



Senate

General Assembly

File No. 418

January Session, 2005

Substitute Senate Bill No. 1237

Senate, April 19, 2005

The Committee on Public Health reported through SEN. MURPHY of the 16th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING COMMUNITY-BASED MENTAL HEALTH CARE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective July 1, 2005*) (a) On or before June 30,
2 2006, the Commissioner of Mental Health and Addiction Services, in
3 consultation with the Commissioner of Children and Families, the
4 Chief Information Officer of the Department of Information
5 Technology and the Community Mental Health Strategy Board,
6 established under section 17a-485b of the general statutes, shall
7 provide for the development, implementation, promotion and
8 maintenance of a single resource web site to provide timely access to
9 mental health care information and assistance for children, adolescents
10 and adults. The resource web site shall include, but not be limited to:
11 (1) Directory information on available federal, state, regional and
12 community assistance, programs, services and providers; (2) current
13 mental health diagnoses and treatment options; (3) links to national
14 and state advocacy organizations, including legal assistance; (4)

15 summary information on federal and state mental health law,
16 including private insurance coverage; and (5) an optional, secure
17 personal folder for web site users to manage information concerning
18 their individual mental health care and assistance.

19 (b) On or before January 1, 2008, the Commissioner of Mental
20 Health and Addiction Services, in consultation with the Commissioner
21 of Children and Families, the Chief Information Officer of the
22 Department of Information Technology and the Community Mental
23 Health Strategy Board, established under section 17a-485b of the
24 general statutes, shall provide for the development, implementation,
25 promotion and maintenance of toll-free telephone line for mental
26 health care screening, assistance and follow-up for adults and families
27 and other caregivers of children and adolescents.

28 Sec. 2. (NEW) (*Effective July 1, 2005*) On or before January 1, 2007,
29 the Commissioner of Mental Health and Addiction Services, in
30 consultation with the Community Mental Health Strategy Board,
31 established under section 17a-485b of the general statutes, shall
32 provide for the development and implementation of training programs
33 for parents and families, early childhood providers and educators,
34 school and higher education professionals, police, senior center staff
35 and general pediatric, family medicine and geriatric health care
36 professionals to improve mental health awareness, early identification
37 and referral.

38 Sec. 3. (NEW) (*Effective from passage*) (a) On or before December 31,
39 2005, the Commissioner of Social Services, in consultation with the
40 Commissioner of Mental Health and Addiction Services and the
41 Community Mental Health Strategy Board, established under section
42 17a-485b of the general statutes, shall take such action as is necessary
43 to amend the Medicaid state plan to provide optional adult
44 rehabilitation services that include assertive community treatment
45 teams to provide intensive, integrated, multidisciplinary services to
46 adults with severe psychiatric disabilities, including, but not limited to,
47 persons who are homeless, persons diverted or discharged from in-

48 patient programs or nursing homes and persons diverted or released
49 from correctional facilities, or who are at risk of incarceration. Such
50 teams shall provide intensive community care management through
51 case managers, nurses and physicians and shall include, but not be
52 limited to, vocational, peer and substance abuse specialists. The
53 Commissioner of Social Services, in consultation with the
54 Commissioner of Mental Health and Addiction Services, shall adopt
55 regulations, in accordance with the provisions of chapter 54 of the
56 general statutes, for purposes of establishing the services specified in
57 this subsection. The Commissioner of Social Services shall implement
58 policies and procedures for purposes of establishing such services
59 while in the process of adopting such policies or procedures in
60 regulation form, provided notice of intention to adopt the regulations
61 is printed in the Connecticut Law Journal no later than twenty days
62 after implementation and any such policies and procedures shall be
63 valid until the time the regulations are effective. Any moneys received
64 by the state as federal reimbursement for optional Medicaid adult
65 rehabilitation services for the services provided in this subsection shall
66 be credited to the community mental health restoration subaccount of
67 the Community Mental Health Strategic Investment Fund, established
68 under section 17a-485 of the general statutes.

69 (b) The Commissioner of Social Services and the Commissioner of
70 Mental Health and Addiction Services, in consultation with the
71 Community Mental Health Strategy Board, established under section
72 17a-485b of the general statutes, shall enter into an interagency
73 agreement to authorize the Commissioner of Mental Health and
74 Addiction Services to provide clinical management of the services
75 provided under subsection (a) of this section. For purposes of this
76 subsection, "clinical management" means the process of evaluating and
77 determining appropriate utilization of mental health services and
78 providing assistance that may include, but is not limited to, prior
79 authorization, concurrent and retrospective review, discharge review,
80 quality management, provider certification and enhancement of
81 provider performance. The Commissioner of Mental Health and
82 Addiction Services may certify providers of assertive community

83 treatment services for purposes of this subsection and subsection (a) of
84 this section, using criteria that are consistent with nationally
85 recognized standards of best practice. The Commissioner of Mental
86 Health and Addiction Services shall adopt regulations, in accordance
87 with the provisions of chapter 54 of the general statutes, for purposes
88 of certification of such providers. The Commissioner of Mental Health
89 and Addiction Services shall implement policies and procedures for
90 purposes of such certification while in the process of adopting such
91 policies or procedures in regulation form, provided notice of intention
92 to adopt the regulations is printed in the Connecticut Law Journal no
93 later than twenty days after implementation and any such policies and
94 procedures shall be valid until the time the regulations are effective.

95 Sec. 4. (NEW) (*Effective from passage*) (a) The Commissioner of Social
96 Services, in consultation with the Commissioner of Mental Health and
97 Addiction Services and the Community Mental Health Strategy Board,
98 established under section 17a-485b of the general statutes, shall take
99 such action as is necessary to obtain a waiver from federal law to
100 establish a Medicaid-financed home and community-based pilot
101 program to serve at least fifty adults with severe and persistent
102 psychiatric disabilities who would otherwise require residential
103 nursing home care.

104 (b) On or before January 1, 2007, the Commissioner of Social
105 Services, in consultation with the Commissioner of Mental Health and
106 Addiction Services and the Community Mental Health Strategy Board,
107 established under section 17a-485b of the general statutes, shall
108 establish and implement a pilot program in accordance with
109 subsection (a) of this section to provide community-based services and,
110 if necessary, housing assistance to adults with severe and persistent
111 psychiatric disabilities being discharged or diverted from nursing
112 home residential care. The Commissioner of Social Services and the
113 Commissioner of Mental Health and Addiction Services shall enter
114 into an interagency agreement to authorize the Commissioner of
115 Mental Health and Addiction Services to provide clinical management
116 of the services provided under this section. For purposes of this

117 subsection, "clinical management" means the process of evaluating and
118 determining appropriate utilization of mental health services and
119 providing assistance that may include, but is not limited to, prior
120 authorization, concurrent and retrospective review, discharge review,
121 quality management, provider certification and enhancement of
122 provider performance. The Commissioner of Social Services shall
123 adopt regulations, in accordance with the provisions of chapter 54 of
124 the general statutes, for purposes of certification of such providers. The
125 commissioner shall implement policies and procedures for purposes of
126 such certification while in the process of adopting such policies or
127 procedures in regulation form, provided notice of intention to adopt
128 the regulations is printed in the Connecticut Law Journal no later than
129 twenty days after implementation and any such policies and
130 procedures shall be valid until the time the regulations are effective.
131 On or before January 1, 2007, the Commissioner of Social Services shall
132 report, in accordance with the provisions of section 11-4a of the general
133 statutes, on the pilot program under this section to the joint standing
134 committees of the General Assembly having cognizance of matters
135 relating to public health and human services.

136 Sec. 5. (*Effective July 1, 2005*) On or before July 1, 2006, the
137 Commissioner of Mental Health and Addiction Services, in
138 consultation with the Commissioner of Correction and the Community
139 Mental Health Strategy Board, established under section 17a-485b of
140 the general statutes, shall establish and implement a pilot program to
141 divert or release twenty persons with serious psychiatric disabilities,
142 otherwise deemed eligible for diversion or release, from correctional
143 facilities to the community with appropriate housing and treatment
144 services. On or before January 1, 2007, the Commissioner of Mental
145 Health and Addiction Services shall report, in accordance with the
146 provisions of section 11-4a of the general statutes, on the pilot program
147 under this section to the joint standing committees of the General
148 Assembly having cognizance of matters relating to public health,
149 human services and the judiciary.

150 Sec. 6. (NEW) (*Effective from passage*) (a) The Commissioner of Social

151 Services shall, in consultation with the Commissioner of Mental Health
152 and Addiction Services and the Community Mental Health Strategy
153 Board, established under section 17a-485b of the general statutes, take
154 such action as is necessary to amend the Medicaid state plan to
155 provide optional adult rehabilitation services that include intensive
156 age-appropriate community rehabilitation services to young adults
157 with psychiatric disabilities, including young adults being diverted or
158 discharged from hospitals and diverted or released from correctional
159 facilities. The Commissioner of Social Services and the Commissioner
160 of Mental Health and Addiction Services, in consultation with the
161 Community Mental Health Strategy Board shall enter into an
162 interagency agreement to authorize the Commissioner of Mental
163 Health and Addiction Services to provide clinical management of the
164 services provided under this section. For purposes of this subsection,
165 "clinical management" means the process of evaluating and
166 determining appropriate utilization of mental health services and
167 providing assistance that may include, but is not limited to, prior
168 authorization, concurrent and retrospective review, discharge review,
169 quality management, provider certification and enhancement of
170 provider performance. The Commissioner of Social Services shall
171 adopt regulations, in accordance with the provisions of chapter 54 of
172 the general statutes, for purposes of certification of such providers. The
173 Commissioner of Social Services shall implement policies and
174 procedures for purposes of such certification while in the process of
175 adopting such policies or procedures in regulation form, provided
176 notice of intention to adopt the regulations is printed in the
177 Connecticut Law Journal no later than twenty days after
178 implementation and any such policies and procedures shall be valid
179 until the time the regulations are effective. Any moneys received by
180 the state as federal reimbursement for optional Medicaid adult
181 rehabilitation services for the services provided for in this subsection
182 and subsection (b) of this section shall be credited to the community
183 mental health restoration subaccount of the Community Mental Health
184 Strategic Investment Fund, established under section 17a-485 of the
185 general statutes.

186 (b) On or before January 1, 2006, the Commissioner of Mental
187 Health and Addiction Services, in consultation with the Community
188 Mental Health Strategy Board, established under section 17a-485b of
189 the general statutes, shall, in accordance with subsection (a) of this
190 section, expand young adult services to include all catchment areas in
191 the state and shall identify additional services not being provided to
192 young adults with psychiatric disabilities. On or before January 1,
193 2007, the Commissioner of Mental Health and Addiction Services shall
194 report, in accordance with the provisions of section 11-4a of the general
195 statutes, on the implementation of such expanded services and identify
196 additional services needed to the joint standing committees of the
197 General Assembly having cognizance of matters relating to public
198 health and human services.

199 Sec. 7. (*Effective July 1, 2005*) (a) The Commissioner of Children and
200 Families, in consultation with the Commissioner of Mental Health and
201 Addiction Services and the Community Mental Health Strategy Board,
202 established under section 17a-485b of the general statutes, shall
203 maintain the availability of flexible emergency funding for children
204 with psychiatric disabilities who are not under the supervision of the
205 Department of Children and Families at not less than the amount of
206 such funding provided for the fiscal year ending June 30, 2004.

207 (b) On or before October 1, 2005, the Commissioner of Children and
208 Families, in consultation with the Commissioner of Mental Health and
209 Addiction Services and the Community Mental Health Strategy Board
210 shall provide for an additional thirty care coordinators state-wide.

211 (c) On or before January 1, 2006, the Commissioner of Children and
212 Families, in consultation with the Commissioner of Mental Health and
213 Addiction Services and the Community Mental Health Strategy Board
214 shall (1) provide twelve additional family advocates state-wide; and (2)
215 expand for an additional three hours each day, including evenings
216 from 7:00 p.m. to 10:00 p.m. and Saturdays from 10:00 a.m. to 1:00
217 p.m., during which emergency mobile crisis teams provide services.
218 Additional support for such extension of hours shall include at least

219 one licensed staff person and a school liaison for each team to provide
220 on-site consultation in emergency situations, follow-up services, and
221 staff training and coordination.

222 Sec. 8. (*Effective July 1, 2005*) On or before October 1, 2007, the
223 Commissioner of Children and Families, in consultation with the
224 Commissioner of Mental Health and Addiction Services and the
225 Community Mental Health Strategy Board, established under section
226 17a-485b of the general statutes, shall increase from sixteen thousand
227 to thirty-two thousand hours the respite care available to families of
228 children with mental illness. The rate paid for such service shall be not
229 less than thirty dollars per hour.

230 Sec. 9. (NEW) (*Effective from passage*) (a) On or before December 31,
231 2005, the Commissioner of Social Services, in consultation with the
232 Commissioner of Children and Families, the Commissioner of Mental
233 Health and Addiction Services and the Community Mental Health
234 Strategy Board, established under section 17a-485b of the general
235 statutes, shall take such action as is necessary to amend the Medicaid
236 state plan to provide children's rehabilitation services that include the
237 services provided by the Connecticut Community KidCare Program,
238 established under section 17a-22a of the general statutes, to children
239 with mental illness, unless the Commissioner of Social Services, in
240 consultation with the Commissioner of Children and Families, the
241 Commissioner of Mental Health and Addiction Services and the
242 Community Mental Health Strategy Board determines that any such
243 services may be more appropriately funded under other provisions of
244 the state Medicaid plan. Such services shall include, but need not be
245 limited to, additional care coordinators, intensive in-home services,
246 emergency mobile crisis services and expanded family respite care.

247 (b) Any moneys received by the state as federal reimbursement for
248 optional Medicaid child rehabilitation services for the services
249 provided for in this subsection and subsection (a) of this section shall
250 be credited to the community mental health restoration subaccount of
251 the Community Mental Health Strategic Investment Fund established

252 under section 17a-485 of the general statutes.

253 Sec. 10. (*Effective July 1, 2005*) The Supportive Housing Pilots
254 Initiative, established under section 17a-485c of the general statutes,
255 shall be expanded by the Connecticut Housing Finance Authority to
256 finance, on or before July 1, 2006, five hundred additional housing
257 units and, on or before July 1, 2008, an additional five hundred
258 housing units, throughout the state that shall include supportive
259 services to families and individuals eligible to reside in such units.
260 Each of such five hundred additional housing units shall include
261 construction or substantial rehabilitation of three hundred fifty new
262 units and leasing one hundred fifty existing units. One hundred fifty of
263 such five hundred additional housing units shall be designated for
264 families and three hundred fifty of such five hundred housing units
265 shall be designated for single adults, including twenty-five for young
266 adults eighteen to twenty-three years of age.

267 Sec. 11. (NEW) (*Effective July 1, 2005*) (a) On or before January 1,
268 2006, the Commissioner of Social Services, in consultation with the
269 Commissioner of Mental Health and Addiction Services and the
270 Community Mental Health Strategy Board, established under section
271 17a-485b of the general statutes, shall take such action as is necessary
272 to amend the Medicaid state plan to provide optional adult
273 rehabilitation services for adults with severe and persistent psychiatric
274 disabilities who reside in supported or supervised housing.

275 (b) The Commissioner of Social Services and the Commissioner of
276 Mental Health and Addiction Services, in consultation with the
277 Community Mental Health Strategy Board shall enter into an
278 interagency agreement to authorize the Commissioner of Mental
279 Health and Addiction Services to provide clinical management of the
280 services provided under subsection (a) of this section. For purposes of
281 this subsection, "clinical management" means the process of evaluating
282 and determining appropriate utilization of mental health services and
283 providing assistance that may include, but is not limited to, prior
284 authorization, concurrent and retrospective review, discharge review,

285 quality management, provider certification and enhancement of
286 provider performance. The Commissioner of Social Services shall
287 adopt regulations, in accordance with the provisions of chapter 54 of
288 the general statutes, for purposes of subsection (a) of this section. The
289 commissioner shall implement policies and procedures for purposes of
290 establishing such services while in the process of adopting such
291 policies or procedures in regulation form, provided notice of intention
292 to adopt the regulations is printed in the Connecticut Law Journal no
293 later than twenty days after implementation and any such policies and
294 procedures shall be valid until the time the regulations are effective.
295 Any moneys received by the state as federal reimbursement for
296 optional Medicaid adult rehabilitation services for the services in
297 accordance with this section shall be credited to the community mental
298 health restoration subaccount of the Community Mental Health
299 Strategic Investment Fund established under section 17a-485 of the
300 general statutes.

301 Sec. 12. Section 38a-1041 of the general statutes is amended by
302 adding subsection (e) as follows (*Effective from passage*):

303 (NEW) (e) On or before October 1, 2005, the Managed Care
304 Ombudsman, in consultation with the Community Mental Health
305 Strategy Board, established under section 17a-485b of the general
306 statutes, shall establish a process to provide ongoing communication
307 among mental health care providers, patients, state-wide and regional
308 business organizations, managed care companies and other health
309 insurers to assure: (1) Best practices in mental health treatment and
310 recovery; (2) compliance with the provisions of sections 38a-476a, 38a-
311 476b, 38a-488a and 38a-489 of the general statutes; and (3) the relative
312 costs and benefits of providing effective mental health care coverage to
313 employees and their families. On or before January 1, 2006, and
314 annually thereafter, the Managed Care Ombudsman shall report, in
315 accordance with the provisions of section 11-4a of the general statutes,
316 on the implementation of this subsection to the joint standing
317 committees of the General Assembly having cognizance of matters
318 relating to public health and insurance.

319 Sec. 13. (*Effective from passage*) The Legislative Program Review and
320 Investigations Committee of the General Assembly shall undertake an
321 evaluation of compliance with the provisions of section 38a-488a of the
322 general statutes and shall report its findings and recommendations, in
323 accordance with section 11-4a of the general statutes, to the Governor
324 and General Assembly on or before January 1, 2007.

325 Sec. 14. (NEW) (*Effective July 1, 2005*) (a) The Commissioner of Social
326 Services shall increase Medicaid reimbursement rates for enhanced
327 care clinics that provide mental health services to adults, adolescents
328 and children in accordance with subsection (b) of this section.

329 (b) On or before October 1, 2005, the Commissioner of Social
330 Services, in consultation with the Commissioner of Mental Health and
331 Addiction Services, the Commissioner of Children and Families and
332 the Community Mental Health Strategy Board, established under
333 section 17a-485b of the general statutes, shall adopt regulations, in
334 accordance with the provisions of chapter 54 of the general statutes, to
335 establish criteria for outpatient clinics, including hospital-based
336 outpatient clinics, that provide mental health services to adults,
337 adolescents and children, to be designated enhanced care clinics and to
338 provide for certification of such provider. The Commissioner of Social
339 Services shall implement policies and procedures for purposes of such
340 certification while in the process of adopting such policies or
341 procedures in regulation form, provided notice of intention to adopt
342 the regulations is printed in the Connecticut Law Journal no later than
343 twenty days after implementation and any such policies and
344 procedures shall be valid until the time the regulations are effective.
345 The rates of reimbursement to be paid to such enhanced care clinics
346 shall be annually indexed to eighty-five per cent of the Medicare
347 reimbursement rate for adult services in effect on January 1, 2006, and
348 one hundred per cent of the Medicare reimbursement rate for children
349 and adolescent services in effect on October 1, 2005.

350 Sec. 15. (*Effective July 1, 2005*) On or before October 1, 2005, the
351 Commissioner of Social Services shall change the present method of

352 reimbursement for Medicaid-eligible children who receive general
353 hospital mental health inpatient care so that such rate is calculated on a
354 per diem, rather than a per discharge, basis.

355 Sec. 16. (NEW) (*Effective July 1, 2005*) For the fiscal year ending June
356 30, 2006, and biennially thereafter, state payments to private providers
357 of mental health care for children and adults shall be increased by a
358 percentage that is at least equal to the average increase in general
359 wages paid by the state to state employees performing the same or
360 comparable services during the immediately preceding two fiscal
361 years.

362 Sec. 17. (*Effective July 1, 2005*) Any provision of sections 1 to 16,
363 inclusive, of this act that requires that mental health care services be
364 funded under a federal Medicaid option shall require that increases in
365 state payments to private providers in accordance with section 16 of
366 this act apply also to services funded under such Medicaid
367 rehabilitation option.

368 Sec. 18. Section 17b-11 of the general statutes is repealed and the
369 following is substituted in lieu thereof (*Effective July 1, 2005*):

370 [(a)] The Commissioner of Social Services is authorized and
371 empowered to accept any and all allotments of federal funds, federal
372 funds to match private contributions and commodities, and to manage
373 and dispose of the same in whatever manner is required by federal
374 law, and to take advantage of any amendments and supplements to
375 the federal Social Security Act and of any other federal act relating to
376 public welfare, and to conform to such federal requirements as are
377 conditions precedent to the receipt of federal matching grants and are
378 not prohibited by the general statutes.

379 [(b)] The Commissioner of Social Services shall determine that
380 portion of social security increases approved by the federal
381 government or other unearned income which shall be disregarded by
382 the Department of Social Services in the payment of benefits to
383 recipients of, and in the determination of eligibility of applicants for

384 the state supplement program to the Supplemental Security Income
 385 Program. The Commissioner of Social Services, upon application, shall
 386 increase the amount disregarded for unrelated recipients in the state
 387 supplement program to the Supplemental Security Income Program
 388 who share living arrangements. The Commissioner of Social Services
 389 shall adopt regulations in accordance with the provisions of sections 4-
 390 166 to 4-176, inclusive, to establish specific dollar amounts to be
 391 disregarded. Such dollar amounts shall be no less than the amount of
 392 income from the Supplemental Security Income Program disregarded
 393 by the Department of Social Services pursuant to the provisions of this
 394 section in effect on June 30, 1976.]

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2005</i>	New section
Sec. 2	<i>July 1, 2005</i>	New section
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>from passage</i>	New section
Sec. 5	<i>July 1, 2005</i>	New section
Sec. 6	<i>from passage</i>	New section
Sec. 7	<i>July 1, 2005</i>	New section
Sec. 8	<i>July 1, 2005</i>	New section
Sec. 9	<i>from passage</i>	New section
Sec. 10	<i>July 1, 2005</i>	New section
Sec. 11	<i>July 1, 2005</i>	New section
Sec. 12	<i>from passage</i>	38a-1041
Sec. 13	<i>from passage</i>	New section
Sec. 14	<i>July 1, 2005</i>	New section
Sec. 15	<i>July 1, 2005</i>	New section
Sec. 16	<i>July 1, 2005</i>	New section
Sec. 17	<i>July 1, 2005</i>	New section
Sec. 18	<i>July 1, 2005</i>	17b-11

PH *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Various State Agencies	GF - See Below

Municipal Impact: None

Explanation

This bill establishes numerous community based mental health services as detailed below. These changes will require significant additional resources, some of which will be eligible for a 50% match under the federal Medicaid program. The state may also be able to secure federal reimbursement for some existing services through service augmentations included in this bill, and the expansion of the adult and children’s Medicaid rehabilitation option.

Section 1 of the bill requires the Department of Mental Health and Addiction Services (DMHAS), along with the Department of Children and Families (DCF), the Department of Information Technology (DoIT), and the Community Mental Health Strategy Board (CMHSB) to establish both a website and a toll-free telephone line to disseminate information and assistance concerning mental health services. It is estimated that the maintenance of the telephone line will cost \$50,000 annually. The personnel costs to staff the line are estimated to be \$480,000 annually (8 full time equivalent mental health educators/screeners at \$60,000 per year).

Section 2 requires DMHAS to develop and implement training programs to improve mental health awareness, early identification, and referral. It is estimated that to expand the current Prevention Training Collaborative to meet the demands of the populations

identified in the bill would cost \$150,000 annually. Additionally, to expand the current Crisis Intervention Program for police departments statewide would cost approximately \$750,000.

Sections 3, 6 and 11 require the Department of Social Services (DSS) to amend the state Medicaid plan to expand the current optional adult rehabilitation services. The additional services covered will be assertive community treatment teams, intensive community rehabilitation services for young adults, and rehabilitation services for certain adults residing in supported or supervised housing. These sections further authorize DMHAS to provide clinical case management for services provided under the adult rehabilitation option. These sections will significantly expand mental health service costs that are billed under Medicaid. The extent of these costs will be dependent upon the utilization of the provider network by clients as well as the number of previously unserved clients that enter the system due to the entitlement status of Medicaid. Any such expanded costs under Medicaid will be eligible for 50% reimbursement from the federal government. Additionally, some services that are currently 100% state funded will now be provided under the proposed Medicaid waiver. This will allow existing funding streams to be reimbursed at the 50% level by the federal government.

Section 4 requires DSS to obtain a waiver of federal law to establish a Medicaid home and community based pilot program to serve 50 adults with psychiatric disabilities who otherwise would require residential nursing home care. Based on an Intensive Supportive Community Services with Housing Option model, these community services would cost \$1.6 million annually (at \$32,000 per individual). As many of these clients may already be Medicaid eligible, there would be a concurrent savings to the nursing home portion of the Medicaid budget. Given the current average annual Medicaid nursing home cost of \$62,000, this leads to a potential savings of \$3.1 million. However, it is anticipated that some of beds that are made available by transitioning individuals to the community would be filled by other patients, reducing the overall potential savings.

Section 5 of this bill requires DMHAS to establish a pilot program to provide community-based services to 20 people in correctional facilities with psychiatric disabilities. The bill does not specify the type of services that will be offered in this pilot program. The department has previously funded specialized hospital discharge services at \$50,000 annually per individual. Assuming a similar model, the annual cost would be \$1 million for 20 individuals.

The average cost of incarceration in a Department of Correction facility is \$35,040.¹ The savings associated with releasing twenty inmates is approximately \$700,800. However, it is anticipated that if the beds were made available, they would be filled by other inmates needing psychiatric treatment.

Sections 7 and 8 require the Department of Children and Families (DCF) to provide certain mental health services for children and youth. Implementation costs are as follows:

	FY 06	FY 07	FY 08
Flexible Emergency Funding for Non-DCF Involved Children at FY 04 Level	\$1,070,000	\$1,070,000	\$1,070,000
30 Additional Care Coordinators by 10/1/05	\$1,187,550	\$1,583,400	\$1,583,400
12 Additional Family Advocates by 1/1/06	\$331,100	\$662,200	\$662,200
Enhanced Hours of Services & Staffing for Emergency Mobile Crisis (EMC) Teams by 1/1/06	\$1,031,168	\$2,062,336	\$2,062,336
16,000 Additional Respite Care Hours by 10/1/07 ²	\$0	\$0	\$360,000

¹ Figures include operational costs, fringe benefits and debt service and are taken from the Comptroller's Per Capita Cost Calculations, based on the costs of FY 03 (the latest year available).

² Annualized cost of \$480,000 in FY 09.

TOTAL	\$3,619,918	\$5,377,936	\$5,737,936
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Section 9 requires the DSS to amend its Medicaid state plan, by December 21, 2005, to provide children’s rehabilitation services, including those under the Connecticut Community KidCare program, unless the DSS commissioner determines this to not be the most appropriate Medicaid category for these services.

The DCF will incur an FY 06 cost of approximately \$107,800 to support the salaries of one Accountant and one Children & Families Regulatory Consultant needed to perform necessary financial, audit and quality assurance activities to comply with Medicaid standards and thus become eligible for federal reimbursement. The FY 06 fringe benefit cost associated with these positions would be \$24,420. In FY 07, the cost associated with these positions would increase to \$116,800 (DCF) and \$62,950 (fringe benefit), to reflect full year payroll expense.

Section 10 requires the Supportive Housing Pilots Initiative to expand by 500 housing units by July 1, 2006, and an additional 500 units by July 1, 2008. This initiative will require both debt service funding through the Connecticut Housing Finance Authority as well as wrap-around service funding under DMHAS. The annual cost for this initiative during FY 06, FY 07 and FY 08 will be dependent upon the timing of the construction and occupation of the units. The total additional cost to the state when all 1,000 new units are in service is estimated to be \$24 million annually.

Section 12 of the bill requires the Managed Care Ombudsman, in consultation with the Community Mental Health Strategy Board, to establish a process for mental health care providers, patients, business organizations, and managed care organizations to communicate about best practices in mental health treatment and on or before January 1, 2006 to annually report such findings to the Public Health and Insurance Committees. It is anticipated that the Office of the Managed Care Ombudsman would incur costs of \$12,000 - \$18,000 in FY 06 and FY 07 related to data collection and analysis, printing,

mailing, and clerical support in order to implement the provisions of the bill.

Section 13 requires the Legislative Program Review and Investigations committee to perform an evaluation of the compliance with the existing mental health parity requirements and report to the General Assembly by January 1, 2007. It is anticipated that the committee can perform the evaluation within its normal budgetary resources and will not have a fiscal impact on Legislative Management.

Section 14 of this bill requires DSS to establish criteria for outpatient clinics to be designated as enhanced care clinics. The section further requires that these clinics be reimbursed at 85% of the Medicare rate for adult services and 100% of the Medicare rate for children's services. As the criteria and subsequent rates have not been established, the impact of this section cannot be determined at this time. However, given the traditionally low reimbursement rate under Medicaid, setting rates at or near the Medicare rate will likely result in significantly increased costs.

Section 15 requires DSS to reimburse hospital mental health inpatient services for Medicaid eligible children on a per diem, rather than a per discharge, basis. The effect of this change will be dependent upon the per diem rate that is set for this service. If this rate is set so that the per diem rate times the average length of stay equals the current discharge rate, and the average length of stay does not change, the amount paid to hospitals will remain the same. However, the current per discharge basis serves as an incentive for hospitals to reduce the length of stay. If changing to a per diem rate eliminates this incentive, longer lengths of stay, and therefore significantly higher Medicaid costs, may result.

Sections 16 and 17 require state payments to private providers of children and adult mental health services, including those paid under the rehabilitation option, to receive a rate increase that is at least equal to the average increase in general wages paid to state employees

performing similar functions. Based on the most recent biennium, this would require a rate increase of 4.54%. The language of the bill is not clear as to which providers are to be considered mental health providers (i.e. whether providers of substance abuse services or dually diagnosed services are to be included). Assuming that this provision applies to those DMHAS providers who have traditionally received private provider rate increases, the 4.54% rate increase would equate to an additional \$7.2 million annually. Providing a 4.54% COLA for mental health providers under contract with the Department of Children and Families will cost a minimum of \$1,984,376. However, it should be noted that this amount would be increased significantly if any portion of DCF payments for out-of-home care is determined to be for "mental health care". This would be an additional significant cost to apply the 4.54% rate increase on Medicaid services provided under the rehabilitation option.

Section 18 repeals DSS's authority to determine the Supplemental Security Income (SSI) disregard for the State Supplement programs. This change appears to allow SSI recipients to not have the State Supplement payments reduced when they receive increases in the federal SSI payment. This change is expected to cost the Aid to the Disabled, Old Age Assistance, and Aid to the Blind an additional \$1.5 million in FY 06 and \$3 million in FY 07.

OLR Bill Analysis

sSB 1237

AN ACT CONCERNING COMMUNITY-BASED MENTAL HEALTH CARE**SUMMARY:**

This bill establishes several new programs and services to help children and adults with psychiatric disabilities remain in their communities. It requires the state to amend its Medicaid plan or receive Medicaid waivers to enable it to be reimbursed for some of the costs of these and several existing services. Any resulting Medicaid reimbursement must be deposited in the Community Mental Health Strategic Investment Fund. The programs and services the bill affects include supportive housing; assertive community treatment for adults; nursing home, hospital, and incarceration diversion for adults and young adults; in-home and mobile services for children; training; and public information.

The bill requires the Department of Children and Families (DCF) to provide specified levels of service and hire additional staff and requires the Department of Social Services (DSS) to increase Medicaid rates for several services. It requires the managed care ombudsman to establish ways for mental health providers, patients, insurers, and businesses to communicate on mental health practices and compliance with insurance laws. It requires the legislature to study how the state's mental health insurance parity law is being implemented. And it repeals the law requiring DSS to increase the amount it disregards when calculating Supplemental Security payments to reflect increases in Social Security benefits.

EFFECTIVE DATE: July 1, 2005, except for sections concerning assertive community treatment teams, adult diversion from nursing homes and young adult diversion from hospitals and prison, the Medicaid option for children's rehabilitation services, the managed care ombudsman's communication responsibilities, and the legislative study of mental health insurance parity, which are effective on passage.

MENTAL HEALTH WEBSITE AND TELEPHONE SERVICE (§ 1)

The bill requires the Department of Mental Health and Addiction Services (DMHAS) commissioner to provide for the development, implementation, promotion, and maintenance of (1) a website that provides timely access to mental health care information and assistance for children, adolescents, and adults and (2) toll-free mental health telephone screening, assistance, and follow-up for adults and families and caregivers of children and adolescents. He must provide for the website by June 30, 2006 and for the telephone service by January 1, 2008. He must do this in consultation with the DCF commissioner, the Department of Information Technology's chief information officer, and the Community Mental Health Strategy Board (Strategy Board).

The website must contain, at a minimum:

1. directory information on available federal, state, regional, and local assistance, programs, services, and providers;
2. current mental health diagnosis and treatment options;
3. links to national and state advocacy organizations, including legal assistance;
4. summaries of state and federal mental health laws, including those concerning private insurance; and
5. an optional, secure personal folder for people to manage information about their own mental health care and assistance.

TRAINING PROGRAMS (§ 2)

The bill requires the DMHAS commissioner, by January 1, 2007, in consultation with the Strategy Board, to provide for the development and implementation of programs to train people to improve mental health awareness, early identification, and referral. Training is for parents and families; early childhood providers; educators at all levels; police; senior center staff; and pediatricians, family, and geriatric health care professionals.

ASSERTIVE COMMUNITY TREATMENT TEAMS (§ 3)

The bill requires the DSS commissioner, in consultation with the DMHAS commissioner and the Strategy Board, to amend the state's Medicaid plan to provide a Medicaid option for adult rehabilitation services that include assertive community treatment teams. These teams provide intensive, integrated multidisciplinary services to adults with severe psychiatric disabilities, including people who are homeless; diverted or discharged from hospitals and nursing homes; or diverted or released from, or at risk of going to, prison. Under the bill, the teams must provide intensive community care management through case managers, nurses, and physicians and must include vocational, peer, and substance abuse specialists.

The bill requires the DSS and DMHAS commissioners, in consultation with the Strategy Board, to enter into an interagency agreement authorizing DMHAS to provide clinical management of assertive community treatment team services. Under the bill, "clinical management" is the process of evaluating and determining appropriate use of mental health services and providing assistance. It can include prior authorization, concurrent and retrospective review, discharge review, quality management, and provider certification and performance enhancement.

The bill allows the DMAHS commissioner to certify assertive community treatment service providers and requires him to adopt certification regulations. Certification must use criteria that are consistent with national recognized best practice standards. The commissioner must implement certification policies and procedures while in the process of adopting the regulations. He must print notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementing the policies and procedures.

The bill requires the DSS commissioner to consult with the DMHAS commissioner and the Strategy Board before amending the state plan, which she must do before December 31, 2005. She must also consult with the DMHAS commissioner in adopting regulations to establish specific services. The bill requires her to implement policies and procedures that establish these services while in the process of adopting the regulations following the process described above.

Any Medicaid reimbursement the state receives for assertive

community treatment team services under the adult rehabilitation services option must, under the bill, be credited to the Community Mental Health Strategic Investment Fund's community mental health restoration subaccount.

NURSING HOME DIVERSION PILOT PROGRAM (§ 4)

The bill requires the DSS commissioner, in consultation with the DMHAS commissioner and the Strategy Board, to seek a Medicaid waiver to create a Medicaid-financed home and community-based pilot program to divert at least 50 adults with severe and persistent psychiatric disabilities from nursing homes. The program can include housing assistance. The commissioner, in consultation with the above groups, must implement the pilot program by January 1, 2007.

The bill requires the DSS and DMHAS commissioners to enter into an interagency agreement authorizing DMHAS to provide clinical management for this program. It defines "clinical management" in the same way as it does for assertive community treatment, and it requires the DSS commissioner to adopt provider certification regulations and policies and procedures in the same way.

It requires the commissioner to report to the Public Health and Human Services committees on the pilot program. She must do this by January 1, 2007, which is the same date by which she must implement the program.

ADULT PRISON DIVERSION PILOT PROGRAM (§ 5)

The bill requires the DMHAS commissioner, in consultation with the correction commissioner and the Strategy Board, to establish a pilot program to provide appropriate housing and treatment services to 20 people with serious psychiatric disabilities who are eligible for release or diversion from prison. He must establish the program by July 1, 2006 and report on it to the Public Health, Judiciary, and Human Services committees by January 1, 2007.

YOUNG ADULT PRISON AND HOSPITAL DIVERSION PROGRAMS (§ 6)

The bill requires the DSS commissioner, in consultation with the DMHAS commissioner and the Strategy Board, to amend the state's Medicaid plan to include under a Medicaid adult rehabilitation

services option, intensive, age-appropriate, community rehabilitation services to help keep young adults with psychiatric disabilities out of hospitals and prisons. These services are for young adults who are diverted or discharged from hospitals or diverted or released from correctional facilities. The bill does not define “young adult,” but its reference to correctional facilities implies that it covers youths from age 14, which is the age at which youths can be placed in Department of Correction facilities.

The bill requires the DSS and DMHAS commissioners to enter into an interagency agreement authorizing DMHAS to provide clinical management for this program. They must consult with the Strategy Board in doing this. The bill defines “clinical management” in the same way as it does for assertive community treatment, and it requires the DSS commissioner to adopt certification regulations and policies and procedures in the same way (see above).

Any Medicaid reimbursement the state receives under the adult rehabilitation services option for these young adult services must, under the bill, be credited to the Community Mental Health Strategic Investment Fund’s community mental health restoration subaccount.

The bill requires the DMHAS commissioner, by January 1, 2006, to expand young adult services to all catchment areas in the state and identify service gaps for this population. He must consult with the Strategy Board in doing this. He must report to the Public Health and Human Services committees by January 1, 2007 on implementation activities and service gaps.

DCF SERVICES (§ 7, 8, 9)

The bill requires the DCF commissioner to:

1. beginning July 1, 2005, maintain at the level provided in FY 04 the amount of flexible emergency funds for children with psychiatric disabilities who are not under DCF supervision;
2. by October 1, 2005, provide for 30 more care coordinators statewide (care coordinators help families obtain and organize the array of services and supports often needed to keep children with mental illness in their community);

3. by January 1, 2006, provide for 12 more family advocates statewide (family advocates help parents develop individualized service plans for their children with mental illness, provide technical assistance to local system of care community collaborative, and promote parent involvement in all levels of the children's behavioral health system);
4. by January 1, 2006, expand mobile emergency crisis team services for three more hours daily, including evenings and Saturday mornings, and during these additional hours include at least one "licensed staff person" (in the mental health context, licensed staff could include physicians, psychologists, nurses, family therapists, clinical social workers, and professional counselors) and a school liaison for each team to provide on-site consultations during emergencies, follow-up services, and staff training and coordination; and
5. by October 1, 2007, double, to 32,000 hours, the number of respite care hours available to families of children with mental illness and pay at least \$30 per hour for this service.

She must consult with the DMHAS commissioner and the Strategy Board in undertaking all of these actions.

The bill requires the DSS commissioner to amend the state Medicaid plan to include those services DCF provides under its Connecticut Community KidCare Program under a children's rehabilitation services option. It specifies that these services include additional care coordinators, intensive in-home services, emergency mobile crisis services, and respite care. The commissioner must amend the plan by December 31, 2005, in consultation with the DCF and DMHAS commissioners and the Strategy Board unless she and they determine these services may be funded more appropriately under other parts of the state Medicaid plan.

Any Medicaid reimbursement the state receives for these optional child rehabilitation services must, under the bill, be credited to the Community Mental Health Strategic Investment Fund's community mental health restoration subaccount.

SUPPORTIVE HOUSING (§§ 10 & 11)

The bill expands the Supportive Housing Pilots Initiative, which was established in 2001 to create up to 650 housing units in which people with mental illness and their families also receive support services. It requires the Connecticut Housing Finance Authority to finance 500 more units by July 1, 2006 and an additional 500 units by July 1, 2008. Each group of 500 must contain (1) 350 new or substantially rehabilitated units and 150 leased, existing units and (2) 150 units designated for families and 350 designated for single adults, including 25 units for 18- to 23-year olds (see BACKGROUND, Related Bill).

By January 1, 2006, the bill requires the DSS commissioner, in consultation with the DMHAS commissioner and the Strategy Board, to amend the state Medicaid plan to provide optional adult rehabilitation services for adults with severe and persistent psychiatric disabilities who live in supported or supervised housing. Any Medicaid reimbursement the state receives for these services must be credited to the Community Mental Health Strategic Investment Fund's community mental health restoration subaccount.

The bill requires the DSS and DMHAS commissioners to enter into an interagency agreement authorizing DMHAS to provide clinical management for this program. It defines "clinical management" in the same way as it does for assertive community treatment, and it requires the DSS commissioner to adopt implementing regulations and policies and procedures in the same way (see above).

INSURANCE PRACTICES (§ 12, 13)

The bill requires the managed care ombudsman, in consultation with the Strategy Board, to establish a process for mental health care providers, patients, business organizations, and managed care organizations to communicate about and assure:

1. compliance with state insurance laws governing (a) compliance with federal law on guaranteed coverage availability and renewability of, mental health parity, and discrimination based on health status, (b) standards concerning psychotropic drug coverage, (c) mental health parity, and (d) coverage continuation for children with mental disabilities;
2. best practices in mental health treatment and recovery (presumably to assure that these practices are followed); and

3. the relative costs and benefits of providing effective mental health coverage to employees and their families (it is not clear what is to be assured by this provision).

The ombudsman must report annually to the Public Health and Insurance committees, beginning January 1, 2006, on his implementing this requirement.

The bill requires the Legislative Program Review and Investigations Committee to evaluate compliance with the state's mental health insurance parity law and report its findings to the governor and General Assembly by January 1, 2007.

MEDICAID RATES (§ 14, 15, 16,17)

The bill requires the DSS commissioner to increase the Medicaid rates the state pays outpatient clinics it designates as "Enhanced Care Clinics." These are facilities, including hospital clinics that provide mental health services to adults, adolescents and children. The rates must be annually indexed to 85% of the January 1, 2006 Medicare rate for adult services and to 100% of the October 1, 2005 Medicare rate for children and adolescent services.

The bill requires the commissioner to adopt regulations by October 1, 2005 that establish criteria for designating and certifying enhanced care clinics. She must do this in consultation with the DCF and DMHAS commissioners and the Strategy Board. She must implement policies and procedures while adopting the regulations, following the notice requirements described above.

By October 1, 2005, the bill requires the DSS commissioner to begin calculating the Medicaid rate for inpatient children's mental health care on a per diem, rather than a per-discharge, basis. (A per-discharge rate system pays hospitals a flat rate for each admission, regardless of how long a patient stays.)

Beginning in FY 06, and every two years thereafter, the bill requires the state to increase the rate it pays private providers of children and adult mental health care by at least as much as the average increase it gave state employees performing comparable work during the previous two years. It specifies that similar increases apply to state payments for

any services it requires to be funded under a Medicaid rehabilitation option (i.e., assertive community teams, young adult prison and hospital diversion, KidCare services, and supportive housing).

STATE SUPPLEMENT BENEFIT CALCULATION (§ 18)

The bill repeals a provision that requires the DSS commissioner to determine the amount of federal Supplemental Security Income (SSI) she disregards when determining both eligibility and benefits for the State Supplement Program (SSP). This provision also directs her to increase the amount she disregards for people living in shared housing who ask for an increase and requires her to adopt regulations specifying disregard amounts.

Other laws, unchanged by the bill, (1) continue to allow the DSS commissioner to establish SSP disregards as permitted by federal law (§ 17b-104) and (2) freeze, through FY 2005, the SSP benefit level (§17b-106). Thus it is unclear what, if any, effect the bill has.

With one minor exception, the state has not increased the unearned income disregard in the SSP program for the past 17 years or the program's benefit levels, effectively reducing the amount of SSP benefits people receive, if not altogether eliminating their eligibility for assistance.

BACKGROUND

Community Mental Health Strategy Board

This 21-member board develops strategic and financial plans to guide the DMHAS commissioner's disbursements from the Community Mental Health Strategic Investment Fund. It is composed of lay members appointed by the governor and legislative leaders and various state agency heads (most of whom are not voting members).

Medicaid Rehabilitation Option

Medicaid requires states to provide certain services (e.g., inpatient and outpatient hospital care, physician services, nursing home, pregnancy, and post-partum services) and permits them to provide others. Community-based, medically necessary rehabilitation services are one of these options. The services may be provided in any setting (at the state's option) and can include mental health services such as

individual and group psychological therapies, psychosocial services, and addiction treatment services.

Related Bills

sSB 1056, favorably reported by the Public Health Committee, requires the development of 500 new supportive housing units beginning July 1, 2005. The units are for people with psychiatric disabilities or substance abuse dependence who are, or are at risk of, homelessness; families who are eligible for temporary family assistance; young adults who are, or are at risk of, homelessness because they are leaving foster care; and community-supervised offenders with serious mental health needs.

sHB 5290, favorably reported by the Human Services Committee, requires the DSS commissioner to increase the SSP unearned income disregard to reflect increases in SSI benefits, beginning July 1, 2005.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 24 Nay 2