

Introduction

The South Carolina General Assembly directed the South Carolina Department of Health and Human Services (SCDHHS) as part of the 2007-2008 Appropriations Act, Proviso 8.40 (DHHS IMD Study Committee) to coordinate a committee to study the availability of care and services provided to adult residents of community residential care facilities. The proviso reads as follows:

The Department of Health and Human Services shall coordinate a committee to study the availability of care and services provided to adult residents by community residential care facilities in South Carolina. The committee shall consist of seven members as follows; two members appointed by the Governor, one of whom shall serve as chairman, one member appointed by the President Pro Tempore of the Senate, one member appointed by the Speaker of the House, one member appointed by the Chairman of the Senate Finance Committee, one member appointed by the Chairman of the Ways and Means Committee and the Director of the Department of Health and Human Services or his designee who shall serve ex-officio. The appointed members may be from either the public or private sector of the state. The committee is tasked with studying the manner in which services are provided to adults in residential care facilities and making recommendations about the specific services that should be provided and the manner in which they should be provided. The committee shall consider the impact that the Federal Institute of Mental Disease (IMD) exclusion may have on the cost and accessibility of services provided by community residential care facilities. The committee shall report their findings to the General Assembly and the Governor no later than June 9, 2008. Committee members shall serve without compensation.

Overview

In the 1960's a movement began around the country to return persons with mental illness to their respective communities. At the time this was thought to be a humane way of treating individuals who were hospitalized by giving them the opportunity to be treated locally in the community, without the restraints of a hospital setting. The belief nationally was that people who were currently hospitalized could now be better served in an outpatient facility. This effort failed due to a lack of adequate funding to assure a successful transition of thousands of individuals. The failure was due to a series of assumptions that many mental health advocates believe were inherent fallacies in the theory. Some of these assumptions were:

- 1) Entitlements would cover the cost of the treatment in the community. Some proponents supported deinstitutionalization (currently referred to as community integration) to save money---not to increase services, not to increase client choice, and not to increase client independence. Consequently, the money funded

- to the hospitals did not follow the patients to the community. Thus leaving community mental health treatment centers grossly under-funded. There was never a seamless system for individuals----hospitalization should be seen as a short-term solution for acute patients, with discharge the community mental health centers are responsible for their patients. Unfortunately with the competition for dollars, hospitals pushed people to community programs, which being under funded often dumped them back into the state hospital system or ERs, with devastating results to those with mental illness.
- 2) Severely ill patients (some 5% - 15%) released from the hospitals still needed long-term inpatient treatment. Without access to this inpatient treatment, homelessness increased dramatically among this population, emergency rooms filled up, jails filled up, co-occurring disorders increased, and deaths of this population increased.
 - 3) Family members were expected to house this population with no training in how to care for those with serious brain disorders. Many clients did not have family members and for others family members age, illness and stigma prevented the care.
 - 5) Optimal treatment would be stabilization. Many former Department of Mental Health (DMH) consumers do not complete the process of deinstitutionalization, but continue as long-term residents of CRCFs instead of psychiatric treatment facilities. Sometimes this is by choice and other times by lack of other community options.

In South Carolina, the Department of Health and Environmental Control (DHEC) licenses Community Residential Care Facilities (CRCFs). According to DHEC June 2, 2008 statistics there are, in South Carolina, 16,288 CRCF beds in 484 facilities. (<http://www.scdhec.gov/health/licen/hrcrcf.pdf>.) The standards for licensing are set forth in DHEC Regulations at SC Code R. 61-84. These are available at the DHEC website at <http://www.scdhec.gov/administration/regs/docs/61-84.pdf>. Three hundred and thirty (330) South Carolina CRCF facilities participate in the Optional State Supplement (OSS) program described below. Levels of participation vary as an enrolled facility may admit as many or as few OSS residents as they choose.

Approximately 4,000 individuals (or one-fourth) of the South Carolina CRCF beds are occupied by individuals who receive Optional State Supplementation (OSS) funds or are deemed eligible under the OSS program income limits. Most also receive some Supplemental Security Income (SSI), under Title XVI of the Social Security Act, and some Social Security Income, under Title II of the Act. It is also common for these individuals to have other forms of unearned income such as railroad retirement, veterans' or other pensions. In any case, if the individual has total net income of \$1120 or less, meets SSI guidelines to be considered aged, blind or disabled, resides in a CRCF that is in good standing with DHEC and enrolled in the OSS program, then the individual would qualify for OSS. In addition to OSS benefits, which help pay for room and board at the CRCF, recipients of OSS are eligible under the South Carolina Medicaid Program. Thus, for these individuals, the South Carolina Medicaid Program pays for all medically necessary care they receive in or outside the CRCF facility.

Today, the overwhelming majority of DMH consumers are served in the community. The Toward Local Care (TLC) Program was started in 1992, to discharge clients into supportive environments such as apartments and private homes of individuals paid to share their homes with patients maintained by supportive community services. (http://www.state.sc.us/dmh/consumer_tlc.htm)

Another response to the trend toward deinstitutionalization has resulted in an increased number of residents with serious mental illness in CRCFs. Private residential facilities which provided a level of assistance for residents were originally licensed by the DMH but were given the name community residential care facility in the 1988 Health Facility Licensure Act and became the licensing responsibility of the Department of Health and Environmental Control (DHEC). While there have always been some individuals with emotional disabilities living in residential care facilities, today approximately one-third of the 4,000 individuals who participate in the OSS Program have been diagnosed with a serious mental illness. DMH currently serves approximately 1,390 clients who are also residents of CRCFs. Since 2005, there has been a net loss of 687 beds from the pool of CRCF beds available to individuals who rely upon federal or state assistance to help pay for their care.¹

The Medicaid Program was not designed to underwrite large scale institutional care of individuals with mental illness. A recurrent theme in Medicaid regulations on care for persons with mental illness is that this is viewed as a responsibility of the States. In the mid-60's when Medicaid was being enacted by Congress, the census in State Hospitals nationally was over 500,000, mostly indigent persons in need of inpatient medical care, and Congress did not want the Medicaid program to have to take on even 50% of that enormous cost.

Nevertheless, part of the support for the IMD exclusion also came from members of Congress who wanted to encourage the States to re-integrate persons with mental illness into the community. The Community Mental Health Services Act was passed in the early 1960's in which the federal government financially supported the building of community mental health centers, and the provision of community mental health services. The Medicaid program can cover these non-institutional behavioral health services. Therefore, Medicaid is available for all OSS participants (as well as individuals in other categories of eligibility), including those who have a mental illness, as long as they do not live in an institution for mental diseases (IMD). This rule, often referred to as the IMD Exclusion, prohibits payment by Medicaid for services provided to residents of an IMD.

¹ Since 2005, 40 CRCFs have closed that accepted OSS/Social Security as full reimbursement. These 40 CRCFs were licensed for 766 beds. During this same period 14 CRCFs opened that accept OSS/Social Security. These 14 CRCFs are licensed for 179 beds, for a net loss of 687 beds.

What is an IMD?

Various definitions used in the Medicaid Program are set forth in §1905 of the Social Security Act [42 U.S.C. 1396d], which says, in part:

For purposes of this title—

.....

- (i) The term “institution for mental diseases” means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

In the CONFERENCE REPORT (H. REPT. 100-661) ON H.R. 2470 (which later became the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), 134 Cong. Rec. H3765-04 (Wednesday, June 1, 1988), Congress to some degree explained their rationale in defining IMDs:

The conference agreement defines an institution for mental diseases (IMD) as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. This would clarify that Federal Medicaid matching funds would be available for services such as personal care and case management that are furnished through or by group homes or other small facilities serving the mentally ill, if those services are covered by the State under its Medicaid plan. The 16-bed limitation parallels current rules under the SSI program.

The federal regulation is similar to the statute:

42 CFR § 435.1010 Definitions relating to institutional status.

.....

Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

The State Medicaid Manual, which contains specific guidance for the States to operate Medicaid Programs goes into considerable more detail about how federal auditors would determine whether a facility was an IMD:

4390. INSTITUTIONS FOR MENTAL DISEASES

C. Guidelines for Determining Whether Institution Is an IMD.-- HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

1. The facility is licensed as a psychiatric facility;
2. The facility is accredited as a psychiatric facility;
3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and
5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

Although CRCFs were traditionally referred to as "boarding homes," the South Carolina definition of CRCF differentiates them from "boarding houses" in that CRCFs include provision of a degree of personal care. The South Carolina regulation, at SC Code R. 61-84 (101)(L) provides:

L. Community Residential Care Facility (CRCF). A facility which offers room and board and which, unlike a boarding house, provides/coordinates a degree of personal care for a period of time in excess of 24 consecutive hours for two or more persons, 18 years old or older, not related to the licensee within the third degree of consanguinity. It is designed to accommodate residents' changing needs and preferences, maximize residents' dignity, autonomy, privacy, independence, and safety, and encourage family and community involvement. Included in this definition is any facility (other than a hospital), which offers or represents to the public that it offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities. These facilities may be referred to as "assisted living" provided they meet the above definition of community residential care facility.

The CMS Position

The Centers for Medicare and Medicaid Services (CMS) was formerly called the Health Care Financing Administration (HCFA). In the early 1980s, HCFA disallowed payment to Middletown Haven, a 180-bed private facility licensed by the Connecticut Department of Health as a “Rest Home with Nursing Supervision.” Heretofore, HCFA had only applied the IMD Exclusion to facilities that were designated as psychiatric facilities. Ultimately, the Supreme Court upheld HCFA’s application of the Exclusion to a rest home, which was at that time federally categorized as an Intermediate Care Facility (ICF) (This is no longer a federally recognized category.²). Connecticut Department of Income Maintenance v. Heckle 471 U.S. 524, 105 S.Ct. 2210 (1985).

Thereafter, in the late 1980s and in the 1990s there were a number of disallowances involving services to adults between the ages of 22 and 65 who were deemed to be residents of IMDs. In addition, there were a number of audits by the Office of Inspector General (OIG) of the U. S. Department of Health and Human Services (HHS), the parent organization of HCFA, recommending that States reimburse the federal government for Medicaid payments made on behalf of residents of IMDs (both adult facilities and facilities that served children under age 22). By 2003, it began to appear that Medicaid services to residents of South Carolina CRCFs with more than 16 beds³ and with a large percentage of patients with psychiatric diagnoses might be vulnerable to disallowance by HCFA, because the definition of the term IMD could logically include these CRCFs. From the Criteria in the State Medicaid Manual, group homes (or CRCFs) would be especially at risk if the facility were run or staffed or licensed by the DMH or were providing significant amounts of care to mostly residents with mental illness (50% or greater). The letter, dated November 3, 2003, from CMS to the former SCDHHS Director Robert Kerr (unequivocally saying that CRCFs could be considered IMDs) unfortunately confirmed this fear.

However, as the Committee discussed, neither CMS nor the OIG has ever found a private residential service provider which had no on-site Medicaid provider services to be an IMD regardless of the size of the facility and the number of residents who were receiving mental health services elsewhere, and such facilities exist in a large number of States and have for many years. Some of the interested parties urged the Committee to focus its concern on CRCFs larger than 16 beds in size in which Medicaid services are being provided on-site and in which a majority of the residents need of CRCF services is principally due to a mental illness.

South Carolina Concerns about Resident Mix

Locally, DHEC, in conjunction with industry representatives, met to determine what constitutes CRCF as opposed to nursing home levels of care. On June 6, 2002, the Division of Health Licensing issued an advisory letter to CRCF (and Hospice and Home

² In South Carolina, at the time this category ended, about half of the approximately 20 freestanding ICFs became what are now called CRCFs.

³ Note that a facility with 16 beds or fewer completely escapes the designation of IMD.

Health) administrators pointing out the regulatory requirement that facilities only admit and retain those residents for whom the facility can provide adequate care. Due to limited resources, it is often difficult for CRCFs to have the capability to manage residents who require a greater level of staff assistance including those with major mental illnesses whose behaviors necessitate increased monitoring and supervision by facility staff.

The average monthly reported cost for 10 to 20 bed CRCFs is between \$12,420 and \$24,840 monthly⁴. Assuming the ideal of 16 residents (which would absolutely avoid the IMD Exclusion but does create problems in terms of economies of scale for CRCF operators), the average monthly cost of \$19,872 could hypothetically be covered as follows:

\$19,872	Average monthly cost per resident (assuming 16 residents)
- 16,048	Residents' recurring income payments and OSS payments
- 3,000	Supplemental TLC payment.
- 1,050	Integrated Personal Care payment for 3 residents
<hr/>	
\$224	payments in excess of cost

As noted, higher costs occasioned by residents requiring a greater level of personal care in this hypothetical facility could possibly be offset by participation in the Integrated Personal Care (IPC) program. IPC pays a premium of approximately \$350 per month to CRCFs with which it contracts for providing individualized care to qualifying residents. Additional costs could be offset if the CRCF were contracted with DMH under its TLC program to support facilities willing to undertake the additional staffing often required for residents with major mental illnesses.

However, the committee accepted that development of new small (16 beds or less) facilities designed to care for residents whose behaviors require increased monitoring and supervision by facility staff would cost more to operate than current existing facilities, given that both costs and regulatory standards have increased over time. One projection was presented to the committee by Mr. Del Bradshaw, Certified Public Accountant, through committee member, Mr. John Owens. The projection indicated the cost of operation of a newly constructed 16 bed facility to be \$40,555 per month, or more than double the average monthly facility operating cost of current small facilities.⁵

⁴ From DHHS 2007 cost report data.

⁵ Assumptions:

1. The facility would be new.
2. The facility would be 100% occupied.
3. The costs of the facility including land, building, furniture, equipment, soft costs and construction interest are estimated at \$779,000.
4. Debt service is calculated on calculated on \$779,000 at 7.5% for 180 months (\$7221.43 per month).
5. An estimate of the facilities operating costs, excluding debt service is \$300,000 annually.
6. An estimate of operator profit is \$100,000 annually.

There are a limited number of CRCFs that participate in the OSS program and an even smaller percentage of facilities accept individuals with serious mental illness due to the cost and complexity of providing care for these individuals. Many facilities limit admission to frail elders and may admit individuals with mental illness, but not major mental illness frequently associated with difficult behavioral symptoms. Since 2005, there has been a net loss of 687 beds from the pool of CRCF beds available to individuals who rely upon federal or state assistance to help pay for their care. As a result, the overall character of many of those facilities that accept large numbers of individuals with major mental illness (50% of residents or more) are at some risk of being classified as an IMD, if the facility has greater than 16 beds.

Owners and operators of CRCFs that provide care and services to Medicaid recipients with mental illness are justifiably concerned about their facility's potential classification as an IMD. SCDHHS is concerned about the potential for a disallowance of the federal matching funds it claims to pay for the medical care and services for the residents covered by the SC Medicaid program. The DMH depends heavily upon the CRCF industry for community placement of individuals with mental illness that are unable to live independently. Both agencies are concerned about the quality of care and quality of life for individuals with mental illness who are unable to live independently because of mental illness. Current reimbursement rates established for OSS providers is insufficient to provide the level of staffing and care required for residents with major mental illness. Currently the Integrated Personal Care (IPC) program provides a mechanism that enhances reimbursement for residents that require a greater level of personal care assistance than the average resident requires. Residents with major mental illness that reside in a facility that participates in IPC generally qualify for the program. However, the level of reimbursement available through the OSS and IPC programs alone do not adequately cover the number and type of direct caregivers and needed to adequately care and supervise individuals with major mental illness.

Committee Activities

The IMD Study Committee was convened and held its first meeting in November, 2007. The committee was composed of six individuals and one ex-officio SCDHHS staff person. Dr. Felicity Myers, Deputy Director of SCDHHS who was appointed by the Governor's office, chaired the committee. Also appointed by the Governor was Ms. Maxine Giles, owner/operator of South Island Assisted Living located in Georgetown. Mr. Bill Lindsey, Executive Director of the National Alliance on Mental Illness – South Carolina (NAMISC) was appointed by Senator Glenn McConnell. Mr. John Owens, owner/operator of Village Community Care Homes and Easley Retirement Center, both CRCFs located in Anderson and Easley respectively was appointed to serve by Representative Dan Cooper. Mr. Jeff Skinner, Administrator of Heritage Home, a nursing facility located in Florence was appointed by Senator Hugh Leatherman and Mr. Jerry Craig, a retired attorney from the Charleston area was appointed by Representative Bobby Harrell. Mr. Sam Waldrep, Bureau Chief of SCDHHS served as ex-officio.

The committee met six times (agendas and minutes attached) and completed its recommendations in May, 2008. Recognizing that the IMD exclusion limits an already short supply of community placement options, the committee also acknowledged that the risk of losing Medicaid coverage to the individual residents of CRCFs that depend on the Medicaid program for coverage of their medical care (including inpatient hospital care, physician services, pharmaceuticals, clinic services, medical transportation, etc.) is unacceptable. Further, the committee acknowledged that the claiming of federal financial participation for the care and services of individuals under age 65 who reside in IMDs is not allowed under the Federal guidelines governing the Medicaid program. The committee also discussed the difficulties of providing care for a mixed population of frail elders and younger, stronger individuals who exhibit aggressive behavioral symptoms. Deinstitutionalization is a beneficial goal for individuals with mental illness. It allows them to be reintegrated into society, but requires availability and access to adequate community supports. It appears that, at this time, many former DMH clients do not complete the process of deinstitutionalization, but continue as long-term residents of CRCFs instead of psychiatric treatment facilities. This leads to inadequate discharge options for new clients that enter the mental health system. Another factor reducing the discharge alternatives is the reluctance of some CRCF owners and operators to admit individuals with mental illness. The cost of providing care to individuals with major mental illness in a community setting with an acceptable quality of care and quality of life exceeds that currently available under the OSS program. Often CRCF operators' reluctance to accept individuals coming through the mental health system and those coming from the criminal justice system is related to inadequate discharge information, to include medical and social history information. While every CRCF has differing costs associated with its operation, the cost of staffing in higher numbers required by this challenging population with qualified direct caregivers alone make another level of funding necessary.

Recommendations

To Address the IMD issue:

1. **Secure funding to develop and pilot an additional level of care for the OSS program.** This would include a standardized assessment component and reimburse facilities 16 beds or smaller in size at a higher level to meet the care needs of residents with intensive behavioral health needs and aggressive behavioral symptoms. The facility must be staffed with adequate numbers of direct caregivers trained in appropriate care approaches for these residents and provide opportunities for residents to be a part of the community. Direct therapeutic services could be provided, through DMH or other behavioral health providers, in programs of this size and cost determined. The standardized assessment would be refined through the life of the project and used to facilitate appropriate placement and provide adequate medical and social history information to the CRCF so that the facility owner/administrator knows what the individual's care needs are and that they can be adequately met in the CRCF

setting. The standardized assessment process may result in an additional risk assessment by the operator.

2. **Secure funding to provide incentives for new and existing OSS providers that will primarily serve people who are unable to live independently due to mental illness and receive medical coverage under SC Medicaid. The incentives should be limited to facilities with no more than 16 beds in order to eliminate the risk of IMD classification that provide adequate care and services to meet the needs of this vulnerable population.**
3. **Require CRCFs that serve Medicaid recipients with more than 16 beds that primarily serve people with mental illness to ensure that the provision of Medicaid funded psychiatric treatment services are provided off-site. This will be enforced through the post-payment review process.**

To enhance the continuum of care:

4. **Secure funding for SCDMH to expand alternative community placement options, such as the Home Share Program and supervised independent living, to provide housing for people with mental illness.** In conjunction with SCDHHS, DMH should explore home and community based service options under the new 1915i Medicaid authority.
5. **Increase the number of acute care beds available for individuals in community settings that require emergency or crisis placement.** Currently, CRCF owners/operators experience difficulty in arranging for alternate treatment locations for residents who experience an acute episode or decompensate over time to the point that their needs can no longer be met in the CRCF.
6. **A task force should be established to study the issues related to housing for those individuals with behavioral symptoms and/or criminal histories that make them at unacceptably high risk for placement in CRCFs and for which no appropriate housing is readily available.** These include but are not limited to individuals released from Department of Corrections (DOC) with violent criminal backgrounds, those with current/ongoing drug abuse issues, arsonists, etc. Representatives from the following entities should be represented on the task force: NAMI, Protection & Advocacy, DHEC, DMH, DHHS, DOC, DDSN, Department of Social Services (DSS), Hospital Association, Department of Alcohol and Other Drug Abuse Services (DAODAS), South Carolina Association of Residential Care Homes (SCARCH), SC Sheriff's Association, SLED Special Victims Unit. The task force should be charged with identifying the scope and severity of the problem and with developing a plan to address the problems identified.

To Improve Support and Transition services

7. **Provide active management of CRCF residents with both chronic mental health issues and medical conditions (disease management).** This may be accomplished by providing a medical home to these residents to assure they receive consistent and regular medical monitoring.
8. **Obtain funding for DMH to increase the number of CRCFs with which it contracts and through which they can enforce specific requirements related to the care of residents with mental illness.**

Regulatory issues:

9. **Amend Section 44-7-320(A)(1) before the colon to read: “The department may deny, suspend or revoke licenses or assess a monetary penalty or both against a facility for.”** DHEC should be authorized to deny, suspend, or revoke licenses or assess monetary penalties, or both with consideration being given to all pertinent information regarding the facility and the applicant.
10. **Administrative Law Judges should give priority to appeals of DHEC decisions so as to limit the period of time residents are left to reside in facilities that are providing substandard care or where other serious problems are alleged.**

Conclusion

The OSS program has been stable at 4,000 individuals served with no waiting list for the past five years. However, there continues to be an inadequate number of CRCFs willing to admit residents with behavioral disorders at the current funding level available under the OSS program due to the specialized type of assistance and supervision needed. Many such individuals who are currently residing in CRCFs are being served in facilities with very limited training in meeting the care needs of residents with mental illness. In some cases, the facilities that barely meet minimum standards for licensure and are least capable of meeting the needs of these residents are the most likely to admit them. People with mental illness have the potential to return to productive society given the opportunity. But this cannot occur in CRCFs where residents do not consistently receive accurate medication administration and where there is inadequate staff to provide care and facilitate community integration. Many of these units have closed or should be closed as noted by the closing of Peachtree Manor, a residential care facility in Winnsboro.

While funding is needed for additional alternative placements and community support, so are additional CRCFs beds in facilities that have adequate numbers of qualified staff that are able to provide the specialized care needed for these individuals. Unless the level of funding is made available to encourage private entities to build 16 bed and smaller facilities willing to accept publicly funded residents with behavioral disorders, any

measures which would have the effect of reducing the number of available CRCF beds for publicly funded residents with behavioral disorders in need of a CRCF level of assistance would very likely have serious negative impact on all the citizens of South Carolina, including:

- Increasing the lengths of stay in DMH hospitals, private and community hospitals and Emergency Departments of community hospitals for individuals with behavioral disorders who are no longer in need of hospitalization, but who require the level of assistance provided by a CRCF.
- Increasing the wait times for individuals in a behavioral crisis awaiting a hospital bed in a DMH hospital, or private or community hospital with a behavioral health unit, most of whom are waiting in community hospital Emergency Departments, not only to the detriment of the persons in crisis awaiting a hospital bed, but to the detriment of those hospital Emergency Departments and the persons who depend on them by increasing their costs and diverting their resources.

By addressing this one issue of transitional housing the state can comply with federal rules regarding the IMD exclusion thereby eliminating its risk of a major federal disallowance, lessen its load on the state hospitals, reduce emergency room visits, reduce incarcerations, reduce the homeless population, and reduce co-morbid conditions. Most important, people with mental illnesses will have the opportunity to integrate into their community and have access to the resources that enable them to participate fully in the communities of their choice.

CRCF/IMD Study Committee Minority Report

June 3, 2008

I am in agreement with the CRCF/IMD Study Committee Report with the addition of the following three recommendations that are essential to improving the care and outcomes of those living with mental illness in these facilities.

- 1) Provide incentive funding to increase the number of IMD compliant CRCF's to preferred/approved providers of these facilities.**
- 2) Have transportation available for recovery based programs, faith programs, and shopping needs. Require individual plans for each resident to have opportunities to be a part of the community. Additionally, address the isolation with which these resident live. Even in a hospital setting there are group and communal activities.**
- 3) Reward CRCF's that are able to return residents to productive society, recognizing that CRCF placement should not be permanent, but a place of transition for many residents.**

**Bill Lindsey
Executive Director
National Alliance on Mental Illness South Carolina (NAMI SC)
PO Box 1267
Columbia, SC 29202
O (803) 733-9592
C (803) 917-1297
Bill.Lindsey@namisc.org**

June 9, 2008

Minority Report on Proviso 8.40 (DHHS IMD Study Committee)

The South Carolina General Assembly created a committee, by proviso, to study the availability of care and services to adult residents of community residential care facilities. The committee met many times and has issued their report due to the General Assembly due June 9. This is a minority report on one section of the overall findings under the topic of “South Carolina Concerns about Resident Mix.”

As a businessman, I have thoroughly explored the potential of building a 16 bed residential care home. DHEC regulations make it virtually impossible to retrofit an older home for 16 beds. One of my business partners, Del Bradshaw, is a certified public account in Greenville and he has run the numbers for me many times. We submitted these numbers to the committee.

As a committee member, I expressed concerns over “hypothetical” financials provided by Health and Human Services. When we asked for financials, we were told by Health and Human Services staff that cost reports submitted by residential care facilities may be meaningless in many instances; however they chose to use this information to formulate the financial information contained in this report. Also in that same section, there is a comparison between the care for the frail elderly and the care of a younger, chronically ill person with mental illness. Using this information is at best a bad guess depending on the type of person being served in the community residential care facility.

It was our understanding during the last meeting that the information we submitted to the committee would be in the report to counter what we believe to be incorrect financial information. Not all of the information was included.

Debt Service was not sufficiently explained. Debt service is calculated on \$779,000 at 7.5% for 180 months (\$7221.43 per month). In reality the operator/developer would be required to contribute about 20% of the facility cost for traditional lender financing (80%). By using 100% financing we are assuming the operator/developer would be participating in the financing and would be entitled to a return on the investment equal to that of the primary lender (7.5%) on the 20% portion. The total debt service is \$86,657 annually assuming normal amortization.

Using our information included in the report, the annual cash required to operate this hypothetical 16 bed model is \$486,657 or \$40,555 per month. **This is \$83.33 per day per resident required to operate this model or \$2,535 per month per resident based on 100% occupancy.**

An operator can not plan on being 100% occupied for a full operating year. **A more realistic estimate would be 90%. This would require \$92.78 per day per resident to operate this model.** There is not an appropriate way to adjust operating costs monthly if the 16 bed facility is not 100% occupied.

Another cash item that is **not** included is the initial start-up working capital required. The consumers must be fully phased-in with the billing/collection cycle completed at least one time before the cash flow begins to stabilize. This is probably 90 to 120 days. The working capital needed to fund operations, payroll and build some reserve during this time would be \$75,000 to \$90,000. This capital cost has not been estimated for a 16 bed model.

Another item for consideration should be inflation and cost increases. There is no way to avoid the inevitable increase in costs of doing business. Wages, food, insurances, etc will increase and the facility will have to be refurbished. One of the consequences of serving this population is the decompensation of the consumer and the resulting damages to the facility as a result of decompensation. A program must be developed to address these needs.

There are other costs that have not been estimated for this model such as vehicle and transportation with their related expenses. But, the intended purpose for the above estimates is to give you an opportunity to see a clearer financial path to establishing a facility from the ground up. Therefore, some estimates in this 16 bed model are probably low. It is unlikely that they are too high. The estimates used in this model have been obtained from reliable sources that include construction companies, architects, builders and other professionals who have experience in this industry.

I hope you will take this information into consideration as you move forward to better serve the citizens of South Carolina. Thank you for your time and consideration of this matter.

John Owens
Partner, Community Care Properties