When Opportunity Knocks...

How the Affordable Care Act Can Help States Develop Supported Housing for People with Mental Illnesses

Judge David L. Bazelon Center for Mental Health Law

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Introduction

Over the past several decades, supported housing services for people with serious mental illnesses have been successfully implemented throughout the United States. Supported housing provides a housing subsidy to enable an individual to live in his or her own apartment or home, along with a flexible package of supportive services tailored to the individual's needs.

Supported housing offers people with serious mental illnesses the opportunity to have similar lives to people who do not have disabilities, with dignity and independence rather than in special "facilities." It is a key tool that states can employ to promote compliance with federal civil rights requirements, including the Americans with Disabilities Act (ADA) and its integration mandate. In addition, supported housing has demonstrated far better outcomes than congregate housing programs, proving to be cost effective.

Despite these substantial benefits, the availability of supported housing across the nation is limited. As states roll out the remaining portions of the Affordable Care Act (ACA), they should be aware that the ACA provides tools for them to expand supported housing and benefit their residents with disabilities, in addition to helping them comply with the requirements of the ADA. This is an important opportunity that states should pursue to the full advantage of people who have mental illnesses or other disabilities.

Supported Housing
Promotes Independence & Choice

Supported housing is a service that affords people with special needs opportunities to live outside of segregated facilities. It evolved over the last several decades with the intent of allowing older adults and people with disabilities to live in mainstream housing, such as their own homes or apartments. The service has special importance to people with serious mental illnesses, who have endured a long history of being excluded from the mainstream of their communities and consigned to segregated institutions.

Supported housing promotes independence and responsibility. Residents assume the rights and obligations of tenants, and they have access to a flexible package of services to allow them to be successful. These services are tailored to their individual needs, for example: help in learning independent living skills, maintaining housing, finding and keeping employment, and coordinating health care.

Supported housing also fulfills important obligations that states have under the Americans Disabilities Act (ADA). The ADA seeks to ensure that people with disabilities, including serious mental illnesses, have opportunities to move from the margins of society and into the mainstream of their communities. In many ways, public programs serving people with serious mental illnesses have contributed—intentionally or not—to their segregation. Accordingly, the ADA includes an "integration mandate" that requires states to administer services to people with disabilities in the most integrated setting appropriate. The Supreme Court reaffirmed this integration mandate in its 1999 decision, *Olmstead v. L.C.*,[1] which declared that the ADA prohibits the needless segregation of people with disabilities and found such segregation to be a form of discrimination.

Recent decisions by federal courts have found that states violate the ADA by segregating people not only in psychiatric hospitals, but also in nursing homes, adult homes, and other congregate facilities, contrary to the ADA's requirement of community inclusion. Virtually all people with psychiatric disabilities can live in their own apartments or homes with needed and desired supports. By expanding supported housing, states can afford people with psychiatric disabilities the opportunity to be fully integrated into their communities. Supported housing, and its implications for states' compliance with the ADA, is described in greater detail in A PLACE OF MY OWN: HOW

[1] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

THE ADA IS CREATING INTEGRATED HOUSING OPPORTUNITIES FOR PEOPLE WITH MENTAL ILLNESSES.[2]

Supported housing creates the chance for people with mental illnesses to reside in their own homes with the supports they need to succeed, which in turn creates the opportunity for them to live lives that are very different from those limited by placement into hospitals, nursing homes, adult homes and other congregate settings. Supported housing participants can choose where they wish to live, and whether to receive services and from whom. They can also make choices that most people take for granted: what they eat, when they go to bed, who their roommate is and whether they have one at all, how they decorate their living space, what activities they engage in, what friends they spend time with, and what jobs they seek. Obtaining employment may be a challenge, but it is far easier when living in one's own home than it is if one's address is a "special" facility.

Since it affords people such independence, it is not surprising that people with us mental illnesses prefer supported housing to other publicly funded living arrangements. Overwhelmingly, people with serious mental illnesses prefer to live in their own homes, rather than in congregate settings with other people with mental illnesses.[3]

Providing people with mental illnesses opportunities to exercise choice and autonomy in housing improves their health and clinical outcomes. Supported housing has demonstrated remarkably successful results, including for people with the most significant mental illnesses. Compared to congregate living facilities for people with mental illnesses, supported housing has brought greater housing stability, improved mental health symptoms, reduced hospitalization, and increased satisfaction with quality of life.[4] In addition, unlike congregate living arrangements where life and services are routinized for institutional convenience, supported housing does not perpetuate dependence; it encourages people to assume personal responsibilities and it orients services accordingly.

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[2] Bazelon Center, A PLACE OF MY OWN: HOW THE ADA is Creating Integrated Housing Opportunities for People with Mental Illnesses (2014), available at www.bazelon.org/portals/0/Where We Stand/Community Integration/Olmstead/A Place of My Own. Bazelon Center for Mental Health Law.pdf

[3] *See, e.g.*, Ann O'Hara, *Housing for People with Mental Illnesses: Update of a Report to the President's New Freedom Commission*, 58 Psychiatric Services 7, 907-13, 909 (July 2007).

[4] Bazelon Center, Supportive Housing: THE MOST EFFECTIVE AND INTEGRATED HOUSING FOR PEOPLE WITH MENTAL DISABILITIES 1 (2010), available at http://www.bazelon.org/LinkClick.aspx?fileticket=eRwzUzZdIXs%3d&tabid=126.

The Need to Expand Supported Housing

Despite the substantial benefits of supported housing, access to this service is limited. Only 2.6 percent of all people served by state mental health agencies in 2012 received supported housing.[5] Fourteen state mental health agencies provided no supported housing at all and only three states reported providing supported housing to more than 5 percent of the population served.[6] Across the country, the demand for supported housing far outstrips the supply.

The limited availability of supported housing is a "major barrier to community integration" for people with serious mental illnesses.[7] Without supported housing, "resources for services are largely tilted toward crisis-oriented, institutionally based systems, such as psychiatric hospitals, jails and prisons, and nursing homes."[8] Such service systems violate the ADA and *Olmstead* by overreliance on segregated settings. Moreover, resources needlessly spent on these costly settings could be used instead to serve greater numbers of people, and with better results. States have every reason to increase the availability of supported housing; the ACA provides opportunities for states to do just that.

Supported Housing Saves Money

Supported housing is less costly than other forms of government-financed housing for people with serious mental illnesses. Numerous studies have shown that expanding supported housing enables states to realize significant savings by reducing shelter use, hospitalizations, duration of hospital stays, and incarceration among this population.[9]

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[5] Substance Abuse and Mental Health Service Administration, *2012 CMHS Uniform Reporting System Output Tables* (2012) (hereinafter 2012 URS Tables), available at http://www.samhsa.gov/dataoutcomes/urs/urs2012.aspx.

[6] 2012 URS Tables, *supra* note 5.

[7] Kevin Martone, *The Impact of Failed Housing Policy on the Public Behavioral Health System*, 65 Psychiatric Services 3, 313-14, 313 (Mar. 2014).

[8] *Id.*

[9] *See, e.g.*, Dennis P. Culhane et al., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13 Housing Policy Debate 107 (2002), available at http://repository.upenn.edu/cgi/viewcontent.cgi?article=1067&context=spp_papers (supportive housing participants used an average of $16,282 less in services per year, and the cost of providing supportive housing was approximately the same as the cost of having individuals remain homeless); Fairmount Ventures, Inc., *Evaluation of Pathways to Housing PA* (Jan. 2011), available at http://pathwaystohousing.org/pa/wp-content/themes/pathways/assets/uploads/PTHPA-ProgramEvaluation.pdf (supported housing reduced participants' shelter episodes by 88 percent, hospitalization episodes by 71 percent, crisis response center episodes by 71 percent, and prison system

Such cost-savings enable states to serve more people with serious mental illnesses and to do so more effectively. As is explained below, the ACA provides states with significant new opportunities to use their funds to maximum benefit, not only by improving the lives of citizens with disabilities, but also by capturing federal dollars for services like supported housing that can reduce mental health crises, and promote recovery and self-sufficiency.

ACA Opportunities to Expand Supported Housing

Although states have varied somewhat in terms of the eligibility criteria for their traditional Medicaid programs, large numbers of people nationwide who have serious mental illnesses have not qualified for coverage. Such uninsured, indigent people with serious mental illnesses have typically received bare-bones mental healthcare—sometimes little more than medications and emergency services—paid for with state funds and at substantial cost. Under the ACA, states can expand eligibility for Medicaid, thereby securing federal reimbursement for the range of services they need. By expanding Medicaid and covering a comprehensive service package, states can reduce dependence on costly, crisis-oriented institutional services. In addition, they can use expansions in coverage to capture federal reimbursement for the services that allow people to be successful in supported housing. Furthermore, savings in state expenditures from reducing costly institutional care can be reinvested in rental subsidies for supported housing.

Without the Medicaid expansion, the mental health services that uninsured people receive remain a state's responsibility. Not only is this a missed opportunity, but under the ACA, federal subsidies that had been paid to states to help offset the cost of uncompensated care in hospitals will diminish.[10] In other words, states that fail to avail themselves of the opportunities afforded through the ACA's Medicaid expansion will experience a net loss in federal funding for services. These states will forego the very generous federal match for services that would be available under the expansion, and they will have to pay out more from their own funds to preserve existing services to uninsured

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episodes by 50 percent, and cost approximately $28,000 annually per person, compared to $56,600 for programs housing chronically homeless people and $41,000 for residential drug and alcohol programs for homeless people with mental illnesses); Robert Bernstein, *Fourth Report of the Court Monitor on Progress Toward Compliance with the Settlement Agreement: U.S. v. State of Delaware* (Sept. 2013) (net annual savings per person of somewhere between $96,000 to $276,000 when state psychiatric hospital residents, many with protracted stays, moved to supported housing; hospital readmission rate for this high-risk group was about half of that of all individuals with serious mental illness in the state).

[10] 42 USC § 1396r–4(f)(7).

people.

In addition to opportunities for states to expand eligibility for Medicaid, the ACA made improvements to the Medicaid State Plan Option for providing home- and community-based services [known as the "1915(i) option"]. This option can be used to offer people with mental illnesses a comprehensive set of services, largely at federal expense, that promote their success in supported housing.

The Medicaid Expansion

The ACA gives states the option to expand their Medicaid programs to provide coverage to all people with incomes at or below 138 percent of the Federal Poverty Level (FPL).[11] This population includes many people with psychiatric disabilities; over 1 million people with serious mental illnesses would be newly eligible for Medicaid if all states adopted the expansion.[12]

If states choose to expand, they will receive very substantial federal funds to pay for services for newly eligible people: 100 percent of the cost of services will be covered for the first three years (2014-16), and then gradually phasing down to 90 percent in 2020.[13] Ordinarily, states receive far lower federal reimbursement rates; between 50 percent (in states with high per capita incomes) and 75 percent (in states with lower per capita incomes).[14] The average federal Medicaid reimbursement rate is about 57 percent.[15]

As of the date of this report, the Medicaid expansion has been adopted by 27 states, including the District of Columbia, and an additional 5 states are debating the

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[11] State Medicaid programs have varying coverage rules. Some states already have income eligibility standards that cover people up to 138% FPL, while others do not. *See* The Henry J. Kaiser Family Foundation, State Health Facts, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier* (2014), available at http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/.

[12] Genevieve M. Kenney, et. al, The Urban Institute, *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid?* 3, Exhibit 2 (2012), available at http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf; Substance Abuse and Mental Health Service Administration, *Behavioral Health Treatment Needs Assessment Toolkit for States* 10, Table 1 (2013) (hereinafter SAMHSA Toolkit), available at http://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf.

[13] 42 U.S.C. § 1396a(k)(1).

[14] The Henry J. Kaiser Family Foundation, State Health Facts, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier* (2014), available at http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/.

[15] *Id.*

expansion.[16] In states not moving forward with the expansion at this time, approximately 4.8 million uninsured people would qualify for Medicaid under the new eligibility criteria.[17] Many of the states that have not pursued the expansion have high rates of serious mental illnesses. In these states, roughly 8.8 percent of those who would be covered—in excess of 422,000 people with serious mental illnesses—will be deprived of the benefits of the federal funding for their services and their care will remain the responsibility of the states in which they live.[18]

Newly Eligible People with Serious Mental Illnesses Can Receive Traditional Medicaid Coverage

Under the ACA, states that avail themselves of the Medicaid expansion generally need not offer traditional Medicaid benefits to the newly covered population. States may offer this group "alternative benefit plans" (ABPs). ABPs are based on a "blueprint" plan that the state chooses from among several different commercial insurance plans.[19] The ABPs must include the coverage offered by the blueprint plan, as well as a set of "essential health benefits" including mental health and substance use disorder services.[20] The ABPs must also comply with the federal Mental Health Parity and Addiction Equity Act, and include mandatory Medicaid services such as comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children.[21]

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[16] The Henry J. Kaiser Family Foundation, State Health Facts, *Status of State Action on the Medicaid Expansion Decision*, 2014 (Mar. 26, 2014), available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[17] The Henry J. Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, p. 4 (Oct. 2013).

[18] SAMHSA Toolkit, *supra* note 12, at 4.

[19] The federal government issued a detailed set of rules concerning how closely the ABPs must follow the blueprint plan that the state has selected. Certain variations are permitted. *See* 78 Federal Register 42160-42322 (July 15, 2013), available at http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf.

[20] The essential health benefits package chosen by the state must include services in the amount, duration and scope offered by the "base benchmark plan" chosen by the state (or equivalent services), and must include services in each of the following categories: ambulatory patient services, emergency room services, hospitalization, maternity and newborn care, mental health and substance abuse disorders, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. 42 C.F.R. §§ 440.345(d), 440.347, 45 C.F.R. §§ 156.100, 156.115.

[21] Cindy Mann, Letter to State Medicaid Directors, *Essential Health Benefits in the Medicaid Program* 2 (Nov. 2012), available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf.

States are allowed to establish ABPs that cover fewer mental health services than traditional Medicaid.[22] However, they may choose to have their ABPs cover the same services as their regular state Medicaid plan. In fact, a number of states that have chosen to participate in the expansion have adopted ABPs that more or less align with their traditional Medicaid plans in order to simplify administration of their Medicaid program.

Importantly, people with serious mental illnesses in the expansion population have the right to choose traditional Medicaid services *instead* of ABP coverage provided under the expansion.[23] The federal government still pays the higher matching rate for those expansion enrollees who choose traditional Medicaid services.[24] This offers a tremendous advantage to states adopting the expansion: they can provide people with serious mental illnesses a more comprehensive array of services than under their APBs at very little cost to the state.

States Can Save Money by Covering People with Serious Mental Illnesses in the Medicaid Expansion

The number of people with psychiatric disabilities eligible for coverage under the Medicaid expansion is substantial. The federal government estimates that, of the total population that would be newly eligible if all states adopted the Medicaid expansion, 7.1 percent have a serious mental illness.[25] This means that in the states that have adopted the expansion, over a million people with serious mental illnesses will be newly eligible for Medicaid. In some states, up to 17 percent of the adults in the Medicaid expansion are expected to have a serious mental illness.[26]

For states with a high percentage of people with serious mental illnesses who would be newly eligible under the expansion—Alabama and Indiana are examples—the potential state cost-savings are tremendous. Expanding Medicaid would enable such

[22] The ABPs are based on commercial insurance plans, which typically cover few of the intensive mental health services generally covered by states' traditional Medicaid programs.

[23] 78 Federal Register 42160, 4229-34 (July 15, 2013), available at http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf. People with serious mental illness are ''medically frail'' and thus exempt from being mandatorily enrolled in the ABPs. They must be given an informed choice between the ABP and traditional Medicaid coverage.

[24] 42 U.S.C. §1396a(k)(1).

[25] SAMHSA Toolkit, *supra* note 12, at Table 3.

[26] *Id*.

states to reduce state mental health spending in multiple ways. First, many uninsured people with serious mental illnesses today receive state-funded public mental health services that are usually focused on crisis-oriented care. The Medicaid expansion enables states to shift this group of people into Medicaid coverage that is almost entirely paid for by the federal government.

Second, expanding Medicaid will benefit states by shifting spending away from expensive, late-stage crisis interventions in such settings as emergency rooms, state psychiatric hospitals and criminal justice systems. The Medicaid expansion allows states to offer a far more robust array of services and to intervene earlier—largely at the expense of the federal government—thereby reducing the use of expensive, high-end services such as hospitals and emergency rooms.[27] By reducing spending on high-cost services, states can redirect funds to supported housing and use federal money to provide (and expand) the services they currently pay for with state dollars.[28]

While the Medicaid funds generally cannot be used to pay for housing,[29] states may use Medicaid to cover the supportive services provided to supported housing residents. States may choose to cover services such as intensive case management, assertive community treatment, mobile crisis teams, skill-building services, supported employment, personal care services, and peer support services. Adopting the Medicaid expansion will enable states to offer these services to large numbers of people with serious mental illnesses who were previously uninsured.

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[27] Joel Miller, National Ass'n of State Mental Health Program Directors, *Too Significant to Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illnesses, for Their Families and for Their Communities* 63 (2012), available at http://www.nasmhpd.org/docs/publications/Too%20Significant%20To%20Fail.pdf ("Health-services research shows that comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay and reduce average days of detention by approximately 40 percent").

[28] John Holahan et al., Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* 23 (July 2013), available at http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf; Joel Miller et al., National Ass'n of State Mental Health Program Directors, *The Waterfall Effect: Transformative Impacts of Medicaid Expansion on States* 14, 17 (Jan. 2013), available at http://www.nasmhpd.org/docs/publications/NASMHPDMedicaidExpansionReportFinal.

[29] Typically state or federal housing subsidies are used to cover the housing portion of supported housing, together with a contribution from an individual's SSI, SSDI or employment income.

Adopting the Expansion Will Reduce State Payments for Psychiatric Hospital Stays

Using the Medicaid expansion to afford people with mental illnesses the services they need to succeed in the community will significantly reduce psychiatric hospitalizations.[30] The savings states realize from reducing such stays are particularly important because states' share of costs for psychiatric hospitalization will be increasing—dramatically in some states—in the near future.

Medicaid rules prohibit federal reimbursement for any services provided to people between the ages of 22 and 64 in Institutions for Mental Diseases (IMDs), which include psychiatric hospitals, and accordingly states pay the bulk of the cost of care provided to people in these settings.[31] For example, nationally, states pay 69.3 percent of costs to treat people in state psychiatric hospitals.[32]

State psychiatric hospitals are extremely expensive. For example, Missouri spends 62.4 percent of its entire mental health budget providing state psychiatric hospital services to only 5.2 percent of all people in its public mental health system.[33] New York spends 39 percent of its mental health budget on state hospital care for 1.6 percent of the people in the mental health system.[34] In 2010, 163,347 people (2 percent of all people served by state mental health systems) received services in state psychiatric hospitals at a cost of $9.4 billion.[35] Moreover, state psychiatric hospitals are becoming even more expensive. Daily per patient costs have increased 36 percent between 2003 and 2010.[36]

One of the few forms of federal funding for state psychiatric hospitals is Disproportionate Share Hospital (DSH) allotments.[37] These payments were established to

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[30] Miller, *Too Significant to Fail*, *supra* note 27 at 63.

[31] 42 U.S.C. §§ 1396d(i), 1396d(a)(14), 1396d(h).

[32] National Ass'n of State Mental Health Program Directors Research Institute, *State Mental Health Agency Profiles Systems and Revenues Expenditures Study* 2010 Data (last accessed Sept. 11, 2013) (hereinafter NRI 2010 Data), available at http://www.nri-inc.org/projects/Profiles/Prior_RE.cfm#2010.

[33] Original Bazelon Center calculations using data from Substance Abuse and Mental Health Service Administration, *2010 CMHS Uniform Reporting System Output Tables* (2010), available at http://www.samhsa.gov/dataoutcomes/urs/urs2010.aspx2010 URS Tables, and NRI 2010 Data, *supra* note 29.

[34] *Id.*

[35] *Id.*

[36] Ted Lutterman, National Association of State Mental Health Program Directors Research Institute, Inc., *Fiscal Year 2010 Revenue and Expenditure Study Results* 4 (December 2012), available at http://www.nri-inc.org/reports_pubs/2012/RESummary2010.pdf.

[37] Robert W. Glover and Joel E. Miller, National Ass'n of State Mental Health Program Directors, *The Interplay between Medicaid DSH Payment Cuts, the IMD Exclusion and the ACA Medicaid Expansion*

help offset the costs of serving people who lack healthcare insurance. Since the ACA was designed to drastically reduce the number of uninsured people, these payments are scheduled to be reduced, starting in 2014 and 2015, and will be cut almost in half in 2018 through 2020.[38] Therefore, states that have chosen *not* to expand Medicaid will lose significant federal reimbursement for serving people in state psychiatric hospitals, though the number of uninsured people requiring treatment will remain unchanged.

In 2010, states received $1.6 billion in DSH payments for state psychiatric hospitals—states' match for those funds was an additional $1.1 billion.[39] Missouri, New Jersey, New York, Pennsylvania, and Texas all received more than $100 million in federal DSH funds and seven states received over $50 million.[40] As DSH payments are reduced, states will have to pay a much larger share of the cost of these institutional services from state funds. The DSH payments that go to psychiatric hospital care vary from state to state, but a number of states rely heavily on these payments. In such states, DSH payments account for anywhere from 11 percent to more than 35 percent of their mental health budget.[41] In states that rely heavily on DSH funding to finance psychiatric hospital services, failure to adopt the Medicaid expansion will result in dramatic increases in state costs.

While the Medicaid program, including the expansion, generally does not cover inpatient psychiatric care in state hospitals or other IMDs, it does cover psychiatric hospital care when it is provided in a general hospital. States that shift the locus of inpatient psychiatric care from IMDs to general hospitals not only capture federal reimbursement, which is particularly generous for the expansion population, but also provide needed hospital care in a setting that is prepared to deal with the whole person's physical and mental health needs. This is especially important for people with serious mental illnesses because of their remarkably high rates of co-occurring nutritional and metabolic diseases, cardiovascular diseases, viral diseases, respiratory tract diseases, musculoskeletal diseases, dental diseases, and possibly obesity-related cancers, as well as their extremely elevated mortality rates.[42] In part, these poor health outcomes are attributable to people with serious mental illnesses not receiving appropriate physical

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Program: Impacts on State Public Mental Health Services (2013), available at http://www.nasmhpd.org/docs/publications/TheDSHInterplay04_26_13WebsiteFINAL.pdf.

[38] 42 USC § 1396r–4(f)(7).

[39] NRI 2010 Data, *supra* note 33, Table 29.

[40] *Id.*

[41] Original Bazelon Center analysis using data from 2010 URS Tables, *supra* note 33, and NRI 2010 Data, *supra* note 33, Table 29.

[42]Marc De Hert, et. al., *Physical Illness in Patients with Severe Mental Disorder: Prevalence, Impact of Medications, and Disparities in Health Care*, 10 World Psychiatry 52–77 (Feb 2011), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048500/.

health care services,[43] a situation that is particularly likely among those who do not have Medicaid or other health insurance. For these reasons, when people covered by Medicaid require inpatient psychiatric care, treatment in a general hospital has clear advantages. This is particularly the case for people newly covered through the Medicaid expansion because federal reimbursements cover virtually the entire cost of care and because, due to previously being uninsured, they are at very high risk of co-occurring physical health problems.

Adopting the Expansion Will Reduce State Payments for Emergency Room Visits

The reduction in DSH payments also affects states' spending on hospital emergency room care in states that do not adopt the Medicaid expansion. In 2007, there were 95 million visits made by adults to hospital emergency departments in the U.S.[44] Of these visits, 7.6 million were related to mental health conditions and 1.4 million visits involved co-occurring mental health and substance abuse conditions.[45] People visiting emergency departments due to mental health conditions represent a significant expense for the emergency care system because they "tend to require resource-intensive care, and their inpatient admission rates are high."[46] In 2007, people with mental health conditions were 24 percent more likely to be admitted for inpatient care than people without a mental condition.[47] The high uninsured rates among this group also mean that much of the resource-intensive care is uncompensated.[48] DSH payments currently finance approximately 60 percent of the uncompensated care provided by emergency departments. [49]

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[43] *Id.*

[44] Pamela Owens et al., Agency for Healthcare Research and Quality, *Mental Health and Substance Abuse-Related Emergency Department Visits Among Adults, 2007* 8, Table 1(July 2010), available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf.

[45] *Id.*

[46] Institute of Medicine, *Hospital-Based Emergency Care: At The Breaking Point* 59-62 (National Academies Press 2007).

[47] Owens et al., *supra* note 44, at 10, Figure 1.

[48] *Id.* at 8, Table 1. 13.8 percent of emergency department patients with mental health conditions were uninsured and 26.3 percent of patients with mental-health as a co-occurring condition were uninsured.

[49] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* 55 (National Academies Press 2003) (approximately 60 percent is paid by the federal government, 30 percent is paid for by state and local governments, and "between 10 and 20 percent of [hospitals'] surplus revenues subsidize care to the uninsured.").

The Urban Institute estimated that if all states were to adopt the Medicaid expansion, state uncompensated care costs—including care in emergency rooms, hospitals, and other health care settings—would decrease by $18.3 billion over a ten-year period.[50] These estimates vary by state, with the largest projected savings being in Florida ($1.3 billion), Texas ($1.7 billion), North Carolina ($1.4 billion) and California ($1.9 billion).[51]

One reason for such savings is an expected reduction in emergency department visits by people with mental illnesses in states that expand Medicaid. Large numbers of these newly insured people will for the first time receive community services that reduce the likelihood that crises occur, and that provide alternatives to emergency rooms when they do. While the amount of savings achieved through the availability of more effective treatment depends upon the scope of services that a state covers in its Medicaid program, the potential savings in uncompensated care from adopting the Medicaid expansion are substantial.

Adopting the Expansion Will Reduce Spending on Criminal Justice Involvement

States that adopt the Medicaid expansion can also drastically reduce state spending on people with mental illnesses in the criminal justice system. As numerous studies have pointed out, "[o]ne of the consequences of the inadequate treatment of persons with severe mental illness [due to lack of health insurance coverage] is their disproportionate and potentially avoidable involvement with the criminal justice system."[52] People with mental illnesses are more likely to be arrested[53] and studies have found that rates of arrest among public mental health service recipients are "roughly 4.5

[50] John Holahan, et. al, The Urban Institute, The Henry J. Kaiser Family Foundation, *The Cost of Not Expanding Medicaid* 11 (July 2013).

[51] *Id.* at 12, Table 5.

[52] *Id.* at 79.

[53] Bazelon Center for Mental Health Law, *The Role of Mental Health Courts in System Reform* 2 (2003), available at http://bazelon.org/LinkClick.aspx?fileticket=xQf5_1grKcI%3D&tabid=104.

times higher than those observed in the general population."[54] On average, 17 percent of people incarcerated in jails are estimated to have serious mental illnesses.[55]

The costs of arresting and incarcerating people with mental illnesses are high. A study of 1991 data suggested that "approximately $2 billion was spent on jailing, prosecuting, and imprisoning [people with schizophrenia] in that year, about 10 percent of the estimated cost of treatment-related services provided to persons with schizophrenia in that year."[56] A recent study in Connecticut found that adults with serious mental illnesses who were involved with the criminal justice system "incurred costs approximately double those of the group with no involvement—$48,980 compared with $24,728 per person."[57]

Reducing recidivism and initial imprisonment would bring significant cost savings to states, in addition to bringing obvious benefits to the people involved. States are the primary payers for corrections costs. In 2011, 95.8 percent of corrections spending came from the state funds.[58] Moreover, state spending on corrections has risen faster over the last 20 years than spending on nearly any other state budget item.[59]

Expanding Medicaid would reduce states' correctional costs by affording previously uninsured people with mental illnesses access to community services that enable them to avoid incarceration. In addition, recidivism rates should decline in expansion states as large numbers of people with mental illnesses who are currently incarcerated become eligible for Medicaid services for the first time upon their release. One study estimated that up to 33.6 percent of state and federal prisoners released annually would be eligible for Medicaid under the expansion if all states adopted it.[60]

Programs that help incarcerated people with mental illnesses obtain Medicaid coverage immediately upon release have demonstrated great success in reducing recidivism. The New York City-based Center for Alternative Sentencing and

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[54] William H. Fisher, et. al., *Risk of Arrest Among Public Mental Health Services Recipients and the General Public*, 62 *Psychiatric Services* 62 (Jan. 2011).

[55] Alex M. Blandford & Fred C. Ocher, Council of State Governments Justice Center, *A Checklist for Implementing Evidence-Based Practices and Programs for Justice-Involved Adults with Behavioral Health Disorders* 1 (Aug. 2012).

[56] Institute of Medicine, *Hidden Costs*, *supra* note 49, at 79.

[57] Jeffrey Swanson, *Costs of Criminal Justice Involvement Among Persons With Serious Mental Illness in Connecticut* 64 *Psychiatric Services 7*, 630-37, 636 (July 2013).

[58] National Association of State Budget Officers, *State Expenditure Report, Examining Fiscal 2010-2012 State Spending* 33 (2012), available at http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf.

[59] Miller, *Too Significant to Fail*, *supra* note 27, at 33.

[60] Alison Evans Cuellar & Jehanzeb Cheema, *As Roughly 700,000 Prisoners Are Released Annually, About Half Will Gain Health Coverage and Care Under Federal Laws*, 31 Health Affairs 5, 931-38, 934-35 (May 2012).

Employment Services' Nathaniel Project has demonstrated a "70 percent reduction in the mean number of arrests in the two years following program admission compared to the two years before."[61] The Oklahoma Collaborative Mental Health Reentry Program reduced "the recidivism of participants by 41 percent when compared to similar groups."[62] With the Medicaid expansion, such programs will be able to assist far greater numbers of people with mental illnesses and help prevent their re-incarceration.

Of course, extending Medicaid coverage to people involved with the criminal justice system will bring benefits far beyond simply reducing recidivism. By providing Medicaid-funded services to people with mental illnesses released from jails and prisons, for example, the Nathaniel Project has reduced the average length of participant homelessness by 60 percent; increased the level of employment and recipient enrollment in education, vocational training, and volunteering; and decreased rates of psychiatric hospitalization and harmful behaviors.[63] The Oklahoma program saw a 6 percent decline in inpatient hospitalizations and increases in use of community-based outpatient services, higher Medicaid enrollment, and increased Social Security benefit enrollment.[64] States adopting the Medicaid expansion will be able not only to shift spending from corrections to more effective services with better outcomes, but also to have those services paid for primarily by the federal government.

The "1915(i)" Home & Community-Based Services Option

Another important tool that the ACA offers states is an improved Medicaid option for financing home and community-based services. In 2005, Congress created an option that states could choose to include in their Medicaid plans that would provide a package of home and community-based services to people with disabilities. This option, known as the "Section 1915(i) Option," because of its location in the Medicaid statute, allows states to cover certain community services that could not be covered under other Medicaid options. While states were previously allowed to cover these services under Medicaid

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[61] Center for Alternative Sentencing and Employment Services, *Nathaniel ACT ATI Program: ACT or FACT?* 4 (last accessed Sept. 11, 2013) (hereinafter CASES Brief), available at http://www.cases.org/articles/ACTBrief051111.pdf.

[62] National Center for Justice Planning, *Addressing the Intersection: The Oklahoma Collaborative Mental Health Reentry Program* (last accessed April 1, 2014), available at http://ncjp.org/content/addressing-intersection-oklahoma-collaborative-mental-health-reentry-program.

[63] CASES Brief, *supra* note 62, at 3, 5.

[64] National Center for Justice Planning, *supra* note 63.

home and community-based "waivers," Medicaid rules prevented them from developing such waivers for most people with serious mental illnesses.

The 1915(i) Option gives states important flexibility to use federal dollars to fund services that enable people with serious mental illnesses to be successfully served in their communities and in their own homes, while also controlling admissions to institutional facilities. Unlike waivers, the 1915(i) Option does not limit services to people who are eligible for admission to an institution. Thus, states can use the 1915(i) Option to tighten institutional admission standards and decrease institutional services while expanding community services.

The ACA made the 1915(i) Option even more useful by authorizing coverage of additional benefits and requiring that the option apply to all eligible people in the state who need the covered services. The 1915(i) Option now allows states to cover a very broad range of community services important to people in supported housing, including security deposits required to obtain a lease; set-up fees or deposits for utility or service access; essential furnishings and moving expenses; and a range of supported employment services broader than those that may be covered under other state plan options.

A number of states use the 1915(i) Option to cover services for people with serious mental illnesses; some have 1915(i) Options exclusively targeted for this group. For example, Iowa has chosen to cover case management and supported employment services.[65] Oregon covers rehabilitation services.[66] Oregon determined that the 1915(i) Option "[i]ncreases the use of Medicaid funding while reducing the use of state general funds," since it may be used to cover such a wide range of services.[67]

A robust 1915(i) Option would enable states to substitute federal funds for state funds to finance the start-up costs and services that are a part of supported housing for people with serious mental illnesses, as well as a wide range of employment and other services that enable community integration. In a state that has adopted the Medicaid expansion, the 1915(i) Option would enable the state to receive between 90 percent and 100 percent federal reimbursement for providing these services to people in the newly covered population.

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[65] IOWA, 1915(I) STATE PLAN AMENDMENT APPLICATION (2006), available at http://www.ime.state.ia.us/docs/07-001-1915i-StatePlanHCBS-FINAL.doc.

[66] OREGON HEALTH AUTHORITY, AMH MEDICAID POLICY UNIT, INTRODUCTION TO OREGON'S 1915(I) Plan (2013), available at http://www.oregon.gov/oha/amh/docs/1915i-overview.pdf.

[67] *Id.*

Responding When Opportunity Knocks…

The ACA has created tremendous opportunities for states to develop additional supported housing for people with serious mental illnesses. The Medicaid expansion and the associated cost savings allow states to reallocate substantial state funds to finance the development of additional supported housing. Moreover, the 1915(i) Option allows states to receive federal reimbursement for much of the cost of supported housing. In states with the Medicaid expansion, the federal government would pay nearly all of this cost for newly eligible people.

Supported housing has proven to be an effective service for people with serious mental illnesses. It furthers states' legal obligations to them and breaks the cycles of hospitalization, incarceration, homelessness, and needless dependence that far too often define their lives. The ACA creates new opportunities for states to make a comprehensive array of services available to people with serious mental illnesses available, mostly at federal expense. It also allows states to free up substantial state dollars that have been invested in crisis- and institutional-responses and to redirect these funds to housing and other essential services. In the history of public services to people with serious mental illnesses, rarely have there been opportunities for states to achieve dramatic reforms through an influx of such significant new federal funds. The ACA represents one of those game-changing opportunities that states' mental health systems have long awaited.