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THE PATH FORWARD: INVESTING IN THE ILLINOIS COMMUNITY MENTAL HEALTH SYSTEM

November 2013 Policy Brief

Improving Lives, Saving Money

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Executive Summary

Mental illnesses, like other medical conditions, are treatable. Individuals living with a serious mental illness can live a full, productive, and healthy life in the community when they have access to the right care and support services at the right time. These services not only improve health outcomes and help people on their journey through recovery, but also save the state significant dollars, as the analysis in this report demonstrates.

Medicaid is the primary insurer for individuals living with mental illness who also often live in poverty, in large part because of their untreated mental illness. However, because of the fragmented Medicaid system and a lack of the right set of coordinated services in the community, persons with disabilities, including those with mental illnesses, account for 55 percent of the Medicaid costs though they represent just 15 percent of the total Medicaid population.[1] Without the right set of community mental health and other services in place, along with strong coordination of these services, individuals with serious mental illnesses are not able to stabilize their illness, continuing a vicious cycle of repeated hospitalizations. Further, they frequently end up in institutional care in nursing homes, homeless, or in the justice system, never receiving any real, sustained mental health treatment.

We want to recognize that the state is on the road to systems change through the implementation of the *Williams* consent decree, the promise of the *Colbert* consent decree, and the development of Medicaid care coordination entities. We are grateful for the leadership of the Governor's Office, the Department of Human Services' Division of Mental Health, the Department of Healthcare and Family Services, and our legislative partners in each of these efforts, and look forward to creating a stronger, more effective mental health safety net as we move into the implementation of health care reform. To this end, the Medicaid expansion, coordinated and managed care, and health care reform together provide Illinois policymakers with an historic opportunity to make the needed investments in the state's long neglected community mental health safety net that will result in better health for those living with a mental illness *and* reduced state costs.

To date, Illinois has not invested adequately in community mental health treatment services, or has cut the services offered so deeply that thousands of individuals living with serious mental illnesses are left without treatment. Data provided by the Illinois Hospital Association (IHA) on trends in emergency room visits and hospitalizations for people in psychiatric or behavioral health crisis shows that as the state eliminated more than $113 million[2] in community mental health treatment services between fiscal years 2009 and 2011, hospitalizations and institutional placements increased.[3] Cost data shows that this spike cost the state an estimated $131.4 million between 2009

and 2012, using a very conservative methodology.[4] Accordingly, the state actually *increased* its costs by an estimated $18.4 million when it cut community mental health treatment services, illustrating the short-sightedness of reducing community mental health services.

This policy brief is a call to action for state leaders to invest in the state's community mental health safety net, as well as transform the mental health system in the new healthcare environment, in a way that enables individuals with mental illness to get the care they need when they need it to stabilize their illness, and in a way that is cost-effective for the state. In this effort, policymakers must approach improving the mental health safety net from a policy perspective, rather than only from a Medicaid programmatic approach. While Medicaid is the primary source of funding for community mental health services for people living in poverty, policy is not just an investment in one or two programs. Policy reflects a government-wide objective that aligns multiple programs to provide high-quality services and supports in a coordinated fashion.

The state must make a number of specific investments in the community mental health safety net to begin building a strong community mental health system that will improve health outcomes for people living with a mental illness, while also reducing costly reliance on the inappropriate use of hospitals, nursing homes, and jails. If these investments are *not* made, the state will continue to pay for ineffective, high-cost services far into the future. The state will take on the cost of covering 10 percent of the new Medicaid expansion population beginning in 2020. In addition, thousands of individuals with mental illness covered under the expansion will move to traditional Medicaid, for which the state covers 50 percent of the cost once these individuals receive a Medicaid disability determination. Policymakers therefore would be wise to make these investments on the front-end of Medicaid expansion to control preventable hospitalization and institutionalization costs in the future.

Key Findings

Thresholds used data provided by the IHA to analyze trends in emergency room use and hospitalizations for individuals in psychiatric or substance abuse crisis following the state's cuts to the mental health system between 2009 and 2011. The cost of this care was estimated using data from the IHA, the 2012 Medicare Cost Reports for hospitals statewide, and data provided by the Illinois Department of Healthcare and Family Services. The following are the findings of our analysis:

- In the span of just three years between fiscal year 2009 and 2011 the state cut more than $113 million in community mental health treatment services.[5] It is important to underscore that prior to these cuts the state's community mental health safety net was anything but robust.

- The state is currently under two *Olmstead* consent decrees for its longtime failure to invest in community-based mental health treatment and affordable housing.[6]

- Between 2009 and 2012, hospital emergency room visits for people in psychiatric or substance abuse crisis climbed by 19 percent—an increase of more than 35,000 emergency room visits. This is an increase of 12 percentage points higher than other medical ER visits. These increased mental and behavioral health (*i.e.*, substance abuse) emergency room visits cost the state and hospitals an estimated $71.5 million.[7]

- In 2012, approximately 25 percent of mental and behavioral health emergency room visits resulted in inpatient hospital stays for an average length of 6.7 days. Estimating just the increased number of hospitalizations from the rise in emergency room visits as a result of the cuts to community treatment services, we found that the increased ER visits resulted in approximately 8,819 additional hospitalizations, costing the state and hospitals approximately $37.9 million.

- While total inpatient hospital stays for individuals in psychiatric or substance abuse crisis declined by three percent between 2009 and 2012, this decline did not keep pace with the overall decline in hospitalizations for medical care (a decline of 5.3 percent across Illinois) as outpatient, community-based care has become more accessible and effective. Data was not available for hospital stays in state-operated psychiatric hospitals. However, it is highly likely that those hospitalizations increased as community mental health treatment services were significantly curtailed. The overall trend in declining private hospitalizations should hold true for hospitalizations for mental illnesses given the advances in psychiatric medications and evidence-based practices in community care. It is therefore estimated that the state would have saved an additional $13.9 million if community treatment services had not been significantly curtailed by the cuts between 2009 and 2011.

- It is worth highlighting that most hospitals are not designed to provide sustained treatment for mental illnesses or other medical conditions. While hospitals play a critical role in the health care system, most are generally intended to treat medical crises or emergencies, or perform specialized procedures. Treatment typically happens in outpatient community settings for mental illnesses, just as with other medical conditions.

- The estimated average cost of an ER visit is $2,027, while the estimated average cost of a mental or behavioral health hospital stay lasting 6.7 days is $4,301.[8] It is not uncommon for a person with an untreated serious mental illness to be hospitalized multiple times a year for psychiatric reasons. Yet, these costs do not include any sustained treatment, but only the hospital care to stabilize the crisis. To compare costs, a *full year* of Assertive Community Treatment, an evidence-based practice that is the most intensive level of community care aimed at long-term recovery for an individual with a serious mental illness, and a proven model for reducing hospitalizations,[9] is $10,243.[10] It is important to note that not all individuals with a serious mental illness need this level of care in the community to manage their illness. Given that individuals with a serious untreated mental illness repeatedly cycle through hospitals, it is far more cost-effective to provide a full year of community-based treatment using Assertive Community Treatment or less intensive community models of care than for individuals to be hospitalized multiple times and still go without the recovery services that are essential to enabling sustained management of a serious mental illness.

- Based on data provided by the Illinois Department of Human Services' Division of Mental Health, approximately 80 percent of individuals hospitalized for a psychiatric crisis who are screened for the next level of care (using a pre-admission screening process) are referred to institutional care in nursing homes, most often because not enough community mental health treatment services are available for the individual. Applying this percentage to the estimated number of increased hospitalizations due to the cuts to community mental health services, approximately 258 of these individuals were placed in institutional care simply because they

wound up at the emergency room and lacked access to community care as a result of the cuts. This costs the state approximately $8.1 million *annually*.

- ❖ All told, the state's $113 million in cuts to community mental health services between fiscal year 2009 and fiscal year 2011 cost the state and hospitals an estimated $131.4 million through 2012, yet none of these additional costs included sustained recovery-based treatment services to enable these individuals to get their mental illness under control.

- ❖ Many individuals experiencing homelessness who cycle in and out of the hospital because of their untreated mental illness end up in nursing homes because hospitals do not want to discharge these individuals back into homelessness. A full year of Assertive Community Treatment (which is only needed in the most severe cases), plus a housing voucher, costs approximately $18,043,[11] compared to the average annual cost of $31,400 for a nursing home placement.[12] If the state invested in affordable housing for this population in addition to community-based mental health treatment services it would save an average of $13,357 per individual case.

Recommendations for Investing in the State's Community Mental Health Safety Net and Reducing Reliance on Settings that were Never Intended to Enable Long-Term Recovery

As the Medicaid expansion population is enrolled in the program, the state must invest in its community mental health safety net and reduce reliance on expensive settings like hospitals and nursing homes that were never intended to become primary settings to help individuals recover from mental illness. Approximately 17 percent of the expansion population, or 58,000 individuals, are expected to have significant mental health needs.[13] If the state does not make this investment, individuals with serious mental illnesses will continue to use high-cost services like hospitals and nursing homes, which are not the appropriate places for sustained recovery and treatment services, driving *up* Medicaid costs.

The following are Thresholds' recommendations for refocusing the state's community mental health safety net on the right set of services that will save the state money and improve the health and well-being of individuals living with a mental illness:

1. **The State Must Reduce the Number of Nursing Home Beds for Individuals with Mental Illness, and Rather, Invest in Affordable Housing and Community-Based Treatment Services, Which Will Save the State Millions of Dollars Annually.** Given that the state is deinstitutionalizing thousands of individuals with serious mental illnesses from nursing homes and Institutions of Mental Disease (IMDs) under the two *Olmstead* consent decrees, it is critical that the state prevents new individuals from unnecessarily cycling into these facilities, the vast majority of which provide only custodial care instead of recovery services that would help individuals leave an institutional setting. The state must begin to reduce the number of nursing home beds for people with mental illness.

    - ❖ A housing voucher *plus* a full year of Assertive Community Treatment costs approximately $18,043, while the average annual cost of a nursing home stay costs the state $31,400.

- ❖ If the state reduced the approximately 22,000 nursing home beds for this population by 20 percent and invested in affordable housing (*e.g.*, a housing voucher) and community mental health treatment services, it would save an estimated $58.7 million. If it reduced the number of nursing home beds by 40 percent, it would save an estimated $117.5 million. A 60 percent reduction in the number of nursing home beds for persons with mental illness would lead to $176.6 million in state savings if these individuals were provided Assertive Community Treatment and a housing voucher.

- ❖ From a financial perspective alone, it is far less expensive to support a person with mental illness in the community with a housing voucher and Assertive Community Treatment than it is to support them in an institutional setting. From a human perspective, it is also the right thing to do.

2. **The State Should Reinvest These Savings into the Community Mental Health System to Enable the System to Treat People with Mental Illnesses at the Earliest Sign of Illness Rather Than Waiting Until Crisis Care is Needed.** The system needs to be refocused toward prevention, treatment, and wellness rather than being so heavily crisis-focused. The state must invest in services that prevent the exacerbation of mental illnesses and allow individuals to get the treatment and services they need at the earliest possible sign or onset of mental illness.

3. **For Services Delivered to Individuals Not Enrolled in a Managed Care Entity, Reimbursement Should Be Tied to Mental Health and Health Outcomes Rather Than Based on a Fee-for-Service Payment Structure.** In line with Budgeting for Results and the state's move to coordinated and managed care, payment for community mental health services should allow for more flexibility in service delivery and should be tied to achieving certain specified mental health, general health and quality of life outcomes, like a reduction in emergency room visits or improved ability to manage co-occurring medical conditions. The outcomes measures developed must, however, also recognize that mental illness is not a linear illness, as with other serious medical conditions. The fee-for-service payment structure under the existing community mental health rules limits providers' ability to get paid for the services that are often necessary to stabilize a person and get them on the path to wellness, and it incentivizes providers to give more care rather than better care that would result in better outcomes.

4. **Affordable Housing is a Critical Precursor to Stabilizing Individuals Experiencing Homelessness Who are Living with Mental Illness.** Health coverage alone will be insufficient to stabilize the segment of the Medicaid population that is homeless and living with a serious mental illness. Given the numerous other daily challenges they face, it is nearly impossible for an individual living on the streets with untreated schizophrenia or other serious mental illness to focus on managing their mental illness. The state must invest in affordable housing for this population. If it does not, this population will continue to churn through hospitals and nursing homes, driving up Medicaid costs once they are enrolled.

5. **Preserving Funding for Supportive Housing Services is Critical to Prevent Individuals with Mental Illness from Becoming Homeless Again.** State-funded

supportive housing services have been braided together with federal Housing and Urban Development (HUD) dollars to create integrated community-based housing and residential settings that enable providers to help individuals with serious mental illnesses stabilize their lives, manage their illness, and remain out of hospitals and nursing homes. The Division of Mental Health is in the process of proposing rules governing reimbursement rates for supportive housing and residential services (for crisis, supervised, supported, and permanent supportive housing services) that are currently funded with capacity dollars. The rate structure for supportive housing and residential services must be designed in a way that does not result in back-door funding cuts for providers that would lead to a loss of capacity. If rate structures are not revised with provisions to keep providers at current funding levels, many providers will experience significant funding reductions that will force them to close supportive housing or residential beds, forcing previously homeless or unstably housed individuals with serious mental illnesses back out onto the streets or into nursing homes.

6. **Payment Reform That Covers the Actual Cost of Services and Allows Providers to Increase Services as Medicaid Expansion Begins.** State reimbursement rates for community mental health services have been held flat since 2006, while the cost of doing business rises every year with inflation. Because rates do not cover the actual cost of providing services, many providers are forced to seek additional private foundation dollars to cover the growing shortfall, or cut services altogether. Low reimbursement rates also mean wages are kept low for critical frontline workers and remain stagnant across the industry, making it harder to hire and retain workers. Moreover, increasing service capacity, particularly with thousands of new Medicaid enrollees coming through Medicaid expansion, is extremely difficult with the existing rate structure. If the state paid a reimbursement rate that covered the real cost of services providers would not be as reliant on non-Medicaid dollars to cover the shortfall or be forced to cut needed services.

7. **Children and Young Adults with a Mental Illness Must Have Access to Mental Health Services.** When children with a mental illness do not get the mental health care they need to stabilize and grow into healthy, productive adults they often spin out of control, tearing families apart and ending up in the justice system, homeless, or cycling in and out of the hospital. The state has made it particularly difficult for children and young adults with a mental illness to get the services they need at the earliest possible sign of mental illness, or to continue the services they receive into young adulthood. In particular, the Division of Mental Health's Individual Care Grant (ICG) Program, which provides funding for residential or intensive community services for children under the age of 17 who are living with a severe mental illness, has seen a decline of 88 percent in applications granted between fiscal year 2006 and fiscal year 2012.[14] While the ICG Program is for children with very serious mental illnesses, the state must reform the existing application process and its interpretation of the rules to ensure that children who need intensive community-based mental health services or residential care get it before it is too late. This is a *federal requirement* under the Medicaid Early and Periodic Screening, Diagnostic and Treatment rules.[15] Families desperate to get their child into care have even been forced to relinquish custody of their child because it is the only avenue they have left for services. This must change.

8. **The State Must Expand Opportunities for Persons Living with a Mental Illness to Work in Competitive Employment Positions of Their Choice.** Supported employment, an evidence-based practice, has been found to be the most effective approach for securing employment for people with psychiatric disabilities.[16] Studies have shown that when persons with mental illness are engaged in meaningful employment they use fewer public services.[17] Since the state drastically reduced access to employment services in 2010 through eligibility restrictions, fewer people with serious mental illnesses have access to supported employment, an important ingredient in mental health recovery.

9. **The State Must Continue to Build Stronger Peer Support Throughout the Mental Health Continuum.** Individuals with lived experience of mental illness play a meaningful role in the recovery process, providing individuals with a sense of hope that recovery and wellbeing is possible and attainable. Peer support is a promising practice that adds tremendous value to the recovery process.

10. **The Pre-Admission Screening (PAS) Process, Which Directs Approximately 80 Percent of Individuals in Psychiatric Crisis Who are Screened for the Next Level of Care to Nursing Home Care Rather Than to Community-Based Care, Must Be Reformed.** The challenges with the current PAS screening process are multi-fold: There are not enough community-based treatment services available, there is often a waiting list to get into certain services or programs, many of the PAS screeners are unfamiliar with the network of community services available for persons with mental illness, and many PAS screeners simply do not believe that almost all individuals with serious mental illness are able to live independently in the community with the proper supports. If the PAS process, as well as the training of PAS screeners, is not reformed, many people who are hospitalized due to a psychiatric crisis will continue to be inappropriately placed in institutional settings when community-based services would offer recovery.

11. **The State Must Hold the New Specialized Mental Health Rehabilitation Facilities (SMHRFs), Which Were Formerly IMDs, Accountable for Reforming Themselves into Short-Term, Recovery-Oriented Facilities, Rather Than Custodial Nursing Homes.** Under recently passed legislation,[18] IMDs are required to move away from a nursing home model, which is an inappropriate model of care for individuals with a mental illness, to a crisis stabilization and recovery-focused model intended to help individuals transition back to community-based living as quickly as possible. The state must hold these facilities accountable for reforming. The state must close the facilities that fail to reform. The state does not need the more than 5,600 institutional IMD/SMHRF beds that currently exist. The state must begin to invest in affordable housing and community-based treatment services (which, as shown in this report, are more appropriate and more cost-effective) and phase down the number of institutional beds for this population.

12. **The State Supplemental Security Income (SSI) Rules Relating to Keeping Benefits When a Person Enters an Institutional Setting Temporarily, or is Ready to Transition Out, Must Be Reformed.** Under current state law a person must forfeit all but $30 a month of their SSI, often their sole source of income, when they enter a nursing home, IMD, or SMHRF due to a psychiatric crisis. The forfeited SSI is applied to the cost of their care in the facility. Earning just one dollar a day, it is virtually

impossible for individuals to maintain an existing housing arrangement or save for a deposit on an apartment when they are ready to move out. As a result, many individuals whose mental illness has stabilized are not able to move out because they simply do not have the financial means to do so. Thousands of individuals remain institutionalized for years, even life, for this reason. The state must reform the SSI rules so individuals with a mental illness who enter these institutional settings are able to move out when they have stabilized.

13. **The State Must Hold Managed Care Companies Accountable for Providing the Medicaid Services Individuals Living with Severe Mental Illnesses Need to Successfully Manage Their Illness and Live in the Community.** While many managed care companies understand the needs of individuals with mental illness, some companies are less familiar with this population, their needs, and the services that are necessary to help them manage their illness and live successfully in the community. The state must ensure that the managed care companies for the Medicaid population authorize the permitted and medically necessary Medicaid services for this population to prevent multiple hospitalizations and unnecessary nursing home placement.

Introduction

I. Data Shows That State Funding Cuts to Community Mental Health Treatment Services Lead to Increased Emergency Room Visits, Hospitalizations, and Nursing Home Placements

It is well-documented that serious mental illnesses such as schizophrenia, bi-polar disorder, and other brain disorders are successfully treatable with the right combination of the appropriate medications, psychiatry, therapy, and other support services. However, when care is not available, symptoms worsen, the person becomes more isolated as they decompensate, and this in turn can lead to homelessness, joblessness, incarceration, psychiatric hospitalizations, poverty, and institutionalization.

The state's community-based mental health safety net has never been robust enough to catch the estimated 2.6 million Illinoisans living with a mental illness.[19] According to the state, only about one-third of individuals living with a mental illness in Illinois are able to access care, leaving two-thirds without any care at all due in large part to the lack of community-based mental health treatment services.[20] Even before the state made substantial cuts to community mental health services, Illinois has long lagged behind other states across the nation in investing resources in effective community-based care, directing far more funding into institutional settings like nursing homes and IMDs.[21] The state is currently subject to two *Olmstead* consent decrees to deinstitutionalize individuals with mental illness from these settings for these reasons.[22]

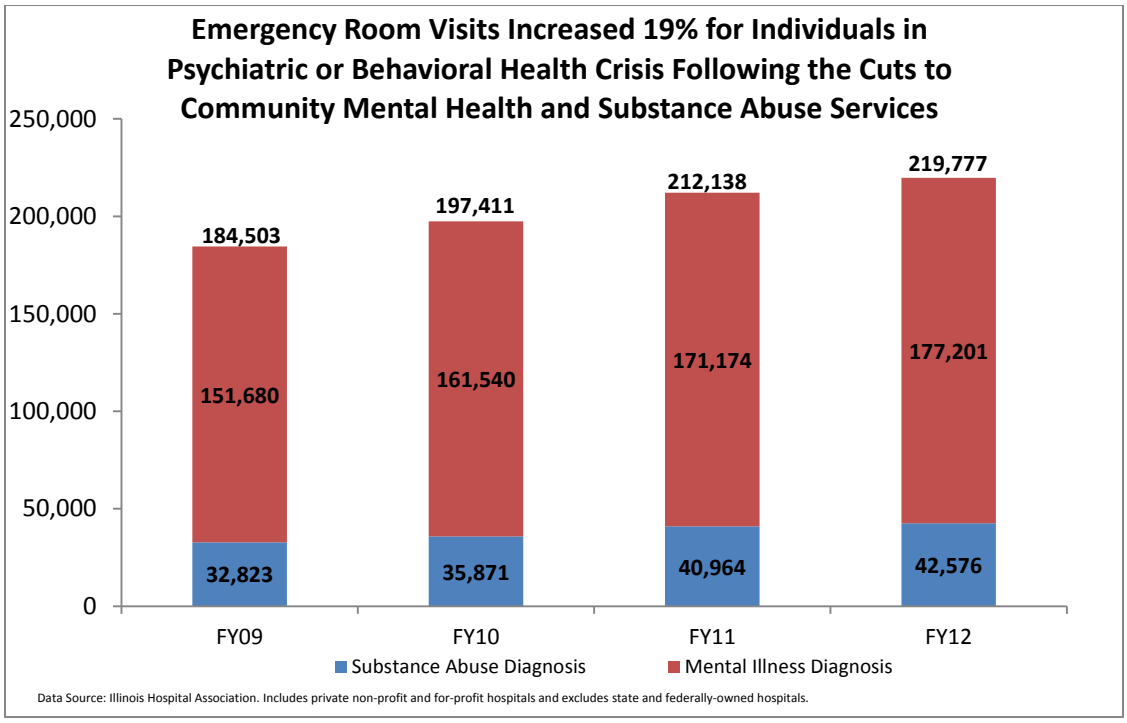
While the state has embarked on a rebalancing effort over the last several years to direct more resources into community-based mental health services aimed at recovery and wellness, they have a long way to go. The Illinois community mental health safety net experienced one of the largest reductions in state funding in the country between 2009 and 2011, when more than $113 million in community mental health services were eliminated because of the state's severe budget constraints.[23] The overwhelming majority of these cuts eliminated services for individuals who

were uninsured.[24] Prior to the cuts, community mental health providers received state general revenue funding to begin services for these individuals as they waded through the Medicaid disability determination process, which is cumbersome and can take two years or more. Following the funding cuts, most uninsured individuals with a serious mental illness have been forced to wait for a Medicaid disability determination before they can access community-based treatment services, meaning hospital emergency rooms have been the only avenue of care for this population.[25]

That said, hospitals do not provide ongoing treatment for mental illness. Most hospitals were never designed for long-term treatment, only to stabilize a crisis or emergency, or perform specialized procedures. Ongoing treatment that enables individuals to improve is provided in outpatient, community-based settings, as are most other medical treatments. Without ongoing treatment, persons living with a severe mental illness will continue the vicious cycle of emergency room use and hospitalizations, and will not be able to get their mental illness under control.

Data demonstrates that the cuts to the state's community-based mental health system between fiscal year 2009 and fiscal year 2011 are directly related to an increase in emergency room visits and hospitalizations. Chart 1 below shows that emergency room visits for people in psychiatric or substance abuse crisis in hospitals statewide increased 19 percent during the period when community mental health treatment services were cut in Illinois.[26] Emergency room visits for all mental health and substance abuse cases combined went from 184,503 visits in 2009 to 219,777 visits in 2012, an increase of more than 35,000 visits. This increase is 12 percentage points higher than total emergency room visits over the same time period. Uninsured ER visits increased by 17 percent, three percentage points higher than those with Medicaid coverage, and 10.6 percentage points higher than those with a general medical emergency. The data clearly demonstrate that cuts to community mental health treatment services result in increased emergency room use and costs.

Chart 1



An emergency room visit costs Illinois hospitals on average approximately $2,027.[27] Accordingly, the additional 35,274 mental and substance abuse ER visits following the cuts to community treatment services cost the state and hospitals an estimated $71.5 million.

In 2012, approximately 25 percent of mental and behavioral health emergency room visits resulted in inpatient hospital stays for an average length of stay of 6.7 days. The average length of stay for a psychiatric hospitalization did not decline between 2006 and 2012, with the average length of a hospitalization due to a primary diagnosis of a mental illness at 6.8 days. Using an average estimated cost of $4,301 for an inpatient mental or behavioral health hospital stay, the total estimated cost incurred for these additional hospitalizations between 2009 and 2012 that resulted directly from cuts to community mental health services was $37.9 million.[28]

Total inpatient hospital stays for individuals in psychiatric or substance abuse crisis declined slightly—by 3 percent—between 2009 and 2012. However, this decline did not keep pace with the overall decline in hospitalizations for medical care, a decline of 5.3 percent across Illinois hospitals, as outpatient care has become more accessible and effective. The overall trend of declining hospitalizations should also hold true for individuals in psychiatric crisis, given the advances in medications that treat serious mental illnesses and evidence-based practices used in community-based care when such care is made available. Based on an average estimated cost of $4,301 for a hospitalization, if mental and behavioral health hospitalizations had declined by the same rate as other medical hospital stays, the state and hospitals would have saved an estimated $13.9 million.[29]

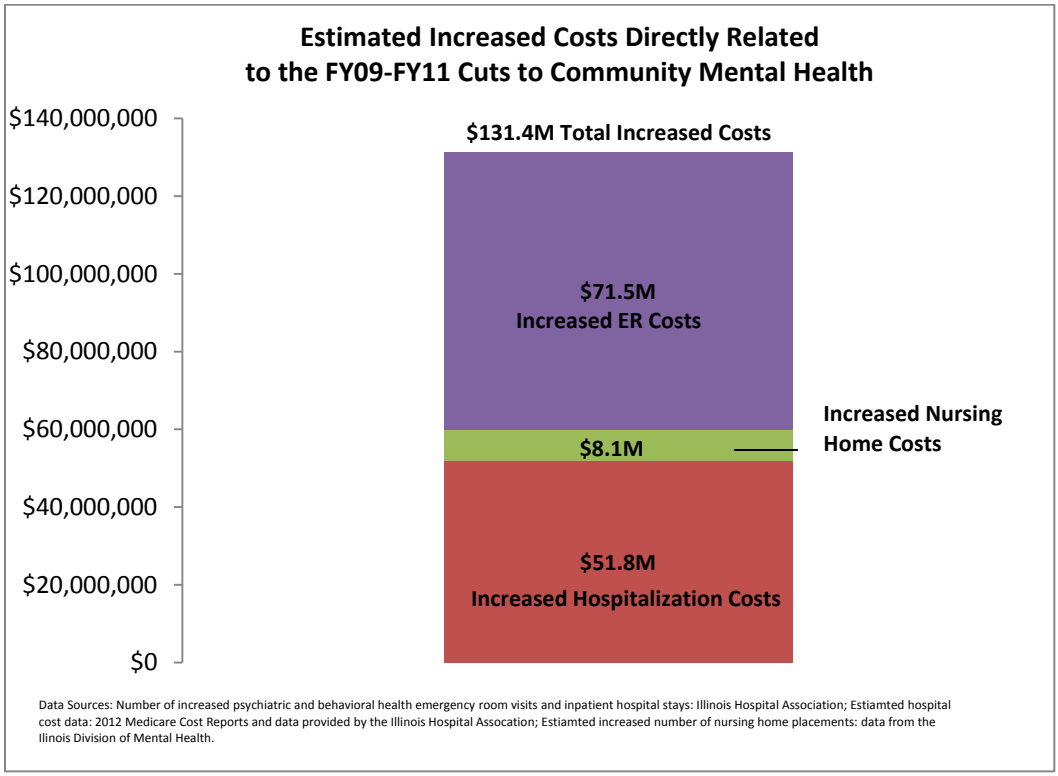
To compare costs, a *full year* of Assertive Community Treatment, which is a psychiatrist-led, team-based approach and the most intensive level of care provided in the community for someone living with a serious mental illness, costs the state approximately $10,243.[30] It is important to note that this cost estimate is based on the *Williams* consent decree population whose service needs are significantly *higher* than the needs of most individuals with mental illness who have not been institutionalized for years and become institution-dependent. A full year of community-based treatment on average is therefore *lower* than this estimated cost.

Only about 2.9 percent of the total psychiatric hospitalizations are screened for longer-term care through a process that is called a Level II PAS screen. According to the Division of Mental Health, about 80 percent of individuals in psychiatric crisis who are Level II PAS screened are referred for institutionalization in a nursing home rather than for community-based care, largely because there are either not enough community-based services available, or there is a lack of understanding by PAS screeners on how effective some community-based services (*e.g.*, Assertive Community Treatment) can be in supporting persons with serious mental illness in the community. Applying these numbers to the increased emergency room visits that resulted in a psychiatric hospitalization between 2009 and 2012, an estimated 258 individuals with a serious mental illness were institutionalized in nursing homes due to cuts to community-based mental health services. It is worth noting that this number is based on just the increased number of institutionalizations due to the increase in emergency room visits. It is likely that far more individuals wound up in nursing homes because of the lack of community mental health services generally. That said, using an average annual cost of $31,400 for a nursing home stay,[31] the increased institutionalizations directly related to the community-based cuts cost the state approximately $8.1 million *annually* for the custodial care of these individuals in institutional settings.

II. Estimated Increased Costs to the State and Hospitals as a Result of the Cuts to Community-Based Mental Health Treatment Services

Chart 2 below illustrates that the $113 million in cuts to the community mental health safety net made between 2009 and 2011 cost the state and hospitals an estimated $131.4 million in increased emergency room visits, hospitalizations, and nursing home placements, $8.1 million of which is incurred year after year for inappropriate institutionalization. This is a very conservative estimate for the reasons stated above. These increased costs demonstrate that it actually costs the state money when community mental health treatment services are eliminated.

Chart 2



III. Investments the State Must Make to Strengthen the Community Mental Health System as Medicaid Expansion is Implemented

Of the estimated 342,000 uninsured individuals expected to be covered under the Medicaid expansion beginning in January 2014, 4.9 percent are estimated to have a serious mental illness, 12.1 percent are estimated to be in serious psychological distress, and 14.9 percent are estimated to have substance use disorders.[32] Health coverage will enable access to much needed mental and behavioral health community-based treatment services for this population for the first time.

In addition, the state's effort to move the majority of the Medicaid population into systems of coordinated and managed care has the potential to drive preventable and unnecessary hospitalizations and institutionalizations out of the system. People with serious mental illnesses on average die 25 years younger than the general population, typically not because of their mental illness, but because of other undiagnosed co-occurring medical conditions.[33] The coordination of both mental health and health care, in combination with payment tied to improved health outcomes

rather than on the number of services delivered, holds real promise for improving the mental and physical health of individuals with mental illness, as well as reducing hospital and nursing home costs.

That said, policymakers must take the opportunity to make the right kinds of investments in our state's long-neglected mental health safety net to ensure that individuals get the care they need when they need it to stem health care costs. Moreover, coverage alone will not stabilize a small subgroup within the Medicaid expansion population that has a serious mental illness and also struggles with homelessness and poverty. For this segment of the population with mental illness, the state must invest in the right set of services that are necessary to stabilize them. If policymakers do not, once this population gains Medicaid coverage, they will continue to cycle in and out of the hospital, and many will end up in nursing homes, driving up Medicaid costs. Given that this population will move to traditional Medicaid (of which the state pays 50 percent of the cost) once they receive a disability determination, the state would be wise to make the investments in the right set of services that are needed to stabilize their mental illness.

A. Stable Housing is a Necessary Precursor to Recovery for Homeless Individuals Living with a Serious Mental Illness.

The National Alliance to End Homelessness estimates that about 32 percent of the 14,144 homeless individuals living across Illinois have an untreated, serious mental illness.[34] These individuals will not be able to get their mental illness under control while living on the streets in poverty. They will continue to cycle in and out of hospitals and nursing homes until they are stabilized in housing.

Data suggests that when a homeless person is repeatedly hospitalized for an untreated serious mental illness his/her housing situation influences whether he/she is referred to a nursing home or to community-based care upon hospital discharge, irrespective of the level of care that is most appropriate. Data shared by the Division of Mental Health shows that of individuals discharged from the hospital to IMDs between January and June of 2013, 12 percent were homeless and 19 percent were living in unstable housing arrangements with family or friends.[35] This shows that housing is a significant factor in hospital referral decisions for people with severe mental illnesses. When the only option for a person with a serious mental illness is to be discharged into homelessness, hospitals send them to a nursing home, not necessarily because they need that level of care, but because the hospital is reluctant to discharge the person back into homelessness, largely because there is no avenue for housing combined with community-based treatment.

As county jails look for a solution to the problem of where inmates with serious mental illnesses should go upon discharge from the jails, the state must look for a housing solution for this population, many of whom were previously homeless or unstably housed and have no housing option upon leaving the jail. Cook County Jail alone estimates that it has about 2,000 inmates with severe mental illness who likely will not have housing arrangements upon discharge from the jail, greatly increasing the chances that they will soon cycle back into the justice system or an emergency room.[36]

If the state does not address the housing problem for this segment of the newly covered Medicaid population, many of the individuals will end up in nursing homes—not because they need that level of care, but because they have no other place to live—and the state's institutional care costs will only continue to increase. It is worth underscoring that the state is under two *Olmstead* consent decrees—*Williams* and *Colbert*—for inappropriately institutionalizing people with a serious mental

illness when community-based care would enable them to live independently. The state must therefore invest in affordable housing for the small segment of the population with mental illness that is homeless or will be homeless when coming out of the justice system, rather than having this population inappropriately institutionalized in nursing homes.

Use of nursing homes for persons with serious mental illness grew exponentially as the state deinstitutionalized thousands of people from state mental hospitals in the 1960s and 1970s without making the investment in community-based mental health services and affordable housing.[37] The state would be wise to learn from that experience.

B. The State Would Save Money by Reducing the Current Number of Nursing Home Beds for Individuals with Mental Illness and Investing in Community Treatment Services *and* Housing.

If the state makes the necessary investments in affordable housing for homeless individuals with mental illness as they gain coverage to community mental health services through the Medicaid expansion, it should be able to eliminate a significant portion of the more than 22,000 nursing home beds[38] currently available for people with mental illness. Chart 3 below shows that the state will *save* money by investing in community mental health care *and* housing while closing nursing home beds.

It costs the state an estimated $31,400 per person for a year of custodial care in a nursing home.[39] The most intensive level of community-based care, Assertive Community Treatment, is proven to enable recovery and independent living while also preventing hospitalizations. Assertive Community Treatment costs the state approximately $10,243 per person. A housing voucher costs approximately $7,800 a year.[40] The combined cost for housing and community-based services cost approximately $18,043. This is $13,357 less than nursing home care.

Chart 3

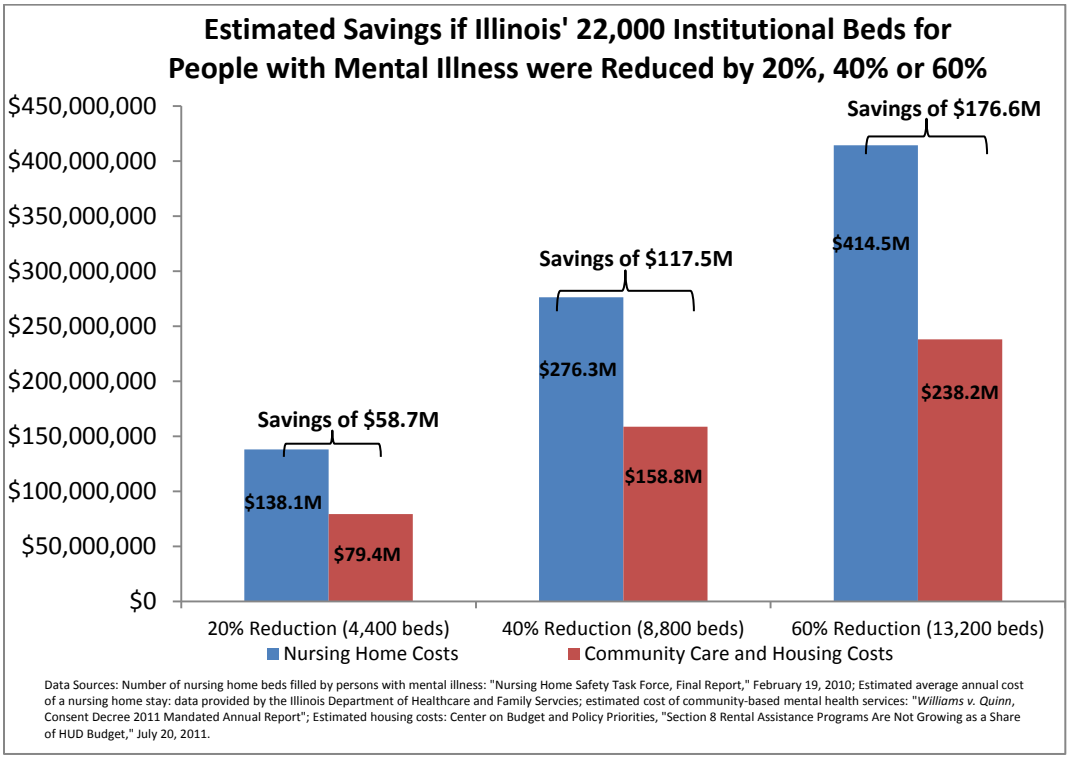


Chart 3 shows that if the state reduced the number of nursing home beds for persons with serious mental illness by 20 percent, and supported those individuals in the community with Assertive Community Treatment and a housing voucher, it would save an estimated $58.7 million. If 40 percent of the nursing home beds were closed, the state would realize savings of $117.5 million. If nursing home beds were reduced by 60 percent, the state would save an estimated $176.6 million. From a financial perspective alone, it is less expensive to support a person with a serious mental illness in the community using the most intensive level of community mental health services and a housing voucher than it is in a nursing home setting. The savings estimates in Chart 3 are likely greater given that not nearly all individuals living in nursing homes need Assertive Community Treatment to live safely and independently in the community.

Conclusion

The Medicaid expansion provides state policymakers a tremendous opportunity to make the right kinds of investments in the state's community mental health safety net. Evidence shows that when there is a shortage of community treatment services available to individuals with a mental illness, expensive hospitalizations and institutionalizations increase, costing the state millions of dollars. We must change this as 342,000 new individuals are enrolled in Medicaid, many of whom have significant mental health needs. It is the right thing to do and the smart thing to do. We hope Illinois policymakers will seriously consider the recommendations outlined above as a roadmap for refocusing the community mental health safety net on services that enable individuals living with a mental illness to get the care they need when they need it to move into recovery, which will also save the state money.

Endnotes

[1] Illinois Department of Healthcare and Family Services, "The Future of Care Coordination for Seniors and Persons with Disabilities," July 2012.
[2] National Alliance on Mental Illness, "State Mental Health Cuts: A National Crisis," March 2011.
[3] The data provided by the Illinois Hospital Association included the number emergency room visits and hospitalizations for mental health or substance abuse crises for all private non-profit and for-profit hospitals across the state for calendar years 2009 – 2012. The data excluded publicly owned state and federal hospitals.
[4] Emergency room and hospitalization costs were estimated by converting hospital charges provided by the Illinois Hospital Association to cost by multiplying the average charges for an emergency room visit and mental or behavioral health hospital stay by the average statewide cost-to-charge ratio for hospitals across the state (2012 Medicare Cost Reports). The average annual cost of a nursing home stay for 2012 was provided by the Illinois Department of Healthcare and Family Services.
[5] National Alliance on Mental Illness, "State Mental Health Cuts: A National Crisis," March 2011.
[6] *Williams* Consent Decree Implementation Plan, *Colbert* Consent Decree Implementation Plan.
[7] We recognize that we cannot establish direct causality without examining other factors that may have contributed to the increase in emergency room visits and hospitalizations. However, the data clearly demonstrates a strong correlation between cuts to community treatment services and increased hospital usage when preventable crises could have been treated through outpatient care had it been available.
[8] Estimated costs were calculated by converting hospital charges provided by the IHA to cost using the 2012 cost-to-charge ratios reported in the Medicare Cost Reports.
[9] Ellen, I.G., and O'Flaherty, B., How to House the Homeless, at Chapter 3, Housing First: Ending Homelessness, Promoting Recovery and Reducing Costs.
[10] *Williams v. Quinn*, Consent Decree 2011 Mandated Annual Report.
[11] Center on Budget and Policy Priorities, "Section 8 Rental Assistance Program Are Not Growing as a Share of HUD Budget," July 20, 2011 (average annual cost of a housing voucher).
[12] Data on the average annual cost of a nursing home stay was provided by the Illinois Department of Healthcare and Family Services.
[13] Substance Abuse and Mental Health Services Administration, "Enrollment under the Medicaid Expansion and Health Insurance Exchanges: A Focus on Those with Behavioral Health Conditions In Illinois."
[14] Division of Mental Health, Individual Grant Program Annual Reports for FY11 and FY12.
[15] 42 USCS § 1396d(r).
[16] Bond, G.R., Drake, R.E., Becker, D.R., "An Update on Randomized Controlled Trials of Evidence-Based Supported Employment," *Psychiatric Rehabilitation Journal* 31: 280-290, 2008; and Becker, D.R., Drake, R.E., "A Working Life for People with Severe Mental Illness," *Oxford, United Kingdom: Oxford University Press*, 2003.
[17] Latimer EA., "Economic impacts of supported employment for the severely mentally ill," *Canadian Journal of Psychiatry* 2001; 46:496-505; Schneider J, Boyce M, Johnson R, et al. "Impact of supported employment on service costs and income of people with mental health needs," *Journal of Mental Health* 2009; 18:533-542.
[18] 210 ILCS 49 (Specialized Mental Health Rehabilitation Act of 2013).
[19] Illinois Department of Human Services, Division of Mental Health, "Illinois Mental Health 2013-2018 Strategic Plan," at 1.
[20] *Id*.
[21] Report of Dennis R. Jones, *In the Matter of Williams v. Blagojevich*, September 8, 2008.
[22] The *William* Consent Decree and the *Colbert* Consent Decree.
[23] National Alliance on Mental Illness, "State Mental Health Cuts: A National Crisis," March 2011.
[24] Illinois Department of Human Services, Division of Mental Health, "Illinois Mental Health 2013-2018 Strategic Plan."
[25] *Id*.
[26] Based on data provided by the Illinois Hospital Association. Includes hospital emergency department visits in non-profit or for-profit private hospitals for individuals with a primary or secondary diagnosis of mental illness or substance abuse for calendar years 2009 through 2012.
[27] The average cost of an emergency room visit was estimated using average hospital charges provided by the IHA multiplied by an average state-wide cost-to-charge ratio of .318, calculated from the hospital cost-to-charge ratios reported in the 2012 hospital Medicare Cost Reports.
[28] This cost estimate is based on the average charges for a mental or behavioral health inpatient stay provided by the IHA multiplied by the estimated average statewide hospital cost-to-charge ratio of .318.
[29] *Id*.

[30] *Williams v. Quinn*, Consent Decree 2011 Mandated Annual Report.
[31] Data provided by the Illinois Department of Healthcare and Family Services.
[32] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Enrollment Under the Medicaid Expansion and Health Insurance Exchanges: A Focus on Those with Behavioral Health Conditions in Illinois."
[33] National Association of State Mental Health Directors, Medical Directors Council, "Morbidity and Mortality in People with Serious Mental Illness," October 2006.
[34] National Alliance to End Homelessness, "The State of Homelessness in America 2013," April 2013.
[35] Division of Mental Health, "Community Expansion Under SB26," (slide on characteristics of individuals referred to IMDs through PAS screens).
[36] Chicago Tribune, "Cook County jail's inmate population rising: Police crackdown, closing of mental health facilities cited as causes," September 13, 2013.
[37] Kaiser Commission on Medicaid and the Uninsured, "Learning from History: Deinstitutionalization of People with Mental Illness as a Precursor to Long-Term Care Reform," August 2007.
[38] Nursing Home Safety Task Force, "Final Report," February 19, 2010 (the state has more than 22,000 nursing home beds for persons with serious mental illness, including IMD beds).
[39] Provided by the Illinois Department of Healthcare and Family Services.
[40] Center on Budget and Policy Priorities, "Section 8 Rental Assistance Program Are Not Growing as a Share of HUD Budget," July 20, 2011. While the full cost of a housing voucher for Illinois *Williams* class members costs $9,200 according to the *Williams* Consent Decree Implementation Plan, nearly all Medicaid-covered individuals with a severe mental illness also receive Supplemental Security Income and therefore contribute to a portion of the cost of their housing.