NAMI Connecticut
National Alliance on Mental Illness

Testimony before the Commission on Enhancing Agency Outcomes
December 14, 2009

Good morning, Chairs and members of the Commission on Enhancing Agency Outcomes. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). NAMI-CT is the largest member organization in the state of people with psychiatric disabilities and their families. I am here today to testify on the Commission's preliminary proposed areas of focus. Specifically, this testimony will address NAMI-CT's support for recommendations 17, 26, and 27.

Recommendation 17: NAMI-CT strongly supports the recommendation to provide community services to approximately 1,400 persons in prison who are incarcerated for low-level, non-violent offenses. Many individuals with psychiatric disorders in the prison system are non-violent offenders. People with mental illnesses are no more violent than other people and are *more often victims of violence and abuse*. As of October 2007, the Department of Corrections reported that there were 1,428 persons with moderate to serious mental illnesses incarcerated for low-level, non-violent offenses[1]. It would cost dramatically less to invest taxpayer dollars in the community mental health system, jail diversion programs, crisis intervention teams, and alternatives to incarceration residential programs. The average cost of community based services and housing is $20,000, whereas the cost of a correctional setting ranges from $40,000 - $60,000, depending upon the level of mental health treatment or use of a specialized facility. Furthermore, we have successful models in place to build upon in CT for jail diversion, accelerated rehabilitation, and alternative to incarceration programs for persons with serious mental illnesses.

People with mental illnesses serve longer and harder time -- reports show that prisoners with mental illnesses often find themselves in violation of the prison rules for symptom-related reasons, have greater than average disciplinary rates, are more likely to be abused in prison, and are more likely to serve their full sentence ("Ill-Equipped: US Prisoners and Offenders with Mental Illness", Human Rights Watch, 2003). By serving their full sentence, people with mental illnesses are released as being "end of sentence", which means that they can be released with none of the services, housing, or treatment planning associated with jail diversion or alternative to incarceration programs. This greatly increases the risk of recidivism, resulting in more harm and costs to the individual and the state.

Recommendation 26: The state must provide opportunities for community integration for people with mental illnesses by assuring access to the least-restrictive, individualized level of care. Investing in a comprehensive community mental health system can shift dollars from costly criminal justice settings, nursing facilities, prolonged hospitalizations and emergency care, to cost effective community supports and housing options. There are many DMHAS services currently state grant funded that could be covered as optional[2] rehabilitation services under Medicaid[3].

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[1] *As of October 2007, the Department of Corrections (DOC) reported that of the 3,897 inmates with mental health issues classified as level 3, 4 and 5, 1,741 were not convicted of, or on bond for, a violent or serious offense.* The DOC reports the Mental Health level 3 numbers to be inflated by approximately 20% because they include inmates with problems that are probably not directly attributable to serious psychiatric illness. *This still leaves 1,428 inmates with moderate to serious mental illnesses who are in prison for low level offenses.*

[2] The state can also expand Medicaid under the 1915(i) state plan option, which enables states to provide a prescribed set of home and community based services to individuals that earn less than 150% of the Federal Poverty Level and require less than institutional levels of care.

[3] The federal Medicaid program has both mandatory and optional services.

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An actuarial study conducted by the Mercer Consulting Group for the Department of Social Services (DSS) identified the following ***new federal revenue for these existing DMHAS services as Medicaid rehabilitation services:***

Assertive Community Treatment Teams (ACT)	$10,554,692
Supervised Housing (services only)	$11,141,684
Supported Housing (services only)	$ 7,074,768
Mobile Crisis	$ 6,167,272
Total estimated	$34,938,416[4]
Targeted Case Mgt. current revenues	$7,000,000
NET NEW FEDERAL FUNDS	**$27,938,416**[5]

OPM and DMHAS have moved cautiously on Medicaid coverage for adult mental health services, only covering rehabilitation services at group homes thus far. However, the state has allocated funds to build the capacity of community providers to comply with Medicaid requirements.

In addition, the state now operates a home and community based services waiver for persons with mental illness who can be diverted or discharged from nursing homes. In the course of developing this waiver, DSS and DMHAS have developed service definitions and a rate-setting methodology for services to be covered under the waiver. Two of these, assertive community treatment and community support services (included as ACT in the Mercer study), could be covered by the Medicaid state plan expanding the population served and increasing federal revenue.

In order for the Medicaid maximization of community mental health services to work long-term, DMHAS must retain grant funds for the transition costs into Medicaid fee-for service, non-medical services (social support), and non-Medicaid eligible clients. In addition, the rate-setting structure must cover the cost of providing services, and funds must be targeted to expand housing options and services for individuals with complex needs. The impact of these measures must be monitored to report the outcomes on inappropriate institutional and emergency room care.

Recommendation 27: Federal revenue can also be maximized by assuring that outpatient services provided by state operated and contracted providers are billed to Medicaid to the fullest extent allowed. It is our understanding that DMHAS and other state agencies do no direct billing, nor are their budgets dependent upon any income generated. The state should determine if standards regarding timely and accurate billing have been established to maximize what the state does collect for its billable services.

Thank you for your time and attention. I am happy to answer any questions that you may have.

[4] Group homes are excluded since DMHAS and DCF are already proceeding with coverage of their services under the Rehab Option.
[5] Mercer Government Consulting Group, ***Estimate of the Budget Neutrality of the Connecticut Behavioral Health Partnership, Technical Appendix,*** Feb. 2004, Appendix J.5.

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