U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

FEDERAL FINANCING OF SUPPORTED EMPLOYMENT AND CUSTOMIZED EMPLOYMENT FOR PEOPLE WITH MENTAL ILLNESSES:

FINAL REPORT

February 2011

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This report was prepared under contract #HHSP23320095655WC between HHS's ASPE/DALTCP and Westat, Inc. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Pamela Doty, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Pamela.Doty@hhs.gov.

FEDERAL FINANCING OF SUPPORTED EMPLOYMENT AND CUSTOMIZED EMPLOYMENT FOR PEOPLE WITH MENTAL ILLNESSES: Final Report

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TABLE OF CONTENTS

LIST OF TABLES

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EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) in conjunction with the Federal Employment Workgroup on Disability commissioned a review of the federal financing mechanisms used by state agencies to implement the evidence-based employment models known as Individual Placement and Support (IPS) and Customized Employment (CE). This review comes with the recognition that the federal financing of employment services for people with serious mental illness is a shared responsibility across multiple federal agencies, including the U.S. Social Security Administration (SSA), the HHS Centers for Medicare and Medicaid Services (CMS), the HHS Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Education (ED) Rehabilitation Services Administration, the U.S. Department of Veterans Affairs, and the U.S. Department of Labor (DOL). It is believed that improvements in this shared responsibility can lead to more effective support for these evidence-based employment models at the state and local levels. The purpose of this report is to identify strategies for improved access to federal financing of IPS and CE services through case studies of current state and local practices.

The overall employment rate for the general population was 64.5% in 2009. Among those who were working, 80% were working full-time (Bureau of Labor Statistics, 2010). The employment rates among people with serious mental illness are much lower than the general population, estimated to be 22% at any given time, with a little more than half of these individuals (12%) working full-time. While the likelihood of having a job is approximately 1 in 1.5 for the general population, the likelihood among individuals with a serious mental illness is not much better than 1 in 5.

Over the past two decades, substantial attention has been devoted to understanding the poor employment rates of people with serious mental illness and to improving them. However, two employment models developed independently during these years have demonstrated particular success in helping people with a serious mental illness get jobs. The IPS model of supported employment (SE) developed by Drake and Becker (1996) has a strong body of experimental evidence showing that it is effective in helping people with serious mental illness get jobs. CE, a more recent but conceptually convergent employment model has also demonstrated success in assisting people with serious mental illness obtain jobs. Developed and fostered by the DOL (Federal Register, 2002) over the past decade, CE has been less rigorously tested than has IPS.

The IPS and CE models both seek to assist individuals with severe mental illness find jobs that fit their particular needs, interests, and skills, and to support them in ways that enable them to succeed in the workplace. IPS is built on a foundation of seven core principles; including the following: (1) *Consumer choice*; (2) *Integrated services*; (3) *Competitive employment in regular work settings*; (4) *Place when individual feels ready*; (5) *Personalized follow-on support*; (6) *Person-centered services*; and (7) *Benefits*

counseling. A recent empirical review of 11 randomized controlled trials of IPS programs serving individuals a serious mental illness concluded that vocational outcomes are consistently significantly higher than the alternative control program. The 11 studies included a total of 1,690 individuals (812 IPS, 878 Control), all of whom had been diagnosed with a severe mental illness, but who varied in their receipt of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). In these studies, members of the control group received either vocational services as usual, or a specific non-IPS vocational rehabilitation (VR) service.

In 2002, DOL's Office of Disability Employment Policy (ODEP) put forward a formal definition of CE and a major grant initiative to fund programs around it. CE is:

> "*a flexible process designed to personalize the employment relationship between a job candidate and an employer in a way that meets the needs of both. It is based on an individualized match between the strengths, conditions, and interests of a job candidate and the identified business needs of an employer. Customized Employment utilizes an individualized approach to employment planning and job development -- one person at a time…one employer at a time*" (ODEP, 2011).

The focus of the funding was to assist people with disabilities in creating an individualized competitive employment opportunity that meets the needs of both the job seeker and the employer (Federal Register, 2002). The CE model has been used to provide employment services to people with serious mental illness, but the strategy was not developed specifically for this population. CE has six core principles, including the following: (1) *Negotiation with employers*; (2) *Customized job tasks*; (3) *Person-centered services*; (4) *Client control*; (5) *Discovery*; and (6) *Jobs have the potential for advancement*.

Case Studies

Working closely with ASPE and with the Federal Employment Workgroup, the study team identified four states (Illinois, Kansas, Maryland, and Washington) that serve this population using a variety of methods to provide IPS and CE services through braided state general funds, VR funds, mental health block grants, Medicaid funds (rehabilitation option and/or through waivers). The objective of the case studies was to gather information and document the range of funding sources that each state uses to finance IPS/CE services, determine barriers to achieving adequate funding, and identifying how the funding sources are being combined to achieve what little success the state may be having.

Based on the review of four states' experiences, it is clear that the coordination of state agencies including mental health, VR, and Medicaid, is particularly vital in organizing a viable and successful plan for funding IPS and CE services. The case study findings provided opportunities to clarify (identify) funding strategies using existing mechanisms of support. However, the case studies also pointed to a number of

concerns about improving the flow of funds to local levels. These concerns include the following:

1. Collaboration in most states between state mental health and VR offices is less than ideal for supporting implementation of IPS and CE.
2. Access to VR services is an important challenge for people with mental illness.
3. VR's focus on case closure is not aligned with IPS/CE principles.
4. Ticket to Work (TTW) payments are not aligned with IPS/CE principles.
5. One-Stop Career Centers do not have the expertise to serve people with mental illness.
6. Stronger federal policies in conjunction with steady federal funding that is based on process measures are needed to provide employment support to individuals with serious mental illness.

Funding Models

Based on the case studies and discussions with leading experts, two primary federal funding possibilities were identified: Medicaid and ED funding for state VR services as well as several secondary funding sources, including mental health block grants funded by SAMHSA, one-stop employment centers funded by DOL, and TTW funding from SSA. As noted throughout the report, the main funding source for IPS services has been Medicaid. Medicaid has its limitations, not the least of which is that it covers only those who are Medicaid eligible, leaving those who are not without these critical employment services. Despite some special provisions to encourage employment of people with disabilities, Medicaid financial eligibility rules typically require individuals to be low income and permit them to have almost no savings. Moreover, individuals with serious mental illness can seldom meet Medicaid financial and functional eligibility criteria until they have had more than one and often several acute episodes and their conditions have become chronic. Thus, Medicaid is extremely limited as a funding source for early interventions that might favorably change the long-term prognosis of individuals who have had a first episode of serious mental illness but for whom mental illness is not yet a chronic condition requiring long-term -- perhaps even lifelong -- medical care and social supports. The research identified four primary options for state level funding for SE services through the existing Medicaid infrastructure. These options include using: (1) the Rehabilitation option; (2) the Targeted Case Management option; (3) the 1915(c) Home and Community-Based Services Waivers; and (4) the 1915(i) Home and Community-Based Services option. In order to assist states with each of these options, specific details and procedures are further elaborated in the report.

1. INTRODUCTION

Having a job remains one of the most valued roles in society. It is viewed as essential to community integration and is associated with greater independence and self worth, and a more fulfilling social life. Having a job adds structure to daily life, increases social contacts and support, and enhances opportunities for personal achievement. In 2009, the general population had an overall employment rate of 64.5% Among those who were working, 80%were working full-time (Bureau of Labor Statistics, 2010). Unfortunately, the employment rates among people with serious mental illness are much lower than the general population. Researchers providing a best estimate note that at any given time the employment rates for these individuals are around 22% with a little more than half of them (12%) working full-time (Mechanic, Bilder, & McAlpine, 2002). Thus, the likelihood of persons with serious mental illness having a job is a little better than 1 in 5, and the likelihood of having a full-time job is approximately 1 in 8.

In the past two decades, substantial attention has been devoted to understanding the poor employment rates of people with serious mental illness and to improving them. Two employment models developed independently during these years have demonstrated particular success in helping people with a serious mental illness get jobs. The Individual Placement and Support (IPS) model of supported employment (SE) developed by Drake and Becker (1996) has a strong body of experimental evidence showing that it is effective in helping people with serious mental illness get jobs. The result is greater earnings and job retention, improved mental health, and greater satisfaction with life when compared to treatment as usual. However, despite its strong body of supporting evidence (discussed below), the IPS model of SE is not widely available to the people with serious mental illness that need them (Bond, et al., 2001). The reason is primarily due to the difficulties in financing these services (Drake et al., 2009). Local mental health service providers cannot recover the costs associated with hiring, keeping, or training employment specialists (ES). Federal and state funding for these services creates significant barriers to the development and sustainability of evidence-based SE programs. In many states, Medicaid will pay for some portion of these employment services, but not all. Medicare will not pay for any of these services. Without a consistent and substantive financial base from which to draw, it is not surprising that community mental health centers (CMHCs) do not provide these evidence-based services.

Customized Employment (CE), a more recent but conceptually convergent development, has also demonstrated success in assisting people with serious mental illness obtain jobs. Developed and fostered by the U.S. Department of Labor (DOL) (Federal Register, 2002) over the past decade, CE has been less rigorously tested than has IPS. However, experience has also shown that it has been successful and, in fact, is sometimes used by IPS ESs to help in the job placement of individuals facing more complicated barriers to sustained employment. Unfortunately, CE is not readily available either. CE was originally funded through a grant program to One-Stop Career Centers.

While the grants were considered very successful, the program had little sustainability in most centers where CE was implemented once funding stopped (Elinson, et al., 2008).

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) in conjunction with the Federal Employment Workgroup on Disability commissioned a review of the federal financing mechanisms used by state agencies to implement the IPS and CE employment models. This review comes with the recognition that the federal financing of employment services for people with serious mental illness is a shared responsibility across multiple federal agencies, including the U.S. Social Security Administration (SSA), the HHS Centers for Medicare and Medicaid Services (CMS), the HHS Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Education (ED) Rehabilitation Services Administration (RSA), the U.S. Department of Veterans Affairs (VA), and DOL. It is believed that improvements in this shared responsibility can lead to more effective support for these evidence-based employment models at the state and local levels.

The purpose of this report is to identify strategies for improved access to federal financing of IPS and CE services. While there are many issues associated with increasing access to evidence-based employment services for this underserved population, financing is the key barrier. With an adequate and consistent source of funds available to appropriate providers, more people with serious mental illness will have successful employment outcomes. However, moving these models of employment into the mainstream of mental health services will require new thinking about the policies and approaches associated with financing of employment services for these individuals.

This report is divided into three sections. Section 1 presents an overview of the IPS and CE employment models. We include a definition and a summary of the supporting evidence for each model. In Section 2 we present a brief discussion of the current issues in financing employment services for people with serious mental illness including case examples. In Section 3, we provide more detailed guidance to states seeking to “blend and braid” several federal financing sources (e.g., Medicaid, mental health block grant, and vocational rehabilitation (VR) funds) and technical assistance in identifying appropriate Medicaid benefits and how to access these funding mechanisms in compliance with federal requirements.

The Individual Placement and Support and Customized Employment Models

The IPS and CE models both seek to assist individuals with serious mental illness find jobs that fit their particular needs, interests, and skills, and to support them in ways that enable them to succeed in the workplace. The two models share many features, but their core principles and approaches also differ in some important ways. This section provides a summary of each model, its core principles, and the evidence supporting its use.

Individual Placement and Support

The IPS model is a well-defined form of SE that has developed into an evidence-based practice (EBP) specifically targeting individuals with serious mental illness. A key feature of IPS is integrating employment services with mental health services.

IPS is built on a foundation of seven core principles (Bond, 2004). These principles include the following: (1) *Consumer choice* -- individuals who are interested in work are eligible for IPS without exception; (2) *Integrated services* -- vocational and mental health services together are a part of the overall treatment approach; (3) *Competitive employment in regular work settings* -- no pre-employment training or placement in sheltered or segregated work settings; (4) *Place and train* -- placing individuals in competitive work settings as soon as they feel ready, without extensive training or a career exploration period; (5) *Personalized follow-on support* -- after placement individuals and their employer (if desired) receive ongoing support for as long as they need it; (6) *Person-centered services* -- client's personal preferences, experiences, strengths, and choices drive the job search and follow-on supports rather than the judgment of the ES; and (7) *Benefits counseling* -- is provided to clients to ensure successful navigation of any impact of employment on government entitlements such as Medicaid or Social Security benefits. Any program adopting the IPS model must demonstrate fidelity to these core principles if it expects to achieve the measured outcomes (Bond, 2004; Loveland, Driscoll, & Boyle, 2007).

To supplement the core principles, Becker and Drake (2003) have identified organizational and staffing features that appear to be essential to the success of an IPS program. The principles already specify that vocational services and mental health treatment should be integrated into a single treatment team approach. However, it is also essential that the ES be dedicated to employment-related services, and should not engage in more general case management activities. While it is tempting for agency directors to gain organizational efficiencies by having the ES perform duties typically associated with case management, experience shows that these other duties dilute the focus on employment. A second essential feature is caseload of the ES. Again, experience shows that the ES caseload should not exceed 20-25 clients. Both of these additional staffing requirements are intended to ensure that the ES has an appropriate amount of time available to devote to each client and potential employer.

The body of evidence supporting IPS effectiveness began to develop in the early 1990s with quasi-experimental conversion studies of day treatment programs to SE programs. When combined across all of the early studies, comparisons of people receiving SE services to the day treatment groups showed that the SE model was significantly more effective than the day treatment model at increasing competitive employment rates; while 38% of the SE group achieved competitive employment, the comparison group remained static at 15% competitive employment (Bond, 2004).

Subsequent research on the IPS model moved to experimental trials for the purpose of establishing a causal impact. A recent empirical review of 11 randomized

controlled trials of IPS programs serving individuals with a serious mental illness (Bond, Drake, & Becker, 2008) concluded that vocational outcomes are consistently significantly higher than the alternative control program. The 11 studies included a total of 1,690 individuals (812 IPS, 878 Control), all of whom had been diagnosed with a serious mental illness, but who varied in their receipt of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). In these studies, members of the control group received either vocational services as usual, or a specific non-IPS VR service. The length of follow-up varied across the studies from 6 months to 24 months, and thus the number of months elapsed from baseline to outcomes varied by study. The overall rate of competitive employment across the multiple studies was 61% for the IPS arm and 23% for the control arm of the studies. IPS programs found employment for the individuals they served more quickly than did the control programs (138 days versus 206 days), and individuals in the IPS programs were more likely than those in the control programs to be working more than 20 hours per week (44% versus 14%). A subsequent meta-analysis (Campbell, Bond, & Drake, 2009) replicated these findings in a similar sample of 681 individuals with a diagnosis of serious mental illness that varied in their receipt of SSI and SSDI.

The key rationale for the IPS model lies in its compliance with the ideal features of an EBP, including the following:

1. **The model is well specified.** IPS principles and clinical details have been refined continuously as research has evolved over 20 years (Bond, 2004; Swanson & Becker, 2010). It is a manualized practice which clearly details specific principles of the model and clinical interactions (Swanson, et al., 2008; Swanson & Becker, 2010). Further, an IPS fidelity scale (Bond, et al., 1997) measures adherence and predicts vocational outcomes (Bond, et al., in press).

2. **The model is sensitive to client goals**. The majority of mental health clients want competitive employment (McQuilken, et al., 2003). IPS emphasizes competitive jobs and client preferences regarding the timing, goals, and procedures of finding and maintaining employment. Thus, client satisfaction has always been high in IPS studies (Bond, et al., 2008).

3. **The model is consistent with societal goals.** American society and disability laws seek to promote social inclusion, recovery, and mainstreaming. IPS addresses social inclusion, lost productivity, increasing disability roles, and other societal goals (Bond, et al., 2010). Thus, IPS has been endorsed by federal reports (e.g., New Freedom Commission on Mental Health, 2003) and numerous federal and state agencies (e.g., the Veterans Healthcare Administration and SAMHSA).

4. **The model has strong and consistent evidence of efficacy and effectiveness**. Numerous reviews of randomized controlled trials confirm that IPS is superior to other vocational programs (e.g., Crowther, et al., 2001). One recent review of 11 IPS studies concluded that 61% of IPS clients obtained

competitive employment in one year while only 23% of those in active control conditions achieved competitive employment (Bond, et al., 2008). In addition to randomized controlled trials, several day treatment conversion studies and correlational fidelity-outcome studies support IPS (Bond, et al., 2010). The Dartmouth Community Mental Health Program funded by the Johnson and Johnson Foundation has overseen successful implementation of the IPS model in over 120 mental health settings in 12 states (Drake, et al., 2006).

5. **The model has minimal negative side effects and many positive effects.** Despite concerns regarding the potential negative effects of high-expectations programs, studies of IPS have consistently failed to detect negative effects (Bond, 2004). For people with mental illnesses, as for others in society, unemployment appears to be more stressful than employment. In fact, many longitudinal studies show that employment leads to other positive outcomes, such as increases in self-esteem, social functioning, and quality of life, and decreases in substance abuse and mental health service utilization (Bush, et al., 2009; Bond, et al., 2001; Burns, et al., 2009; Xie, et al., 2010).

6. **The model has excellent long-term durability.** Two studies have documented excellent long-term outcomes of IPS. The amounts of competitive employment improved rather than declined over 10 years (Becker, et al., 2007; Salyers, et al., 2004). Other studies of SE have also demonstrated durability of employment outcomes (Bond, et al., 1995; McHugo, et al., 1998; Test, 1992).

7. **The model has reasonable costs.** A recent cost review study suggests that per unit cost figure (in 2005 dollars) for IPS is in the range of $3,500-$5,000 per client (Salkever, 2010). IPS has consistently been shown to be cost-effective compared to other vocational programs (Bond, et al., 2010). Economic modeling suggested that IPS might reduce long-term federal costs (Drake, et al., 2009).

8. **The model is relatively easy to implement and sustain.** Three large national demonstrations have shown that IPS is relatively easy to implement with high fidelity within 6 months. These include the National Evidence-Based Practices Project (Bond, et al., 2008), the Johnson and Johnson-Dartmouth Community Mental Health Program (Drake, et al., 2006), and the Social Security Mental Health Treatment Study (Frey, et al., 2008) with a combined total of over 160 IPS implementations. One unique finding regarding IPS is that the number of programs continues to expand despite the lack of clear funding sources, presumably because vocational services are highly valued by all stakeholders.

9. **The model is adaptable to diverse client groups and communities.** IPS has been studied in rural areas, mid-sized cities, and large cities (Bond, et al., 2008); with different ethno-racial groups (Campbell, Bond, & Drake, 2009); with different age groups (Bond & Drake, 2008); and in several other countries (Bond, et al., 2008). These diverse groups appear to benefit from the IPS model in approximately similar degrees.

Customized Employment

The CE model was introduced conceptually by Secretary of Labor Elaine Chao in 2001 as a future trend in employment (Inge, 2008). In 2002, DOL's Office of Disability Employment Policy (ODEP) put forward a formal definition of CE and a major grant initiative to fund CE programs. CE is a flexible process designed to personalize the employment relationship between a job candidate and an employer in a way that meets the needs of both. It is based on an individualized match between the strengths, conditions, and interests of a job candidate and the identified business needs of an employer. CE utilizes an individualized approach to employment planning and job development -- one person at a time…one employer at a time (ODEP, 2011). The focus of the funding was to assist people with disabilities in creating an individualized competitive employment opportunity that meets the needs of both the job seeker and the employer (Federal Register, 2002). The CE model has been used to provide employment services to people with serious mental illness, but the strategy was not developed specifically for this population. Instead, the target population for CE includes any individual with a complex life that poses challenges for achieving competitive employment (e.g., people with disabilities who may be chronically homeless, have limited job skills, or face other barriers to employment) (ODEP, 2009).

CE has six core principles (ODEP, 2009). They include the following: (1) *Negotiation with employers* -- employers voluntarily negotiate specific job duties or expectations with the job seeker; (2) *Customized job tasks* -- the distinct job tasks are carved from existing job descriptions, re-structured from one or more jobs, or created so that they match the interests and skills of the job seeker, and so that they also meet a specific workplace needs of the employer; thus the resultant job descriptions are "customized;" (3) *Person-centered services* -- the job seeker is the primary source of information and guidance about jobs to explore in the job market; (4) *Client control* -- the job seeker, not the ES or counselor, controls the planning process; (5) *Discovery* -- is the process used to reveal assessment, is used to reveal the job seeker's interests, skills, and needs (but can be supplemented -- not replaced -- by traditional assessment); and (6) *Jobs have the potential for advancement* -- identified jobs should have potential for advancement even if the job seeker was previously unemployed, underemployed, or never held a job.

No randomized controlled trials of CE programs were found in the published literature. However, a number of non-experimental studies were identified. Citron et al. (2008) describe a CE program that provided services to individuals with mental illness, developmental disabilities, and addictive disorders. The program served nearly 200 job seekers, and of those 71% achieved employment in a competitive employment setting (including through a self-employment opportunities). Wages ranged from a lowest wage of $5.15 per hour to a high wage of $40 per hour, and the typical number of hours worked per week was 15-20. Rogers, Lavin, Ran, Gantenbein, and Sharpe (2008) summarized findings from a CE program that targeted young people with disabilities, and sought to improve competitive job placement in the transition from school to work.

The program served 475 individuals over the course of 5 years, including people with developmental and intellectual disabilities, serious mental illness, and behavioral and physical health disabilities or challenges. Unlike many CE programs, this program engaged in extensive coordinated services beyond employment, including mental and physical health services and assistance with housing and transportation. The program also offered substantial skills and vocational training if the discovery process suggested this was necessary. Additionally, the program paid wage subsidies to some individuals to allow employers to try out the customized position (a "temp-to-hire" approach), with the understanding that the employer would then hire the temporary employee and assume responsibility for full wages. Overall, 62% of these individuals achieved competitive employment, working an average of 27 hours per week. The wages per hour ranged from $5.15 to $25, with an average of $8.16.

Luecking, et al. (2008) also described a CE program in which a One-Stop Career Center was adapted to provide CE services to 66 individuals with intellectual disabilities, mental illness, mobility disabilities, autism, and other disabilities, who were not engaged in competitive employment at intake. As a result of CE services, 89% of the individuals served achieved employment, working an average of 22 hours per week. Per-hour wages ranged from $6.15 to $18, with an average of $9.31. The time required from program entry to employment ranged from 1 month to 21 months, with an average of 5.25 months.

Elinson, et al. (2008) published an evaluation of outcomes across 31 of the ODEP demonstration programs, using a one-group pretest-posttest design. Vocational outcomes were examined at three time periods. The programs served a combined 6,555 individuals over the course of 5 years, including people with psychiatric disabilities, learning disabilities, intellectual disabilities, and physical disabilities. Across all individuals served, 44.8% obtained employment. Individuals who achieved employment worked approximately 24-26 hours per week on average. Per-hour wages ranged from $5.15 to over $8.15, with an approximate average hourly wage between $8.60-$8.95. Only a quarter of the positions included fringe benefits.

Thus, although there are no experimental evaluations of CE, an initial phase of non-experimental research supports the potential of CE for facilitating employment in people with a variety of challenging circumstances, including people with a serious mental illness.

2. CURRENT FINANCING ISSUES

Although most federal agencies recognize the IPS model of SE as an EBP, the federal funding mechanisms in place to support availability of these services are not viable at the state and local levels, and thus do not result in available services. At least there is no mainstream source of funds that adequately support the integration of SE with mental health care in CMHCs, One-Stop Career Centers, or anywhere else. Providers of mental health services must cobble together funding from a variety of sources in order to effectively offer state of the art IPS services. If a center director chooses to provide SE services through his/her center, then funding must be brokered with various sources, such as grants (such as Johnson and Johnson, DOL, etc.), Medicaid, VR, the Ticket to Work (TTW) program, or other disparate sources. In many states and local communities, mental health providers face challenges in obtaining the resources to make these services a viable option should they choose to make it available. Instead, they may provide other services that are less effective and not evidence-based.

The following describe financing as the main reason why people with mental illness do not have access to SE services across the country. The three areas of primary concern are: (1) fragmented funding sources; (2) the stigma associated with mental illness; and (3) inadequate knowledge of potential funding sources.

Fragmented Funding Sources. SE programs are based on an approach that integrates evidence-based vocational services with mental health services. In order to accomplish integration of services, people with mental illness need services and support from a variety of agencies, all of which have different policies, cultures, values, and eligibility requirements (Bond, Becker, et al., 2001; SAMHSA, 2009). For example, a person with a mental illness who is seeking employment may need to access services from a mental health agency for clinical services that may be funded by Medicaid; employment assessment, counseling, and training that may be funded by state VR agency; and access to employers that may be funded by the One-Stop Career Center (a component of the workforce development system). However, bringing all these different funding sources together to fund all components of SE would require systems change and is a challenging task for ESs and for people with serious mental illness.

Stigma of serious mental illness and employment. Individuals with serious mental illness are stigmatized and getting funding to receive employment services may be subject to how agencies perceive their prospects for employment (Harnois & Gabriel, 2000; Cook, 2006). For example, some VR counselors may approve an application of a client if, in their estimation, the client is able to work, and since some VR staff may have lower expectations about the ability of people with mental illness to work, people with mental illness may lose out on potential funding for employment services. In addition, One-Stop Career Centers often provide a one-size fits all approach to employment services which often ends in referral to VR agencies for people with serious mental illness. CMHCs, which provide services to treat mental illness, but they may not

adequately integrate employment goals into treatment plans and often will only pursue employment goals after the person is considered “stable”. CMHC’s may actively seek funding from CMS for mental health services but they may not be aware of opportunities to receive funding for employment services from CMS.

Inadequate knowledge of existing funding opportunities. The ability to access and use multiple funding streams requires knowledge of the rules and regulations relating to funding that is available from CMS, VR, SSA, and DOL. However, the degree of success in accessing these funds for SE varies substantially across states (Drake & Goldman, 2003; Wehman & Revell, 2000). Often, states do not have a common understanding of how Medicaid waivers and state plan amendments (SPAs) may be used to provide funds for SE services. VR agencies (and counselors) do not necessarily have a uniform approach to SE funding and there is considerable variation in the interpretation of VR regulations across and within states, especially as these relate to employment supports for persons with serious mental illness.

Current Federal Financing Sources

There are two distinct phases involved in SE -- each of which is funded differently. The first phase includes job development, placement, the arrangement of natural supports, and initial skill acquisition and the second phase includes all ongoing support afterwards. While the first stage is usually paid for by the State Office of VR, the funding for a given SE provider is usually a combination of funds “braided” or “blended” from any number of different federal, state, and local agencies (West, et al., 1998).[1]

The most common sources for funding IPS and CE services include the following:[2]

- **State Office of VRs** are funded by RSA. State VRs provide support to local providers typically during the initial or time-limited phase of SE.

- **Community Mental Health Services Block Grant Program** -- States often use portions of this grant program to SE services.

- **State Mental Health Authority (MHA)** can pay either with ongoing services budget or with time-limited grants.

- **Medicaid** -- Medicaid dollars can be used to pay for those medically necessary services that support an individual to be able to attain and maintain competitive employment. Medicaid is used most often by states to cover the services of a

[1] The term "blended funding" is used to describe mechanisms that pool dollars from multiple sources and make them in some ways indistinguishable. "Braided funding" utilizes similar mechanisms, but the funding streams remain visible and are used in common to produce greater strength, efficiency, and/or effectiveness.

[2] SAMHSA, 2003; Training and Technical Assistance for Providers (T-TAP), 2005; DOL, 2009; Smith, Kennedy, et al., 2005.

case manager who assists the individual in gaining access to a range of necessary services and supports including vocational services, and/or to cover those clinical services such as counseling or medication management that support the individual in their recovery. There are also several Medicaid options and/or waivers available for the states to provide vocational services.

- **One-Stop Employment Centers** -- Coordinated by DOL's Employment and Training Administration, these centers are designed to provide a full range of assistance to job seekers under one roof. Established under the Workforce Investment Act (WIA), the centers offer training referrals, career counseling, job listings, and similar employment-related services.

- **SSA** -- Provides SSI and SSDI to many people with disabilities. SSA also provides a host of work incentives (e.g., Plans for Achieving Self Support (PASS), Impairment Related Work Expenses, and the Trial Work Period (TWP)) that can fund some employment services.

- **TTW and Self-Sufficiency Program** -- Funded by SSA and created by the Ticket to Work and Work Incentives Act (TWWIA) of 1999). Any VR Agency, One-Stop Career Center, or provider can become an Employment Network (EN) and provide SE services.

- **VA** -- Through Vocational Rehabilitation and Education (VR&E) program.

- **Private donors/charitable organizations/"Micro Enterprise Centers."**

Table 1a and Table 1b show the possible funding sources and extent of coverage by IPS/CE components. The checkmarks indicate availability of a potential funding for a service by an agency (the exact nature and the extent of the service are determined by the agency) when all eligibility requirements are met. For example, state VR agencies pay for support services that would help an individual with serious mental illness to obtain employment. After finding employment and after VR case closure, VR funds cannot be used to provide job coaching and/or ongoing SE to maintain employment. If an individual obtains a Ticket from the SSA's TTW program, then there may be additional funding for the post-placement employment services. Veterans receive funding support for all components of the SE services from the VR&E since the VA sees vocational services as an integrated part of the rehabilitation plan. However, for all other individuals, SE providers have to work very hard to find funding from other resources. In Section 3, we will discuss the Medicaid as a source of funding in greater detail.

TABLE 1a. Components of IPS and CE and Possible Funding Sources					
	Private Health Insurance	**SSA/TTW[1,2]**	**Vocational Rehabilitation**	**VA VR&E**	**Other Funding Sources (e.g., block grants)**
Mental Health Treatment and Support Services					
Mental health assessment	√			√	√
Mental health counseling	√			√	√
Medication management	√			√	√
Case management				√	√
Other mental health services[3]				√	√
Vocational Services					
Discovery process		√	√	√	√
Vocational skills assessment		√	√	√	√
Job development		√	√	√	√
Job placement		√	√	√	√
Job coaching		√	√[4]	√	√

1. SSA disability beneficiaries with a Ticket may obtain SE services from an EN. After the beneficiary obtains an employment, EN receives payment depending on wage and duration of employment milestones set by the SSA.
2. A recent letter by CMS states that state agencies acting as ENs should keep Ticket payment funding separate from resources used by the state to comprise the state's Medicaid share, in accordance with applicable Federal Regulations at 42 CFR 433.51 (CMS, SMD#10-002, January 28, 2010).
3. Examples of other mental services include Assertive Community Treatment (ACT), peer recovery support services, and day treatment.
4. An 18 month time limit for job coaching funded by VR is recommended by RSA.

TABLE 1b. Components of IPS and CE and Possible Medicaid Funding Sources						
	Medicaid State Plan[1]			**Medicaid Waivers[1]**		
	State Plan	**Rehabilitation Option**	**1915(i)**	**1915(b)[2,3]**	**1915(c)**	**1115**
Mental Health Treatment and Support Services						
Mental health assessment	√	√	√	√	√	√
Mental health counseling	√	√	√	√	√	√
Medication management	√	√	√	√	√	√
Case management	√	√	√	√	√	√
Other mental health services[4]	√	√	√	√	√	√
Prevocational and Supported Employment Services						
Assessment[5]			√	√	√	√
Vocational skills assessment			√	√	√	√
Job development			√	√	√	√
Job placement			√	√	√	√
Job coaching			√	√	√	√

1. 1915(j) Self-directed Personal Assistance Services can be used to offer self-direction of existing state plan or waiver services.
2. 1915(b)(3) allows for the use of cost savings to provide additional services. Reinvestment services can include listed services in the table.
3. A recent letter by CMS states that state agencies acting as ENs should keep Ticket payment funding separate from resources used by the state to comprise the state's Medicaid share, in accordance with applicable Federal Regulations at 42 CFR 433.51 (CMS, SMD#10-002, January 28, 2010).
4. Each state plan option and waiver has a variety of mental health treatment supports that could be included (e.g., ACT, peer recovery support services, and day treatment).
5. Assessment is the service classification used for Medicaid billing purposes and it can include "discovery process."

Case Study of Four States

Working closely with ASPE and with the Federal Employment Workgroup, the study team identified four states that serve this population using a variety of methods to braid state general funds, VR funds, mental health block grants, Medicaid funds (rehabilitation option and/or through waivers) to provide IPS and CE services. These states -- Illinois, Kansas, Maryland, and Washington -- were selected for case studies due to their relative success and/or longer experience in efforts to fund IPS/CE services. The objective of the case studies is to gather information and document the range of funding sources that each state uses to finance IPS/CE services and how these funding sources are being combined.

Customized Employment Services

While states are implementing different methods and using various sources of funding for IPS SE, CE services have been most often funded by grants and cooperative agreements with the DOL. The CE Initiative, begun by ODEP at the DOL in 2001, provided funding support to selected local Workforce Investment Boards to demonstrate how the workforce development system can better serve persons with significant disabilities. The goal was to build the capacity of statewide One-Stop Career Centers to more effectively serve people with severe disabilities through a CE approach.

The study team interviewed state officials, CE providers from the States of Georgia and Washington, researchers and other key informants regarding CE financing. The providers participated in these demonstration grants view CE as an effective strategy within the realm of SE services. Providers also consider CE to be particularly beneficial in providing services to clients with more complex set of needs. However, both the state representatives and the providers state that the infrastructure and service delivery approaches for SE are appropriate for delivering CE services within them, and the financing approaches for SE would also satisfy the needs for CE services. CE demonstrations funded by ODEP yield findings that suggest using diversified funding for CE services may prove to be successful. Diversified funding involves establishing a flexible funding base that includes multiple sources of funding support and assuring that support dollars can follow and adapt to the employment goals and support needs of each consumer that needs CE (DOL, 2009).

Individual Placement and Support Supported Employment Services

The study team interviewed key state officials and providers in four states. The interviews focused on an examination of the current financing mechanism for IPS and CE services, historical developments, challenges, solutions, and implications for federal level funding mechanisms. Staff from the state departments of VR, mental health, and Medicaid, Medicaid managed care organizations, Workforce Investment Board, IPS/CE providers, academic researchers, members of the advocacy boards and committees participated in the interviews as well.

Illinois

The IPS SE program was initiated in the State of Illinois through a braided funding model between the Division of Mental Health (DMH) and Division of Rehabilitation Services (DRS). Today, the IPS services are provided at 25 sites in 18 mental health centers. IPS programs are supported by DMH contract awards and DRS milestone payments for 15, 45, 90-day successful employment outcomes. Fee-for-service (FFS) billing of vocational services through DMH is established in two broad categories: Vocational code billing, or V-Codes, and all other FFS billings to support persons with mental illness in the community (Medicaid funds). The State of Illinois does not have a Medicaid waiver or state plan option specific to persons with serious mental illnesses. However, Illinois uses Medicaid Rehab Option to fund certain services that are related to treatment and recovery goals. For other vocational services they use general funds and VR milestone based payment systems. The following table presents type of services and payment sources.

TABLE 2. Funding Sources by Components of SE Services in Illinois

Type of Services	DMH -- Medicaid	DMH -- Non-Medicaid
Engagement services	General interventions related to treatment and recovery goals	Activities for a specific client to engage the client in making a decision to actively seek competitive employment or formal credit/certificate bearing education
Vocational assessment	As part of the mental health assessment	Assessment that is not part of the overall mental health assessment
Job development/job finding support	Therapeutic support to help client manage their illness as they work toward achieving their health and recovery goals	Activities for a specific client, directed toward helping them find and procure a job
Job retention supports	Therapeutic support to help client manage their illness as they work toward achieving their recovery goals Interventions carried out by mental health team members to help client function more effectively in the community and at work	Interventions targeted to helping client succeed on a specific job
DRS -- $1000 milestone payment for 15 days of job tenure **DRS** -- $1300 milestone payment for 45 days of job tenure **DRS** -- $2500 milestone payment for 90 days of job tenure		
Job leaving/termination supports	General therapeutic support	Interventions targeted to helping with leaving/ terminating a job

Kansas

Funding efforts for SE for persons with mental illness in Kansas occur in the publicly funded agencies of Medicaid and the state MHA, with some VR funding to a

limited extent. Medicaid covers SE in the state plan, and pays certified providers an enhanced rate for using the evidence-based approach. The MHA invests block grant dollars in training and technical assistance at the University of Kansas to certify providers in EBPs, and to conduct ongoing fidelity monitoring of providers. VR is a payer of last resort for SE services to individuals on Medicaid (i.e., pays for supports that are not covered by Medicaid) but does also cover employment supports for individuals who are not on Medicaid, whether insured privately or uninsured; and indicates that 36% of the persons it serves have a mental illness.

The University of Kansas developed a Medicaid billing guide for providers. The guide provides details about Medicaid reimbursable and non-reimbursable activities. The 1915(b) waiver services are provided by or under the supervision of a mental health professional. Providers have a specific SE code that is used when billing their SE-related activities. In addition, providers also may bill Targeted Case Management (TCM) for specific case management activities for individual clients (not groups of clients). SE-related activities that are not reimbursed include phone calls, outreach attempts, transportation (without the client present), and collateral contacts such as with VR, mental health therapist, etc. (A case consultation code is used in Medicaid but its use is restricted to providers of therapy services.) A few providers have Pay-for-Performance (P4P) contracts with VR that can offset some of their non-reimbursable Medicaid services. Most providers either provide those services without reimbursement or use a limited pool of general funds appropriated to each mental health center until those funds are exhausted.

Maryland

In Maryland, two state agencies, the MHA and the Division of Rehabilitation Services (DORS) are promoting and supporting IPS. The MHA manages the public mental health system (PMHS), which includes both Medicaid-funded mental health services and non-Medicaid supports funded by the state's general funds. SE providers are required to become certified vendors for both systems if they want to access funds. Components of SE services and related funding source are shown in Table 3.

The process begins when a prospective client informs a provider of their interest in employment. The SE provider requests prior authorization from the local MHA. If the person meets the criteria (is eligible for public mental health services), then state-funded pre-placement services (mental health vocational assessment, discussion with an ES, benefits counseling) start.

The mental health vocational assessment includes the information needed for DORS to determine eligibility. Individuals determined eligible for SE in the mental health system are **presumed** eligible for VR services. The DORS counselor can view the assessment and the treatment and rehabilitation plans in the web-based authorization system used by MHA. Then, DORS authorizes job development services. When a person starts a job, DORS authorizes intensive job coaching. To encourage job placement, MHA pays a state-funded fee when a person obtains a job. After the job

begins, state-funded SE services remain available as long as the person qualifies for PMHS. The person may also receive Medicaid-funded psychiatric rehabilitation if the person is eligible for Medicaid. Maryland also has a Medicaid Buy-In Program to enable people to maintain coverage while working.

TABLE 3. SE and Related Services with Funding Source		
Service	**Agency**	**Funding Source**
SE -- pre-placement (includes assessment and benefits counseling)	MHA	State-funded
Job development	DORS	Vocational Rehabilitation
SE -- job placement	MHA	State-funded
SE -- intensive job coaching	DORS	Vocational rehabilitation
Ongoing SE to maintain employment	MHA	State-funded
Clinical coordination for EBP SE	MHA	State-funded
Psychiatric rehabilitation	MHA	Medicaid

Washington

In addition to the State Plan services, Washington is able to provide three additional non-traditional service types defined within its waiver under the authority of Section 1915(b)(3): Mental Health Clubhouse, Respite, and Supported Employment. The Medicaid 1915(b)(3) waiver enables states to use savings associated with implementation of Medicaid managed care to provide additional services such as, SE. Managed care related savings are distributed to the 13 Regional Support Networks (RSNs, mostly counties, 12 of whom are non-profit). CMHCs contract with local RSNs to provide SE services for people with mental illness. The reimbursement mechanism can vary across RSNs (capitated, FFS, etc.). RSNs have the discretion on the nature of services (e.g., crisis management, respite care, or SE, and some do not cover SE) and how to pay for these federally funded vocational services such as those provided through the Division of Vocational Rehabilitation (DVR). Later, this requirement was further clarified to ensure that clients received services while awaiting DVR decision on eligibility.

The components of SE funded through the waiver system include:

- An assessment of work history, skills, training, education, and personal career goals.
- Information about how employment will affect income and benefits that the consumer is receiving because of their disability.
- Preparation skills such as resume development and interview skills.
- Involvement with consumers served in creating and revising individualized job and career development plans that include: Consumer strengths; Consumer abilities; Consumer preferences; and Consumer's desired outcomes.

- Assistance in locating employment opportunities that is consistent with the consumer strengths abilities, preferences, and desired outcomes.

- Integrated SE, including outreach/job coaching and support in a normalized or integrated work site, if required.

VR's primary SE responsibilities are intensive training and support services during the first 18 months as well as stabilization of SE. DVR reimburses providers using outcomes-based payments where a payment is made upon completion of a particular task, such as the completion of a plan of employment or job placement. Individuals generally begin receiving services through VR, but are able to begin receiving services through waiver funding if VR funding is unavailable, the individual is ineligible for VR, or if the individual already has a job but needs ongoing support (beyond the time-limited support available through VR).

In addition, in Seattle, funding from a 0.1% sales tax (approved by the King County Council (October 2008) and authorized by the state legislature) provides funding for SE services for people who do not have Medicaid coverage or for components of services that are not funded by the (b)(3) reinvestment. Eight of the mental health agencies in King County provide specialty SE services through this mechanism.

Challenges, Obstacles, Solutions, Lessons Learned

Based on the review of four states' experiences, it is clear that the coordination of state agencies including mental health, VR, and Medicaid, is particularly vital in organizing a viable and successful plan for funding IPS and CE services for people with mental illnesses.

Collaboration Between Mental Health and VR is Not Ideal.

In most case study states, the collaboration between mental health and VR is not at the level to support all components of the SE services. Leadership appears to affect the nature and extent of buy-in from both agencies. In all four states, the collaboration between mental health and Medicaid agencies has led to coordination of funding streams and activities to support the adoption and use of SE EBP among providers. While agencies do not blend their funding together, they have coordinated their activities leading to enhanced payment opportunities for providers and the use of high fidelity practices in Illinois, Kansas, and Maryland. However, in some states, the reimbursement rates are not in line with the amount of resources needed to provide SE services among people with serious mental illnesses. In all states, the dependence on state general funds for vocational services that are paid by the mental health agency does not promise a stable and sustainable funding stream due to shortfalls in state's budget.

Maryland has a relatively mature system in place that is established on a long standing collaboration between mental health and VR agencies. Leadership at both agencies have been instrumental in the development of such collaboration with mental health receiving the full support of VR after presenting data that evidence-based SE results in better rates of case closure compared with VR case closures among people with mental illness. Early on, the state decided to promote only evidence-based SE and this resulted in increased level of awareness, understanding, and experience in provision of SE for people with mental illness. SE providers are certified vendors of both the mental health and VR agencies which creates a single point of entry into the system. Single SE providers deliver discrete and mutually exclusive services in mental health and VR systems. VR counselors have guest access privileges for the related management information systems in order to follow rehabilitation and treatment information. The system is built on an enhanced funding principle based on the process measures that are based on the fidelity to the IPS model.

Access to VR Services is an Important Challenge for People with Mental Illness.

Individuals must meet the following three conditions to be eligible for VR services: (1) S/he must have a physical or mental disability which constitutes a substantial impediment to employment; (2) S/he must be able to benefit from VR services in achieving an employment outcome; and (3) S/he must require VR services to prepare for, enter, engage in, or retain gainful employment. In all four case study states, providers expressed that the rules and regulations around eligibility for VR services are not clear, and thus, are open for interpretation. They suggested that due to the differences in the interpretation of the regulations by the VR counselors, eligibility determinations are not uniform across the state regional areas. The requirement of health assessment to determine mental health disability, which may take up to 8 hours of medical examination, proves to be an important deterrent for people with mental illness to even apply for VR benefits. In addition, the average length of time to determine eligibility for services may be between 30 to 90 days after application. In some cases, individuals may not be able to receive Medicaid payments for vocational services (i.e., under a waiver program) while their application is pending with the state VR office.

Despite these issues affecting access to VR benefits, people with mental health disability constitute the largest group of clients for many state VR agencies. Nevertheless, there are possibly still many more potential clients with mental health disability who are having problems in accessing VR benefits. VR has been paying particular attention to tracking and reporting the prevalence of mental illness among persons they serve. However, this does not appear to be an indicator influencing how they adapt their program policies, rules, regulations or procedures and P4P program. While VR is emphasizing innovative P4P contracts, the milestones for payment create disincentives for providers working with persons with mental illness as persons with mental illness are less likely to meet the timelines in the VR P4P.

VRs Focus on Case Closure is not Aligned with IPS Principles.

VR has a particular focus on employment outcomes and case closures. However, the principles of IPS allow for rapid job search and trying a variety of jobs prior to maintaining stable employment. Thus, the principles of the IPS model can sometimes be at odds with the VR focus. In case study states, interviews showed that there is very limited implementation of co-location of VR counselors at CMHC. It is hard to build such relationships and hard to sustain traffic to sustain such VR resources on site. The incentives to serve people with mental illness should be aligned with all agencies' objectives and strategic missions. For example, VRs focus is on outcomes and the funding is contingent on performance. However, outcome-focused incentives may not always be consistent with the evidence-based approach to SE and/or the needs of persons with mental illness. It may lead to "cherry picking" selection (targeted selection) effect which is inconsistent with the IPS of SE. Since the evidence base is already established for IPS employment services, process based (e.g., fidelity) reimbursement mechanisms can improve access to services for people with mental illness by changing incentives, thus creating a reliable, sustainable funding system for providers.

TTW Payments are not Aligned with IPS Principles.

The goal of the TTW program is to increase opportunities and choices for Social Security disability beneficiaries to obtain employment, VR, and other support services from public and private providers, employers, and other organizations. The TTW program is for people who are already awarded Social Security disability benefits under the adult rules and are receiving cash benefits. Eligibility depends on making "timely progress" towards reaching employment goals -- that includes following work plan and meeting deadlines specified by the program.

SSA's TTW pays provider for milestones and outcomes achieved after Ticket assignment and after a Ticket holder goes to work. Milestones are triggered when a beneficiary's gross earnings are above the specified threshold, and outcome payments are attained when the beneficiary's net earnings are above Substantial Gainful Activity (SGA) and the beneficiary is in zero cash payment status. Phase 1 Milestones may not available to an EN if, during the 18 months prior to the beneficiary first assigning his/her Ticket, the beneficiary worked and had earnings at a level equal to or above the amount designed as the TWP level earnings for that year.

Individuals with serious mental illness are usually unemployed at program intake, take longer to obtain employment, require extensive postemployment support, and may not desire full-time employment with earnings above SGA, which threatens cash benefits and health insurance coverage. In all four case study states, state representatives and providers suggested that provider payment system offers too little financial incentive to serve certain clients, including those with mental illnesses and mental retardation. Since, actual earnings seldom reaches levels that would trigger payments to providers, it is still debatable whether the TTW program adequately compensates providers who serve people with psychiatric disabilities. In addition,

follow-up employment data collection proves to be a very costly effort and due to the risk of not getting an adequate level of reimbursement, mental health providers do not want to invest in a follow-up data collection process. Efforts to identify providers or entities, such as Medicaid managed care organizations, to become ENs have not materialized due to concerns about access to data, data tracking and timelines before outcome based reimbursement is received. Some providers and VR agencies interviewed during the case studies have engaged in TTW but do not feel that the principles of such payment is very much aligned with the IPS principles and the experiences of people with serious mental illness in the labor market.

One-Stop Career Centers do not have the Expertise to Serve People with Mental Illness.

There are very limited partnerships with DOL funded One-Stop Career Centers. CMHCs often do not have direct relationships with the Workforce Development Board and have little familiarity with the potential use of WIA funds. One-Stop Career Centers, in general, do not have expertise to serve persons with serious mental illness and in most cases they refer clients to VR agency. It appears that most One-Stop Career Centers have been trained and equipped with adaptive technologies to serve persons with physical disabilities and, to some extent, to serve persons with developmental disabilities; however, there have been almost no specific trainings related to serving persons with serious mental illness. In addition, the performance measures for One-Stop Career Centers (e.g., employment rate, earnings rate, literacy rate (youth), and retention) may create inadvertent disincentives to invest in serving persons with serious mental illness. In Washington State, the Work Force Development Board has been actively examining ways to improve access to their WorkSource Centers for people with mental illness and their participation in program services. Some WorkSource Centers in Washington have made attempts to increase access to people with mental illness through grant funds such as, CE and Disability Navigator Projects. However, such efforts were not sustainable after the grant funding ceased. Providers in Washington see CE as an innovative flavor of SE and see it as a valuable tool particularly for some people with mental illness that require a more individualized (customized) approach to employment. Also, in Washington State, Medicaid managed care savings go through RSNs -- mostly counties -- and the RSNs have a large variation in their approach to SE. The system may require changes in order to attain a consistent approach to SE service in Washington.

Stronger Federal Policies Coupled with Steady Federal Funding that is Based on Process Measures are Needed to Provide Employment Support to Individuals with Serious Mental Illness.

Stronger federal policies are needed to get states to commit to provision of vocational services for people with mental illnesses. Such policies should lead various state agencies to work together and collaborate effectively. These policies should be backed by a sustainable federal funding stream. Rules and regulations should be predictable, easy to understand, clear, and not left to individual interpretation. There is a

need for investment in the data infrastructure to streamline the processes and improve interagency collaborations in serving individuals. Also, providers and states need education, training, and technical assistance related to the most effective use of TTW funding. Collaborations and partnerships with DOL's One-Stop Career Centers and use of related WIA funds should be promoted. The incentives to serve people with mental illness should be aligned with all agencies' objectives and strategic missions. For example, VR's focus on outcomes and funding contingent on performance may be aligned with the VR's own mission but it may not always be consistent with the principles of IPS and/or the mission of DMH. Since the evidence base is already established for IPS SE services, process based (e.g., fidelity) reimbursement mechanisms can improve access to services for people with mental illness by changing incentives and create a reliable, sustainable funding system for providers. Attitudinal barriers and stigma regarding ability to work must be specifically addressed in federal agency policies and training. Training efforts to support individuals with disabilities must specifically address persons with mental illness and their right to work.

3. CURRENT STATE LEVEL MEDICAID FUNDING OPTIONS[3]

States use a range of strategies to cover services needed by individuals with mental illness to live and work in the community. Exactly what services are available and how they are used by providers to assist people in accessing and sustaining competitive employment varies and depends in part on how States use available Medicaid state plan options and waivers. It is important to keep in mind that the Medicaid program operates under broad federal guidelines but is administered by the states. This means that Medicaid programs vary considerably from state to state in terms of who is covered, services provided, and how those services are delivered. While there are certain mandatory benefits that must be covered through each state's Medicaid plan, such as outpatient hospital services, physician services, and emergency room care, states can elect to amend their Medicaid plan to include a variety of additional "optional" benefits. For example traditional behavioral health services such as diagnostic evaluations, individual therapy and medication management are often provided through the mandatory outpatient hospital benefit and/or the optional clinic benefit. The behavioral health services offered through the outpatient hospital or clinic options however, are limited in terms of service location and the types of providers who are eligible to deliver the services and under what conditions (e.g., must be provided under the direction of a physician). As discussed below, the limitations inherent in both the clinic option and the mandatory outpatient hospital benefit have led some states to pursue other optional benefits that allow for greater flexibility in service location, provider type, and benefit design so as to better serve individuals with mental illness in community-based settings.

Rehabilitation Option

The "Rehab Option" as this option is commonly referred, is used by states to offer services and supports to individuals with mental illness. 42 CFR §440.130(d) defines rehabilitation services as including, "any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." The advantage of using the Rehab Option as opposed to the Clinic Option is that it allows for greater flexibility in service location including home, work and other community settings, provider type, and benefit design. States have used the Rehab Option to cover illness management and recovery programs, peer specialists, ACT programs, community support programs, and mobile crisis intervention services.

[3] See Appendix A for the definitions of SE services under Medicaid program for the two states, Kansas and Washington, which have explicit definitions.

The Rehab Option as it relates to SE, can be used to offer those services that support an individual in their mental health recovery thereby assisting them in attaining and sustaining employment; as opposed to providing direct job placement activities or coaching/training on specific job-related tasks. Under the Rehab Option only those services and activities that are considered *rehabilitative* as defined in 42 CFR §440.130(d) can be covered. Services that are *habilitative* in nature are not permissible under the Rehab Option. A State Medicaid Director Letter from June 1992 distinguished the two by clarifying that the focus of rehabilitative services is to assist individuals in attaining their best possible functional levels; while habilitative services are intended to assist an individual in acquiring, retaining, and improving self-help and adaptive skills, but are not intended to remove or reduce individuals' disabilities.

For example, some states have elected to include services provided by peer specialists, someone who is a consumer of behavioral health services, under their Rehab Option. While a peer specialist could discuss with an individual how to better manage symptoms of her mental illness that interfere with her ability to maintain her job; using a peer specialist to teach her *how* to perform her specific job task(s) would *not* be acceptable under the Rehab Option. ACT is another example of a service covered by some states under their Rehab Option that includes a SE component. ACT is a nationally recognized EBP for treatment of individuals with serious mental illness. ACT teams will often include vocational specialists whose function is to assess for symptoms of the individual's mental illness that might interfere with the individual's ability to attain or sustain competitive employment, and plan and develop interventions that would promote that individuals' ability to obtain or maintain a job. The vocational specialist may work with the individual in developing a system to help them to remember to take prescribed medications during the work day. It is important to keep in mind however that the vocational specialist on an ACT team that is reimbursed using Medicaid dollars under the Rehab Option can only perform those activities that would be considered rehabilitative not habilitative. States have been audited by the HHS Office of the Inspector General for delivering services under the Rehab Option that upon audit were found to be habilitative not rehabilitative in nature.[4]

Targeted Case Management

Under 1915(g) of the Social Security Act, states may elect to provide case management services to a defined or "targeted" group of Medicaid eligible individuals, such as individuals with serious mental illness. The TCM option allows states to cover case management services for Medicaid beneficiaries only in specific geographic areas as opposed to the entire state, and/or to offer a benefit, case management, only to a particular population defined by the state rather than having to offer case management to all eligible beneficiaries. States specify who is qualified to deliver case management services under TCM, which may include criteria specific to working with a particular

[4] Crowley, J.S. and O'Malley, M. (August 2007). *Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

population. In the case of states that use TCM for persons with mental illness, the state may further limit TCM providers to specific, selected entities.

The case management interim final rule as updated by 74 FR 31183 in June 2009, describes the following as allowable activities under TCM:

- Assessment of an eligible individual to determine service needs, including those necessary to determine the need for any medical, educational, social, or other services.

- Development of a specific care plan that specifies case management goals and a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities to help an individual obtain needed services, including activities that help link the eligible individual with medical, social, educational providers, or other programs and services.

- Monitoring of the plan and performing follow-up activities necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual.

The advantage of using TCM is that it can be used to assist the target population with gaining access to needed medical, social, educational, and other services regardless if those services are covered by Medicaid. If a state has defined the seriously mentally ill as a target population, then a case manager could work with an individual who has expressed interest in working in gaining access to vocational services or job placement supports as specified in the individual's plan of care.

It is important to keep in mind that a case manager can only bill for those activities outlined above (e.g., assessment, plan development, referral, etc.) under the auspices of TCM. Other activities such as providing direct clinical or therapeutic services are not allowable activities under TCM. States must use other strategies (e.g., clinic option, services under the Rehab Option) to provide availability of Medicaid services that are indicated in a TCM plan of care.

1915(c) Home and Community-Based Services Waivers

States use 1915(c) waivers to offer an array of community-based services to: (a) persons over 65 or disabled, or both; (b) persons with intellectual or developmental disabilities; or (c) persons with mental illness, who might otherwise require costly institution-based care in a nursing facility, intermediate care facility for the mentally retarded (ICF-MR), or a hospital. States may also elect to include any optional eligibility groups that are included under their state plan in the waiver. This would include individuals covered under Medicaid "Buy-In" programs authorized by the Balanced Budget Act (BBA) of 1997 and the TWWIA of 1997. Medicaid "Buy-In" programs

(discussed in detail in a later section) allow working adults with disabilities whose income would otherwise make them ineligible for Medicaid to access Medicaid services and benefits by paying a deductible or income adjusted premium.

As mentioned above, while a 1915(c) waiver affords states the option to cover a myriad of services that providers could utilize to help individuals interested in working to attain and maintain competitive employment such as SE, job coaching, prevocational services, psycho-social rehabilitation services,[5] and case management, few states have utilized a 1915(c) waiver to offer home and community-based services (HCBS) to individuals with mental illness. To date only, a handful of states have used a 1915(c) waiver to cover services for adults with mental illness due to the difficulty in calculating cost-neutrality for individuals with mental illness because of the institutions of mental disease (IMD) rule. Under 1915(c) in order to be eligible for waiver services, the individual must meet established criteria for institutional level of care, which explicitly excludes IMD for individuals who are over 21 and under 65 years of age from the list of "qualified institutions".[6] Since an IMD is not considered a qualified institution,[7] this makes it difficult for states to use a 1915(c) waiver to support individuals with mental illness.

Additional issues of note when considering whether a 1915(c) waiver is the best approach for covering services for individuals with mental illness include:

- The 1915(c) waiver authority permits states to cap or limit the number of individuals served under the waiver. This has led to long waiting lists for access to waiver services in many states.

- For persons eligible for Medicaid through a "Buy-In" program (if included under the state's Medicaid plan), he/she must **also** meet the institutional level of care criteria in order to be eligible for the waiver. Currently states may only cover one target population per waiver. This regulatory requirement leads to states operating more than one waiver if they want to serve multiple target populations, even if those populations have similar functional limitations. However, through an Advanced Notice of Proposed Rule Making at 74 FR 29453, CMS has indicated this may change in the future.

[5] Psycho-social rehabilitation services covered under a waiver cannot duplicate services that are covered under the state plan unless the service(s) proposed under the waiver differ in nature, scope, supervision arrangement, or provider type from those offered under the state plan. Vocational services, prevocational services, and SE services cannot be covered using the psycho-social rehabilitation category.

[6] Qualified institutions under a 1915(c) waiver include hospitals, nursing facilities, and ICF-MRs.

[7] The IMD exclusion does not permit for federal Medicaid reimbursement for services provided to individuals between the ages of 22 and 64 in facilities greater than 16 beds and those where the current need for institutionalization for more than 50% of all the patients in the facility results from mental diseases.

1915(i) Home and Community-Based Services Option

For states interested in supporting individuals with serious mental illness in attaining and sustaining competitive work, the 1915(i) HCBS state plan option presents them with a vehicle to do just that. Differences in the design of the 1915(i), such as using needs-based rather than institutional level of care eligibility criteria, make it easier for states to develop services for persons with serious mental illness than under 1915(c). While the ability to offer HCBS including SE and prevocational services via a state plan option as opposed to a 1915(c) waiver or 1115 demonstration program, has been available to states since enabling legislation as part of the Deficit Reduction Act (DRA) was enacted in 2005, few states have taken advantage of this option. This was in part due the capping of financial eligibility at 150% of the federal poverty level (FPL) level. Because 1915(c) waivers allow states to enroll individuals with incomes higher than 150% of the FPL, states could not use the 1915(i) for persons with incomes greater than 150% of the FPL. Also individuals with disabilities eligible for Medicaid under "buy-in" programs with incomes greater than 150% of FPL were not able to take advantage of services such as SE available under 1915(i). States were also limited to a more restricted range of services than was allowed under the 1915(c) waiver program.

Section 2402 of the Affordable Care Act modifies the original legislation and makes major changes and improvements to how states may amend their state plans using the 1915(i) option; including changing the issues described above that made the 1915(i) option less attractive to states. These changes became effective October 1, 2010. Modifications to the 1915(i) state plan option as part of the Affordable Care Act include:[8]

- Permits states to propose additional HCBS beyond those that are defined in statute in order to design benefit packages that are customized to a particular population. For example, states are now able to cover non-medical transportation, home accessibility adaptations, and community transition services that were previously not permitted under the former regulations governing 1915(i).

- Under 1915(i) individuals do not have to meet institutional level of care in order to be eligible for the waiver; states develop criteria based on need. This allows states to offer HCBS to individuals whose needs are substantial, but not serious enough to meet institutional level of care.

- Offers states the option of expanding eligibility to 300% of the SSI Federal Benefit Rate (FBR) for those individuals who would otherwise be eligible for HCBS under 1915(c), (d), or (e) waiver or an 1115 demonstration program. This is a significant change from the prior iteration of 1915(i) as it allows States to create a new optional eligibility category, allowing them to extend the services available as part 1915(i) to more individuals than previously allowed.

[8] For more information, please refer to State Medicaid Director Letter #10-013 from August 6, 2010.

- Services offered under 1915(i) must be offered statewide.

- States are now permitted to target 1915(i) benefits to certain populations (effectively waiving the comparability requirement) to allow them to design different benefit packages for different target populations. For example, states could design a benefit package to meet the needs of individuals with serious and persistent mental illness.

- States are no longer allowed to limit the number of individuals who can receive services offered as part a state's 1915(i) Services State Plan Option or create waiting lists. This important change to 1915(i) will allow more individuals to take advantage of HCBS that can assist persons in gaining and sustaining employment.

TABLE 4. Comparison of 1915(i) under DRA and the Affordable Care Act		
	1915(i) under DRA	**1915(i) as amended by Affordable Care Act**
Geography	Could limit to certain geographic areas or political subdivisions	Must be available statewide
Financial eligibility	Up to 150% of FPL	Up to 300% of SSI FBR as long as the person meets criteria for an existing 1915(c) waiver or 1115 demonstration.
Non-financial eligibility	States develop needs-based criteria.	States develop needs-based criteria can tighten needs-based criteria but must continue to offer services to eligible persons served under the former standards.
Targeting criteria	Not allowed to target benefits to certain populations	Can target to certain populations and can have more than one benefit by target group.
Services	States not permitted to propose "other services" as available under 1915(c)	States permitted to propose all services available under 1915(c) including "other services."
Number served	Could place caps on the number served and maintain waiting lists.	Must be available to all eligible Medicaid beneficiaries without limitation.

If states elect to pursue the 1915(i), it is an opportunity to provide individuals with mental illness a more comprehensive array of HCBS that could support them in attaining and sustaining competitive employment. There is no cost-neutrality requirement in the 1915(i) state plan option nor do individuals have to meet institutional level of care criteria; these functional differences in the structure of 1915(i) reduce historical barriers to states covering HCBS for individuals with serious mental illness.

Additional Medicaid Strategies

Additional strategies that states can use alone or in combination with some of the strategies outlined above to offer services and supports necessary for individuals with mental illness to participate in competitive work include:

- **1115 Research and Demonstration Programs** are used by states to design and test policy innovations that "further the objectives of the Medicaid program." States have used their 1115 authority to expand eligibility to otherwise ineligible groups such as childless adults, to provide for services not typically covered, and employ innovative service delivery and reimbursement systems.

- **1915(b) Managed Care/Freedom of Choice waivers** are used by states to require the enrollment of eligible individuals in managed care (including persons dually eligible for Medicare and Medicaid) and/or limit the number of providers. Savings under 1915(b)(3) can also be used by plans to cover additional services such as SE. Many states also elect to operate 1915(b) waivers concurrently with 1915(c) HCBS waivers in order to employ managed care strategies in the operation of the waiver.

- **Section 1915(a)** of the Social Security Act allows states to contract with a managed care vendor(s) to manage services for Medicaid beneficiaries who voluntarily elect to enroll in the managed care plan. It is important to note that 1915(a) and the 1932 SPA authority described below are managed care enrollment authorities only and must be joined with other strategies in order to offer HCBS services for individuals with mental illness.

- **1932 State Plan Amendment** authority allows states to enroll certain allowable populations into managed care without a waiver. Enrollment in managed care under this authority must be voluntary for dually eligible persons, Native Americans (unless meeting certain standards), and certain children with special needs. Authorized as part of the BBA and TWWIA Medicaid "buy-in" programs have been used by many states to afford access to Medicaid services and benefits for working adults with disabilities whose income would otherwise make them ineligible for Medicaid. As commercial employer-sponsored insurance plans do not provide the array of services that are offered under Medicaid (e.g., psycho-social rehabilitative services, HCBS, etc.), Medicaid buy-in programs are an important tool for those individuals with mental illness who want to work but would be challenged to gain or maintain employment without access to the services and supports covered under Medicaid. In order to "buy-in" to the program individuals pay a premium adjusted for their income. It is important to note that this provides an opportunity for persons to obtain access to Medicaid services only and must be joined with other strategies in order to offer SE for individuals with mental illness.

- Administered by the CMS the **Medicaid Infrastructure Grant (MIG)** program has been used by states to remove barriers to employment for individuals with disabilities. Authorized under Section 203 of the TWWIA, MIGs are designed to assist states in implementing Medicaid "buy-in" programs, developing comprehensive employment systems that promote linkage between Medicaid and non-Medicaid services. 2011 is the final year for which Congress has authorized funding for the MIG program.

- **Money Follows the Person Rebalancing Demonstration** was enacted by the DRA of 2005. It is part of a comprehensive, coordinated strategy to assist states, in collaboration with stakeholders, to make widespread changes to their long-term care support systems. The aim is to reduce their reliance on institutional care, while developing community-based long-term care supports, enabling the elderly and people with disabilities to fully participate in their communities.

Guidance to States

Given the time and significant resources involved in making changes to a state's Medicaid platform (use of state plan options and/or waivers), it is unlikely that a state will pursue developing a waiver or amending their state plan simply to add SE as a covered service. The work described above will likely be conducted as part of larger initiatives going on in the state that might include:

- Developing EBPs.

- Rebalancing the long-term care system.

- Maximizing opportunities for federal match.

- Promoting recovery-oriented care for individuals with serious mental illness.

- Reducing unemployment among individuals with disabilities.

SE should be introduced as an important option for meeting the goals of any of the initiatives outlined above. The benefit to including SE in these discussions is that by offering an individual with serious mental illness the opportunity to engage in meaningful work states can simultaneously meet broader goals and initiatives that benefit other stakeholders as well. States should undertake the following steps:

First, states should begin by identifying what system outcomes they want to achieve. States would benefit in discussions with consumers and stakeholders including individuals affiliated with local mental health recovery communities or clubhouse programs, service providers, the state National Alliance on Mental Illness chapter, State Mental Health Planning and Advisory Councils, and other advocacy

organizations. These groups can provide information about necessary services and supports.

Second, states need to project the financial resources needed to achieve the identified goals. This includes expected cost for services based on and numbers of persons who may use the service.

Third, states need to assess how they are currently expending their dollars for persons with mental illness across funding streams. Are they attending day treatment or partial hospital programs, participating in sheltered workshops, living in hospitals? In many instances, these individuals are receiving other Medicaid or state-funded services that for many, SE could replace. This analysis will help identify opportunities for re-direction of funds from high-cost poor-outcome services to SE services.

Fourth, states need to examine their current Medicaid platform and assess their ability to use those strategies to fund SE and other services, such as case management, that are necessary to successfully deliver SE to persons with mental illness. This analysis will inform states on whether their existing Medicaid program can be amended to include SE and other services; or if they would have to seek new options or waivers for such coverage.

Finally, while understanding Medicaid opportunities is key, the next step for states involve identifying strategies to collaborate across funding streams such as amongst the Medicaid agency and the state mental health and VR authorities. Given that Medicaid has certain restrictions and limitations on its use, identifying possibilities where Medicaid dollars can be blended or braided to more fully exploit the possibilities for bringing evidence-based SE programs to scale in the state is crucial. This is especially true in light of findings that suggest that programs that integrated mental health care with vocational support services had the best employment outcomes.[9] For example it might be that covering the service of "supported employment" through a 1915(c) waiver or 1915(i) SPA is not necessarily what is needed (or even allowed if offered by the state under the Rehabilitation Act or Individuals with Disabilities Education Act for transition-age youth). For some states using the available Medicaid options to develop a more robust array of clinical supports for individuals with mental illness that can be integrated with vocational services is the most feasible option. For example including peer counselors as a covered service under the Rehab Option who can work as part of a team that might include a case manager funded under the TCM option, who coordinates a range of needed supports and services, and an ES paid for through VR dollars, might be one option for bringing SE to scale.

[9] HHS, SAMHSA. *Supported Employment: A Guide for Mental Health Planning and Advisory Councils.*

Summary of Findings -- State Funding of Individual Placement and Support/Customized Employment

In summary, we find that the limited implementation of IPS/CE is due in large measure to the difficulty states and local programs have in using the various mainstream funding mechanisms that could be used to finance IPS/CE. There are (or have been) a variety of sources to fund IPS/CE -- direct grants and contracts from states (e.g., from state VR and behavioral health agencies) and the Federal Government (e.g., from DOL and SAMHSA), various strategies for Medicaid reimbursement, TTW from the SSA, and partnership agreements between behavioral health agencies and VR agencies. States and local providers each describe considerable difficulty in obtaining and utilizing these resources to finance IPS/CE on an ongoing basis. It often takes personal relationships to build the partnerships required, and these can end when the individual leaders change positions. Some of the grant programs have disappeared. And some of the potential financing mechanisms are complex and difficult to implement, particularly Medicaid.

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APPENDIX A. STATE SERVICE DEFINITIONS

State of Kansas -- Rehabilitation Option Service Definition

The State of Kansas has a Rehab Option service (defined below) that when used with a separate code and modifier indicates the delivery of SE components that are Medicaid reimbursable.

<table>
<tr><th colspan="2">COMMUNITY PSYCHIATRIC SUPPORT AND TREATMENT (CPST)</th></tr>
<tr><td colspan="2">Definition</td></tr>
<tr><td colspan="2">Goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the consumer's individualized treatment plan. CPST is a face-to-face intervention with the consumer present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the person lives, works, attends school, and/or socializes.</td></tr>
<tr><td colspan="2">Components</td></tr>
<tr><td colspan="2">A. Assist the consumer and family members or other collaterals to identify strategies or treatment options associated with the consumer's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the consumer's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.

B. Individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the consumer, with the goal of assisting the consumer with developing and implementing social, interpersonal, self care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.

C. Participation in and utilization of strengths based planning and treatments which include assisting the consumer and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness.

D. Assist the consumer with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the consumer and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

E. Evidenced Based Practices which include integrated dual diagnosis treatment, strength based service delivery, and employment supports are included.</td></tr>
<tr><td>Provider Qualifications</td><td>Eligibility Criteria</td></tr>
<tr><td>Must have a BA/BS degree or four years of equivalent education and/or experience working in the human services field.

Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program.</td><td>Meets functional assessment criteria for target population.

Meets Medical Necessity criteria for rehabilitation services</td></tr>
</table>

Limitations/Exclusions	Allowed Mode(s) of Delivery
Ratio: Caseload Size must be based on the needs of the clients/families with an emphasis on successful outcomes and consumer satisfaction and must meet the needs identified in the individual treatment plan. The following general ratio (Full-time equivalent (FTE) to Medicaid Eligible) should serve as a guide: – 1 FTE to 15 youth consumers – 1 FTE to 25 adult consumers – No other limitations apply	Individual On-site Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.

2. EBP's require prior approval and fidelity reviews on an ongoing basis as determined necessary by the State MHA.

3. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a Qualified Mental Health Professional or PAHP-designated LMHP with experience regarding this specialized mental health service.

Reimbursement and Coding Summary

HCPCS Code	Modifier (1)	Modifier (2)	Provider Qual.	Tx. Context	Description	Units
H0036	HA		BA/BS	Ind.	CPST -- Child	15 Min.
H0036	HB		BA/BS	Ind.	CPST -- Adult	15 Min.
H0036	HH		BA/BS	Ind.	CPST -- EBP Integrated Dual Diagnosis	15 Min.
H0036	HK		BA/BS	Ind.	CPST -- EBP Strength Based	15 Min.
H0036	HJ		BA/BS	Ind.	CPST -- EBP Employment Support	15 Min.

State of Washington Service Definition -- 1915(b)(3) Waiver Definition

Supported employment is a service for Medicaid enrollees who are not currently receiving federally funded vocational services such as those provided through the Department of Vocational Rehabilitation. Services include:

- An assessment of work history, skills, training, education, and personal career goals.

- Information about how employment will affect income and benefits the consumer is receiving because of their disability.

- Preparation skills such as resume development and interview skills.

- Involvement with consumers served in creating and revising individualized job and career development plans that include:
  (a) Consumer strengths
  (b) Consumer abilities
  (c) Consumer preferences
  (d) Consumer's desired outcomes.

- Assistance in locating employment opportunities consistent with the consumer's strengths, abilities, preferences, and desired outcomes.

- Integrated SE, including outreach/job coaching and support in a normalized or integrated work site, if required.

- Services are provided by or under the supervision of a mental health professional.

- Other supportive employment services that cannot legally be provided by a VR program, such as extended services defined under the federal Rehabilitation Act.

FEDERAL FINANCING OF SUPPORTED EMPLOYMENT AND CUSTOMIZED EMPLOYMENT FOR PEOPLE WITH SERIOUS MENTAL ILLNESS

Reports Available

Federal Financing of Supported Employment and Customized Employment for People with Mental Illnesses: Final Report

HTML http://aspe.hhs.gov/daltcp/reports/2011/supempFR.htm
PDF http://aspe.hhs.gov/daltcp/reports/2011/supempFR.pdf

Toward a Social Cost-Effectiveness Analysis of Programs to Expand Supported Employment Services: An Interpretive Review of the Literature

HTML http://aspe.hhs.gov/daltcp/reports/2010/supempLR.htm
PDF http://aspe.hhs.gov/daltcp/reports/2010/supempLR.pdf

To obtain a printed copy of this report, send the full report title and your mailing information to:

U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

NOTE: All requests must be in writing.

RETURN TO:

Office of Disability, Aging and Long-Term Care Policy (DALTCP) Home
http://aspe.hhs.gov/_/office_specific/daltcp.cfm

Assistant Secretary for Planning and Evaluation (ASPE) Home
http://aspe.hhs.gov

U.S. Department of Health and Human Services (HHS) Home
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