Persons being considered for nursing home placement who have a high diversion potential, or persons currently living in a nursing home with a high discharge potential. Diversion and discharge potential will be based on a clinical and community service cost estimate assessment.

Although persons of any age would be eligible, it is likely that most would be between the ages of 18 and 64 (Some individuals, aged 65 and older, would be eligible for the Connecticut Home Care Program for Elders). Once an individual is selected for inclusion in the proposed waiver, he/she could choose to continue receiving waiver-supported

[13] Not be eligible for services under any other Connecticut HCBS Waiver.

services beyond age 65, if he/she is still Medicaid-eligible and in need of waiver covered services.

HCBS Waiver for Persons with Serious Mental Illness in Connecticut: A Proposal

The Waiver Study Taskforce recommends that Connecticut adopt an HCBS Waiver for persons with serious mental illness currently receiving long-term institutional care within Medicaid-funded facilities, and for those who could be diverted prior to institutional care. This waiver should be limited to 72 persons in the first year. The Taskforce also recommends that the number be increased by a maximum of 72 each year, depending upon waiver utilization to date. Up to 216 people could be included in the initial 3-year waiver application. A ten percent attrition rate is expected among waiver participants (about 22 people during the 3-year waiver period). In order to maximize nursing home diversion and discharge opportunities created by the waiver, each person who drops out of the program will be replaced.

If the waiver were successful, a second five-year renewal could be requested. This would allow all currently institutionalized persons with "high discharge potential," and other persons from the "high diversion potential" population to be served by the end of the renewal period.

Cost containment would be accomplished through utilizing an aggregate cap for the overall waiver. The Taskforce recommends setting the aggregate at the current cost of institutional care. In other words, the total cost of the waiver would never exceed what it would have cost the State if the individuals served had remained in institutions, rather than receive community-based services.

Under Medicaid regulations, states may select either an aggregate or an individual cap for the overall waiver, to achieve the required federal cost neutrality. Unlike the Connecticut HCBS Waiver for the Elderly, which utilizes an individual cap, the Taskforce believes that an aggregate cap is more appropriate for people with serious mental illness. Unlike the elderly, whose service needs tend to increase over time, service needs for some people with serious mental illness are expected to diminish as they adjust to community life. Utilizing an aggregate cap will allow Connecticut to serve individuals who initially require a very high level of services to return to the community, which may diminish over time, while still containing costs across the entire waiver population.

The key to developing a comprehensive system of recovery-oriented community-based services for people with serious mental illness is individual choice and consumer satisfaction. The waiver program must be able to promote activities that will serve to increase the individual's personal independence and life satisfaction. It must promote the integration of the individual into the community. Finally, to truly be a viable alternative to institutionalization, the proposed HCBS Waiver must include a comprehensive menu

of services and daily living supports that can be tailored to meet the diverse individual needs of the target group. These services and supports must be flexible and able to vary in intensity throughout the recipient's life.

Menu of Services

Based on the consensus of subject matter experts regarding the specialized community services needs of persons with serious mental illness, particularly those with co-occurring medical conditions, the Taskforce recommends that the following services be covered in the proposed waiver program:

- Basic Living, In Home, and Community Supports and Skills
- Community Transition Services
- Environmental Modifications and Specialized Medical Equipment
- Employment-Related Services
- Family Support and Psychoeducation
- Homemaker Services
- Mobile Crisis Assessment
- Mobile Crisis Intervention and Stabilization
- Peer Support
- Personal Care Assistant Services
- Respite
- Transportation
- Services Coordination
- Substance Abuse Programs

Expanded definitions for these services, and associated per diem or per unit costs are shown in Appendix B.

Clinical Profiles

The following clinical profiles, developed from actual assessments of nursing home residents, represent the cohort of individuals who could be discharged to community settings with the appropriate combination of treatments and supports. Each profile contains a description of the person's service needs, and a comparison of nursing home versus community-based service costs.

The cost of community care was calculated by developing three, one-year "service packages" for each individual profiled. Service package costs included an estimate of the number of units, or days of care, as applicable, for each type of service that the person would require for successful community tenure. These individualized service packages include the cost of services that would be provided under the HCBS waiver, plus the cost of State Plan Amendment services provided to each profiled individual.

Thomas[14]

Thomas is a 51-year-old man who began developing Schizoaffective Disorder in his late teens shortly after graduating from high school. He began hearing voices that made derogatory comments about his behavior and were constantly putting him down. The voices also told him that others were against him. Because Thomas has difficulty recognizing that the voices are part of his illness, he is often upset and suspicious of others. In addition, he does not see the need to take medications that help reduce these symptoms. His inconsistent use of medications, coupled with the seriousness of his psychotic symptoms has resulted in the need for periodic psychiatric hospitalizations. This pattern has also interfered with his ability to work, retain an apartment, and keep his finances in order. It has also made it difficult for him to maintain lasting relationships with others, thus compounding his social isolation. Thomas frequently drinks to "self-medicate" and mask his problems. In fact, his admission to a nursing home came after he was injured in an alcohol-related fall. Although he has recovered from his injuries, he is still in the nursing home. Thomas does not want to continue living there, but he has lost his apartment, and there is no placement option available where he will have the support and supervision he needs.

His nursing home care is costing the State of Connecticut $79,791 on an annual basis.

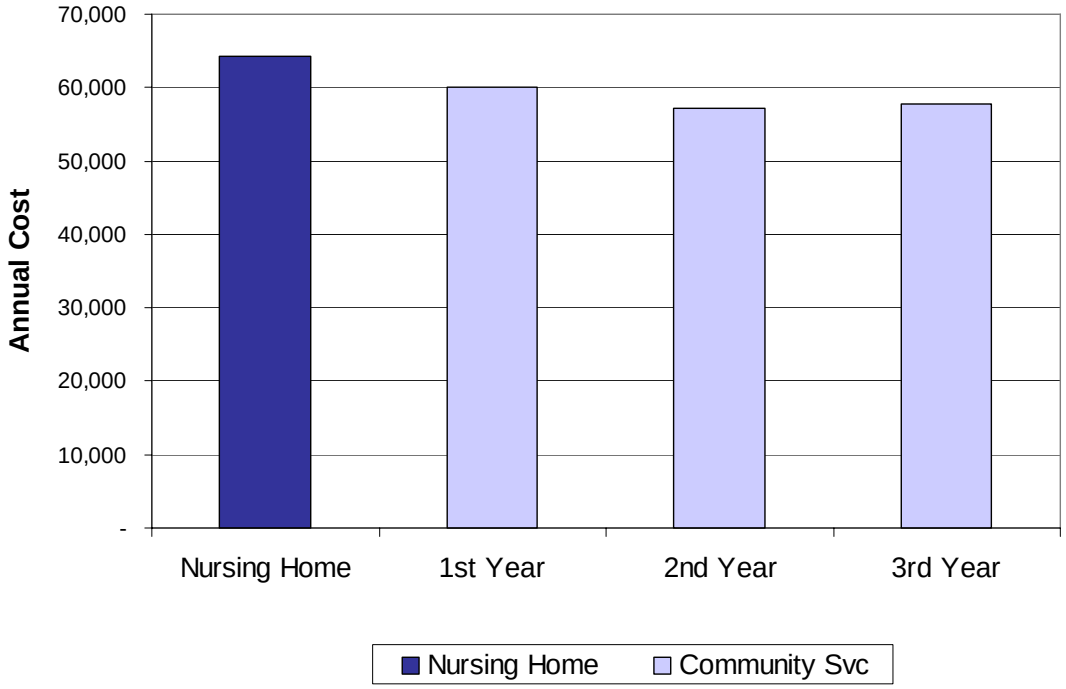
Thomas could live in a community setting if the right combination of services was in place. He would need daily in-home support, basic living and social skills training, medication management, a structured day program to address social and recreational needs, substance abuse treatment, peer support, assistance with finances, transportation, and service coordination.

The annual Medicaid cost of these community services for each of the next three years is estimated at: Year 1 = $59,994; Year 2 =$57,173; Year 3 = $57,842. An additional $4,202 per year will be needed to cover housing costs that cannot be covered by Medicaid. Housing costs are shown in the bar graphs for each of the five people profiled in this analysis.

[14] In each profile, actual client names have been replaced by fictitious names.

Client Name: Thomas					
	Nursing Home	Community Svc	Housing	Comm Svc & Housing	Medicaid Savings
	64,178				
1st Year		59,994	4,202	64,196	4,184
2nd Year		57,173	4,202	61,375	7,005
3rd Year		57,842	4,202	62,044	6,336

Thomas: Cost Comparison
Nursing Home - Community Service



Pamela

Pamela is a 56-year-old woman who was the victim of sexual abuse during her childhood and adolescence. As a result, she has Post-Traumatic Stress Disorder, and suffers from flashbacks, insomnia, anxiety (she becomes agoraphobic[15] and is afraid to leave her house), and depression. Tormented memories of her past cause her to experience suicidal ideation on a frequent basis. Pamela also has been diagnosed with Bipolar Disorder, a form of mental illness often characterized by recurrent manic and depressive episodes. She has had a number of inpatient psychiatric hospitalizations for depression. She also has asthma, non-insulin dependent diabetes, and hypertension. In addition, she has a history of taking excessive doses of her prescribed pain and anxiety medications.

Although Pamela is a high school graduate, her mental health problems made it difficult for her to keep steady employment or to maintain appropriate housing. In the absence of an effective support system she struggled with feelings of hopelessness and isolation, and became too depressed to cook, bathe regularly, do housework, manage her money properly, or take her medications as prescribed. This necessitated an admission to a nursing home.

The actual cost to the State of Connecticut of Pamela's stay in the nursing home is $82,767 per year.

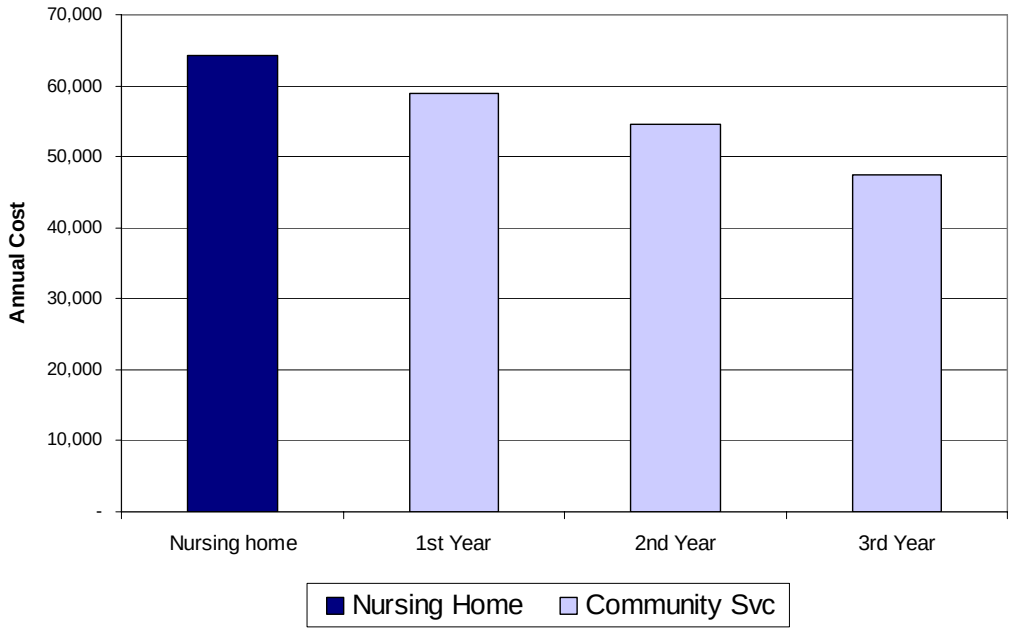
A clinical assessment at the time of Pamela's admission to the nursing home concluded that with the right combination of treatments and supports she could live in the community. In order to do this Pamela would require the assistance of a visiting nurse to address her physical health needs and medication usage problems, a structured treatment-oriented day program (including trauma services and cognitive behavioral therapy), substance abuse counseling, mental health basic living and social skills training to: 1) address her isolation, 2) assist with money management and 3) support psychoeducation regarding other activities of daily living. Finally, she would need service coordination to ensure the effective utilization of the various supports she receives.

The annual Medicaid cost of these community services for each of the next three years is estimated at: Year 1 = $58,967; Year 2 = $54,543; Year 3 = $47,412. An additional $4,202 per year will be needed to cover housing costs.

[15] Agoraphobia is a mental disorder characterized by marked fear of being alone or of being in public places. People with agoraphobia are often afraid to leave home unless accompanied by a friend or relative.

Client Name: Pamela					
	Nursing Home	Community Svc	Housing	Comm Svc & Housing	Medicaid Savings
	64,178				
1st Year		58,967	4,202	63,169	5,211
2nd Year		54,543	4,202	58,745	9,635
3rd Year		47,412	4,202	51,614	16,766

Pamela: Cost Comparison
Nursing Home - Community Service



Dario

Dario is a 29-year-old man with a 10-year history of severe and recurrent Major Depression with psychotic features. He also suffers from epilepsy. Dario worked at a service industry job for two years after high school, and had his first psychiatric hospitalization at age 19, when auditory hallucinations told him to harm himself. Dario has struggled with depression since that time. His feelings of worthlessness, hopelessness, and difficulty making decisions have interfered with his ability to work, maintain stable housing, and form lasting interpersonal relationships. He also has developed a substance abuse problem, and has had several hospital admissions for alcohol detoxification. He became homeless after his aunt and uncle asked him to leave their home when he relapsed on alcohol and marijuana. With many of his family members in Puerto Rico, and having alienated those who live locally because of his behavioral instability and substance abuse, Dario has no social supports. Dario's proficiency in English enables him to benefit from psychiatric treatment in English.

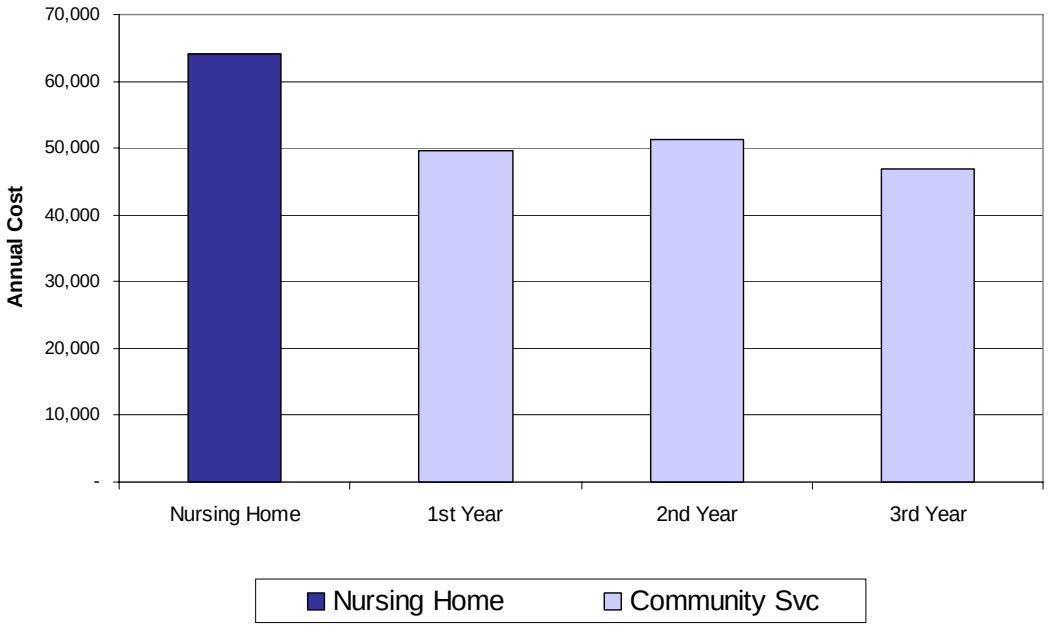
As a consequence of his physical and psychiatric needs, Dario was admitted to a nursing home at an annual cost of $66,374 to the State of Connecticut.

A clinical assessment of Dario's needs indicates that he could be discharged to a community setting with the following services: substance abuse treatment, cognitive behavioral therapy, medication and health management, mental health basic living and social skills training, peer support, and service coordination. He would require in-home support in order to maintain sobriety and manage his depression.

The annual Medicaid cost of these community services for each of the next three years is estimated at: Year 1 = $49,570; Year 2 = $51,312; Year 3 = $46,792. An additional $4,202 per year will be needed to cover housing costs.

Client Name: Dario					
	Nursing Home	Community Svc	Housing	Comm Svc & Housing	Medicaid Savings
	64,178				
1st Year		49,570	4,202	53,772	14,608
2nd Year		51,312	4,202	55,514	12,866
3rd Year		46,792	4,202	50,994	17,386

Dario: Cost Comparison
Nursing Home - Community Service



Megan

Megan is a 30-year-old woman diagnosed with Bipolar Disorder. She also has Post-Traumatic Stress Disorder, caused by severe trauma in childhood. Megan experiences rapid mood swings, flashbacks, nightmares, and chronic suicidal ideation in response to stress and perceived abandonment by others. She has turned to alcohol and cocaine, and has been arrested for possession of the latter. Megan has had many inpatient psychiatric hospitalizations during the past seven years. Although she managed to earn her GED, she becomes overwhelmed by everyday life, and has not been able to hold a steady job, or cope with living alone in her own apartment.

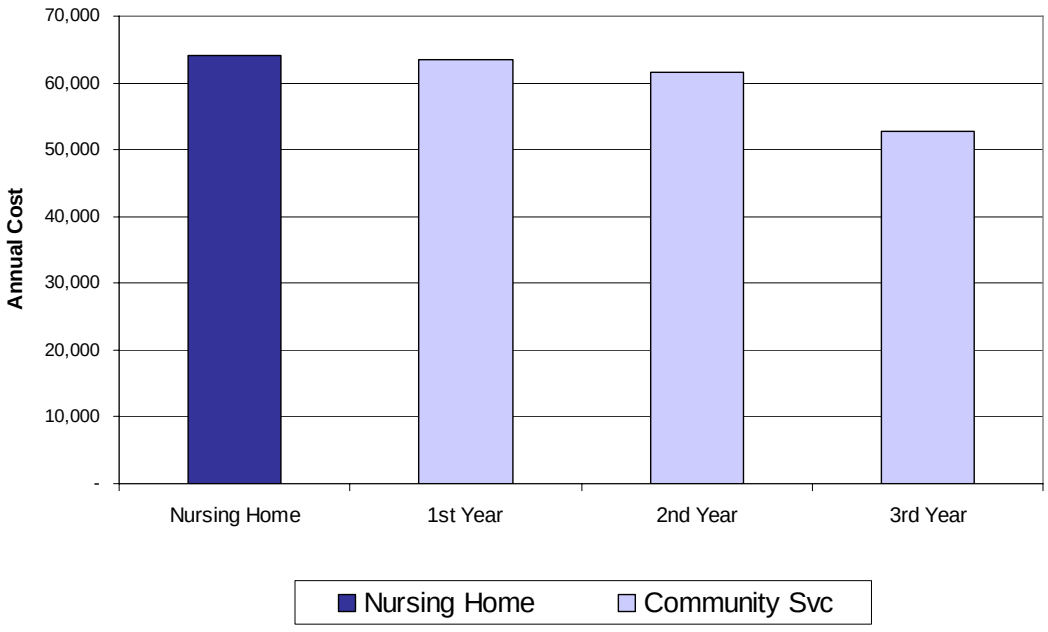
Because Megan was persistently unstable and did not have enough support services in the community to keep her out of an institution, she was admitted to a nursing home, costing the State of Connecticut $71,384 per year.

In order to live in the community, Megan would need the following services: intensive outpatient therapy (currently covered under the existing Medicaid clinic option). In addition, she would need substance abuse treatment, mental health basic living and social skills training, employment-related services, peer support, medication management, in-home support, and service coordination.

The annual Medicaid cost of these community services for each of the next three years is estimated at: Year 1 = $63,502; Year 2 = $61,649; Year 3 = $52,794. An additional $4,202 per year will be needed to cover housing costs.

Client Name: Megan					
	Nursing Home	Community Svc	Housing	Comm Svc & Housing	Medicaid Savings
	64,178				
1st Year		63,502	4,202	67,704	676
2nd Year		61,649	4,202	65,851	2,529
3rd Year		52,794	4,202	56,996	11,384

Megan: Cost Comparison
Nursing Home - Community Service



Aisha

Aisha is a 28-year-old woman who was diagnosed with schizophrenia in her late teens. She dropped out of high school after the ninth grade and, because of the disorganized thinking and paranoia caused by her mental illness, has not been able to maintain meaningful employment. Although her two sisters are very supportive and have advised her to stay in psychiatric treatment, Aisha has a difficult time accepting that she has mental illness. Consequently, she often refuses their help and stops taking her medications. Without medications her confusion increases, and she exhibits a pattern of behaviors that put her at risk of self-harm. For example, she wanders the streets alone, gets involved with strange men, and does not adhere to recommended treatments for her mental and physical illnesses (she has asthma and other health problems associated with obesity). Her cycle of confusion and risky behaviors has resulted in repeated acute psychiatric hospitalizations.

As soon as Aisha resumes taking her medication, she quickly regains her ability to think clearly. However, as is common among people with her problems, she is also depressed and discouraged by her long struggle with mental illness. When she leaves the hospital she does not care for herself. Eventually this leads to another downward spiral. Because her pattern of self-neglect has become so well established, and is more than can be resolved by her sisters, both of whom have their own families, Aisha was admitted to a nursing home earlier this year. She is presently the youngest person in residence.

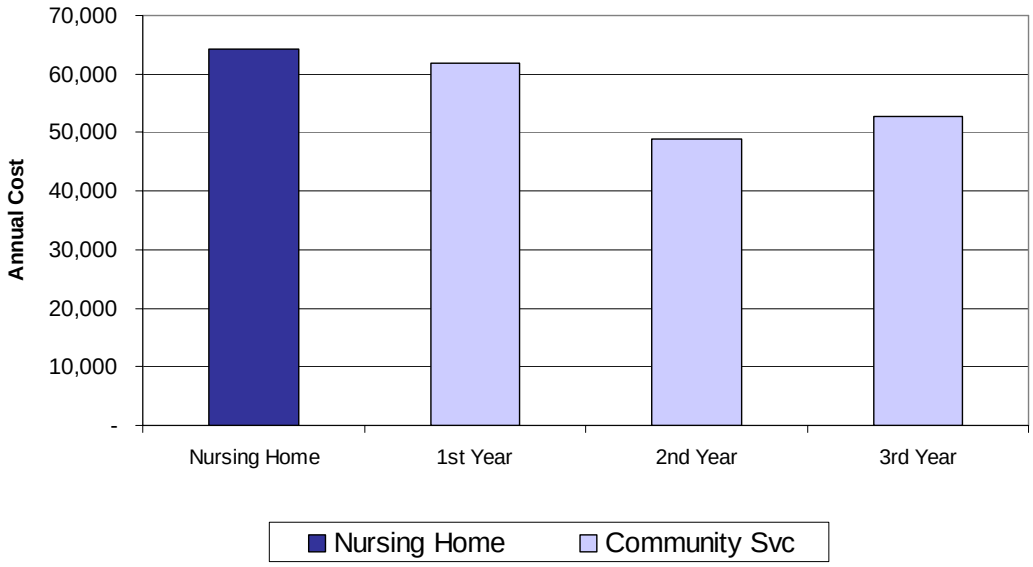
Aisha's stay in the nursing home is costing the State of Connecticut $70,805 per year.

Behavioral health clinicians who know Aisha believe that she could make a successful adaptation to community life, if she has adequate support services. First, she will need community transition services in order to get set up in a new apartment. She will also need to establish and maintain basic living skills, understand the importance of taking her medications, and strengthen risk avoidance abilities. She will need medication management, and health maintenance supports, daily in-home support for several months, peer support, and periodic crisis assessment and stabilization. Finally, she will need employment-related, and service coordination to ensure effective use of these multiple resources.

The annual Medicaid cost of these community services for each of the next three years is estimated at: Year 1 = $61,913; Year 2 = $48,829; Year 3 = $52,822. An additional $4,202 per year will be needed to cover housing costs.

Client Name: Aisha					
	Nursing Home	Community Svc	Housing	Comm Svc & Housing	Medicaid Savings
	64,178				
1st Year		61,913	4,202	66,115	2,265
2nd Year		48,829	4,202	53,031	15,349
3rd Year		52,822	4,202	57,024	11,356

Aisha: Cost Comparison
Nursing Home - Community Service



Fiscal Impact

The actual annual cost to the State of Connecticut of nursing home care for the five individuals profiled in this feasibility study was found to be higher than the average annual cost of such care for all Connecticut nursing home residents. Furthermore, the "Applied Income" of the five individuals profiled was less than the statewide average for Connecticut nursing home residents. [16] Use of higher than average nursing home cost data coupled with lower than average Applied Income data would have biased the outcome of the fiscal impact analysis, making it easier to conclude that the cost neutrality requirement was met. Therefore, in order to establish a fair and conservative basis for cost comparison, two adjustments were made. First, we obtained the average per diem gross cost for all Connecticut nursing home residents ($204.00 per day, or $74,460 per year). Second, since income that nursing home residents receive is applied toward the cost of their care, we subtracted the average annual Applied Income of Connecticut nursing home residents ($854.84 per month, or $10,282 per year) from the average annual gross cost. This yielded an average annual net cost of nursing home care ($64,178), which was use to perform the fiscal impact analysis.

For each person profiled, the cost of community services was calculated for each of the three years following their discharge from the nursing home. Annual and monthly average, per person, Medicaid savings are shown in Table 1.

Table 1

Medicaid Savings Per Person Per Year

	Pamela	Aisha	Megan	Dario	Thomas	Average Savings per Person Per Year	Average Savings per Person Per Month
1	2	3	4	5	6	7	8
1st Year	$ 5,211	$ 2,265	$ 676	$ 14,608	$ 4,184	$ 5,389	$ 449
2nd Year	$ 9,635	$ 15,349	$ 2,529	$ 12,866	$ 7,005	$ 9,477	$ 790
3rd Year	$ 16,766	$ 11,356	$ 11,384	$ 17,386	$ 6,336	$ 12,646	$ 1,054
Grand Total						$ 9,170	$ 764

As can be seen, the Medicaid cost neutrality requirement is met – compared with the net cost of their nursing home stay, all five people profiled had lower Medicaid costs for each

[16] Nursing home residents covered by Medicaid are required to sign-over any income they receive to help offset the cost of their nursing home care. These transferred funds are called "Applied Income." Applied Income includes sources such as Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) payments. Nursing home residents are permitted to retain a small portion of their income each month for incidental expenses. In Connecticut the allowance is $57 per month.

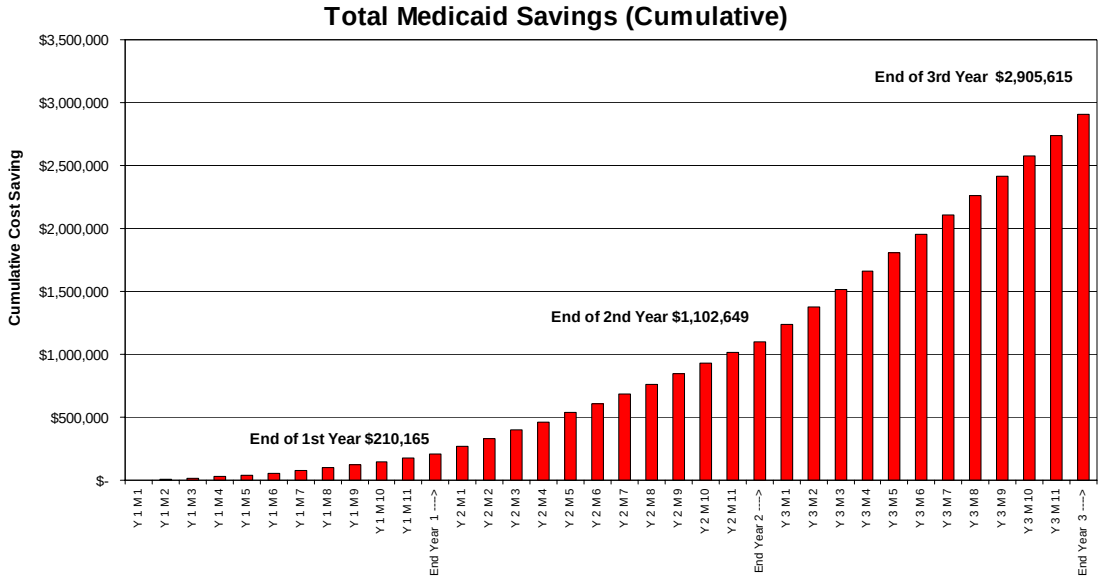
of the three years following discharge from the nursing home. The average, per person, annual savings was $5,389 in Year 1, $9,477 in Year 2, and $12,646 in Year 3 following discharge. We also calculated the average, per person, monthly savings. These were $449 in Year 1, $790 in Year 2, and $1,054 in Year 3 following discharge.

In order to calculate an estimate of Medicaid savings for each year of the waiver, we developed a "phase-in" model. The model assumes that 72 new people will be covered under the waiver per year, at a rate of 6 people per month, or a total of 216 people during the three-year waiver period. We used the average monthly, per person, savings for the each of the three years of the waiver as the basis for the cost analysis for persons covered during that year. We took into account the arrival rate of new clients each month. This yielded a conservative estimate of savings. Table 2 reveals a Medicaid savings of $210,165 in Year 1 of the HCBS waiver, $892,485 in Year 2, and $1,802,966 in Year 3, for a cumulative Medicaid savings of $2,905,615 by the end of Year 3 of the wavier.

Table 2

Total Cumulative Savings

Year	Month	Monthly Average Savings per Person	Medicaid Savings Per Year	Total Cumulative Clients	Total Cumulative Madicaid Savings
1st Year	1	$ 449		6	$ 2,694
1st Year	2	$ 449		12	$ 8,083
1st Year	3	$ 449		18	$ 16,167
1st Year	4	$ 449		24	$ 26,944
1st Year	5	$ 449		30	$ 40,416
1st Year	6	$ 449		36	$ 56,583
1st Year	7	$ 449		42	$ 75,444
1st Year	8	$ 449		48	$ 96,999
1st Year	9	$ 449		54	$ 121,249
1st Year	10	$ 449		60	$ 148,193
1st Year	11	$ 449		66	$ 177,832
1st Year	12	$ 449	$ 210,165	72	$ 210,165
2nd Year	1	$ 790		78	$ 269,719
2nd Year	2	$ 790		84	$ 331,968
2nd Year	3	$ 790		90	$ 396,911
2nd Year	4	$ 790		96	$ 464,549
2nd Year	5	$ 790		102	$ 534,881
2nd Year	6	$ 790		108	$ 607,908
2nd Year	7	$ 790		114	$ 683,628
2nd Year	8	$ 790		120	$ 762,044
2nd Year	9	$ 790		126	$ 843,154
2nd Year	10	$ 790		132	$ 926,958
2nd Year	11	$ 790		138	$ 1,013,456
2nd Year	12	$ 790	$ 892,485	144	$ 1,102,649
3rd Year	1	$ 1,054		150	$ 1,238,077
3rd Year	2	$ 1,054		156	$ 1,376,199
3rd Year	3	$ 1,054		162	$ 1,517,016
3rd Year	4	$ 1,054		168	$ 1,660,527
3rd Year	5	$ 1,054		174	$ 1,806,733
3rd Year	6	$ 1,054		180	$ 1,955,633
3rd Year	7	$ 1,054		186	$ 2,107,227
3rd Year	8	$ 1,054		192	$ 2,261,516
3rd Year	9	$ 1,054		198	$ 2,418,499
3rd Year	10	$ 1,054		204	$ 2,578,177
3rd Year	11	$ 1,054		210	$ 2,740,549
3rd Year	12	$ 1,054	$ 1,802,966	216	$ 2,905,615



Other Feasibility Related Issues

In developing a Medicaid Home and Community Based Services waiver for people with serious mental illness in nursing homes, we should consider several related issues. For example, prior experience from the *Nursing Home Transition Grant* and from the *Acquired Brain Injury – Home and Community Based Services* (ABI) waiver has shown that some people being discharged from nursing homes may need assistance with their housing costs (Medicaid does not cover the cost of housing). In the present study, the annual cost to the state for housing each of the five people profiled is displayed in their individual bar graph (see above). This average net cost is estimated at $4,202 per person, per year, and includes support for one-time costs associated with setting up an apartment (e.g., security deposit, food, simple furnishings, bedding, utility deposits, telephone service, basic household goods and supplies, etc.).[17]

The cumulative cost to the state of housing for people in the waiver program would be determined by the number of people being discharged per month from nursing homes into community settings. The average housing subsidy cost is estimated at $350 per month (i.e., 1/12th of $4,202). Using this monthly figure, we can calculate that if six people enter the waiver program per month (or 72 by the end of the first year, 144 by the end second year, and 216 by the end of the third year), the cost of the housing subsidy would be:

[17] This average net housing cost was chosen based on similar experience with people being served in the Acquired Brain Injury – Home and Community Based Services Waiver.

- Year One = $163,800.
- Year Two = $466,200.
- Year Three = $768,600
- Fully annualized cost = $907,416.[18]

Additionally, in order to ensure that quality services are provided, and that Medicaid compliance requirements are met, the waiver program will need ongoing supervision and operational management of complex clinical, administrative, and fiscal functions (such as ensuring that *cost neutrality* is maintained, as mandated by federal regulation). Clinical functions will include the development, implementation, and monitoring of an individualized plan of care for each person served under the waiver. These plans, developed based on the preferences of the service recipient, would specify the amount of each type of service to be provided. Administrative functions will include identifying, enrolling, and training service providers. Providers must be prepared to address the specialized needs of people who have co-occurring psychiatric, substance use, and medical conditions. A claims adjudication and processing capability also will be required to make payments to providers. Resources will be needed to accomplish these functions. The resources that will be needed at DMHAS and DSS to implement the waiver are contained in Appendix C.

Assuming the General Assembly supports the Taskforce proposal to move forward with the federal waiver application, it is estimated that a wavier program could be implemented by July 1, 2007. It should be understood that development of the program would not include an extension of the entitlement to higher income levels than those presently in effect.

Although the waiver program is expected to significantly improve the quality of life for persons returning to community living, its impact on the closure of existing nursing home beds is uncertain. Nursing home savings would be contingent on the actual reduction in Medicaid reimbursed nursing home beds. In addition, while Medicaid reimbursed beds may be reduced, individual nursing homes may request interim rate adjustments in an effort to address these downward fluctuations in census and the corresponding reduction in revenues. This may need to be budgeted. Therefore, while the cost neutrality condition for the projected cohort of individuals to be covered under the waiver was met in our analysis, it is not anticipated that there will be a corresponding one to one reduction in utilization of nursing home beds in Connecticut.

[18] Additional cost would be incurred if more people were added during the waiver renewal period, after year three.

Conclusion and Recommendation

Connecticut nursing homes are an important asset for all our citizens. The Taskforce has concluded that some people with serious mental illness currently residing in Connecticut nursing homes could be returned to community living if they had the right combination of services and supports. This is particularly important for younger adults with serious mental illness, many of whom seem out of place in these facilities. However, it must be understood that persons with mental illness should not categorically be denied nursing home care. For example, if a woman with medically stable bipolar disorder breaks her hip, she should have the same right to rehabilitative nursing home care as anyone else. As with any other nursing home resident, the duration of this care should not be extended beyond a period justified by the medical condition and functional impairment. Those who can, should be returned to community living.

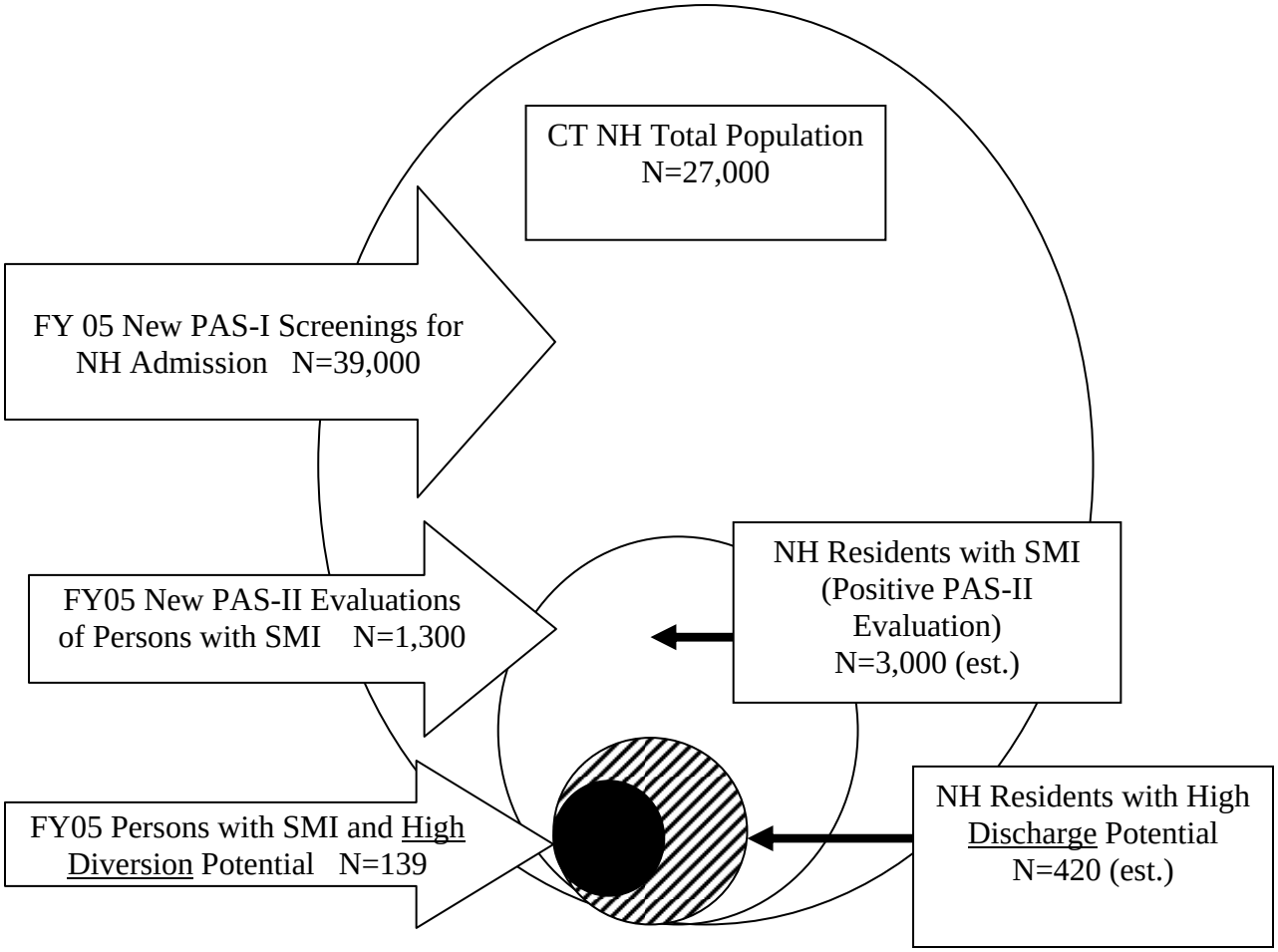
After a careful review of client profiles, services needs, and service package options, the study Taskforce concluded that the cost of community-based Medicaid services would be less than the cost of nursing home care for all persons included in the feasibility sample group. The Taskforce estimates cumulative Medicaid savings of $2.9 million for persons covered under the proposed waiver. While there are additional costs to the state associated with implementing the waiver (such as housing subsidies and administrative costs – See Appendix C), the benefits to people with serious mental illness, and to other nursing home residents are judged to be well worth this expense.

Therefore, the study Taskforce strongly recommends that the legislature direct the Department of Social Services and the Department of Mental Health and Addiction Service to collaborate in developing and implementing a Home and Community Based Services waiver for adults with serious mental illness. The legislature also should consider supporting a mechanism designed to assess the needs of persons with serious mental illness residing in Connecticut nursing homes on an annual basis and for identifying those who might be suitable for discharge.

Finally, since waiver programs of this type are a potentially important means of providing alternatives to institutional care for Medicaid recipients, it is recommended that an evaluation be performed to assess outcomes and to determine whether the program is cost-effective. If this pilot program is successful, it should be recommended for continuation beyond the initial three-year waiver period and expanded to include additional participants.

Figure 1

CT Nursing Home Population Characteristics as of FY 05



Legend:

NH – Nursing Home
SMI – Serious Mental Illness
PAS-I – Persons receiving a "Level I, Pre-Admission Screening" as part of nursing home admission.
PAS-II – Persons with Serious Mental Illness receiving a "Level II, Evaluation" to determine if they are suitable for nursing home placement.

Appendix A – Definition of Serious Mental Illness

(1) Serious Mental Illness - Individuals with a diagnosis of serious mental illness as defined by PASRR regulation 42 CFR 483.102 which require a Level II evaluation:

(a) The individual has a major mental disorder diagnosable under the current Diagnostic and Statistical Manual of Mental Disorders;
(b) This mental disorder is a schizophrenic, mood, paranoid, panic, or other severe anxiety disorder, somatoform disorder, personality disorder, other psychotic disorder, or another mental disorder that may lead to a chronic disability.
(c) The disorder results in functional limitations in major life activities within at least the past 3 to 6 months that are appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:
  (i) Serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation;
  (ii) Serious difficulty in sustaining focused attention for a long period of time to permit completion of tasks commonly found in work settings, or in work-like structured activities occurring in schools or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in completion of these tasks;
  (iii) Serious difficulty adapting to typical changes in circumstances associated with work, school, family, or social interaction, which manifests as agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.
(d) The treatment history indicates that the individual has experienced at least one of the following:
  (i) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (for example, partial hospitalization); or
  (ii) Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

NOTE: In Connecticut, the following diagnoses always require a PAS Level II Evaluation: schizophrenia, delusional (paranoid) disorder, psychotic disorders not elsewhere classified (brief reactive psychosis,

schizoaffective disorder, and psychotic disorders NOS), bipolar disorder, and major depression.

EXCLUSIONS: A major mental disorder does not include a primary diagnosis of dementia, including Alzheimer's disease or related disorder, or a non-primary diagnosis of dementia with a primary diagnosis that is not a serious mental disorder. Additionally, a major mental disorder excludes mental retardation as defined in CT General Statute 17a-621(7), or any mental disorder related to alcohol dependence as defined in CT General Statute 17a-621(1), or any mental disorder related to Acquired or Traumatic Brain Injury.

Appendix B – Service Definitions[19]

Basic Living, In Home, and Community Supports and Skills – includes one-on-one rehabilitative activities designed to assist an individual in managing his/her psychiatric, substance use, or medical problems, and meeting the requirements of everyday independent living at home, at work, or in school, and in other community settings. Services emphasize hope for recovery, self-reliance, empowerment, and building on the individual's strengths. Services involve monitoring of the individual, education, and direct supportive interventions in the following areas:

- Transition to community living
- Wellness and recovery Planning
- Community resource utilization and integration skills
- Supportive counseling
- Education and/or employment-related skills
- Interpersonal communication and relationship building skills
- Mental and physical illness symptom monitoring and management skills
- Relapse prevention skills
- Crisis assistance
- Medication monitoring and medication management
- Development of health care directives
- Household management skills
- Budgeting and shopping skills
- Cooking and nutrition skills
- Transportation skills

Cost: $29.47/hour

Community Transition Services – services and supports provided by a mental health practitioner prior to the discharge of a patient from a hospital, nursing home, or ICF-MR, that are designed to facilitate the discharge, or to support continued community tenure for a person covered under the waiver.

Cost: $35.00/hour

Environmental Modifications and Specialized Medical Equipment – includes: 1) changes in physical plant or vehicle modifications designed to promote accessibility/use, and 2) specialized medical equipment or supplies (to include devices, controls, or appliances), specified in a plan of care, that enable individuals to increase their abilities to

[19] The cost for services shown in this section is not meant to connote payment rates. Rate setting for services covered under Medicaid is the responsibility of the Department of Social Services.

perform activities of daily living, or to move within, perceive, control, or communicate with the environment in which they live.

Cost: Maximum of $10,000, with prior authorization

Employment-Related Services – includes two services: Supported Employment and Pre-Vocational

Supported Employment - services that allow an individual to participate in employment. Services are provided at the worksite and must be focused on assisting the individual to manage the symptoms of mental illness, and not learn job tasks.

Cost: $53.19/hour

Pre-Vocational - services that prepare the individual for future participation in employment. These interventions will fall primarily in the areas of achieving the required level of concentration, task orientation and development of communication and work skills appropriate for interaction with employers, supervisors and counselors.

Cost: $35.25/hour

Family Support and Psychoeducation – includes supportive counseling for first-degree relatives (or significant others) of persons covered under the waiver, and basic education regarding behavioral health disorders, community support resources, self-care and coping mechanisms for family members, and strategies for supporting persons with serious mental illness in the community.

Cost: $47.14/hour

Homemaker Services – includes general household activities (meal preparation, light housekeeping, laundry, and other routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily unable or unavailable to perform them, or if the person served under the waiver is unable to manage the home.

Cost: $15.34/hour

Mobile Crisis Assessment – includes an immediate face-to-face appraisal by a physician, mental health professional, or a mental health practitioner under the clinical supervision of a mental health professional, following a determination that suggests the recipient may be experiencing a mental health crisis. The crisis assessment evaluates any immediate needs for which emergency services are necessary and, as time permits, the

recipient's life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

Cost: $115.00/assessment

Mobile Crisis Intervention and Stabilization – includes:

A) **Face-to-face**, short-term, intensive services provided in the individual's home, and in other non-office based community settings during a mental health crisis. Mobile Crisis Intervention and Stabilization is designed to help a recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to his/her baseline level of functioning. Such services also provide information regarding ways to avoid future crises and about how to access community resources to support continued stability. Crisis intervention must be available 24 hours a day, 7 days a week.

B) **Follow-up telephone contact** with an individual who has recently been in crisis to monitor his/her present adjustment and to provide additional supports, as may be needed, in order to solidify gains made during the stabilization process.

Cost: $65.00/face to face, Mobile Crisis Intervention and Stabilization
Cost: $32.50/telephone follow-up

Peer Support - includes face-to-face interactions that are designed to promote engagement of persons covered under the waiver in addressing problems resulting from a psychiatric or substance use disorder(s), and promoting the individuals strengths and abilities to improve socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer Support may also include interactions designed to stabilize the service recipient during a crisis. Peer Support is provided by a person in recovery from a psychiatric or substance use disorder(s), under the supervision of a mental health professional. Peer Support services are directed toward achievement of specific goals defined by the service recipient in his/her individual service plan.

Cost: $16.00/hour

Personal Care Assistant (PCA) Services – includes support with day-to-day activities to enable individuals served under the waiver to become more independent in the home and community. These supports may include some or all of the following: 1) Assistance in performing activities of daily living, including eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning; 2) Assistance with other daily activities such as meal planning and preparation, managing finances, shopping for essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community; 3) Assistance with behavioral

health or physical health-related functions, including prompting to take medication or prompting to adhere to self-management of a health condition, and; 4) Redirection and intervention to avoid risky behaviors (e.g., careless smoking), including observation and monitoring. Personal Care Assistant Services may be consumer-directed.

Cost: $24.54/hour

Respite – includes both "in-home" and out-of-home respite. In-home respite involves the provision of temporary services provided by a peer support counselor, or a mental health practitioner, in the consumer's home that are designed to defuse conflicts or resolve problems that are destabilize the home environment. Out-of home respite involves temporary placement outside the home (for the consumer, or for a roommate) when doing so would help to defuse conflict or resolve problems for the person covered under the waiver. Respite may also be used as temporary lodging to facilitate transition to permanent housing.

Cost: $23.72 (In Home)
$24.80 (Out of Home)

Transportation – enables individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies will be utilized to provide this service without charge.

Cost: $0.39/mile

Service Coordination – includes: 1) working with the service recipient to develop and implement an individualized plan of care designed to ensure that the appropriate configuration of services is in place to meet his/her needs, 2) promoting access to behavioral health and physical health services, 3) promoting continuity of care across service episodes and providers, 4) assessing the appropriateness of behavioral health care used by the service recipient, 5) coordination of behavioral health and physical health services, and 6) providing assistance to clinicians and to the service recipient to promote optimal use of resources. Care management also may include, prior authorization of care, continued-stay, and retrospective care reviews, discharge planning, and provider monitoring to assure compliance with quality standards, as well as other provider performance enhancement activities.

Cost: $17.43/hour

Substance Abuse Programs – Individually designed interventions to reduce/eliminate the use of alcohol and/or drugs by the waiver participant that may interfere with the individual's ability to remain in the community if not dealt with effectively. Substance Abuse Programs are provided in an outpatient congregate setting or in the waiver participant's community and include the following: an in-depth assessment of the inter-relationship between the individual's substance abuse and mental illness; a learning/behavioral assessment; development of a structured treatment plan; implementation of the plan; ongoing education and training of the waiver participant, his/her family members, caregivers and all other service providers around participant-specific sequelae; individualized relapse strategies; periodic reassessment of the plan and ongoing support. The plan may include both group and individual interventions and reflects the use of curriculum and materials adapted from a traditional substance abuse program to meet the needs of individuals with serious mental illness. Linkages to existing community-based self-help/support groups such as Alcoholics Anonymous, faith-based, or secular organizations for sobriety will be part of the treatment plan. Substance Abuse Programs will communicate treatment regimens with all of the waiver participant's service providers. All Substance Abuse Programs must be documented in the service plan and provided by individuals or agencies approved as providers of this waiver service.

Cost: $42.45/hr

Appendix C – Resource Requirements at DMHAS and DSS

The following resources will be required to implement and administer the wavier program. It is recommended that funds be budgeted to new "Other Current Expenses" accounts at DMHAS and DSS.

DMHAS Resource Requirements

FTEs	Position Title	Position Function	Salary (Mid-point of range)	Subtotal
1.0	Mental Health Services Clinical Manager 2 (MP 66)	Program Director	$88,886	$88,886
1.0	Nurse Consultant (HC-28)	Oversee program quality and regional clinical operations	$68,641	$68,641
1.0	Housing Program Coordinator (SH-21)	Locate housing for waiver participants	$54,527	$54,527
5.0	Clinical Social Worker Associate (HC-26)	Administrative case management and provider oversight within region	$62,476	$312,380
1.0	Administrative Assistant	Clerical and administrative support	$49,850	$43,499

YEAR 1 DMHAS COST

DMHAS Staff Cost Total	$567,933
Housing Support	$163,800
Program Evaluation	$25,000
TOTAL DMHAS Year 1 Program Cost	$756,733

YEAR 2 DMHAS COST

DMHAS Staff Cost Total	$567,933
Housing Support	$466,200
Program Evaluation	$25,000
TOTAL DMHAS Year 2 Program Cost	$1,059,133

YEAR 3 DMHAS COST

DMHAS Staff Cost Total	$567,933
Housing Support	$768,600
Program Evaluation	$25,000
TOTAL DMHAS Year 3 Program Cost	$1,361,533

Housing Support (fully annualized)	$907,416

DSS Resource Requirements

FTEs	Position Title	Position Function	Salary (Mid-point of range)	Subtotal
1.0	Nurse Consultant (HC-28)	Review and approve admissions	$68,641	$68,641

DSS Staff Cost Total	$68,641
Fiscal Intermediary (to qualify, enroll and train providers, and to pay claims)	$750,000
TOTAL Program Cost at DSS (annualized)	$818,641

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