REVIEW AND EVALUATION OF CONGREGATE CARE LIVING ARRANGEMENTS FOR INDIVIDUALS WITH MENTAL ILLNESS IN NEVADA

REPORT TO THE LEGISLATIVE COMMITTEE ON HEALTH CARE

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REVIEW AND EVALUATION OF CONGREGATE CARE LIVING ARRANGEMENTS FOR INDIVIDUALS WITH MENTAL ILLNESS IN NEVADA

Legislative Charge

Assembly Bill 343 (2017) requires the Legislative Committee on Health Care (LCHC) to conduct an interim study concerning rates paid by the state to group homes contracted with Southern Nevada Adult Mental Health Services (SNAMHS) through the Division of Public and Behavioral Health (DPBH), Department of Health and Human Services (DHHS).

The bill requires the study to include:

- A comprehensive review and evaluation of the rates paid by the state to group homes contracted with SNAMHS and whether any changes in the rates may be necessary;
- A comprehensive evaluation of the impact a change in such rates would have on group homes contracted with SNAMHS as well as on any person who uses the services provided by such group homes;
- A comprehensive evaluation of state and federal funding for the group homes contracted with SNAMHS and the impact a change in rates paid by the state to such group homes would have on such funding;
- Consideration of the applicable provisions of federal law; and
- An examination of any other matter the LCHC determines to be relevant to the study.

The LCHC determined the study should also include a review of:

- The various types of congregate living and community-based support services available to persons with a mental health condition in Nevada;
- Policies and procedures for screening and assessing the needs of individuals with mental illness who receive housing assistance through congregate living and community-based support services, including the effectiveness of case management in achieving treatment goals; and
- The rationale for current models of congregate living and community-based support services with special consideration of the: (1) rationale for maintaining the current array of housing and support options; and (2) need to establish consistent oversight and standards.

At the direction of the LCHC, staff of the Legislative Counsel Bureau (LCB) analyzed these issues, working collaboratively with DPBH; the Aging and Disability Services Division (ADSD), DHHS; group home providers and representatives; individuals who provide services on behalf of group homes; client advocates; and others.

While the focus of this study pertains to group homes for the seriously mentally ill in southern Nevada, the spectrum of state-supported congregate living and community-based services spans multiple models and populations. A study of a single component, in isolation, would not adequately address the intent of the bill or Committee. In order to provide context and historical perspective, this report considers several housing models supported in whole or part by DPBH or ADSD, in addition to group homes contracted with SNAMHS.

Disclaimer

The LCB is a nonpartisan agency; as such, LCB staff neither advocate for nor against any ideology, issue, or position. The purpose of this report is to present information in an unbiased manner to better assist legislators in making informed decisions regarding the subjects addressed herein.

As AB 343 primarily focuses on homes contracted with SNAMHS, cost analyses throughout the report relate primarily to individuals receiving housing and supportive services through SNAMHS. Analyses are based on summary information provided by DPBH for group home and community-based living arrangement (CBLA) contracts concluding on June 30, 2018, the end of state Fiscal Year (FY) 2017–2018. Summary information was collected by DPBH for internal purposes and may be subject to errors or omissions. It is important to note that average costs and program structures may differ for homes contracted with Northern Nevada Adult Mental Health Services (NNAMHS).

Executive Summary

In Nevada, DHHS contracts with various community-based housing models to provide housing and supportive services to certain individuals with serious mental illness (SMI), intellectual disabilities, or who are frail elderly. While the housing models, populations served, and funding mechanisms vary, they all provide a bed in a home in the community for individuals with similar disabilities. Within this broader context, this study analyzes two housing models for individuals with mental illness—group homes and community-based living arrangements (CBLAs)—and identifies key issues and challenges with the existing model of serving individuals with SMI. A few key issues are highlighted below.

- While group homes and CBLAs largely serve the same populations, inconsistencies exist between the level of service provided, the amount of regulation, and reimbursement rates for the two models. Specifically, CBLAs receive an average of nearly 80 percent more reimbursement per month than mental health group homes, yet are subject to fewer statutory and regulatory requirements.

- Providers are shifting away from mental health group homes in favor of offering CBLA services. This trend is evident in the declining number of mental health group homes contracted with Southern Nevada Adult Mental Health Services (SNAMHS) over the past few years, as well as the fact that there are currently no pending applications for mental health group home licensure in Nevada.

- In practice, there does not appear to be a clear path from high-need intensive care to lower-need intermittent care within the continuum of mental health housing services in Nevada. Clear demarcation between the level of service provided by group homes and CBLAs may benefit access, consumer choice, and transparency. However, as observed, these models are often used interchangeably.

- There appears to be a disparity between an individual's level of need and the level of services provided. An individual's placement often is determined based on where a bed is available, rather than on the model that best serves his or her needs.

- A disparity exists in available funding mechanisms to help serve individuals with an intellectual disability or the frail elderly and those with a mental health condition in Nevada. Currently, the state has Medicaid 1915(c) waivers to support the intellectually disabled and frail elderly populations, but not those with mental illness. Exploration of available federal funding mechanisms to serve individuals with mental illness may help expand the pool of available services and providers.

In conjunction with evaluating the existing system in Nevada, it may be helpful to explore how other states and localities provide similar housing and supportive services; most now separate the provision of housing from the provision of services. This issue is discussed and a few examples are provided in the final section of this study.

Introduction

Having a safe and stable place to call home is a critical component of recovery for individuals with long-term disabilities, including those with SMI, intellectual or developmental disabilities; frail elderly populations; the chronically homeless; and other vulnerable populations who have low or no income. Individuals with long-term disabilities often rely on federal programs such as Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) for support. However, this income is insufficient to fully cover the cost of food, housing, medicine, and other household expenses. Unless these individuals receive rental assistance or live with other household members who have additional income, they will likely experience difficulty finding affordable housing.

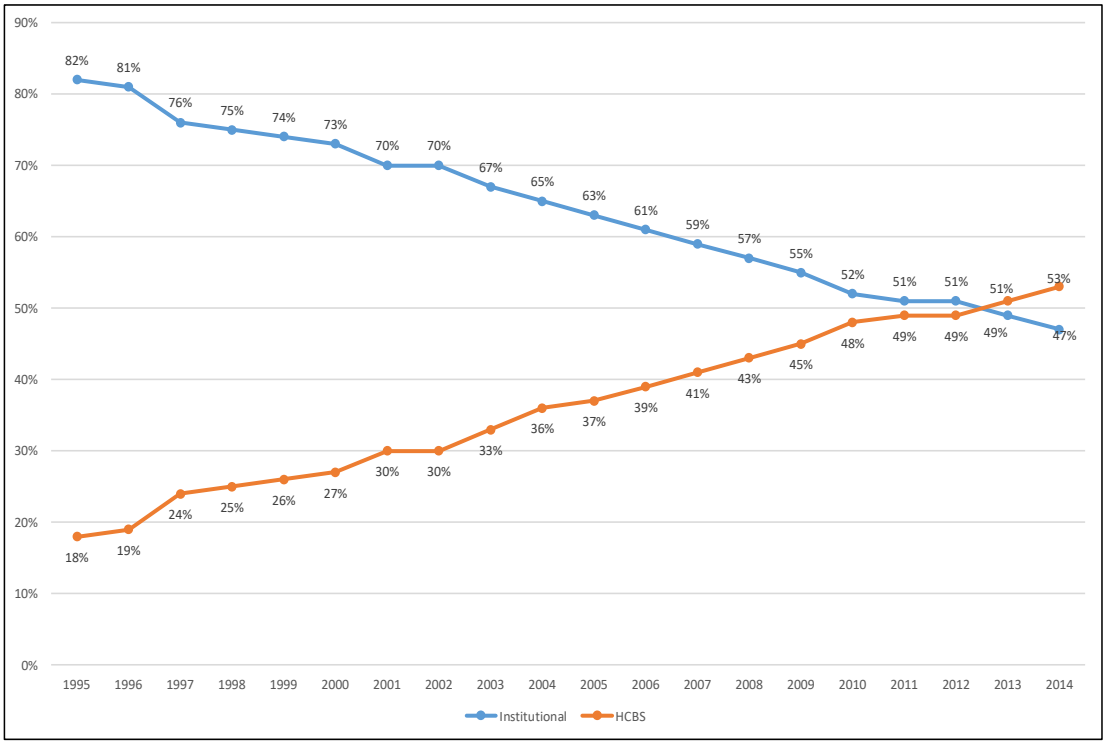
At its peak in 1955, an average of 559,000 mental health patients were hospitalized in the United States.[1] The advent of antipsychotic drugs and behavior therapy, among other things, reduced the need for long-term mental health hospitalization and, instead, shifted the focus to outpatient treatment. In 1963, the Community Mental Health Centers (CMHC) Act passed, making federal subsidies available for the construction of CMHCs. In 1999, the U.S. Supreme Court, in *Olmstead v. L.C.*, held the unjustified segregation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act. The Court further found that states must provide community-based services for individuals with disabilities who might otherwise be served in an institutional setting if such a placement is appropriate, can be reasonably accommodated by the state, and the individual does not oppose it.[2]

Nevada's group homes and other congregate care housing models are representative of these historic shifts away from institutionalization toward outpatient, community-centered care. The chart below depicts this shift at a national level within Medicaid. As institutional expenditures declined, home- and community-based service expenditures rose.

[1] Gerald N. Grob, "Public Policy and Mental Illness: Jimmy Carter's Presidential Commission on Mental Health," *The Milbank Quarterly,* Vol. 83, No. 3, 2005 (pp. 425-456).

[2] Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead, Civil Rights, U.S. Department of Health and Human Services.

Figure 1: Medicaid Home and Community-Based Services Expenditures as a Percentage of Total Medicaid Long-Term Services and Supports Expenditures, FY 1995–2014



Source: S. Eiken, K. Sredl, B. Burwell, and P. Saucier (2016), *Medicaid Expenditures for Long-Term Services and Supports in FY 2014*, Figure 6. Truven Health Analytics. https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

States have developed several different housing models to assist the aforementioned populations live as independently as possible. In Nevada, DPBH funds, in whole or in part, group homes, special needs group homes, and various types of CBLAs for individuals with SMI. The ADSD funds, in whole or in part, group homes for the frail elderly, as well as supported living arrangements (SLAs) for individuals with intellectual disabilities. ***While all of these housing models have different names, target populations, and funding mechanisms, the fundamental services provided in each is the same—they provide a bed in a home for individuals with similar disabilities within a community residential neighborhood.*** Depending on the type of housing model or the needs of a particular client, they also typically provide varying levels of support services, such as bathing, daily social and recreational activities, meal preparation, medication management, skill development, supervision, and transportation. Each housing model is described in more detail in the infographic and sections that follow.

Nevada Housing Supports

What are the differences in services for vulnerable populations?

The state provides funding and supports to help vulnerable populations such as the seriously mentally ill, the frail and elderly, and individuals with developmental disabilities facilitate daily living in the least restrictive setting possible, embracing outpatient, community-centered care.

	Division of Public and Behavioral Health	Aging and Disability Services Division
Residential Facilities for Groups 	*Group Home*: 24-hour staff provide supervision and assisted living support. Clients share a room. Monthly flat rate of $940 per person paid by the state. *Special Needs Group Home*: 24-hour staff provide supervision and support similar to group homes, however, includes additional medical support for individuals with chronic illnesses or physical limitations. Clients share a room. Monthly flat rate of $1,318 per person paid by the state.	*Medicaid Home and Community Based Waiver for the Frail and Elderly (>65 years):* 24-hour staff provide supervision and assisted living support. Client pays provider SSI income of $1,019 (monthly flat rate), however, if SSI income is higher, the amount paid varies by client. Additionally, Medicaid pays augmented personal care rates per client, depending on the assessed level of care (LOC) at the following daily rates: LOC 1: $23 per day LOC 3: $69 per day LOC 2: $52 per day LOC 4: $83 per day
Community Based Housing & Service Supports 	*Community Based Living Arrangements (CBLAs)*: Apartments or homes for clients who require up to 74 hours of rehabilitative services per month. Clients do not share a room. Rent and service expenses vary by client and are paid by the state. *Long-Term Care CBLA*: Apartments or homes with 24-hour staff. Clients receive 75 to 150 hours of rehabilitative services per month. Clients do not share a room. Rent and service expenses vary by client and are paid by the state. *Intensive CBLA*: Apartments or homes with 24-hour staff. Clients receive more than 150 hours of rehabilitative services per month. Clients do not share a room. Rent and service expenses vary by client and are paid by the state. *HUD Supported CBLA*: A portion of the client's living expenses are paid by HUD. SNAMHS provides services as a match.	*Supportive Living Arrangements (SLA) for Individuals with Intellectual Disabilities or Related Conditions:* Residential supports to individuals who require assistance to live in the least restrictive community setting possible. Rent and service expenses vary by client and are paid by state and federal funds. *Intermittent SLA:* Provide services in the client home, ranging from several hours per week to daily. Provides less than 160 support hours per month. *Intensive SLA (ISLA):* Provide 24 hour services for individuals who require a level of supervision and support. Provide 160 to 320 support hours per month. *Intensive SLA Plus (ISLA+):* Provide the same services as a 24 hour ISLA, but serve individuals who require more than 320 support hours per month.

Note: A client's individual income, if any, is applied to housing expenses. The state is a payer of last resort.

I. HOUSING MODELS CONTRACTED BY THE DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

The DPBH, through NNAMHS and SNAMHS, contracts with group homes and CBLAs to provide housing and supportive services to certain individuals with SMI in Nevada.

➢ Group Homes

Group homes, referred to formally as residential facilities for groups under *Nevada Revised Statutes* (NRS) 449.017, or informally as "board and care homes" or "care homes," provide 24-hour care to mental health clients who require constant supervision. Services include assistance with activities of daily living, housing, and medication management. While group homes can assist with medication reminders, the level of service they provide is limited. For example, they cannot administer certain types of injections or other services that may require skilled nursing staff. In this model of care, it is common practice for multiple adults with SMI to share a bedroom.

Regulation

Group homes, regardless of associated state agency or type of clientele, are regulated under Chapter 449 of both NRS and *Nevada Administrative Code* (NAC). They are licensed and overseen by the Bureau of Health Care Quality and Compliance (HCQC), DPBH, DHHS. *Nevada Administrative Code* 449.011 through 449.0118 outline general requirements for group home licensure and renewal and allow for the denial, suspension, or revocation of a license.

Specific group home licensure requirements are outlined in NAC 449.204 through 449.269, and include requirements related to issues such as:

- Advertising;
- Automatic sprinkler systems;
- Bedroom floor space, lighting, privacy, storage, and window size, ;
- Fire marshal occupancy approval;
- Food service;
- Health and sanitation; and
- Supervision and resident activity.

Additionally, the services of the State Long-Term Care Ombudsman, Office of the State Long-Term Care Ombudsman, ADSD, DHHS, extend to homes licensed under Chapter 449 of NRS, including mental health group homes. The Ombudsman represents the interest of residents by investigating complaints; monitoring relevant laws, policies, and regulations; providing information; and regularly visiting facilities. While the Ombudsman does not enforce state regulations, it may provide information to oversight entities as a result of a visit or a complaint.

Compensation

Group homes are generally compensated in one of two ways: (1) through contracts with state agencies; or (2) by individual clients who privately pay for their own care. Northern Nevada Adult Mental Health Services and SNAMHS contract with group homes through DPBH to provide housing and services to individuals with mental illness. Each contract is client-specific: every individual residing in a group home who is paid for, in whole or in part, by DPBH has a contract between DPBH, the housing provider, and the client.

The DPBH only contracts with a small number of all group home facilities—3 in northern Nevada and 30 in southern Nevada. Of the approximately 8,300 licensed group home beds in the state, only 230 beds (2.8 percent) are available for mentally ill clients whose placement is arranged, contracted, and paid for, either in whole or in part, by NNAMHS or SNAMHS. On average, each group home contracted with SNAMHS provides housing to 7.7 clients. The majority of the 8,300 licensed group home beds serve aging individuals who pay for their own services, rather than those with mental illness.

Mental health group homes provide two levels of service to individuals: traditional and special needs. Each home can provide one or both levels of service. Traditional group home services are provided to individuals who can safely evacuate a home in four minutes or less—defined as Category 1 residents in NAC 449.1591. Traditional group home services are compensated by DPBH at a flat monthly rate of $940 per individual. Special needs group services are provided to individuals with additional medical needs—those who cannot safely evacuate the home in four minutes or less. Defined as Category 2 residents in NAC 449.1595, special needs group home services are compensated by DPBH at a flat monthly rate of $1,318. In addition, DPBH provides residents of mental health group homes a monthly "personal needs stipend" of $181.22. The personal needs stipend is not included as part of the compensation rate for service providers. *According to DPBH, rates paid to group home providers have not changed since 2008.*

Figure 2: Compensation for Mental Health Group Homes Contracted with Southern Nevada Adult Mental Health Services

Facility Type	Individual Contracts as of 6/30/18	Monthly Living Expenses per Person	Monthly Stipend per Person	Total Monthly Cost Per Person
Traditional Group Home (Category 1)	175	$ 940.00	$ 181.22	$ 1,121.22
Special Needs Group Home (Category 2)	47	$ 1,318.00	$ 181.22	$ 1,499.22
Total / Weighted Average	**222**	**$ 1,020.03**	**$ 181.22**	**$ 1,201.25**

While SNAMHS pays group homes a flat monthly rate per client per month, the total amount the state pays each month may vary depending on a client's income—such as that from employment, SSI, or SSDI. If a client has a source of income, the income is applied to the flat monthly rate first, and the state pays the difference. For example, 145 of the 175 individuals (83 percent) residing in traditional group homes contracted with SNAMHS receive SSI or SSDI. This income is applied to their housing costs and the state pays any remaining balance.

In aggregate, SNAMHS pays 44 percent of the cost of all group home expenditures in southern Nevada, while clients, in aggregate, pay the remaining 56 percent. Amounts vary significantly per person depending on a client's individual monthly income. Other state agencies providing housing supports use different funding models; a comparison of the rates associated with each agency and target population is provided in Figure 11.

- **Community-Based Living Arrangements**

The CBLA is another model of congregate living that serves individuals with SMI through NNAMHS and SNAMHS. As defined in NRS 433.605, CBLAs provide flexible, individualized services—including training and habilitation—that are: (1) provided in the home, for compensation, to individuals with mental illness or developmental disabilities; and (2) designed to maximize an individual's independence. In practice, several types of CBLAs provide care for individuals with varying levels of need.

Some CBLAs provide 24-hour supervision while others offer only intermittent care. According to DPBH staff, CBLAs were originally intended to serve individuals with lower levels of need than those placed in group homes. However, this distinction is not universal and *no policy clearly identifies whether an individual should be placed in a CBLA or a group home.*

Community-based living arrangements are not a new congregate residential living model in Nevada. During the 2013 Legislative Session, the then Mental Health and Developmental Services Division, DHHS, was split into the current DPBH and ADSD. Both divisions referred to their supportive housing services as SLAs but operated distinct programs for different populations. To avoid confusion and better differentiate supportive housing services for individuals with mental health needs from those for individuals with intellectual disabilities, DPBH began referring to its mental health SLAs as CBLAs.

Regulation

In 2017, the Legislature passed AB 46 creating a formal, statutory oversight framework for CBLAs under Chapter 433 of Title 39 ("Mental Health") of NRS. The bill requires the State Board of Health to adopt regulations—outlined in NRS 433.601 through 433.621—governing the certification and operation of CBLAs. However, DPBH currently is considering additional regulations related to certification and fees, fire and other safety requirements, quality assurance and oversight, and shared bedroom space, among other issues. (See Legislative Counsel Bureau [LCB] File No. R134-18.)

Compensation

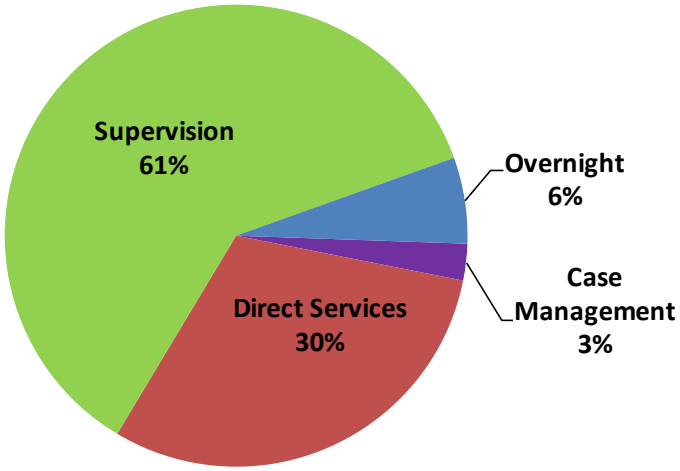
Generally, CBLAs are described as paid state placements through DPBH and are considered a transitional stage on the path to independent living. Housing may be located in either an apartment or a house, with each client traditionally having his or her own private bedroom. Similar to the group home model, every individual residing in a CBLA whose services are paid for, in whole or in part, by DPBH has a contract between DPBH, the housing provider, and the client. These contracts typically include a variable number of direct service hours as well as

living expenses such as food, rent, and utilities. *While DPBH pays a fixed monthly amount for clients residing in group homes, CBLA costs vary widely by client, depending on the number of specialized service hours provided.*

Review and Evaluation of Contracts between Southern Nevada Adult Mental Health Services and Community-Based Living Arrangements

As of June 30, 2018, 325 individuals were in a CBLA placement contracted by SNAMHS. Of these, 271 individuals receive a total of 26,968 specialized service hours per month, for an average of 100 hours of service per person per month. Daily supervision accounts for 61 percent of all service hours, and an additional 6 percent of supervision is provided during sleeping hours. In contrast to the group home model, which provides 24-hour supervision, 7 days per week, for a flat monthly rate, the *CBLA model reimburses supervision on an hourly basis and is the primary driver of specialized service hours*. Direct services are provided by the housing provider and include skill development to conduct activities of daily living, such as assisting a client with cleaning, cooking, managing doctors' appointments, using the phone, et cetera. In addition, case management services link individuals to outside service agencies and activities.

Figure 3: Monthly Specialized Service Hours for Individuals Placed in a Community-Based Living Arrangement Contracted by Southern Nevada Adult Mental Health Services As of June 30, 2018



The level of care for CBLA clients is defined by the number of specialized support hours received, and SNAMHS further categorizes CBLA placements by the number of service hours per month provided to the client. According to SNAMHS, there are four different types of CBLAs:

1. ***Standard CBLA (0 to 74 hours*):** As of June 30, 2018, 143 individuals (44 percent of all SNAMHS CBLA clients) received services through a standard CBLA; 54 individuals received zero service hours, and 89 individuals received between 1 and 74 services hours. Of the 89 individuals who received services, 77 percent of total service hours represent supervision hours. Standard CBLAs provide an opportunity for independent living combined with the security of limited supervision and behavioral skills training in a community setting.

2. ***Long-Term Care CBLA (75 to 150 hours)*:** As of June 30, 2018, 148 individuals (46 percent of all CBLA clients) were long-term care (LTC) clients and received 24-hour supervision and 75 to 150 service hours per month. Long-term care CBLAs serve individuals who are chronically mentally ill and whose plan of care includes both rehabilitative and habilitative services. As such, individuals in LTC CBLA placements have a slightly broader mix of specialized service hours, with 57 percent of total service hours representing supervision and 39 percent representing direct services.

3. ***Intensive CBLA (150 hours or more)*:** As of June 30, 2018, 34 individuals (10 percent of all CBLA clients) were intensive CBLA clients and received 24-hour supervision and 150 service hours or more per month. Intensive CBLAs are designed for clients who have been unsuccessful in other residential settings, demonstrate poor social skills, and have experienced repeated emergency room visits, hospitalizations, and/or incarcerations. Supervision hours accounted for 83 percent of total specialized service hours for individuals residing in an intensive CBLA.

4. ***Housing and Urban Development CBLA*:** As of June 30, 2018, 157 individuals received housing and supportive services through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care grant. The majority of living expenses for HUD CBLAs are paid through the federal grant, and SNAMHS provides a 25 percent match in the form of specialized services. Individuals eligible for this program have a documented history of chronic homelessness. Out of the 157 individuals residing in a CBLA placement through HUD, 89 percent did not receive any specialized service hours.

The table that follows demonstrates the average monthly costs per person by CBLA placement type. The HUD CBLA data are shown separately due to the significant differences between a HUD CBLA placement and a state-funded CBLA placement.

Figure 4: Compensation for Various Types of Community-Based Living Arrangements Contracted with Southern Nevada Adult Mental Health Services

Facility Type	Individual Contracts as of 6/30/18	Monthly Living Costs per Person	Monthly Specialized Service Costs per Person	Total Monthly Cost Per Person
Standard CBLA	143	$ 895	$ 442	$ 1,337
Long-Term Care CBLA	148	$ 669	$ 1,820	$ 2,489
Intensive CBLA	34	$ 625	$ 3,609	$ 4,234
State Funded CBLAs Total / Average	**325**	**$ 764**	**$ 1,401**	**$ 2,165**
HUD CBLA Total / Average	**157**	**$ 1,323**	**$ 56**	**$ 1,379**

As illustrated in Figure 4, compensation provided to CBLAs contracted with SNAMHS is highly variable depending on the cost of specialized services. Similar to group home compensation, the total amount the state pays to a provider on behalf of a client each month may vary depending on whether a client has a regular source of income, such as employment, SSI, or SSDI. If a client does have a source of income, that income is applied to the contracted monthly rate first and then the

state pays the difference. However, since the average monthly costs of CBLAs are substantially higher than the cost of group homes, and since the amount of income a client contributes toward housing is the same regardless of their placement, the state pays an aggregate total of 86 percent of all costs for clients residing in state-funded CBLA placements, compared to an aggregate total of 44 percent of all costs for those living in state-funded group house placements.

Comparative Cost Analysis: Group Homes and Community-Based Living Arrangements Contracted with Southern Nevada Adult Mental Health Services

There appears to be an inconsistency between the level of service provided, amount of regulation, and compensation for CBLAs compared to group homes. *In practice, LTC CBLAs and intensive CBLAs often provide similar levels of services as group homes, yet they must comply with fewer regulations and are reimbursed at a higher rate.*

Regulation

As illustrated below, CBLAs are subject to fewer statutory requirements and administrative regulations than group homes. While this table does not provide a comprehensive comparison of all requirements for CBLAs and group homes, it provides a representation of the difference in the level of regulation between the two housing models.

Figure 5: Select Statutory and Administrative Regulations for Group Homes and Community-Based Living Arrangements

	Group Home	CBLA
	NRS/NAC 449	NRS/NAC 433
Administrator	Requires licensed administrator (NRS 449.186)	No requirements for licensed administrator
Health and Sanitation	Group home must be free from accumulations of dirt and garbage, offensive odors, hazards, and insects (NAC 449.209)	"Assure the health and welfare of persons receiving services." (NAC 433.348)
Activities	10 hours of scheduled activities per week (NAC 449.260)	No requirements for activities
Bedroom and Floor Space	Common Area: 15 sq. ft. per person Bedroom: 60-80 sq. ft. per person Storage: 10 sq. ft. per person (NAC 449.216, 449.218)	No requirements for space
Automatic Sprinklers	Requires automatic sprinkler system (NAC 449.211)	No requirements for sprinklers
Supervision	Operates 24 hours per day (NAC 449.0064, 449.194, and 449.199)	No requirements for supervision
Fees	Initial $2,386 per facility, $200 per bed Renewal $1,193 per facility, $100 per bed (NAC 449.016)	NRS 433 allows for a certification fee, no fee currently set
Training	Multiple requirements including 8 hours of annual training regarding the provision of services Initial and annual training in elder abuse (NRS 449.093) Additional training requirements for group home endorsements (NAC 449.2754 to NAC 449.2768)	Initial 16 hours of training regarding provision of services for the CBLA provider (NAC 433.336) No subsequent training requirements for the CBLA provider once certified No requirements for any employees of the CBLA provider

Compensation

Group homes and CBLAs provide services at different costs. A summary of these differences is presented in the table below.

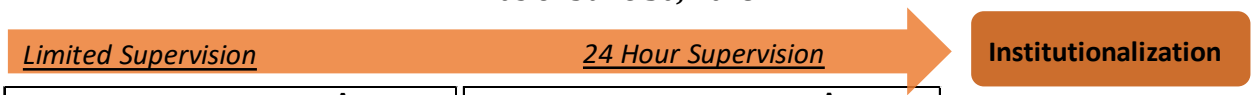
Figure 6: Compensation Comparison for Group Homes and Community-Based Living Arrangements Contracted with Southern Nevada Adult Mental Health Services

Facility Type	Individual Contracts as of 6/30/18	Monthly Living Costs per Person	Monthly Stipend per Person	Monthly Specialized Service Costs per Person	Total Monthly Cost Per Person
Group Home	175	$ 940	$ 181	$ -	$ 1,121
Special Needs Group Home	47	$ 1,318	$ 181	$ -	$ 1,499
Total / Weighted Avg Group Home	**222**	**$ 1,020**	**$ 181**	**$ -**	**$ 1,201**
Standard CBLA	143	$ 895	$ -	$ 442	$ 1,337
Long-Term Care CBLA	148	$ 669	$ -	$ 1,820	$ 2,489
Intensive CBLA	34	$ 625	$ -	$ 3,609	$ 4,234
Total / Weighted Avg State CBLA	**325**	**$ 764**	**$ -**	**$ 1,401**	**$ 2,165**

The average monthly cost of a CBLA placement is $2,165 (with a range of $1,337 to $4,234), compared to that of a group home placement with an average monthly cost of $1,201. In addition, whereas standard CBLAs simply provide housing with some services, long-term care CBLAs and intensive CBLAs provide staff 24 hours per day and a high number of service hours per month; however, the majority of these service hours consist of supervision rather than direct services. According to DPBH, clients placed in a long-term care or intensive CBLA are some of the most difficult clients to treat; they may have a history of violence or sex offenses, or pose a credible risk of harm to themselves or others. These individuals are likely to require this high level of care for the rest of their lives. A CBLA providing 24-hour supervision often has fewer clients in the home and requires a higher per person compensation rate to provide 24-hour care for this housing model.

Both group homes and CBLAs have a valid role in providing care to the spectrum of DPBH clients when used as intended. Individuals with SMI differ in the degree of their disability; many can live stable, fairly independent lives with some level of assistance and support. Others are able to live in the community if someone is available to assist them on-site, as needed, on a 24-hour basis. While both group homes and certain CBLAs provide 24-hour supervision, it is unclear when and why an individual is placed in one housing type or the other. However, the placement matters, as DPBH pays significantly more for CBLAs.

Figure 7: Continuum of Supervision and Cost of Care Provided in Group Homes and Community-Based Living Arrangements, as of June 30, 2018



Facility Type	Individual Contracts	Average Monthly Cost Per Person
Standard CBLA	143	$ 1,337

Facility Type	Individual Contracts	Average Monthly Cost Per Person
Group Home	175	$ 940
SN Group Home	47	$ 1,318
LTC CBLA	148	$ 2,489
Intensive CBLA	34	$ 4,234

Long-term care CBLAs, intensive CBLAs, and group homes provide similar services, and yet, on average, CBLA placements are reimbursed at higher monthly rates than group home placements. In addition, group homes are subject to more regulation and yet are reimbursed at a lower rate than CBLAs.

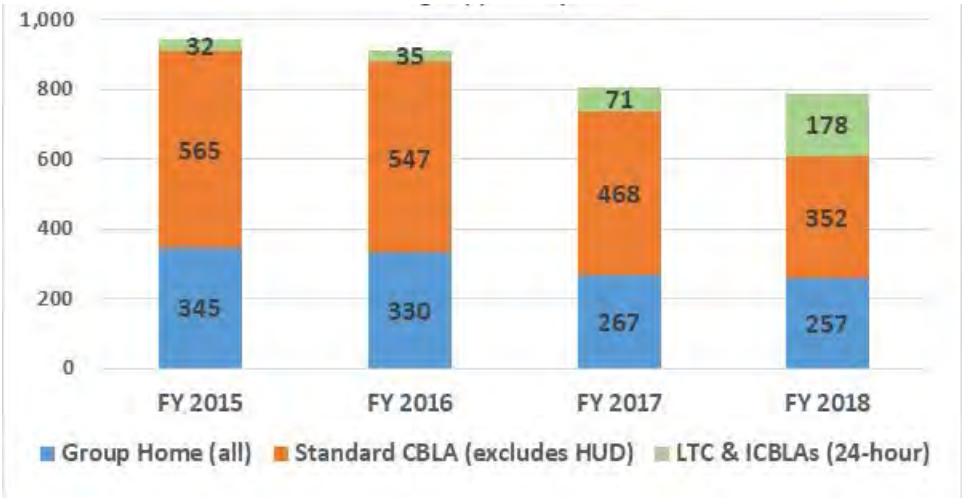
This misalignment of level of care, regulation, and reimbursement incentivizes housing providers to move away from providing group home services and instead provide CBLA services. Feedback from the provider community and data provided by DPBH confirm this shift. At a provider meeting to solicit input for this report, four current SNAMHS group home providers commented that they have pending CBLA applications and indicated they will cease providing group home services if the group home reimbursement rate remains unchanged. In addition, according to DPBH, as of August 31, 2018, 125 applications were pending for certification as a CBLA and no applications were pending for licensure as a mental health group home. While the current number of pending CBLA applications is artificially high due to recent changes in certification requirements and oversight, the trend indicates preference for the CBLA model over the group home model.

Furthermore, 54 distinct facilities received a payment from SNAMHS at some point in FY 2013. In FY 2018, 42 facilities received a payment at some point—a decline of 22 percent over five years.[3] As of August 2018, 30 group home providers contract with SNAMHS to provide group home services.

This information may help provide context to the shift in the number of individuals receiving housing support through DPBH overall during the past few years.

[3] These figures represent the distinct count of mental health group homes that did business with SHAMHS at any point during a fiscal year and will be greater than or equal to the count of actively contracted facilities at any single point within a fiscal year.

Figure 8: Average Number of Individuals Receiving Housing Supports Contracted Through Division of Public and Behavioral Health, FY 2015–2018



Source: Behavioral Health Chart Pack, Director's Office, DHHS, July 2018

The total number of individuals receiving housing support and services through DPBH over the last four fiscal years decreased from an average of 942 individuals in FY 2015 to 787 in FY 2018, a decline of 16.5 percent. However, the rate of decline for individuals receiving care in the lower-cost group homes, special needs group homes, or standard CBLAs was 33.1 percent—more than double the overall decline. Meanwhile, the average number of individuals placed in housing models with higher reimbursement rates—LTC and intensive CBLAs—grew from 32 in FY 2015 to 178 in FY 2018, an increase of 456 percent.

II. HOUSING MODELS CONTRACTED BY THE AGING AND DISABILITY SERVICES DIVISION

While DPBH contracts with providers of the two housing models described above to provide services to individuals with mental health conditions, ADSD contracts with other housing models—SLAs and group homes for the elderly—to provide similar services to individuals who are frail elderly or intellectually disabled.

➢ Supported Living Arrangements

Another model of congregate care in Nevada is the SLA with which ADSD's Developmental Services contracts. These SLAs provide housing and direct services to individuals with intellectual disabilities and related conditions. While SLAs are not a primary component of this study, they are included for context as part of the comprehensive review of Nevada's supportive housing models.

Supported living arrangements offer three general levels of service based on the total number of hours required by an individual contract. Contracts that require less than 160 hours of care are intermittent placements in which clients receive limited direct support, typically in their own home, and are not considered 24-hour homes. Contracts between 160 and 320 hours are

intensive supported living arrangements (ISLAs) that include 24-hour care in a congregate setting. Supported living arrangements that provide more than 320 hours of service per month are ISLA Plus (ISLA+). The ISLA and ISLA+ models provide identical services and are only differentiated by the number of hours required. The SLA model provides community-based and person-centered habilitative or rehabilitative services in the least restrictive environment possible. All SLAs contract with ADSD to serve state clients; SLAs do not contract with private individuals.

Regulation

SLAs are regulated under Chapter 435 of NRS and NAC and overseen by ADSD, which ensures policy adherence, monitors individual placement safety, and reviews provisional and renewal certifications.

Compensation

On paper, SLAs are very similar to CBLAs. Each is reimbursed for a variable number of direct service hours and for items like food and rent. Unlike CBLAs or mental health group homes, Nevada has a current Medicaid 1915(c) waiver, the home and community-based waiver for persons with intellectual disabilities and related conditions, which allows for federal reimbursement for certain services provided to individuals with an intellectual disability. Like other housing models, the state's share of total cost is reduced by available personal income from employment, SSI, or SSDI. A summary of specialized service costs for 24 hour SLAs that contract with ADSD is presented below.

Figure 9: Compensation for 24-Hour Supported Living Arrangements Contracted with the Aging and Disability Services Division

Facility Type	Individual Contracts as of 3/31/18	Monthly Specialized Service Costs per Person †
Intensive SLA (ISLA)	770	$ 4,880
Intensive SLA Plus (ISLA+)	466	$ 8,241
24 Hour DS SLA Total / Average	**1,236**	**$ 6,147**

† Total average contract cost unavailable, only service cost provided. Does not include any living expenses, such as room and board or food.

- **Group Homes**

The majority of group homes in Nevada provide care to elderly persons. Most of these group homes do not contract with ADSD; they serve individual, privately paying clients, which generate higher revenue. Facilities that accept ADSD clients generally reserve only a small portion of beds for state-funded placements, which can make it difficult to place state clients.

Regulation

Group homes for the elderly are considered residential facilities for groups and, like mental health group homes, are regulated under Chapter 449 of NRS. They are licensed and monitored by HCQC and fall under the auspices of the State Long-Term Care Ombudsman. Additionally, group homes for the elderly that accept state placements are reviewed and monitored by ADSD for compliance with the Medicaid 1915(c) frail elderly waiver.

Compensation

Similar to SLAs, the state has a Medicaid 1915(c) waiver, the frail elderly waiver, which allows for federal reimbursement for certain services provided by group homes to individuals over 65 years of age. Clients who qualify for services under the waiver are categorized into four levels of care, with Medicaid reimbursement ranging from $690 to $2,490 per month. (See table below for more detail.) Individual income from employment, SSI, or SSDI also is used to reduce the state's share of total cost, and those who qualify under the waiver make a minimum SSI contribution of $1,019 per month. On average, ADSD group home placements are paid between $1,709 and $3,509 per month.

Figure 10: Compensation to Group Homes for the Elderly Under the Medicaid 1915(c) Frail Elderly Waiver

ADSD Frail Elderly Group Home Compensation				
Level of Care	Individual Contracts as of 8/31/18	Monthly Living Expenses per Person*	Monthly Specialized Service Costs per Person	Total Monthly Cost Per Person
1	141	$ 1,019	$ 690	$ 1,709
2	256	$ 1,019	$ 1,560	$ 2,579
3	260	$ 1,019	$ 2,070	$ 3,089
4	-	$ 1,019	$ 2,490	$ 3,509
* Minimum, can be more based on individual SSI income				
* Level of Care 4 is recently implemented but not yet utilized				

III. UNREGULATED HOMES

By definition, unregulated homes are not licensed or certified to provide medical or direct-care services by any state entity. They include a variety of different living situations. For example, the state generally does not have oversight of several individuals who share a common living space and also receive state assistance. Other homes may offer services that do not rise to the level requiring a license or certificate. However, in still other cases, homes may illegally offer CBLA or group home services without being certified or licensed.

Unregulated homes represent a regulatory balancing act that requires weighing the risk of unlicensed, uncertified care against overburdening individuals who provide care to family members. The challenge is to identify and ensure that homes requiring regulation are properly

overseen without needlessly burdening those who are caring for family. While unlicensed homes are not a focus of this study, they are part of the broader context of mental health housing.

IV. COMPARATIVE ANALYSIS OF CONGREGATE CARE HOUSING MODELS WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The nexus between housing and supportive services for individuals with long-term disabilities in the State of Nevada is complex and multifaceted. The level of care, oversight, regulation, and reimbursement structures vary significantly depending on a client's primary diagnosis.

Figure 11: Comparison of Congregate Care Housing Models in Nevada

	DPBH		ADSD	
	Group Homes	**CBLA**	**Group Homes**	**SLAs**
Primary Diagnosis	Seriously mentally Ill	Seriously mentally Ill	Frail and elderly	Intellectually disabled
Regulatory Oversight	DPBH HCQC	DPBH SNAMHS & HCQC	DPBH HCQC, ADSD QA	ADSD QA
NRS / NAC Chapters	NRS & NAC 449	NRS & NAC 433	NRS & NAC 449	NRS & NAC 435
Long-Term Care Ombudsman	Yes	No	Yes	No
Services Provided				
Housing	Yes	Yes	Yes	Yes
Service Hours	Fixed Amount	Varies by Need	Fixed Amount	Varies by Need
Average Monthly Rate	**$1,201**	**$2,165**	**$2,594**	**$6,147**
Funding Sources				
Client Income (SSI, SSDI)	Yes, if available	Yes, if available	Yes, if available	Yes, if available
State General Fund	Yes	Yes	Yes	Yes
County General Fund	No	No	Yes	Yes
Medicaid Waivers	No	No	Yes, 1915 (c) Frail Elderly	Yes, 1915 (c) ID HCBW

The DPBH and ADSD both serve individuals with disabilities (the seriously mentally ill, the frail elderly, and the physically or intellectually disabled). The congregate care models with which they contract provide each individual a bed in a home for people with similar disabilities, in the least restrictive housing environment possible within the community. These individuals require varying degrees of assistance with certain activities of daily living.

Despite the fact that DPBH and ADSD provide similar services to individuals with disabilities, the state receives federal Medicaid home and community-based services waiver funds to help serve individuals who are elderly or have intellectual disabilities, but not for individuals with SMI. This additional funding reduces the cost of care for the state and counties and provides an incentive for housing providers to serve state clients. *It also creates a disparity in the treatment of individuals with disabilities in Nevada, as the services and resources available are not based on an individual's need, but on his or her primary diagnosis.*

Challenges with Existing Congregate Care Housing Models in Nevada

Various challenges exist for the current system of congregate care for individuals with SMI in Nevada. The common thread, however, appears to be that the system is neither built around nor operated in the best interest of the client. Individuals often are placed in housing models not based on their needs, but on availability of beds. Housing providers are more likely to serve individuals who require a high number of service hours and are financially disincentived from helping clients progress to their highest level of independence, which corresponds to fewer service hours and lower reimbursement.

Continuum of Care

The existing service system often does not provide flexibility or a continuum of care to meet the changing needs of individuals with SMI who also are in need of housing support. For some individuals with mental illness, the ideal model of care may begin with a placement that provides a high level of care, likely at a higher cost, and as the individual progresses, he or she transitions to a placement that provides a lower level of care at a lower cost, with the ultimate goal of living as independently as possible. However, in practice, there does not appear to be a clear path from high-need intensive care to lower-need intermittent care within the continuum of mental health housing services in Nevada.

Disparity Between Level of Need and Level of Services Provided

Currently, there appears to be a disparity between an individual's level of need and the level of services provided. This disparity may be exacerbated by the inconsistency between level of care, regulation, and compensation for group homes and CBLAs. While not all providers of congregate care may be interested in serving high-needs clients, they are financially discouraged from accepting individuals who require only a few hours of service in favor of accepting those who require more care and thus pay more. Because housing providers often are also the service providers, the financial incentive is to provide as many service hours as possible—rather than to help individuals achieve their highest level of independence. This type of situation may maintain an individual's housing placement, but create a disparity in services needed and those provided. Or, if individuals transition to a lower level of care, they may lose their housing placement since services are tied to housing, If individuals who are seriously mentally ill are not able to access housing supports, in the extreme, they may end up homeless or institutionalized. Some individuals may always require a certain level of service to maintain independent housing.

Furthermore, it appears that an individual's placement in either a group home or CBLA often is determined based on whatever housing is available, rather than on the services that best meet the individual's needs.

Lack of Federal Funding

In addition, the state does not currently make use of all available Medicaid waivers to draw down federal funding to help broaden the range of supportive services for individuals with mental illness.

Fully utilizing available waivers could expand the number of providers and available state placements for individuals with mental illness.

V. EVIDENCE-BASED SUPPORTIVE HOUSING AND SERVICE MODELS

Similar to the transition from providing mental health care in an institutionalized setting to providing care in home-and community-based settings, many states have transitioned to a system in which housing supports and supportive services are not connected. *In fact, a key component of many modern mental health systems is that housing is provided independent of services and is not contingent on participation in or compliance with specific program requirements*. The two key components of these systems include supportive housing and separate supportive services.

Supportive Housing

Supportive housing is an evidence-based model that integrates affordable housing options with supportive services. It builds on the Housing First framework, which provides immediate access to permanent housing without preconditions, such as sobriety or participation in certain programs. Housing First completely separates housing from supportive services, while also helping individuals access flexible, person-centered treatment and services that increase housing stability. This model contrasts with programs that require individuals to achieve certain goals or comply with certain requirements prior to receiving permanent housing. Housing First has been used by cities, counties, and states for the past 30 years and currently is used by SNAMHS, specifically in HUD CBLAs.

Supportive housing offers individuals permanent housing with rent that is no more than 30 percent of their income and no other preconditions, such as compliance with treatment goals. Supportive services are easy-accessible and tailored to individual needs. Core services provided in supportive housing generally include:

- Pre-tenancy services including application assistance, engagement, housing search, move-in assistance, and outreach;

- Tenancy sustaining services including crisis intervention, eviction prevention, landlord relationship management, subsidy program adherence, and tenancy rights and responsibilities education; and

- Assistance connecting with physical and mental health care providers.

Additional services may include counseling, employment training, independent living skills, and peer support networks. In addition, clients receive assistance from case managers. Supportive housing aims for autonomy, dignity, and stability during complex, individual life challenges. The model usually targets vulnerable individuals, including those suffering from chronic health conditions, mental illness, and substance abuse. A supportive housing program may have scattered housing across a city, centralized locations, or mixed-income buildings with certain units assigned to a supportive housing program.

Supportive Services

A variety of services can be used in conjunction with supportive housing models. It is important to select the right type and quantity of services for each community, based on existing services and resources. A few evidence-based models are described below.

- Assertive Community Treatment

  Assertive community treatment (ACT) is a flexible, multidisciplinary team approach that provides services and treatment to individuals with SMI who are most vulnerable to homelessness and substance abuse. This model addresses the different dimensions of a person's life including community support, employment, housing, medication, and social support and often is used in conjunction with permanent supportive housing.

  Assertive community treatment targets individuals with the most severe forms of mental illness that impact their overall functioning and require frequent use of inpatient psychiatric services and emergency rooms. These individuals often suffer from a low quality of life due to instability and precarious financial, social, and societal circumstances. This model focuses on person-centered relationships to increase positive outcomes and improve quality of life. Teams comprised of nurses, occupational therapists, psychiatric case workers, psychiatrists, social workers, and substance abuse counselors provide client-specific treatment, support, and habilitative and rehabilitative services, which are available 24 hours per day, 7 days per week. They are highly flexible and can modify the amount and intensity of services, for example, during a client's mental health crisis.

  Southern Nevada Adult Mental Health Services currently deploys ACT teams. Case managers usually have a caseload of 12 clients. Northern Nevada Adult Mental Health Services does not use ACT.

- Case Management

  Case management is a service provision method in which qualified professionals, such as social workers, assess a client's needs and level of functioning, and based on the results, they advocate, arrange, and coordinate services and resources. Case managers have in-depth knowledge of local, regional, state, and federal resources as well as the services for which a client may qualify. They may connect a client to local mental health providers, assist with applications for affordable housing opportunities, or help the client build a social support network. Case managers regularly communicate with clients and bring in other professionals as needed.

  A Medicaid-approved form of case management is Targeted Case Management (TCM). This model provides person-centered care to specific populations within Medicaid, such as adults with SMI who may have other co-occurring medical or substance abuse challenges. Targeted Case Management also can be provided to individuals within a designated geographic area.

Currently NNAMHS and SNAMHS provide two types of case management services: traditional case management and intensive case management. The complexity of a client's needs and level of functioning determines which type they receive, as well as a case manager's case load. Nevada Medicaid offers TCM for adults with SMI with up to 30 hours per recipient per calendar month. *The costs of TCM can be substantial and are not included in the rate analysis throughout this report.*

- Crisis Resolution and Home Treatment Team

A Crisis Resolution and Home Treatment Team (CRHT) is used when adults with acute mental health crisis need a level of assistance generally provided in an inpatient psychiatric care setting. Instead of being admitted to an inpatient facility, a CRHT assists clients in their own home or enables early release from a psychiatric hospital with subsequent community-based treatment. After an initial assessment, the CRHT treats the client in the least restrictive environment possible (home, shelter, congregate housing) aiming for the lowest possible disruption in the client's life. This model offers a community-based alternative to hospital admission, and typically offers assistance 24 hours per day, 7 days per week. A CRHT has intensive support systems and functions like a gateway, as it assesses clients for CRHT home treatment suitability before admission to an inpatient facility.

Northern Nevada Adult Mental Health Services does not have a CRHT for its clients. Individuals experiencing an acute mental health crisis in northern Nevada have limited options and usually are admitted to NNAMHS' inpatient psychiatric facility. Southern Nevada Adult Mental Health Services offers limited in-home crisis resolution services. It may provide de-escalation assistance for clients enrolled with intensive case management services.

Both NNAMHS and SNAMHS work with counties to provide Mobile Outreach Safety Teams (MOST), which pair a behavioral health provider with a law enforcement officer or an emergency medical service provider to visit adults in the community who are at risk of incarceration or hospitalization due to SMI or substance use disorders. The program aims to connect these individuals with appropriate community services before they experience a crisis that could lead to hospitalization or arrest by providing immediate assessment, de-escalation, intervention, and referral to outpatient services.

- Peer Support

Peer support networks help individuals with SMI, and studies show that peer support can help lower the cost of public services, decreasing emergency room visits and inpatient mental health stays. Certified peer specialists are paid staff that can help increase the quantity of mental health workers in a state, and are often part of supportive services teams in supportive housing models. They aid, educate, and support individuals with SMI in the recovery process as they build a trusting relationship and share experiences and lessons from the recovery process. Furthermore, they assist their peers with navigating the community and health services offered by the different public service agencies, and play a role in preventing clients from spiraling into a mental health crisis.

- Psychiatric Rehabilitation Services

  Psychiatric Rehabilitation Services (PRS) are aimed at individuals who have lost or are at risk of losing skills and functions required for daily living due to disabling severe and persistent mental illnesses. They are person-centered and emphasize an individual's choices. The goal of PRS is to assist persons with SMI to develop the emotional, intellectual, and social skills required to live, learn, and work in a community. These services help individuals shift from an incapacitating form of a disability to a functional form. Psychiatric Rehabilitation Services may include occupational, physical, and speech and language therapy and are provided in inpatient or outpatient settings. Psychiatric rehabilitation is also known as psychosocial rehabilitation. Both NNAMHS and SNAMHS either offer PRS or refer individuals to community providers.

Select Evidence-Based Models of Supportive Housing and Services

Using the frameworks discussed above, states and localities have developed a variety of approaches to provide housing and supportive services to individuals with SMI. As evident in the examples below, services are designed to address a community's specific needs using available resources. These examples provide insight into how services and housing can be provided concurrently but separately, and how an overarching state framework for serving individuals with SMI can provide a guide, but enough flexibility for counties to implement the approach that best meets the needs of their community.

California

In 2004, California passed the Mental Health Services Act (MHSA), which imposed a 1 percent tax on income above $1 million. The funds generated support community-based mental health programs in California counties, with the objectives of improving quality of life for individuals with SMI and reducing homelessness, incarceration rates, and the overuse of preventable inpatient care.

Counties must align their programs with five core components of the MHSA, which provide a comprehensive framework to address the needs of individuals with mental illness. The main component, community services and support (CSS), aims to fund integrated mental health and supportive services for individuals with a focus on "community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved." An important part of CSS is housing for individuals with SMI. Counties have three funding choices under the CSS component, one of which is called Full Service Partnerships (FSP).

Full Service Partnerships are aimed at adults with SMI who respond well to intensive services. This model combines subsidized permanent housing with multidisciplinary treatment teams that focus on recovery and rehabilitation. An FSP does "whatever it takes" to help individuals with SMI recover and improve their quality of life. This model uses a low staff to client ratio, 24/7 crisis intervention services, and a focus on building meaningful partnerships between mental health staff

and clients. In addition to treating co-occurring mental health and substance abuse disorders, FSPs assist with education and employment. Studies have shown that FSP programs reduce homelessness, increase the use of outpatient services, improve quality of life, and decrease the use of inpatient and emergency services. Full Service Partnerships use the ACT model to provide supportive services. Participants in FSP programs do not have to engage in treatment to retain their housing, but they must meet monthly with their treatment team. Services are administered at an individual's home, work, or other community setting based on preference and need.

One example of how an individual county has applied the framework developed by the MHSA is evident in Los Angeles (LA) County. The LA County Department of Mental Health (DMH) created FSP programs for adults between 26 and 59 years of age. Potential clients first receive outreach and engagement services, which are CSS funded, to connect them to a FSP program and determine the appropriateness of the client. Prospective clients must have a diagnosis of a major psychiatric disorder and be homeless or at risk of becoming homeless, incarcerated, or hospitalized in an inpatient psychiatric care facility. To secure housing, the DMH uses multiple sources, such as the county's Housing for Health program, and its locally funded rental subsidy program. The LA County Department of Health Services also provides permanent supportive housing to individuals with complex medical and behavioral health needs. A recent study of this program showed that the cost of public services, such as emergency room and inpatient care, decreased by nearly 60 percent and program participants' mental health improved.

Philadelphia, Pennsylvania

Similar to Nevada, Philadelphia has a long history of providing congregate housing options (group homes) to individuals with SMI. In 2008, the Philadelphia Housing Authority began working with the Philadelphia Office of Homeless Services and the Department of Behavioral and Intellectual Disability Services (DBHIDS), to create the Blueprint Voucher Program to provide tenant-based rental assistance vouchers to individuals with SMI who were homeless or had a history of homelessness. The program uses the state's Medicaid 1915(i) amendment to fund services provided by a network of more than 300 community-based behavioral health care providers to assist individuals with SMI in applying for a housing voucher under the federally funded Housing Choice Voucher[4] (HCV) program.

Blueprint Voucher recipients receive supportive services—such as certified peer specialist services, psychiatric rehabilitation, and targeted case management—based on their needs and level of functioning. Once services are initiated, a case manager assists clients in applying for the voucher program at the Philadelphia Housing Authority. Services continue once a client moves into their own home.

Medicaid funding is a foundational piece of the program. Almost 90 percent of the Blueprint Voucher recipients were Medicaid-eligible when they began receiving housing, which helped increase federal reimbursement for supportive services. Overall, the Blueprint Voucher

[4] Formerly known as Section 8, the HCV program is a federally funded affordable housing program for low-income individuals and families. It helps qualifying individuals find affordable, clean, decent, and safe housing on the private market and gives them the freedom to choose appropriate housing for their specific needs.

program decreased Medicaid costs by helping reduce recipients' use of high acuity, high cost services.

The Blueprint Voucher Program provided more than 1,400 people with permanent housing between 2009 and 2017, and an average of 89 percent of participants retained their housing for at least one year. In addition, by combining efforts, the Blueprint Voucher program reduced the burden on HCV staff and led to an expansion of 200 additional housing units per year.

In addition, Philadelphia created an overarching framework that focuses on recovery oriented systems of care and takes into account social determinants of health. Services target not only clinical interventions, but include and build on four domains, including:

1. Assertive outreach and initial engagement;
2. Screening, assessment, service planning, and delivery;
3. Continuing support and early reintervention; and
4. Community connection and mobilization.

In addition, the three separate agencies—DBHIDS, Office of Homeless Services, and the Housing Authority—annually combine data to evaluate program fidelity and track achievements and outcomes.

While this example may not be applicable across the entire state of Nevada, it may be worth considering in the large metropolitan areas.

South Dakota

South Dakota provides limited residential services for individuals with SMI and instead aims to keep individuals with SMI in the community. While some individuals with SMI are served in the state's psychiatric hospital or out of state, the vast majority receive assistance through outpatient treatment services provided by 11 regionally based community mental health centers (CMHCs). These centers rely on a range of programs that provide supportive services, such as ACT, to treat clients in their homes and the community. Centers in Sioux Falls and Rapid City, the state's two most populous cities, developed mobile crisis team services that provide short-term intensive mental health crisis management services 24 hours per day, 7 days per week. The model has been so successful that it is expanding to other localities. Centers in other counties are required to offer 24-hour crisis intervention services as well. In addition, rural frontier areas of the state rely on telehealth psychiatric services to provide care, given the state's limited mental health workforce and high staff turnover in the rural CMHCs.

Community mental health centers are accredited by and contract with South Dakota's Community Behavioral Health Program, located within the Division of Behavioral Health, Department of Social Services. They are funded through a mix of state and federal funds as well as grants and donations. South Dakota also has one state mental health hospital and four private psychiatric care hospitals. The state does not have a Medicaid 1915(i) State Plan Option for home- and

community-based services that would facilitate supportive housing as a health care option to the SMI population. This model may be helpful as policymakers consider how best to serve individuals with SMI in rural Nevada.

VI. PUBLIC POLICY OPTIONS

In addition to considering other states' approaches to providing patient-centered housing and supportive services to individuals with mental illness, policymakers may wish to take steps to address some of the challenges associated with the existing congregate care housing models in Nevada.

Align Statutory and Administrative Regulations for Congregate Care Housing Models

According to DHHS, the Department has considered consolidating all housing models that contract with the state under a single regulatory authority, Chapter 449 of NRS. This change would expand regulatory requirements currently applied to group homes to CBLAs and SLAs. It would also include transferring regulatory oversight of SLAs from ADSD to DPBH. Generally, this change is supported by group home providers and DPBH and opposed by ADSD and CBLA providers.

During the 2017–2018 Interim, the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs approved a bill draft request (BDR 40-170) to relocate provisions regarding CBLAs to Chapter 449 of NRS. The Committee did not consider a similar recommendation to place SLAs under Chapter 449 of NRS and instead recommended an audit be conducted relating to SLA provider requirements and compliance.

Differentiating Habilitative and Rehabilitative Services

Certain individuals, such as those with certain mental health conditions or intellectual disabilities, will not progress from a higher to a lower level of care and instead require long-term habilitative services to maintain their current level of independence. Differentiating habilitative and rehabilitative services, based on disparate goals and outcomes, could assist with outcome measurement and program evaluation and transparency.

Federal Funding to Support Mental Health Supportive Housing

Nevada could consider a Medicaid waiver to draw federal funds for supportive housing for individuals with mental illness. Currently, ADSD group homes and SLAs benefit from federal funding provided through Medicaid 1915(c) waivers for the intellectually disabled and the frail elderly. This funding helps to expand the services available to these populations. However, the state has not applied for and does not receive similar funding for individuals with mental health conditions.

Another opportunity for federal funding is to expand the state's existing Medicaid 1915(i) waiver. Currently, DHHS is exploring this option to include permanent supportive housing services for Nevadans experiencing chronic homelessness who may also have a diagnosed mental health condition. According to DPBH, this would support existing congregate housing options and

provide services to individuals who require stable housing and assistance with activities of daily living. These efforts likely would also help conserve community resources, prevent hospitalizations, and reduce the frequency of emergency room visits.

VII. CONCLUSION

Through a review of rates and models of congregate care living in Nevada, this report highlights opportunities to better align models of care, funding, and the goal of providing person-centered habilitative or rehabilitative services to individuals with mental illness in the least restrictive environment possible. It provides a framework for future discussions and the development of a supportive housing system that reinforces the objectives of individual client treatment plans. The challenges identified provide a catalyst for considering policy options to enhance the effectiveness of community-based care and ultimately to improve the lives of individuals with SMI in Nevada.

VIII. APPENDIX—ADDITIONAL ISSUES RAISED BY HOUSING PROVIDERS

Definition of Assisted Living Services

Nevada Revised Statutes 449.0302(7)(b)(1) requires that group homes providing "assisted living services" contain individual toilet facilities for residents. This provision prevents facilities that meet all other requirements under the section from labeling their services as assisted living services or obtaining a license from HCQC to operate an assisted living facility. Group homes still care for elderly and/or disabled patients and obtain a group home license from HCQC, but they cannot promote their services as assisted living services or use the terminology "assisted living facility." The statute allows DPBH to make certain exceptions to this rule, but only for facilities licensed prior to July 1, 2005.

State Fire Marshall Residency Approval

During the provider feedback process, several groups and individuals expressed concern over the current occupancy certification process for group homes from the State Fire Marshal Division (SFMD), Department of Public Safety. Section 449.229 of NAC requires a satisfactory report of inspection from the SFMD prior to the issuance of a group home license from HCQC. The SFMD refers to the International Fire Code as it determines residency type. Key considerations include the level of care provided and the number of residents in each home. Different occupancy types have varying minimum requirements for fire and life safety. Please refer to this document from the SFMD for more information regarding occupancy standards.