Recommendations for Utilizing Medicaid Rehabilitation Option (MRO) Services as the Services Platform for the Indiana Permanent Supportive Housing Initiative

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PURPOSE

The purpose of this paper is to report findings and recommendations from an analysis of the fit between needed services for people to access and sustain permanent supportive housing as part of the Indiana Permanent Supportive Housing Initiative (IPSHI) and the proposed services under Indiana's Medicaid Rehabilitation Option (MRO). This report also provides information on the Medicaid and SSI/SSDI eligibility of potential IPSHI project recipients and on key cross cutting management issues associated with implementing the Permanent Supportive Housing (PSH) and MRO initiatives.

BACKGROUND

In January 2008, the Indiana Housing and Community Development Authority (IHCDA), the Transformation Work Group (TWG) of the Division of Mental Health and Addiction (DMHA) in the Indiana Family and Social Service Administration, the Corporation for Supportive Housing (CSH), and the Great Lakes Capital Fund launched the Indiana Permanent Supportive Housing Initiative (IPSHI). The IPSHI is a public/private venture designed to develop a minimum of 1,100 permanent supportive housing units in Indiana over six years for persons who are homeless with challenges of mental illness and substance abuse.

In March 2008, the State's Transformation Work Group adopted IPSHI as a strategic goal for Transformation. A Supportive Housing Work Group was convened as part of the Transformation process. A sub-committee of the Work Group was created to focus on the development of a fidelity model for permanent supportive housing and address service funding to support the model. The sub-committee includes DMHA, OMPP (Office of Medicaid Program and Policy), IHCDA, and CSH. The Technical Assistance Collaborative (TAC) is providing technical assistance and consultation to this effort.

In September 2008, the group began discussion of the mutuality of the IPSHI housing goals, the State's Transformation Plan, and the State's work to improve the financing and delivery of mental health services through re-defined Medicaid Rehabilitation Option (MRO) covered services. Specifically the group discussed how to forge a clear linkage between the PSH units

being developed and the services needed to support people in these units. The group also addressed which people are eligible and what services can be covered by Medicaid and what needs to be covered through other funding sources either because of eligibility restrictions or timeliness of coverage or because the services are not coverable.

The sub-committee developed a scope of work and defined the components necessary to develop a successful PSH model for Indiana. This committee completed its first task, a **crosswalk of the services needed in permanent supportive housing and services in the proposed updating of the state's MRO**. The crosswalk identifies services that are covered through the Medicaid Rehabilitation Option as defined by the Finance and Delivery Transformation work for individuals who are eligible for Medicaid, and also those services that need to be funded through other sources. The crosswalk includes the role of property management in supportive housing and includes a description of the role of property management in supportive housing and the link between property management and services. The PSH/MRO crosswalk was also aligned with CSH's ***Dimensions of Quality***. This crosswalk has emerged as a fidelity model for what is needed to make permanent supportive housing successful and has been recognized as a key component of the State's Recovery Model. The PSH/MRO initiative is an important element of mental health system transformation because:

- **There is a significant body of evidence that permanent supportive housing (PSH) works for people with disabilities, including those with the most severe impediments**. Individuals with the most severe impediments may benefit the most. People with disabilities vastly prefer to live in their own apartment or their own home and supportive housing is less costly than other forms of government-financed housing or residential services. Studies show that PSH leads to greater housing stability, improvement in mental health symptoms, reduced institutionalization, and increased life satisfaction. Adequate stable housing is a prerequisite for improved functioning for people with disabilities; it is a powerful motivator for people to seek and sustain treatment and it is cost effective.

- **Permanent supportive housing is effective when it is created with quality rental housing stock with a deep rental subsidy so people living on very low fixed incomes can afford to live in the community.** Rental resources can come from Housing Choice Vouchers (Section 8), other housing subsidies availability through public housing authorities, McKinney-Vento Homeless Assistance Act funds, and/or deeply discounted rents in units subsidized with tax credits, trust funds, or other sources. People using one of these sources have a standard lease that defines tenant protections but also defines responsibilities for the lease holder. People can access housing even with credit problems or some history in the criminal justice

system through reasonable accommodation. The IPSHI is uniquely positioned to gain access to these resources on behalf of people with behavioral health and other disabilities.

- **People will more likely be successful in this type of housing if they have assistance in obtaining and sustaining this housing, if they have a choice in housing, and if the housing is not conditioned on treatment.** Providing services so a person can be successful in their own home is often the major determining factor in a person thriving in the community. The types and amount of services and supports tailored for and successful with this approach are now well defined. Services are individualized and provided in the home and community, and when necessary, include harm reduction, crisis intervention, assistance with negotiating with landlords, neighbors and others, community orientation, and often self monitoring and life skills training. These skills are not necessarily transferable without planning, adaptation, training, and careful oversight.

The body of literature documenting effectiveness of permanent supportive housing is growing and is bolstered by cost effectiveness data emerging from studies from Seattle to Chicago to Massachusetts and Maine and states in between. A summary of this data is referenced in ICDHA's White Paper: "Cost Effectiveness of Permanent Supportive Housing" (August 2009) outlining benefits for Indiana. While this paper focuses largely on the studies of outcomes in PSH projects for people who are homeless, there is strong efficacy of PSH when this approach is used systemically for other target populations as described in TAC's "Literature and Bibliography on Supportive Housing Best Practices" (2010). Most studies show the cost benefit accruing to health care and to a lesser extent behavioral health care. This is largely the result of people benefitting from PSH after continuous or significant episodic use of long term, emergency and/or acute care prior to being offered PSH.

In June 2009, the workgroup decided the model of services described in the crosswalk could serve as the practice and fidelity model for permanent supportive housing service delivery for IPSHI projects. Further, the workgroup decided to utilize the organizations participating in the Institute to assess the feasibility of this model as the MRO initiative begins. The goal was to evaluate effectiveness and practicality of these services and this type of funding. *The added benefit to testing this alignment is the information it can provide for assessing the cost effectiveness of permanent supportive housing for the DMHA priority groups, including people leaving psychiatric institutions and people utilizing high cost Medicaid and other stated funded mental health, addiction, and health related services.*

SUMMARY OF ACTIVITIES

The IPSHI Provider Task Force tested the proposed services model utilizing Medicaid Rehabilitation Services as the primary service platform for persons in permanent supportive housing to determine:

- The number of people receiving SSI or SSA disability benefits prior to or after accessing permanent supportive housing and the time between application and receipt;
- Direct services staff time, by type of direct and ancillary service activity at the unit level, necessary for people to be successful in permanent supportive housing; and
- Other service provider activities essential to the success of PSH, includes the funding and organizational arrangements needed for this initiative to be successful.

Timeframe and Process: The Provider Task Force began meeting in October 2009 and completed their tasks during November and December 2009. At the October meeting, IPSHI representatives provided an overview of the proposed tasks, discussed the PSH/MRO crosswalk, and carried out a pre-test of the simulated time study.

The Provider Task Force members and staff in their organizations completed two tasks. The first task was to determine the percent of persons accessing benefits and the amount of time and effort associated with accessing benefits for consumers. The second task was a simulated 'time study' of direct services for a one-month period. For this study, staff completed weekly worksheets for two to four weeks displaying their time in fifteen minute increments for:

- Direct services potentially billable under the Medicaid Rehabilitation Option (MRO) such as case management and skill training and development;
- Non billable support services activities such as travel, training, documentation, staff meetings, supervision and leave; and
- Activities related to outreach and engagement and property manager/landlord contacts.

This time study was conducted as a simulation using mock profiles of persons with severe mental illness, including those with addiction disorders who have histories of multiple hospitalizations, homelessness, and disruptive lives, and for whom living in PSH would be a significant challenge to them and to staff assisting them.

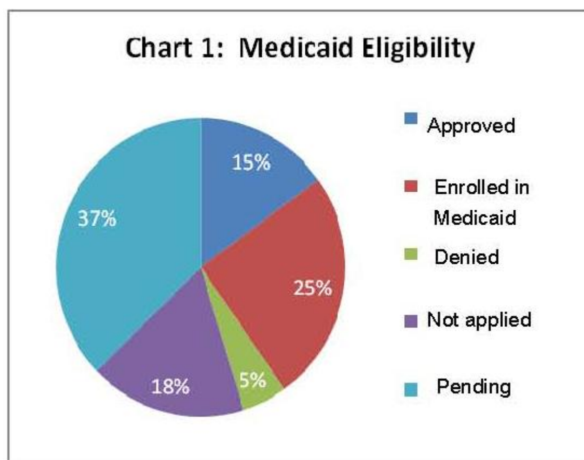
In addition to the above data collection tasks, each agency assigned administrative staff to participate in key informant interviews to discuss their perspective of activities and resources

essential to successful implementation of permanent supportive housing. The key informant interviews also elicited information on the management tasks related to coupling the housing projects with the provision of services covered by the proposed MRO.

ELIGIBILITY ANALYSIS

Table 1 depicts the eligibility of a cross section of persons from four CMHC IPSHI caseload (N=40) for SSI/SSDI and Medicaid who had entered the program in 2009. This analysis was conducted to determine the percentage of people on each agency's caseload who have applied for benefits, the status of their applications, and the amount of time between application and receipt of benefits. This analysis is consistent with expectations for a ***new*** caseload of people entering PSH primarily aimed at persons who have experienced homelessness prior to their admission into the program. It is fairly consistent with percentages found for people entering PSH from institutions, jails, or prisons.

Of people entering the program, 25 percent were already enrolled in Medicaid. An additional 15 percent were approved for and enrolled in Medicaid after entering the program; 37 percent of people had made an application which was pending.



The average time from application to approval for Medicaid was slightly less than four months. Five percent of applicants had been denied at the time of the survey and 18 percent who recently entered the program had not yet applied for Medicaid. These findings suggest that over time a majority of project participants can be made eligible for and be enrolled in Medicaid. However, it appears this does not happen immediately.

Forty eight percent of the sample was receiving either SSI or SSDI benefits. Eighteen percent were still appealing a denial of benefits at the time of the survey; several have appealed multiple times. Eight percent were pending approval and 10% were denied and were no longer appealing their denial. Ten percent had not made application at time of the study. This can be interpreted to project forward that at best, 75 percent of recipients will have a modest income to live on and 25 percent will likely have no income, at least during the first few months of tenancy.

TIME STUDY DATA ANALYSIS

Tables 1-4 depict direct and services support activity for five community mental health agencies (Dunn/Centerstone, CMHC, Regional, Southwestern, and Midtown) during the time study period. The centers were asked to report their total time over a one-month period. Each agency utilizes staff somewhat differently depending on their staffing approach and size of their program. However, these differences were adjusted to assure comparable reporting across agencies. A review of the data did not reveal any variations, such as extended leaves or other variables that might have skewed the data. This study did not include any analysis of cost associated with the time spent in each activity.

Table 1 reflects the breakdown between time spent in direct client and collateral contacts as defined in Indiana's proposed MRO service definitions, time (costs) that are directly allocable to individual practitioners spent in activities that support this direct service and time spent in unique Permanent Supportive Housing activities that support people getting and keeping housing. It is incumbent for providers to develop business and clinical practice to assure staff carry out these functions.

Generally providers set productivity targets for direct staff at 55-65% percent of their available time to cover their costs and deliver quality services. Allocable costs include those costs which are critical to practitioners providing services including supervision, trainings, documentation and record keeping, travel and other administrative activities.

As reflected in the PSH-MRO Crosswalk, providers perform two unique duties that are essential to the success of PSH. One is engaging people who have been chronically homeless or cycling in and out of homelessness and institutions, as well as people who have been institutionalized for a long period of time assuring persons they serve will accept housing and can become eligible for housing as well as eligible for services. These activities often occur before or at the same time Medicaid eligibility is being established. Second, PSH providers must secure and maintain contact and agreements with property managers and landlords. A portion of time spent in this activity is not consumer specific or part of the individual consumer's recovery planning. While it is possible this can be accomplished as part of a provider's business practice, it is not advisable to assume this can be fully accomplished as part of standard business practice.

This analysis reveals that the IPSHI PSH and the proposed MRO services paradigms are compatible, that staff can meet likely productivity requirements and agencies can retain fidelity

to PSH. There are limited but necessary engagement, outreach and property manager/landlord liaison activities.

Table 1: Total Service Activity

Activity	% of Time
Time spent delivering MRO services	57%
Time spent in allocable activities (travel, documentation and record keeping, staff meetings, training, and leave time)	36%
Time spent in activities related strictly to PSH (outreach, property/landlord contact)	7%

Direct Service (Billable) Activities

The agencies were asked to report on Case Management and Skill Training and Development at the sub-service (activity) level as depicted in **Table 2**. This table presents a breakdown of the percentage of time reported in each of the listed sub-service activities as a percentage of billable time.

Table 2: Direct Service (Billable) Activity

Activity	% of time
Case Management	
1. Needs Assessment	7%
2. Service Planning Development	7%
3. Referral and Linkage	9%
4. Monitoring and Follow-up	11%
5. Evaluation	6%
Skill Training and Development	
1. Training in illness self-mgmt.	8%
2. Skills training (food prep, money mgmt., maintaining a living environment)	11%
3. Training in use of community services	11%
4. Medication related education and training	12%
5. Training in skills related to locating and maintaining a home	16%
6. Social skills training related to work environment	2%

Non Billable Activities

Typically, administrative activities such as: documentation, travel, staff meetings, and supervision are typically built into a rate calculation.

Table 3: Direct Allocable Activities

Routine Non Billable Activities	% of total time	% of non billable
1. Staff meetings, training, and supervision	10%	27%
2. Record keeping and documentation	9%	22%
3. Travel	3%	6%
4. Leave and Other	14%	29%

Table 4: Supportive Housing Related Activities

Supportive Housing Related Non Billable Activities	% of total time	% of non billable
1. Property Manager/Landlord contact	2%	5%
2. Outreach/Engagement	5%	11%

Key Informant Interviews

Seven key informant interviews were held with community mental health administrators and staff directly responsible for supportive housing projects across the sites during November 2009. Key informants were queried about their project approach, their history with supportive housing, and their approach to activities listed on the PSH-MRO Crosswalk (size, start-up and management challenges, how responsibilities are aligned within their agency and allocation of time across the various duties). In addition, there were qualitative and process questions regarding preparation for MRO changes, workforce issues, and staff performance.

With respect to their approach to PSH, all the respondents appear to understand the desired PSH approach and relationship between their work in PSH and the MRO changes to the degree that the information about these changes was available at the time of the interview. Several respondents expressed some concern about workforce preparation and the degree to which there would be a steep learning curve for staff taking on PSH and MRO changes simultaneously. In addition, several respondents displayed a high level of understanding of the differences between providing residential services and providing PSH-related services. One respondent

spoke to the paradigm shift that needs to occur with staff as they move toward doing more PSH.

Perhaps the most striking response from several informants was that they would find a way to make these changes work within their agency with current resources because it was the right thing to do and because it was worth the effort, meaning they do this not because they are paid to do it but because it is the right thing to do. Several respondents described staff being asked to wear multiple hats so that their agency could actively pursue PSH. This means managing PSH services delivery along with their other assigned duties. Additionally, one person indicated the time study reinforced what they already knew about how staff time was allocated.

It became clear during the key informant interviews that the agencies selected for participation in the time study have 'self-selected' PSH as a strategic and worthwhile endeavor. All of the interviewees understood the value of the program and the challenges of changing their business and clinical practices to achieve fidelity to the PSH model. While this is a positive reflection on the IPSHI, it remains to be seen how widespread this awareness is with the entire community mental health provider community in Indiana. It also speaks to the need for support for these providers. IHCDA is committing substantial resources that if continued would significantly expand PSH in Indiana. Based on experience in other states, this level of commitment requires a concomitant investment of direct services and services administrative support. To go to scale, provider agencies will need to increase their administrative capacity to manage these programs beyond trying to do it because it is the right thing to do.

RECOMMENDATIONS

The efficacy of using the MRO as described in the draft MRO documents as the principle service resource for PSH in Indiana is indisputable – it works. Housing is a great stabilizer and people who have histories of refusing to enter the service system or who have dropped out but have very compelling service needs often do well in supportive housing particularly if they are provided choice of units, services are flexible, the housing is affordable, and community resources are accessible. Moreover, there is growing and extensive body of research on the efficacy of PSH for very high cost users of emergency rooms, hospital, residential treatment, and nursing homes and other high cost services interventions. Hence, providing and/or arranging for assistance to consumers with getting and keeping a home is an important endeavor for DMHA and local service providers. With the leadership of the IPSHI, the CMHCs in Indiana can help making supportive housing possible and successful for consumers. If

strategically pursued, PSH can also have an extremely positive impact of the costs of health care and other public services in the state.

This initiative requires consistent clear leadership and additional steps to: (1) provide clarity for CMHCs on how to build capacity and proceed to implement PSH; (2) assure Medicaid eligibility is pursued in a timely fashion; and (3) assure regulatory and implementation support of PSH; (4) assure CMHCs can meet MRO standards and achieve fidelity to PSH simultaneously; and (5) assure CMHCs can cover costs associated with effectively implementing PSH.

There are three types of costs associated with implementing the program. The first is the cost to providers of building capacity to deliver services. Judging from key informant interviews, the IHCDA-CSH PSH Institute appears to be an excellent venue for assisting providers to build capacity and is recommended as one approach to accomplish this recommendation. However to do this, DMHA and OPP need to be full partners with IHCDA and CSH assuring providers have the tools and support to meet MRO standards with fidelity to PSH simultaneously. Pre-service training can be helpful to achieving this goal but experience shows staff will need to adopt new skills to shift to the PSH service delivery model that requires resources well beyond pre-service training. This includes resources dedicated to periodic internal and external fidelity reviews and to mentoring and coaching staff who are being asked to shift to delivering PSH services.

The second cost is the direct services cost for interventions for consumers who have not been made eligible for benefits at the time they enter the program. Engaging people when they are living on the street or in a shelter, in jail, or institutionalized can take several months. Providers are more likely to take referrals of more severely disabled individuals who are either homeless or living in a setting where they were precluded from being eligible for benefits if they can be reimbursed during the 'engagement' period. Engagement typically takes three to four months and this study revealed that it takes approximately the same amount of time for potential PSH recipients to gain access to Medicaid benefits. This will have a greater impact during the first year or "start up" year for a PSH project because most new participants are not yet eligible for benefits. In subsequent "maintenance" years, there will likely be a 15-20 percent turnover in PSH tenants, meaning this percentage of participants are not going to be eligible for Medicaid for 90 to 120 days per year. However, since IHCDA will continue to fund new PSH projects, "start-up" will be continuous in some communities. Thus "start-up" and "maintenance" may be blurred and planning for such is advised.

The third cost relates to the administrative level of effort necessary to facilitate and sustain positive working relationships between the services and the housing components of PSH. This

includes active coordination of the roles and responsibilities of both services staff and property managers or landlords. From a direct services perspective this is likely 5 percent of the cost of delivering services. If these PSH related administrative costs are added to the costs associated with the costs associated with serving people not yet Medicaid eligible, it is likely to be 20-25% of the cost of serving someone in PSH.

In summary, the services in the Medicaid Rehabilitation Option can be utilized as the primary service model for people in PSH. There are costs for PSH providers to deliver high quality PSH services, particularly for people who have not had stable housing or been living successfully in the community beyond what is reimbursable in the MRO. However, these costs can either be identified and incorporated into a single per diem for a PSH definable service to be used concurrently with MRO services. If funds are available for this purpose, Indiana can benefit tremendously from the housing and services resources that come with PSH.