JUDGE DAVID L.
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CENTER
FOR MENTAL HEALTH LAW

August 30, 2024

Submitted via Medicaid.gov portal

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: **Comments on California BH-Connect Demonstration Addendum – Use of "Enriched Residential Settings"**

Dear Secretary Becerra:

The Judge David L. Bazelon Center for Mental Health Law writes to express our deep concerns regarding the California BH-Connect Section 1115 Demonstration Addendum Request and the proposed inclusion of "room and board in enriched residential settings" (ERS) as part of a "care continuum."

The Bazelon Center is a national organization that promotes the community integration of individuals with mental disabilities. Among other priorities, we work to prevent the needless incarceration of such individuals. We pursue policy advocacy, work with federal agencies, and provide technical assistance to states and localities in addition to bringing impact litigation. We appreciate the opportunity to provide comments on this important issue.

I. ERS Are Inconsistent with Section 504 and the *Olmstead decision*

We have visited several models of ERS at the invitation of the State. They are not the most integrated settings for the individuals the State proposes to serve in them. They are congregate settings operated in ways that make them institutional by nature. The Americans with Disabilities Act (ADA) and *Olmstead v. LC* requires that these individuals be served in the most integrated setting appropriate and not unnecessarily provided institutional care.[1]

Segregated settings include congregate settings, like ERS, that are populated exclusively or primarily by people with disabilities, especially where, as with ERS, activities are

[1] 45 C.F.R. § 84.76(b); *Olmstead v. Lois Curtis*, 527 U.S. 581 (1999).

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regulated and other restrictions are imposed.[2] The State has not made and is not making mainstream housing, subsidized and with appropriate supports, available to those whom it proposes to serve in ERS. In our experience, these individuals could be served in such settings (i.e. "supported housing") and would do better if they were. When an individual can live in a more integrated setting, but California only pays for placement in ERS, there is a violation of the integration mandate of the ADA and the Rehabilitation Act.

HHS has recently explained that "[T]he civil rights obligations created by section 504 are separate and distinct from the requirements of Medicaid and the Social Security Act. Compliance with Medicaid requirements does not necessarily mean a recipient has met the obligations of section 504."[3] California's proposal may meet Medicaid standards, but it is inconsistent with the ADA and *Olmstead*.

I. ERS is Based on the Discredited Notion of a "Linear Continuum of Care" – a Model that Research and Evidence Debunks

In the "linear continuum" model, people with mental illnesses are moved through one or more transitional congregate settings before they are transitioned to independent housing. The underlying theory was that each transitional step would help individuals build necessary skills, until the person was deemed "ready" for independent living.[4] However, in practice, this model resulted in needless placement in segregated (and expensive) settings and also caused instability through frequent uprooting. In practice, individuals rarely secured permanent housing.[5]

Experts, including court monitors in *Olmstead* cases, have highlighted the shortcomings of this model. In testimony in an *Olmstead* case filed in New York, Court expert Dennis Jones called the linear continuum approach "archaic,"[6] emphasizing that:

> You can place people in the most integrated setting and provide supports to them there, number one. And two, going to what I would call congregate settings to train people so they can move on simply does not work very well. People don't

[2] *See, e.g.*, *Waskul v. Washtenaw Cnty. Cmty. Mental Health*, 979 F.3d 426, 462-64 (6th Cir. 2020); *Steimel v. Wernert*, 923 F.3d 902, 911 (7th Cir. 2016); *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013); *DAI v. Paterson*, 598 F. Supp. 2d 289 (E.D.N.Y. 2009).

[3] 89 Fed. Reg. 40066, 40119.

[4] Under this model "individuals must climb a ladder of program requirements before becoming eligible for an apartment of their own." Deborah K. Padgett, *There's No Place Like(a)Home: Ontological Security Among Persons with Serious Mental Illness in the United States*, SOC SCI MED. (May 2007).

[5] Patrick W. Corrigan and Stanley G. McCracken, *Place First, Then Train: An Alternative to the Medical Model of Psychiatric Rehabilitation* 32, OXFORD UNIV. PRESS (January 2005), *available at* http://www.jstor.org/stable/23721297 ("Each transition is a significant adjustment where individuals cut their ties from one group and replace these connections with people in a different environment."); *see also* Sarah Johnsen & Lígia Teixeira, *Staircases, Elevators and Cycles of Change 'Housing First' and Other Housing Models for Homeless People with Complex Support Needs*, UNIV. OF YORK (2010).

[6] *DAI v. Paterson*, 653 F.Supp.2d 184, 253 (E.D.N.Y. 2009) (Tr. 1140-41).

> transfer skills from one setting to another. So, it's a waste of good public time and money; but more importantly, the technology today says you don't have to do that. Go straight to supported housing where people can live in a permanent setting without having to move again and bring them the support they need there.[7]

Expert Elizabeth Jones in the same case confirmed that the "linear continuum" approach is "outdated." [8] Ms. Jones explained:

> The standard for working with people in housing is no longer that you move from place to place to place, although early on systems developed like that. The standard now is that you look at what the person needs. . . . You look at housing first, and where someone is going to live, and you separate treatment or supports from the housing, so that people are not dislocated from their homes just because their needs for support change.[9]

And Dr. Kenneth Duckworth, medical director of the National Alliance on Mental Illness (NAMI), echoed these sentiments, stating that the notion of requiring people to undergo multiple housing transitions has been thoroughly rejected in the mental health field. He emphasized that individuals need "support, skill development, and to be better where they are," not repeated relocations.[10]

Linda Rosenberg, a former leader of New York's mental health system and President and CEO of the National Council for Behavioral Health, critiqued the "linear continuum model," pointing out its lack of evidence and the disruptive nature of multiple moves. "[T]here is no evidence to show that people do better in the long run with you going through the continuum and, in fact, [people] could be placed directly in their own apartments with the right supports [and] can be quite successful." [11]

These expert opinions are reinforced by numerous studies that show better outcomes for people with mental illness when they are transitioned from institutional settings directly to permanent, supported housing. Research consistently finds that transitional programs in the continuum of care often fail to prepare individuals for independent living in the broader community. Instead, they focus on skills relevant to highly supervised settings. The frequent relocations and the associated need to repeatedly cut ties and establish new connections can be deeply disorienting.[12]

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[7] *DAI v. Paterson*, Trial Transcript at 1140.
[8] *DAI v. Paterson*, 653 F.Supp 2d at 253 (*citing* Tr. 136-38) [*hereinafter* Jones DAI Testimony].
[9] *DAI v. Paterson* Trial Transcript at 137.
[10] *Id.* at 253 (citing Tr. 846).
[11] *Id.* at 653 (*citing* Tr. 755) ("The whole issue of a continuum is also an old idea. It used to be thought that people had to move from ... large congregate settings, to smaller congregate settings, to having a few roommates to eventually graduating to their own apartment. Nobody really thinks that much anymore.").
[12] Corrigan, P. and McCracken, S., *Place First, Then Train: An Alternative to the Medical Model of Psychiatric Rehabilitation*, SOCIAL WORK, Vol. 50, No. 1 (Jan. 2005), 31, 32.

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Studies have shown that the "housing first" approach, which places individuals directly into permanent housing with appropriate supports, is more cost-effective and leads to better outcomes, including overall improvements in health and recovery.[13]

This is true for individuals transitioning from incarceration, as the Olmstead attorneys at the U.S Department of Justice is well-aware. For example, the Nathaniel Project in New York City employs Assertive Community Treatment (ACT), supported housing, and supported employment to help individuals transition from incarceration to community life. This program has achieved a 70% reduction in arrests within two years of program admission compared to the two years prior. Similarly, Chicago's Thresholds program uses ACT and supported housing to assist people with mental illnesses transitioning from the Cook County Jail and state prisons into the community. This program has demonstrated an 89% reduction in arrests, an 86% decrease in jail time, and a 76% reduction in hospitalizations among its participants.

Using transitional settings, such as ERS, does not support long-term community integration. We strongly urge CMS to require California to invest instead in supporting individuals in mainstream housing, with ACT services (Full Service Partnership services) as needed.[14]

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[13] *See*, *e.g.*, Gulcur, L., Stefancic, A., Shinn, S., Tsemberis, S. and Fischer, S. N., *Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes* 13, 171-186, J. OF COMMUNITY & APPLIED SOC. PSYCHOL. (2003) ("Participants randomly assigned to the experimental condition spent significantly less time homeless and in psychiatric hospitals, and incurred fewer costs than controls."); *id., supra* note 12 (finding individuals transitioning from psychiatric hospitals in the experimental group reduced their total time hospitalized by more than half in the first year of the study).Tsemberis, S. and Eisenberg, R. F. *Pathways to housing: supported housing for streetdwelling homeless individuals with psychiatric disabilities*, 51, 487-493 PSYCH. SERV. (2000) (finding the risk of discontinuous housing was approximately four times greater in linear as compared with Pathways samples); Tsemberis, S., Gulcur, L. and Nakae, M. Housing first, *Consumer choice, and harm reduction for homeless individuals with a dual diagnosis,* AM. J. OF PUB. HEALTH, 94, 651-656 (2004) ("The Housing First program sustained an approximately 80% housing retention rate, a rate that presents a profound challenge to clinical assumptions held by many Continuum of Care supportive housing providers who regard the chronically homeless as "not housing ready."); Perlman, J. and Parvensky, J., *Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report*, DENVER: COLORADO COALITION FOR THE HOMELESS (2006) (finding Denver's program was cost-effective).

[14] We appreciate that California has decided to limit its FFP proposal to facilities under 17 beds and are not seeking to undermine Medicaid's "institutions for mental diseases" exclusion (IMD exclusion). The IMD exclusion is essential to ensuring that states are incentivized to invest in community-based services rather than services in IMD settings, where FFP is not permitted.

II. If CMS Approves California's Request, It Should Impose Limitations on the Use of ERS

If CMS approves the inclusion of ERS, CMS should impose limitations on the use of ERS, including:

1. **Durational Limits**
   Require that individuals be served in ERS for a limited number of days, while suitable mainstream housing is being found for the individual and needed supports put in place (i.e. supported housing), with appropriate supports.

2. **Limited Number of ERS beds/slots**
   Require that California:
   - Limit the number of ERS facilities available; and/or
   - Restrict the funding that California may allocate to ERS.

3. **Clarify that Purpose of ERS is to Provide "Bridge Housing"**
   CMS should restrict the use of ERS to populations of individuals transitioning from hospitals or incarceration, and clarify that ERS is "bridge housing," to be used only for a limited duration while mainstream housing and appropriate services including ACT (Full Service Partnership services) are being secured. ERS should not be considered or used as a step in a "linear continuum of care."

We believe that by imposing these limitations, CMS can help mitigate ERS from becoming a step backward in California's efforts to comply with *Olmstead* and ensure that individuals receive the community supports and integration opportunities they deserve.

III. Conclusion

We urge CMS to reject California's proposal to add a "transitional level" to its continuum of care. California should instead focus on providing services in mainstream housing with appropriate supports (i.e. supported housing), as required by *Olmstead*.

We appreciate the opportunity to provide comments on California's proposal. Should you have any questions about these comments, please feel free to contact us at megans@bazelon.org or (202) 467-5730. Thank you for your attention to this critical matter.

Sincerely,
/s/ Megan Schuller

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