

Members

Rep. Charlie Brown, Chairperson
Rep. Cindy Noe
Sen. Connie Lawson
Sen. Timothy Skinner
Kathleen O'Connell
Stacey Cornett
Margie Payne
Ronda Ames
Valerie N. Markley
Bryan Lett
Caroline Doebbling
Kurt Carlson
Chris Taelman
Jane Horn
Rhonda Boyd-Alstott
Dr. Danita Johnson Hughes



COMMISSION ON MENTAL HEALTH

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Authority: IC 12-21-8.5

MEETING MINUTES¹

Meeting Date: October 27, 2010
Meeting Time: 12:30 P.M.
Meeting Place: State House, 200 W. Washington St., House Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 3

Members Present: Rep. Charlie Brown, Chairperson; Rep. Cindy Noe; Sen. Connie Lawson; Sen. Timothy Skinner; Kathleen O'Connell; Stacey Cornett; Margie Payne; Ronda Ames; Valerie N. Markley; Caroline Doebbling; Kurt Carlson; Chris Taelman; Jane Horn; Rhonda Boyd-Alstott; Dr. Danita Johnson Hughes.

Members Absent: Bryan Lett.

I. **Representative Charlie Brown, Chairperson**, called the Commission on Mental Health (COMH) meeting to order at 12:40 P.M.

II. Consideration of Legislative Proposals

PDOC concerning mental health issues (Exhibit 1) - **Senator Lawson** asked **Gina Eckart, Director, Division of Mental Health and Addiction (DMHA) of Family and Social Services Administration (FSSA)** to explain the draft. Ms. Eckart indicated that the

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draft addressed three issues that were considered by the General Assembly last year:

- (1) Makes changes to the definition of "continuum of care"
- (2) Refines the definition of "managed care".
- (3) Changes the distribution of federal alcohol funds.

Three technical changes to the draft were adopted by consent. Since the language for the technical changes was not finalized, the members authorized Representative Brown and Senator Lawson to approve the exact language. The draft, as amended, was adopted by a unanimous voice vote.

PD 3081 concerning training of teachers in recognition of signs that students may be considering suicide (Exhibit 2) - **Representative Brown** indicated that the draft was the draft presented by Senator Miller at the first meeting of the COMH. By consent the COMH amended the draft to add the Behavioral Health and Family Studies Institute at Indiana University-Purdue University Fort Wayne as an example of the type of training programs that could be used for training teachers. Representative Noe asked the following three questions:

- (1) What type of action will be required if it is determined that a child is at risk?
- (2) How much parental involvement will there be in the process?
- (3) Are there any studies as to the causes for the increase in teen suicides?

In response to Representative Noe's questions, it was pointed out that the proposed draft requires training and does not specify what action should be taken if a child appears to be at risk. The draft passed unanimously with a voice vote.

PD 3384 (Exhibit 3) **dealing with Medicaid coverage for services of clinical addiction counselors, was presented by Ms. Amy Flack of Krieg DaVault and Ms. Jean Scallon of Bloomington Meadows at Representative Brown's request.** (Exhibit 4) Ms. Eckart indicated that FSSA would consider making the changes discussed by Ms. Flack and Ms. Scallon without legislative action. Ms. Eckart also indicated that there is some concern about the fiscal impact of the changes. The draft was adopted by a unanimous voice vote with one member abstaining.

PD 3049 (Exhibit 5) **would extend the life of the COMH for five years beyond the current June 30, 2011, expiration date.** **Representative Brown** presented the draft, which passed unanimously with a voice vote.

PD 3082 (Exhibit 6) **creates the Council on Evansville state hospitals was presented by Senator Vaneta Becker.** Senator Becker discussed the issue of the shortage of child psychiatrists in Indiana and discussed the impact on the Evansville Children's Psychiatric Hospital. Since no one will be receiving per diem to serve on the Committee, Senator Becker indicated that there is no fiscal impact. The draft was approved by a unanimous voice vote.

Concurrent Resolution (Exhibit 7) **to support the Medicaid Quality Advisory Committee was presented by Mr. Steve McCaffrey.** (Exhibit 8) Mr. McCaffrey discussed the importance of the Medicaid Quality Advisory Committee in determining what drugs are most effective to treat mental illness for the Medicaid program. The draft was approved by a unanimous voice vote.

Final Report (Exhibit 8) was approved by a unanimous voice vote.

III. Follow-Up Information from FSSA

Ms. Gina Eckart, Director of DMHA, told the members that she would answer questions from the COMH. Ms. Eckart discussed the procedures in place to deal with downsizing all five state hospitals. There have been job fairs for the staff and patient fairs to help families find service in local communities for their family members who will be transitioning back to local communities. Ms. Eckart said that premier providers participated in the patient fairs. Senator Lawson asked how "premier providers" were identified. Ms. Eckart said that providers with a proven track record in the local communities were considered premier providers.

IV. Presentation on Housing Issues

Ms. Sherry Seiwert, Executive Director, Indiana Housing and Community Development Authority, introduced **Mr. Rodney Stockment, Community Services Director of the Housing Authority**, to discuss the housing programs operated by the Indiana Housing and Community Development Authority. (Exhibits 9, 10, and 11) Mr. Stockment reported that the goal is to have 1,400 housing units available over a six year period. **Ms. Marty Knisley, National Director of Community Support, Technical Assistance Collaborative, Inc.**, discussed the importance of permanent housing. Representative Brown indicated that the housing programs are very important and have had little publicity in Indiana. He expressed his hope that Ms. Seiwert would provide information to the relevant standing committees in the General Assembly during the 2011 session.

V. Adjournment

Representative Brown expressed thanks for all who participated in the COMH and adjourned the meeting at 2:40 P.M.

Changes the allocation of federal aid used for drug abuse and alcohol abuse used for local programs. Redefines the services provided by community mental health centers and specifies that instead of a continuum of care, services are to be provided. Removes the authority of the division of mental health and addiction (DMHA) to license respite care. Changes elements of community based residential programs. Eliminates the duty of DMHA to submit a biennial report to the governor and the legislative council on the evaluation of the continuum of care. Requires certain mental health records to be released to a court under certain circumstances. Makes conforming changes. Repeals: (1) respite care for persons with mental illness; (2) listing of elements of community residential programs; (3) children's mental health bureau; (4) certain placement provisions for community residential facilities; and (5) definitions made obsolete by the bill.

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SECTION 1. IC 5-20-1-2, AS AMENDED BY P.L.99-2007, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 2. As used in this chapter:

"Assisted" means, with respect to a loan:

- (1) the payment by the United States or any duly authorized agency of the United States of assistance payments, interest payments, or mortgage reduction payments with respect to such loan; or
- (2) the provision of insurance, guaranty, security, collateral, subsidies, or other forms of assistance or aid acceptable to the authority for the making, holding, or selling of a loan from the United States, any duly authorized agency of the United States, or any entity or corporation acceptable to the authority, other than the sponsor.

"Authority" means the Indiana housing and community development authority created by section 3 of this chapter.

"Bonds" or "notes" means the bonds or notes authorized to be issued by the authority under this chapter.

"Community based residential programs" refers to programs developed by the division of mental health and addiction under IC 12-22-2-3.5.

"Development costs" means the costs approved by the authority as appropriate expenditures and credits which may be incurred by sponsors, builders, and developers of residential housing prior to commitment and initial advance of the proceeds of a construction loan or of a mortgage, including but not limited to:

- (1) payments for options to purchase properties on the proposed residential housing site, deposits on contracts of purchase, or, with prior approval of the authority, payments for the purchase of such properties;
- (2) legal, organizational, and marketing expenses, including payments of attorney's fees, project manager, clerical, and other incidental expenses;
- (3) payment of fees for preliminary feasibility studies and advances for planning, engineering, and architectural work;

- (4) expenses for surveys as to need and market analyses;
- (5) necessary application and other fees;
- (6) credits allowed by the authority to recognize the value of service provided at no cost by the sponsors, builders, or developers; and
- (7) such other expenses as the authority deems appropriate for the purposes of this chapter.

"Governmental agency" means any department, division, public agency, political subdivision, or other public instrumentality of the state of Indiana, the federal government, any other state or public agency, or any two (2) or more thereof.

"Construction loan" means a loan to provide interim financing for the acquisition or construction of single family residential housing, including land development.

"Mortgage" or "mortgage loan" means a loan to provide permanent financing for:

- (1) the rehabilitation, acquisition, or construction of single family residential housing, including land development; or
- (2) the weatherization of single family residences.

"Mortgage lender" means a bank, trust company, savings bank, savings association, credit union, national banking association, federal savings association or federal credit union maintaining an office in this state, a public utility (as defined in IC 8-1-2-1), a gas utility system organized under IC 8-1-11.1, an insurance company authorized to do business in this state, or any mortgage banking firm or mortgagee authorized to do business in this state and approved by either the authority or the Department of Housing and Urban Development.

"Land development" means the process of acquiring land primarily for residential housing construction for persons and families of low and moderate income and making, installing, or constructing nonresidential housing improvements, including water, sewer, and other utilities, roads, streets, curbs, gutters, sidewalks, storm drainage facilities, and other installations or works, whether on or off the site, which the authority deems necessary or desirable to prepare such land primarily for residential housing construction.

"Obligations" means any bonds or notes authorized to be issued by the authority under this chapter.

"Persons and families of low and moderate income" means persons and families of insufficient personal or family income to afford adequate housing as determined by the standards established by the authority, and in determining such standards the authority shall take into account the following:

- (1) The amount of total income of such persons and families available for housing needs.
- (2) The size of the family.
- (3) The cost and condition of housing facilities available in the different geographic areas of the state.
- (4) The ability of such persons and families to compete successfully in the private housing market and to pay the amounts at which private enterprise is

1 providing sanitary, decent, and safe housing.

2 The standards shall, however, comply with the applicable limitations of section 4(b) of this
3 chapter.

4 "Residential facility for children" means a facility:

5 (1) that provides residential services to individuals who are:

6 (A) under twenty-one (21) years of age; and

7 (B) adjudicated to be children in need of services under IC 31-34 (or
8 IC 31-6-4 before its repeal) or delinquent children under IC 31-37 (or
9 IC 31-6-4 before its repeal); and

10 (2) that is:

11 (A) a child caring institution that is or will be licensed under IC 31-27;

12 (B) a residential facility that is or will be licensed under IC 12-28-5; or

13 (C) a facility that is or will be certified by the division of mental health
14 and addiction under IC 12-23.

15 "Residential facility for persons with a developmental disability" means a facility that is
16 approved for use in a community residential program for the developmentally disabled under
17 IC 12-11-1.1.

18 "~~Residential facility for persons with a mental illness~~" means a facility that is approved
19 by the division of mental health and addiction for use in a community residential program for the
20 mentally ill under ~~IC 12-22-2-3(1), IC 12-22-2-3(2), IC 12-22-2-3(3), or IC 12-22-2-3(4).~~

21 "Residential housing" means a specific work or improvement undertaken primarily to
22 provide single or multiple family housing for rental or sale to persons and families of low and
23 moderate income, including the acquisition, construction, or rehabilitation of lands, buildings,
24 and improvements to the housing, and such other nonhousing facilities as may be incidental or
25 appurtenant to the housing.

26 "Sponsors", "builders", or "developers" means corporations, associations, partnerships,
27 limited liability companies, or other entities and consumer housing cooperatives organized
28 pursuant to law for the primary purpose of providing housing to low and moderate income
29 persons and families.

30 "State" means the state of Indiana.

31 "Tenant programs and services" means services and activities for persons and families
32 living in residential housing, including the following:

33 (1) Counseling on household management, housekeeping, budgeting, and money
34 management.

35 (2) Child care and similar matters.

36 (3) Access to available community services related to job training and
37 placement, education, health, welfare, and other community services.

38 (4) Guard and other matters related to the physical security of the housing
39 residents.

40 (5) Effective management-tenant relations, including tenant participation in all

1 aspects of housing administration, management, and maintenance.

2 (6) Physical improvements of the housing, including buildings, recreational and
3 community facilities, safety measures, and removal of code violations.

4 (7) Advisory services for tenants in the creation of tenant organizations which
5 will assume a meaningful and responsible role in the planning and carrying out
6 of housing affairs.

7 (8) Procedures whereby tenants, either individually or in a group, may be given a
8 hearing on questions relating to management policies and practices either in
9 general or in relation to an individual or family.

10 SECTION 2. IC 12-7-2-25 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
11 JULY 1, 2011]: Sec. 25. "Case management" means the following:

12 (1) ~~For~~ **for** purposes of IC 12-10-1 and IC 12-10-10, has the meaning set forth in
13 IC 12-10-10-1.

14 (2) ~~For purposes of IC 12-7-2-40.6 and IC 12-24-19; the meaning set forth in~~
15 ~~IC 12-24-19-2:~~

16 SECTION 3. IC 12-7-2-40 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
17 JULY 1, 2011]: Sec. 40. "Community based residential program", for purposes of IC 12-22-2,
18 refers to the programs described in ~~IC 12-22-2-3:~~ **IC 12-22-2-3.5.**

19 SECTION 4. IC 12-7-2-40.6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
20 JULY 1, 2011]: Sec. 40.6. (a) "Continuum of care" means a range of services: ~~the provision of~~
21 ~~which is assured by a community mental health center or a managed care provider. The term~~
22 ~~includes the following:~~

23 (1) ~~Individualized treatment planning to increase patient coping skills and~~
24 ~~symptom management; which may include any combination of services listed~~
25 ~~under this section:~~

26 (2) ~~Twenty-four (24) hour a day crisis intervention:~~

27 (3) ~~Case management to fulfill individual patient needs; including assertive case~~
28 ~~management when indicated:~~

29 (4) ~~Outpatient services; including intensive outpatient services; substance abuse~~
30 ~~services; counseling; and treatment:~~

31 (5) ~~Acute stabilization services; including detoxification services:~~

32 (6) ~~Residential services:~~

33 (7) ~~Day treatment:~~

34 (8) ~~Family support services:~~

35 (9) ~~Medication evaluation and monitoring:~~

36 (10) ~~Services to prevent unnecessary and inappropriate treatment and~~
37 ~~hospitalization and the deprivation of a person's liberty:~~

38 (1) **defined by the division in rules adopted under IC 4-22-2 to provide a**
39 **comprehensive continuum of care by a community mental health center or**
40 **other provider; and**

1 (2) based on recovery focused models of care and that are intended to meet
2 the individual treatment needs of the behavioral health consumer.

3 (b) The continuum of care may include the following services:

4 (1) Wellness programs.

5 (2) Engagement services.

6 (3) Outpatient and inpatient services.

7 (4) Rehabilitative and habilitative services.

8 (5) Residential care and supported housing.

9 (6) Acute intensive services.

10 All services must support prevention and treatment of mental health and addiction for all
11 populations.

12 SECTION 5. IC 12-7-2-117.6, AS ADDED BY P.L.99-2007, SECTION 45, IS
13 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 117.6. "Individual
14 with a mental illness", for purposes of IC 12-21-2 ~~IC 12-22-1~~; and IC 12-24-17, means an
15 individual who:

16 (1) has a psychiatric disorder that substantially impairs the individual's mental
17 health; and

18 (2) requires care, treatment, training, or detention:

19 (A) because of the psychiatric disorder; or

20 (B) for the welfare of the individual or others of the community in which
21 the individual resides.

22 SECTION 6. IC 12-7-2-127 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
23 JULY 1, 2011]: Sec. 127. ~~(a)~~ "Managed care provider", for purposes of IC 12-14-1 through
24 IC 12-14-9.5 and IC 12-15 (except IC 12-15-21, IC 12-15-33, and IC 12-15-34) means either of
25 the following:

26 (1) A physician licensed under IC 25-22.5 who:

27 (A) is primarily engaged in general practice, family practice, internal
28 medicine, pediatric medicine, or obstetrics and gynecology; and

29 (B) has entered into a provider agreement for the provision of physician
30 services under IC 12-15-11-4.

31 (2) A partnership, corporation, or other entity that:

32 (A) employs or contracts with physicians licensed under IC 25-22.5 who
33 are primarily engaged in general practice, family practice, internal
34 medicine, pediatric medicine, or obstetrics and gynecology; and

35 (B) has entered into a provider agreement for the provision of physician
36 services under IC 12-15-11-4.

37 (b) "Managed care provider", for purposes of ~~IC 12-21-1~~ through ~~IC 12-29-2~~, means an
38 organization:

39 ~~(1) that:~~

40 (A) for mental health services; is defined under 42 U.S.C. 300x-2(c);

- 1 (B) provides addiction services; or
 2 (C) provides children's mental health services;
 3 (2) that has entered into a provider agreement with the division of mental health
 4 and addiction under IC 12-21-2-7 to provide a continuum of care in the least
 5 restrictive, most appropriate setting; and
 6 (3) that is operated by at least one (1) of the following:
 7 (A) A city, town, county, or other political subdivision of Indiana;
 8 (B) An agency of Indiana or of the United States;
 9 (C) A political subdivision of another state;
 10 (D) A hospital owned or operated by:
 11 (i) a unit of government; or
 12 (ii) a building authority that is organized for the purpose of
 13 constructing facilities to be leased to units of government;
 14 (E) A corporation incorporated under IC 23-7-1-1 (before its repeal
 15 August 1, 1991) or IC 23-17;
 16 (F) An organization that is exempt from federal income taxation under
 17 Section 501(c)(3) of the Internal Revenue Code;
 18 (G) A university or college.

19 SECTION 7. IC 12-7-2-149.1, AS AMENDED BY P.L.145-2006, SECTION 57, IS
 20 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 149.1. "Provider"
 21 means the following:

- 22 (1) For purposes of IC 12-10-7, the meaning set forth in IC 12-10-7-3.
 23 (2) For purposes of the following statutes, an individual, a partnership, a
 24 corporation, or a governmental entity that is enrolled in the Medicaid program
 25 under rules adopted under IC 4-22-2 by the office of Medicaid policy and
 26 planning:
 27 (A) IC 12-14-1 through IC 12-14-9.5.
 28 (B) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.
 29 (C) IC 12-17.6.
 30 (3) Except as provided in subdivision (4), for purposes of IC 12-17.2, a person
 31 who operates a child care center or child care home under IC 12-17.2.
 32 (4) For purposes of IC 12-17.2-3.5, a person that:
 33 (A) provides child care; and
 34 (B) is directly paid for the provision of the child care under the federal
 35 Child Care and Development Fund voucher program administered under
 36 45 CFR 98 and 45 CFR 99.
 37 The term does not include an individual who provides services to a person
 38 described in clauses (A) and (B), regardless of whether the individual receives
 39 compensation.
 40 (5) For purposes of IC 12-21-1 through IC 12-29-2, an organization:

1 (A) that:

2 (i) for mental health services, as defined under 42
3 U.S.C.300x-2(c);

4 (ii) provides addiction services; or

5 (iii) provides children's mental health services;

6 (B) that has entered into a provider agreement with the division of
7 mental health and addition under IC 12-21-2-7 to provide services in
8 the least restrictive, most appropriate setting; and

9 (C) that is operated by one (1) of the following:

10 (i) A city, town, county, or other political subdivision of the
11 state.

12 (ii) An agency of the state or of the United States.

13 (iii) A political subdivision of another state

14 (iv) a hospital owned or operated by a unit of government or
15 a building authority that is organized for the purpose of
16 constructing facilities to be leased to units of government.

17 (v) A corporation incorporated under IC 23-7-1.1 (before its
18 repeal August 1, 1991) or IC 23-17.

19 (vi) An organization that is exempt from federal income
20 taxation under Section 5-1(c)(3) of the Internal Revenue
21 Code.

22 (vii) A university or college.

23 SECTION 8. IC 12-7-2-165, AS AMENDED BY P.L.99-2007, SECTION 49, IS
24 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 165. "Residential
25 facility", for purposes of IC 12-28-4 and IC 12-28-5, refers to a residential facility for individuals
26 with a developmental disability. ~~or a residential facility for individuals with a mental illness:~~

27 SECTION 9. IC 12-7-2-168 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
28 JULY 1, 2011]: Sec. 168. "Respite care" means, ~~the following:~~

29 ~~(1) For for~~ purposes of IC 12-10-4 and IC 12-10-5, temporary care or
30 supervision of an individual with Alzheimer's disease or a related senile
31 dementia that is provided because the individual's family or caretaker is
32 temporarily unable or unavailable to provide needed care.

33 ~~(2) For purposes of IC 12-22-1, the meaning set forth in IC 12-22-1-1.~~

34 SECTION 10. IC 12-10-6-2.1, AS AMENDED BY P.L.121-2008, SECTION 1, IS
35 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 2.1. (a) An
36 individual who is incapable of residing in the individual's own home may apply for residential
37 care assistance under this section. The determination of eligibility for residential care assistance
38 is the responsibility of the division. Except as provided in subsections (g) and (i), an individual is
39 eligible for residential care assistance if the division determines that the individual:

40 (1) is a recipient of Medicaid or the federal Supplemental Security Income

1 program;

2 (2) is incapable of residing in the individual's own home because of dementia,
3 mental illness, or a physical disability;

4 (3) requires a degree of care less than that provided by a health care facility
5 licensed under IC 16-28;

6 (4) can be adequately cared for in a residential care setting; and

7 (5) has not made any asset transfer prohibited under the state plan or in 42
8 U.S.C. 1396p(c) in order to be eligible for Medicaid.

9 (b) Individuals with mental retardation may not be admitted to a home or facility that
10 provides residential care under this section.

11 (c) A service coordinator employed by the division may:

12 (1) evaluate a person seeking admission to a home or facility under subsection
13 (a); or

14 (2) evaluate a person who has been admitted to a home or facility under
15 subsection (a), including a review of the existing evaluations in the person's
16 record at the home or facility.

17 If the service coordinator determines the person evaluated under this subsection has mental
18 retardation, the service coordinator may recommend an alternative placement for the person.

19 (d) Except as provided in section 5 of this chapter, residential care consists of only room,
20 board, and laundry, along with minimal administrative direction. State financial assistance may
21 be provided for such care in a boarding or residential home of the applicant's choosing that is
22 licensed under IC 16-28 or a Christian Science facility listed and certified by the Commission for
23 Accreditation of Christian Science Nursing Organizations/Facilities, Inc., that meets certain life
24 safety standards considered necessary by the state fire marshal. Payment for such care shall be
25 made to the provider of the care according to division directives and supervision. The amount of
26 nonmedical assistance to be paid on behalf of a recipient living in a boarding home, residential
27 home, or Christian Science facility shall be based on the daily rate established by the division.
28 The rate for facilities that are referred to in this section and licensed under IC 16-28 may not
29 exceed an upper rate limit established by a rule adopted by the division. The recipient may retain
30 from the recipient's income a monthly personal allowance of fifty-two dollars (\$52). This amount
31 is exempt from income eligibility consideration by the division and may be exclusively used by
32 the recipient for the recipient's personal needs. However, if the recipient's income is less than the
33 amount of the personal allowance, the division shall pay to the recipient the difference between
34 the amount of the personal allowance and the recipient's income. A reserve or an accumulated
35 balance from such a source, together with other sources, may not be allowed to exceed the state's
36 resource allowance allowed for adults eligible for state supplemental assistance or Medicaid as
37 established by the rules of the office of Medicaid policy and planning.

38 (e) In addition to the amount that may be retained as a personal allowance under this
39 section, an individual shall be allowed to retain an amount equal to the individual's state and
40 local income tax liability. The amount that may be retained during a month may not exceed

1 one-third (1/3) of the individual's state and local income tax liability for the calendar quarter in
2 which that month occurs. This amount is exempt from income eligibility consideration by the
3 division. The amount retained shall be used by the individual to pay any state or local income
4 taxes owed.

5 (f) In addition to the amounts that may be retained under subsections (d) and (e), an
6 eligible individual may retain a Holocaust victim's settlement payment. The payment is exempt
7 from income eligibility consideration by the division.

8 (g) The rate of payment to the provider shall be determined in accordance with a
9 prospective prenegotiated payment rate predicated on a reasonable cost related basis, with a
10 growth of profit factor, as determined in accordance with generally accepted accounting
11 principles and methods, and written standards and criteria, as established by the division. The
12 division shall establish an administrative appeal procedure to be followed if rate disagreement
13 occurs if the provider can demonstrate to the division the necessity of costs in excess of the
14 allowed or authorized fee for the specific boarding or residential home. The amount may not
15 exceed the maximum established under subsection (d).

16 (h) The personal allowance for one (1) month for an individual described in subsection
17 (a) is the amount that an individual would be entitled to retain under subsection (d) plus an
18 amount equal to one-half (1/2) of the remainder of:

- 19 (1) gross earned income for that month; minus
- 20 (2) the sum of:
 - 21 (A) sixteen dollars (\$16); plus
 - 22 (B) the amount withheld from the person's paycheck for that month for
 - 23 payment of state income tax, federal income tax, and the tax prescribed
 - 24 by the federal Insurance Contribution Act (26 U.S.C. 3101 et seq.); plus
 - 25 (C) transportation expenses for that month; plus
 - 26 (D) any mandatory expenses required by the employer as a condition of
 - 27 employment.

28 (i) An individual who, before September 1, 1983, has been admitted to a home or facility
29 that provides residential care under this section is eligible for residential care in the home or
30 facility.

31 (j) The director of the division may contract with the division of mental health and
32 addiction or the division of disability and rehabilitative services to purchase services for
33 individuals with a mental illness or a developmental disability by providing money to supplement
34 the appropriation for community based residential care programs established under IC 12-22-2 or
35 community residential programs established under IC 12-11-1.1-1.

36 (k) A person with a mental illness may not be placed in a Christian Science facility listed
37 and certified by the Commission for Accreditation of Christian Science Nursing
38 Organizations/Facilities, Inc., unless the facility is licensed under IC 16-28.

39 SECTION 11. IC 12-10-11-8, AS AMENDED BY P.L.99-2007, SECTION 65, IS
40 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 8. The board shall do

1 the following:

2 (1) Establish long term goals of the state for the provision of a continuum of care
3 for the elderly and individuals with a disability based on the following:

4 (A) Individual independence, dignity, and privacy.

5 (B) Long term care services that are:

6 (i) integrated, accessible, and responsible; and

7 (ii) available in home and community settings.

8 (C) Individual choice in planning and managing long term care.

9 (D) Access to an array of long term care services:

10 (i) for an individual to receive care that is appropriate for the
11 individual's needs; and

12 (ii) to enable a case manager to have cost effective alternatives
13 available in the construction of care plans and the delivery of
14 services.

15 (E) Long term care services that include home care, community based
16 services, assisted living, congregate care, adult foster care, and
17 institutional care.

18 (F) Maintaining an individual's dignity and self-reliance to protect the
19 fiscal interests of both taxpayers and the state.

20 (G) Long term care services that are fiscally sound.

21 **(H) Services that support prevention and treatment of mental health
22 and addiction.**

23 (2) Review state policies on community and home care services.

24 (3) Recommend the adoption of rules under IC 4-22-2.

25 (4) Recommend legislative changes affecting community and home care
26 services.

27 (5) Recommend the coordination of the board's activities with the activities of
28 other boards and state agencies concerned with community and home care
29 services.

30 (6) Evaluate cost effectiveness, quality, scope, and feasibility of a state
31 administered system of community and home care services.

32 (7) Evaluate programs for financing services to those in need of a continuum of
33 care.

34 (8) Evaluate state expenditures for community and home care services, taking
35 into account efficiency, consumer choice, competition, and equal access to
36 providers.

37 (9) Develop policies that support the participation of families and volunteers in
38 meeting the long term care needs of individuals.

39 (10) Encourage the development of funding for a continuum of care from private
40 resources, including insurance.

1 (11) Develop a cost of services basis and a program of cost reimbursement for
2 those persons who can pay all or a part of the cost of the services rendered. The
3 division shall use this cost of services basis and program of cost reimbursement
4 in administering IC 12-10-10. The cost of services basis and program of cost
5 reimbursement must include a client cost share formula that:

6 (A) imposes no charges for an eligible individual whose income does not
7 exceed one hundred fifty percent (150%) of the federal income poverty
8 level; and

9 (B) does not impose charges for the total cost of services provided to an
10 individual under the community and home options to institutional care
11 for the elderly and disabled program unless the eligible individual's
12 income exceeds three hundred fifty percent (350%) of the federal
13 income poverty level.

14 The calculation of income for an eligible individual must include the deduction
15 of the individual's medical expenses and the medical expenses of the individual's
16 spouse and dependent children who reside in the eligible individual's household.

17 (12) Establish long term goals for the provision of guardianship services for
18 adults.

19 (13) Coordinate activities and programs with the activities of other boards and
20 state agencies concerning the provision of guardianship services.

21 (14) Recommend statutory changes affecting the guardianship of indigent adults.

22 (15) Review a proposed rule concerning home and community based services as
23 required under section 9 of this chapter.

24 SECTION 12. IC 12-10.5-2-4 IS ADDED TO THE INDIANA CODE AS A NEW
25 SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 4. The continuum of**
26 **care provided under this article must include services that support prevention and**
27 **treatment of mental health and addiction.**

28 SECTION 13. IC 12-21-2-3, AS AMENDED BY P.L.99-2007, SECTION 100, IS
29 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 3. (a) In addition to
30 the general authority granted to the director under IC 12-8-8, the director shall do the following:

31 (1) Organize the division, create the appropriate personnel positions, and employ
32 personnel necessary to discharge the statutory duties and powers of the division
33 or a bureau of the division.

34 (2) Subject to the approval of the state personnel department, establish personnel
35 qualifications for all deputy directors, assistant directors, bureau heads, and
36 superintendents.

37 (3) Subject to the approval of the budget director and the governor, establish the
38 compensation of all deputy directors, assistant directors, bureau heads, and
39 superintendents.

40 (4) Study the entire problem of mental health, mental illness, and addictions

1 existing in Indiana.

2 (5) Adopt rules under IC 4-22-2 for the following:

3 (A) Standards for the operation of private institutions that are licensed
4 under IC 12-25 for the diagnosis, treatment, and care of individuals with
5 psychiatric disorders, addictions, or other abnormal mental conditions.

6 ~~(B) Licensing supervised group living facilities described in
7 IC 12-22-2-3 for individuals with a mental illness.~~

8 ~~(C) (B) Certifying community residential programs described in
9 IC 12-22-2-3 IC 12-22-2-3.5 for individuals with a mental illness.~~

10 ~~(D) (C) Certifying community mental health centers to operate in
11 Indiana.~~

12 ~~(E) (D) Establish exclusive geographic primary service areas for
13 community mental health centers. The rules must include the following:~~

14 (i) Criteria and procedures to justify the change to the
15 boundaries of a community mental health center's primary
16 service area.

17 (ii) Criteria and procedures to justify the change of an
18 assignment of a community mental health center to a primary
19 service area.

20 (iii) A provision specifying that the criteria and procedures
21 determined in items (i) and (ii) must include an option for the
22 county and the community mental health center to initiate a
23 request for a change in primary service area or provider
24 assignment.

25 (iv) A provision specifying the criteria and procedures
26 determined in items (i) and (ii) may not limit an eligible
27 consumer's right to choose or access the services of any provider
28 who is certified by the division of mental health and addiction to
29 provide public supported mental health services.

30 (6) Institute programs, in conjunction with an accredited college or university
31 and with the approval, if required by law, of the commission for higher
32 education, for the instruction of students of mental health and other related
33 occupations. The programs may be designed to meet requirements for
34 undergraduate and postgraduate degrees and to provide continuing education and
35 research.

36 (7) Develop programs to educate the public in regard to the prevention,
37 diagnosis, treatment, and care of all abnormal mental conditions.

38 (8) Make the facilities of the Larue D. Carter Memorial Hospital available for
39 the instruction of medical students, student nurses, interns, and resident
40 physicians under the supervision of the faculty of the Indiana University School

1 of Medicine for use by the school in connection with research and instruction in
2 psychiatric disorders.

3 (9) Institute a stipend program designed to improve the quality and quantity of
4 staff that state institutions employ.

5 (10) Establish, supervise, and conduct community programs, either directly or by
6 contract, for the diagnosis, treatment, and prevention of psychiatric disorders.

7 (11) Adopt rules under IC 4-22-2 concerning the records and data to be kept
8 concerning individuals admitted to state institutions, community mental health
9 centers, or **managed care other** providers.

10 ~~(12) Establish, maintain, and reallocate before July 1, 1996, one-third (1/3); and~~
11 ~~before January 1, 1998, the remaining two-thirds (2/3) of the following:~~

12 ~~(A) long term care service settings; and~~

13 ~~(B) state operated long term care inpatient beds;~~

14 ~~designed to provide services for patients with long term psychiatric disorders as~~
15 ~~determined by the quadrennial actuarial study under IC 12-21-5-1.5(9). A~~
16 ~~proportional number of long term care service settings and inpatient beds must~~
17 ~~be located in an area that includes a consolidated city and its adjacent counties.~~

18 ~~(13) (12) Compile information and statistics concerning the ethnicity and gender~~
19 ~~of a program or service recipient.~~

20 ~~(14) (13) Establish standards for each element of the continuum of care services~~
21 ~~defined in IC 12-7-2-40.6 for community mental health centers and managed~~
22 ~~care other providers.~~

23 (b) As used in this section, "long term care service setting" means the following:

24 (1) The anticipated duration of the patient's mental health setting is more than
25 twelve ~~(12)~~ months:

26 (2) Twenty-four ~~(24)~~ hour supervision of the patient is available:

27 (3) A patient in the long term care service setting receives:

28 (A) active treatment if appropriate for a patient with a chronic and
29 persistent mental disorder or chronic addictive disorder;

30 (B) case management services from a state approved provider; and

31 (C) maintenance of care under the direction of a physician:

32 (4) Crisis care is available:

33 (c) Funding for services under subsection (a)~~(12)~~ shall be provided by the division
34 through the reallocation of existing appropriations. The need of the patients is a priority for
35 services. The division shall adopt rules to implement subsection (a)~~(12)~~ before July 1, 1995.

36 SECTION 14. IC 12-21-2-8, AS AMENDED BY P.L.99-2007, SECTION 102, IS
37 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 8. (a) The director
38 shall develop a comprehensive system of monitoring, evaluation, and quality assurance for the
39 **continuum of care services** required by this chapter.

40 (b) The director shall determine to whom contracts are awarded, based on the following

1 factors:

- 2 (1) The continuity of services a contractor provides for patients.
3 (2) The accessibility of a contractor's services to patients.
4 (3) The acceptability of a contractor's services to patients.
5 (4) A contractor's ability to focus services on building the self-sufficiency of the
6 patient.

7 (c) This subsection applies to the reimbursement of contract payments to ~~managed care~~
8 providers. Payments must be determined prospectively in accordance with generally accepted
9 accounting principles and actuarial principles recognizing costs incurred by efficiently and
10 economically operated programs that:

- 11 (1) serve individuals with a mental illness or substance abuse patients; and
12 (2) are subject to quality and safety standards and laws.

13 (d) Before entering into a contract under this section, the director shall submit the contract
14 to the attorney general for approval as to form and legality.

15 (e) A contract under this section must do the following:

16 (1) Specify:

17 (A) the work to be performed; and

18 (B) the patient populations to whom services must be provided.

19 (2) Provide for a reduction in funding or termination of the contract for failure to
20 comply with terms of the contract.

21 (3) Require that the contractor meet the standards set forth in rules adopted by the
22 division of mental health and addiction under IC 4-22-2.

23 (4) Require that the contractor participate in the division's evaluation process.

24 (5) For any service for which the division chooses to contract on a per diem basis,
25 the per diem reimbursement shall be determined under subsection (c) for the
26 contractor's reasonable cost of providing services.

27 (6) In contracts with capitated payment provisions, provide that the contractor's
28 cost of purchasing stop-loss insurance for the patient populations to be served in
29 amounts and with limits customarily purchased by prepaid health care plans must
30 be:

31 (A) included in the actuarial determination of the capitated payment
32 amounts; or

33 (B) separately paid to the contractor by the division.

34 (7) Provide that a contract for enumerated services granted by the division under
35 this section to an approved ~~managed care~~ provider may not create or confer upon
36 the ~~managed care~~ provider liability or responsibility for care or services beyond
37 those services supported by the contract.

38 SECTION 15. IC 12-21-5-1.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
39 JULY 1, 2011]: Sec. 1.5. The division shall do the following:

40 (1) Adopt rules under IC 4-22-2 to establish and maintain criteria to determine

1 patient eligibility and priority for publicly supported mental health and addiction
2 services. The rules must include criteria for patient eligibility and priority based
3 on the following:

4 (A) A patient's income.

5 (B) A patient's level of daily functioning.

6 (C) A patient's prognosis.

7 (2) Within the limits of appropriated funds, contract with a network of **managed**
8 **care** providers to provide a **continuum of care services** in an appropriate setting
9 that is the least restrictive to individuals who qualify for the services.

10 (3) Require the providers of services funded directly by the division to be in good
11 standing with an appropriate accrediting body as required by rules adopted under
12 IC 4-22-2 by the division.

13 (4) Develop a provider profile that must be used to evaluate the performance of a
14 **managed care** provider. **and that may be used to evaluate other providers of**
15 **mental health services that access state administered funds; including Medicaid;**
16 **and other federal funding.** A provider's profile must include input from
17 consumers, citizens, and representatives of the mental health ombudsman
18 program (IC 12-27-9) regarding the provider's:

19 (A) information provided to the patient on patient rights before treatment;

20 (B) accessibility, acceptability, and continuity of services provided or
21 requested; and

22 (C) total cost of care per individual, using state administered funds.

23 (5) Ensure compliance with all other performance criteria set forth in a provider
24 contract. In addition to the requirements set forth in IC 12-21-2-7, a provider
25 contract must include the following:

26 (A) A requirement that the standards and criteria used in the evaluation of
27 care plans be available and accessible to the patient.

28 (B) A requirement that the provider involve the patient in the choice of
29 and preparation of the treatment plan to the greatest extent feasible.

30 (C) A provision encouraging the provider to intervene in a patient's
31 situation as early as possible, balancing the patient's right to liberty with
32 the need for treatment.

33 (D) A requirement that the provider set up and implement an internal
34 appeal process for the patient.

35 (6) Establish a toll free telephone number that operates during normal business
36 hours for individuals to make comments to the division in a confidential manner
37 regarding services or service providers.

38 (7) Develop a confidential system to evaluate complaints and patient appeals
39 received by the division of mental health and addiction and to take appropriate
40 action regarding the results of an investigation. A **managed care** provider is

1 entitled to request and to have a hearing before information derived from the
2 investigation is incorporated into the provider's profile. Information contained
3 within the provider profile is subject to inspection and copying under IC 5-14-3-3.
4 ~~(8) Submit a biennial report to the governor and legislative council that includes~~
5 ~~an evaluation of the continuum of care. A report submitted under this subdivision~~
6 ~~to the legislative council must be in an electronic format under IC 5-14-6.~~
7 ~~(9) Conduct an actuarial analysis every four (4) years beginning July 1, 2000.~~
8 ~~(10) Annually determine sufficient rates to be paid for services contracted with~~
9 ~~managed care providers who are awarded a contract under IC 12-21-2-7.~~
10 ~~(11) Take actions necessary to assure the quality of services required by the~~
11 ~~continuum of care under this chapter.~~
12 ~~(12) Incorporate the results from the actuarial analysis in subdivision (9) to fulfill~~
13 ~~the responsibilities of this section.~~

14 SECTION 16. IC 12-22-2-3.5 IS ADDED TO THE INDIANA CODE AS A NEW
15 SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: **Sec. 3.5. Community based**
16 **residential programs include a broad range of living arrangements designed to meet the**
17 **unique needs of individuals with behavioral health disorders in integrated settings and**
18 **described in rules adopted by the division under IC 4-22-2.**

19 SECTION 17. IC 12-22-2-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
20 JULY 1, 2011]: Sec. 5. To the extent that programs described in ~~section 3~~ **section 3.5** of this
21 chapter are available and meet an individual's needs, an individual should be placed in a program
22 that is the least restrictive.

23 SECTION 18. IC 12-22-2-11, AS AMENDED BY P.L.99-2007, SECTION 114, IS
24 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 11. (a) An entity may
25 not:

- 26 ~~(1) operate a program described in IC 12-22-3; or~~
27 ~~(2) hold itself out as operating;~~
28 ~~(A) a program described in IC 12-22-3; or~~
29 ~~(B) a group home for individuals with a mental illness;~~

30 **operate or hold itself out as operating a group home for individuals with serious mental**
31 **illness (SMI), serious emotional disturbance (SED), or chronic addiction (CA) unless the**
32 **entity is licensed or certified by the division of mental health and addiction: the entity is licensed**
33 **or certified by the division with the exception of psychiatric residential treatment facilities.**

34 (b) The division of mental health and addiction shall investigate a report of:

- 35 (1) an unlicensed facility housing a community residential program described in
36 ~~section 3(1), 3(2), and 3(3)~~ **section 3.5** of this chapter;
37 (2) an uncertified operator of a community residential program described in
38 ~~section 3(1), 3(2), and 3(3)~~ **section 3.5** of this chapter; or
39 (3) a licensed or certified entity's noncompliance with this article;

40 and report the division's findings to the attorney general.

1 (c) The attorney general may do the following:

2 (1) Seek the issuance of a search warrant to assist in an investigation under this
3 section.

4 (2) File an action for injunctive relief to stop the operation of a facility described
5 in subsection (b) if there is reasonable cause to believe that:

6 (A) the facility or the operator of a community residential program
7 described in subsection (b) is operating without a required license or
8 certification; or

9 (B) a licensed or certified entity's actions or omissions create an
10 immediate danger of serious bodily injury to an individual with a mental
11 illness or an imminent danger to the health of an individual with a mental
12 illness.

13 (3) Seek in a civil action a civil penalty of not more than one hundred dollars
14 (\$100) a day for each day a facility is operating:

15 (A) without a license or certification required by law; or

16 (B) with a license or certification required under this chapter, but is not in
17 compliance with this article, IC 12-21-2-3, or rules adopted under this
18 article or IC 12-21-2-3.

19 (d) The division of mental health and addiction may provide for the removal of
20 individuals with a mental illness from facilities for individuals with a mental illness described in
21 subsection (c).

22 (e) There must be an opportunity for an informal meeting with the division of mental
23 health and addiction after injunctive relief is ordered under this section.

24 (f) The civil penalties collected under this section must be deposited in the mental health
25 centers fund (IC 6-7-1-32.1).

26 SECTION 19. IC 12-23-1-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
27 JULY 1, 2011]: Sec. 9. ~~One-third (1/3)~~ **(a) A part of the total amount** of the federal money
28 earmarked for Drug Abuse and Alcohol Abuse/Alcoholics Efforts received for disbursement by
29 the division shall be used for ~~treatment~~ **local programs that are not under the direction of a**
30 **community mental health center or a state institution; provide prevention, intervention, or**
31 **treatment services for individuals who:**

32 **(1) have a primary diagnosis of chronic substance abuse and dependence;**
33 **and**

34 **(2) are without significant or immediate treatment needs for mental illness**
35 **or serious emotional disturbance.**

36 **(b) The amount designated in subsection (a) shall be distributed to specialty**
37 **addiction providers that serve the eligible population to provide consumer choice based on**
38 **outcomes determined by the division.**

39 SECTION 20. IC 12-24-19-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
40 JULY 1, 2011]: Sec. 4. Within the limits of appropriated funds, the division shall provide by

1 written contract a continuum of care in the community for appropriate patients who are discharged
2 or transferred under this chapter that does the following:

- 3 (1) Integrates services.
- 4 (2) Facilitates provision of appropriate services to patients.
- 5 (3) Ensures continuity of care **including case management**, so that a patient is not
6 discharged or transferred without adequate and appropriate community services.
- 7 **(4) Provides services that support prevention and treatment of mental health**
8 **and addiction.**

9 SECTION 21. IC 12-26-14-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
10 JULY 1, 2011]: Sec. 4. (a) If a staff member of a program involved in the treatment, supervision,
11 or care of an individual ordered to enter an outpatient therapy program under section 1 of this
12 chapter has reason to believe that the individual has failed to comply with the requirements of
13 section 3 of this chapter, the staff member shall immediately notify the court of the failure to
14 comply.

15 (b) Except as provided in subsection (c), the individual may be transferred from the
16 outpatient therapy program to one (1) of the following:

- 17 (1) The inpatient unit of the facility that has the original commitment.
- 18 (2) ~~A supervised group living program (as defined in IC 12-22-2-3(2)).~~ **A**
19 **community based residential program under IC 12-22-2-3.5.**
- 20 (3) ~~A sub-acute stabilization facility.~~

21 (c) The individual may not be transferred to a ~~supervised group living program or a~~
22 ~~sub-acute stabilization facility~~ **community based residential program under IC 12-22-2-3.5**
23 unless in the opinion of the individual's attending physician:

- 24 (1) it is not necessary for the individual to receive acute care inpatient treatment;
25 and
- 26 (2) the individual is in need of either a ~~supervised group living program or a~~
27 ~~sub-acute stabilization facility.~~ **community based residential program under**
28 **IC 12-22-2-.35.**

29 (d) The individual may not be imprisoned or confined in a jail or correctional facility
30 unless the individual has been placed under arrest.

31 (e) A facility to which an individual is transferred under subsection (b) shall immediately
32 notify the court of the transfer. A transfer to a facility under subsection (b) is subject to review
33 under section 6 of this chapter upon petition by the individual who was transferred.

34 SECTION 22. IC 12-29-2-13, AS AMENDED BY P.L.99-2007, SECTION 151, IS
35 AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 13. (a) This section
36 applies to Lake County.

37 (b) In addition to any other appropriation under this article, the county annually may fund
38 each center serving the county from the county's general fund in an amount not exceeding the
39 following:

- 40 (1) For 2004, the product of the amount determined under section 2(b)(1) of this

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chapter multiplied by seven hundred fifty-two thousandths (0.752).

(2) For 2005 and each year thereafter, the product of the amount determined under section 2(b)(2) of this chapter for that year multiplied by seven hundred fifty-two thousandths (0.752).

(c) The receipts from the tax levied under this section shall be used for the leasing, purchasing, constructing, or operating of community **based** residential facilities for individuals with a mental illness (as defined in ~~IC 12-7-2-167~~; **IC 12-7-2-40**).

(d) Money appropriated under this section must be:

- (1) budgeted under IC 6-1.1-17; and
- (2) included in the center's budget submitted to the division of mental health and addiction.

(e) Permission for a levy increase in excess of the levy limitations may be ordered under IC 6-1.1-18.5-15 only if the levy increase is approved by the division of mental health and addiction for a community mental health center.

SECTION 23. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2011]:
IC 12-7-2-167; IC 12-7-2-188.7; IC 12-22-1; IC 12-22-2-3; IC 12-22-2-4; IC 12-22-2-6;
IC 12-22-2-7; IC 12-22-2-8; IC 12-22-2-9, IC 12-22-2-10; IC 12-22-3; IC 12-24-19-2.

COMH
Meeting 3
October 27, 2010

Exhibit 2



PRELIMINARY DRAFT
No. 3081

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2011 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 12-21-5-2; IC 20-28-3-4; IC 20-28-5-3.

Synopsis: Suicide prevention training for school personnel. Provides for the division of mental health and addiction to work with the department of education to develop programs for teacher training on the prevention of child suicide and the recognition of signs that a student may be considering suicide. Allows a governing body to adjourn its schools to allow teachers to participate in a basic or inservice course of education and training on suicide prevention and the recognition of signs that a student may be considering suicide. Provides that after June 30, 2013, an individual may not receive an initial teaching license unless the individual has completed training on suicide prevention and the recognition of signs that a student may be considering suicide. Requires the department of education to consult with organizations, such as the Jason Foundation, that have expertise in awareness and prevention programs for the prevention of youth suicide, in developing programs for use by school corporations and teacher education programs.

Effective: July 1, 2011.



A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-21-5-2, AS AMENDED BY P.L.99-2007,
2 SECTION 103, IS AMENDED TO READ AS FOLLOWS
3 [EFFECTIVE JULY 1, 2011]: Sec. 2. The division is responsible for
4 the following:

5 (1) The planning, research, and development of programs and
6 methods for the education and treatment of children with an
7 emotional disturbance.

8 (2) The coordination of governmental services, activities, and
9 programs in Indiana relating to such children.

10 (3) The administration of the state supported services concerned
11 with such children.

12 (4) The preparation of the annual report required by IC 7.1-6-2-5.

13 (5) **The development, with input and guidance from the**
14 **department of education, of basic or inservice courses for**
15 **teachers and training for teachers on the following:**

16 (A) **Prevention of child suicide.**

17 (B) **Recognition of signs that a student may be considering**
18 **suicide.**

19 SECTION 2. IC 20-28-3-4, AS AMENDED BY P.L.122-2007,
20 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
21 JULY 1, 2011]: Sec. 4. A governing body may adjourn the governing
22 body's schools for not more than three (3) days in a school year to allow
23 teachers, school administrators, and paraprofessionals to participate in:

24 (1) a session concerning agricultural instruction conducted in the
25 county;

26 (2) a meeting of a teachers' association;

27 (3) a visitation of model schools under a governing body's
28 direction; **or**

29 (4) a basic or inservice course of education and training on autism
30 that is certified by the state board in conjunction with the state
31 health commissioner and any other appropriate entity determined



1 by the state board; or
2 **(5) a basic or inservice course of education and training on the**
3 **prevention of child suicide and the recognition of signs that a**
4 **student may be considering suicide.**

5 A governing body shall pay a teacher the teacher's per diem salary for
6 the teacher's participation.

7 SECTION 3. IC 20-28-5-3, AS AMENDED BY P.L.75-2008,
8 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
9 JULY 1, 2011]: Sec. 3. (a) The department shall designate:

- 10 (1) the grade point average required for each type of license; and
- 11 (2) the types of licenses to which the teachers' minimum salary
- 12 laws apply, including nonrenewable one (1) year limited licenses.

13 (b) The department shall determine details of licensing not provided
14 in this chapter, including requirements regarding the following:

- 15 (1) The conversion of one (1) type of license into another.
- 16 (2) The accreditation of teacher education schools and
- 17 departments.
- 18 (3) The exchange and renewal of licenses.
- 19 (4) The endorsement of another state's license.
- 20 (5) The acceptance of credentials from teacher education
- 21 institutions of another state.
- 22 (6) The academic and professional preparation for each type of
- 23 license.
- 24 (7) The granting of permission to teach a high school subject area
- 25 related to the subject area for which the teacher holds a license.
- 26 (8) The issuance of licenses on credentials.
- 27 (9) The type of license required for each school position.
- 28 (10) The size requirements for an elementary school requiring a
- 29 licensed principal.
- 30 (11) Any other related matters.

31 The department shall establish at least one (1) system for renewing a
32 teaching license that does not require a graduate degree.

33 (c) This subsection does not apply to an applicant for a substitute
34 teacher license. After June 30, 2007, the department may not issue an
35 initial teaching license at any grade level to an applicant for an initial
36 teaching license unless the applicant shows evidence that the applicant:

- 37 (1) has successfully completed training approved by the
- 38 department in:
 - 39 (A) cardiopulmonary resuscitation that includes a test
 - 40 demonstration on a mannequin;
 - 41 (B) removing a foreign body causing an obstruction in an
 - 42 airway; and
 - 43 (C) the Heimlich maneuver;
- 44 (2) holds a valid certification in each of the procedures described
- 45 in subdivision (1) issued by:
 - 46 (A) the American Red Cross;



- 1 (B) the American Heart Association; or
 2 (C) a comparable organization or institution approved by the
 3 advisory board; or
 4 (3) has physical limitations that make it impracticable for the
 5 applicant to complete a course or certification described in
 6 subdivision (1) or (2).

7 **(d) This subsection does not apply to an applicant for a**
 8 **substitute teacher license. After June 30, 2013, the department may**
 9 **not issue an initial teaching license at any grade level to an**
 10 **applicant for an initial teaching license unless the applicant shows**
 11 **evidence that the applicant has successfully completed education**
 12 **and training on the prevention of child suicide and the recognition**
 13 **of signs that a student may be considering suicide.**

14 ~~(d)~~ (e) The department shall periodically publish bulletins
 15 regarding:

- 16 (1) the details described in subsection (b);
 17 (2) information on the types of licenses issued;
 18 (3) the rules governing the issuance of each type of license; and
 19 (4) other similar matters.

20 SECTION 4. [EFFECTIVE JULY 1, 2011] (a) In developing
 21 programs for use by school corporations and teacher education
 22 programs for education and training under IC 20-28-3-4 and
 23 IC 20-28-5-3, both as amended by this act, on the prevention of
 24 child suicide and the recognition of signs that a student may be
 25 considering suicide, the department of education and the division
 26 of mental health and addiction shall consult with organizations
 27 such as the Jason Foundation that have expertise in the
 28 development of awareness and prevention programs for the
 29 prevention of youth suicide.

30 (b) The department of education and the division of mental
 31 health and addiction shall report to the commission on mental
 32 health established by IC 12-21-6.5-2 not later than October 31 of
 33 each year on the programs developed under this SECTION.

34 (c) This SECTION expires December 31, 2013.



COMH

Meeting 3

October 27, 2010

Sub. 3



PRELIMINARY DRAFT

No. 3384

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2011 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 12-7-2-122.7; IC 12-15-5.

Synopsis: Medicaid coverage of mental health services. Requires partial hospitalization and outpatient mental health services to be covered under Medicaid and specifies that reimbursement to licensed clinical addiction counselors for these services must be at a rate consistent with the rate of reimbursement paid to similarly educated professionals providing the same service.

Effective: July 1, 2011.



A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-7-2-122.7 IS ADDED TO THE INDIANA
2 CODE AS A NEW SECTION TO READ AS FOLLOWS
3 [EFFECTIVE JULY 1, 2011]: **Sec. 122.7. "Licensed clinical
4 addiction counselor", for purposes of IC 12-15-5, has the meaning
5 set forth in IC 12-15-5-11.**

6 SECTION 2. IC 12-15-5-1 IS AMENDED TO READ AS
7 FOLLOWS [EFFECTIVE JULY 1, 2011]: Sec. 1. Except as provided
8 in IC 12-15-2-12, IC 12-15-6, and IC 12-15-21, the following services
9 and supplies are provided under Medicaid:

- 10 (1) Inpatient hospital services.
11 (2) Nursing facility services.
12 (3) Physician's services, including services provided under
13 IC 25-10-1 and IC 25-22.5-1.
14 (4) Outpatient hospital or clinic services.
15 (5) Home health care services.
16 (6) Private duty nursing services.
17 (7) Physical therapy and related services.
18 (8) Dental services.
19 (9) Prescribed laboratory and x-ray services.
20 (10) Prescribed drugs and services.
21 (11) Eyeglasses and prosthetic devices.
22 (12) Optometric services.
23 (13) Diagnostic, screening, preventive, and rehabilitative services.
24 (14) Podiatric medicine services.
25 (15) Hospice services.
26 (16) Services or supplies recognized under Indiana law and
27 specified under rules adopted by the office.
28 (17) Family planning services except the performance of
29 abortions.
30 (18) Nonmedical nursing care given in accordance with the tenets
31 and practices of a recognized church or religious denomination to



- 1 an individual qualified for Medicaid who depends upon healing
 2 by prayer and spiritual means alone in accordance with the tenets
 3 and practices of the individual's church or religious denomination.
 4 (19) Services provided to individuals described in IC 12-15-2-8
 5 and IC 12-15-2-9.
 6 (20) Services provided under IC 12-15-34 and IC 12-15-32.
 7 (21) Case management services provided to individuals described
 8 in IC 12-15-2-11 and IC 12-15-2-13.
 9 (22) Any other type of remedial care recognized under Indiana
 10 law and specified by the United States Secretary of Health and
 11 Human Services.
 12 (23) Examinations required under IC 16-41-17-2(a)(10).
 13 **(24) Partial hospitalization or outpatient mental health**
 14 **services.**
 15 SECTION 3. IC 12-15-5-11 IS ADDED TO THE INDIANA CODE
 16 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 17 1, 2011]: **Sec. 11. (a) As used in this section, "licensed clinical**
 18 **addiction counselor" means an individual who is licensed as a**
 19 **clinical addiction counselor under IC 25-23.6-10.5.**
 20 **(b) As used in this chapter, "partial hospitalization or outpatient**
 21 **health services" includes the following:**
 22 **(1) Individual outpatient psychotherapy.**
 23 **(2) Group outpatient psychotherapy.**
 24 **(3) Family outpatient psychotherapy.**
 25 **(c) The office shall reimburse a licensed clinical addiction**
 26 **counselor that provides partial hospitalization or outpatient health**
 27 **services at a rate for the service that is consistent with the rate paid**
 28 **to other similarly educated and trained professionals for the same**
 29 **service.**





BLOOMINGTON MEADOWS HOSPITAL

The right environment for healing.

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Meeting 3

2/20/10 2:00 PM

Session 4

The Honorable Charlie Brown, Chairman
Indiana Mental Health Commission
Indiana State House
200 W. Washington St., House Chamber
Indianapolis, Indiana 46204

**Re: Public Testimony Regarding Medicaid Reimbursement and Licensed
Clinical Addiction Counselors**

Dear Chairman Brown:

We offer this testimony on behalf of Psychiatric Solutions, Inc.'s Indiana freestanding facilities: Meadows Hospital (Bloomington), Valle Vista Hospital (Greenwood), Michiana Behavioral Health Center (Plymouth), Wellstone Regional Hospital (Jeffersonville), and Columbus Behavioral Health Center for Children and Adolescents (Columbus). With this testimony we are setting forth the reasons why licensed clinical addiction counselors should be added to the list of those professionals eligible for Medicaid reimbursement for both the outpatient clinic option and partial hospitalization services ("Outpatient Mental Health Services"). Licensed clinical addiction counselors are permitted by the recently revised rule¹ to provide billable Medicaid Rehabilitation Option ("MRO") services delivered by community mental health centers, but they have been omitted as a billable provider under both the outpatient clinic option and the partial hospitalization provisions of the rule.

In the final rule published in the Indiana Register by the Family and Social Services Administration ("FSSA") on May 24, 2010, licensed clinical addiction counselors are not listed among those professionals who are eligible for Medicaid reimbursement for Outpatient Mental Health Services.² The list of eligible professionals includes only:

- licensed psychologists;
- licensed independent practice school psychologists;
- licensed clinical social workers;
- licensed marital and family therapists;
- licensed mental health counselors;
- persons holding a master's degree in social work, marital and family therapy, or mental health counseling (except that partial hospitalization services provided by such persons shall not be reimbursed by Medicaid); and

¹ See "Attachment A" for LSA Document # 10-45.

² IC § 5-20-8 lists those professional who are eligible for Medicaid reimbursement for outpatient mental health services for group, family, and individual outpatient psychotherapy services.

September 7, 2010

Page 2

- advanced practice nurses who are licensed, registered nurses with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

In other words, licensed clinical addiction counselors are the only type of licensed clinical mental health providers not included in this list.

We as providers who are familiar with the needs of mentally ill individuals, feel strongly that they should be eligible for Medicaid reimbursement for providing care to our patients. As you know, many of our patients with mental illness also have considerable substance abuse and addiction issues. Furthermore, we believe licensed clinical addiction counselors were omitted from the list of those professionals eligible for Medicaid reimbursement for Outpatient Mental Health Services simply because their recognition and certification occurred later than the other providers listed in the rule. This omission is inconsistent with effective treatment and better outcomes for Indiana's Medicaid-eligible patients.

First, it is important to emphasize the immense value and skill that licensed clinical addiction counselors bring to the Outpatient Mental Health Services treatment of individuals suffering from behavioral health and substance abuse and addiction. In order to be licensed in Indiana as a licensed clinical addiction counselor, a professional must meet incredibly stringent requirements. For example, licensed clinical addiction counselors are required to have completed a master's or doctor's degree in addiction counseling, addiction therapy, or a related area with twenty-seven (27) semester hours or forty-one (41) quarter hours of graduate course work that must include graduate level course credits with material in at least the following content areas:

- (A) Addiction counseling theories and techniques.
- (B) Clinical problems.
- (C) Psychopharmacology.
- (D) Psychopathology.
- (E) Clinical appraisal and assessment.
- (F) Theory and practice of group addiction counseling.
- (G) Counseling addicted family systems.
- (H) Multicultural counseling.
- (I) Research methods in addictions.

Additionally, licensed clinical addiction counselors are required to have completed a supervised practicum, internship, or field experience in an addiction counseling setting, providing at least seven hundred (700) hours of clinical addiction counseling services. Finally, licensed clinical addiction counselors are required to have completed two (2) years of related addiction counseling experience. As is evident from the State-imposed licensure requirements, licensed

September 7, 2010

Page 3

clinical addiction counselors are extremely educated and experienced in their field, and trained specifically for treating individuals with the conditions so often treated by our facilities.

A significant proportion of those who are mentally ill also suffer from the co-occurring condition of a substance abuse disorder or addiction. Specifically, it is estimated that 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness.³ We believe that this duality is even higher in the Medicaid population. The prevalence of substance abuse disorders among the population of the Medicaid enrollees we treat for mental illness clearly demonstrates the critical need for the highly-educated and experience-driven treatment provided by licensed clinical addiction counselors as part of the continuum of care.

In addition to the fact that licensed clinical addiction counselors are necessary for effective treatment of our patients, we believe that licensed clinical addiction counselors should be added to the list of those professionals eligible for Medicaid reimbursement for Outpatient Mental Health Services because we believe there is no reason for their omission from the Outpatient Mental Health Services portion of the recently revised rule. Instead, when we commented at the public hearing on LSA #10-45 (Outpatient Mental Health Services and MRO Services final rule) we stated that licensed clinical addiction counselors should be added to the list of professionals who can bill Medicaid. We were told by FSSA representatives that FSSA would not revise the rule to add licensed clinical addiction counselors because they were not included in the original list of those eligible for Medicaid reimbursement. After further examination of FSSA's response, we discovered that licensed clinical addiction counselors could not have been originally included in the list of those professionals eligible for Medicaid reimbursement for Outpatient Mental Health Services because the category of providers did not exist at the time the original Outpatient Mental Health Services rule was written. While the Outpatient Mental Health Services rule has been in existence for many years, the Senate Bill creating the category of licensed clinical addiction counselors was only recently passed in 2009.⁴ If FSSA's concern is additional Medicaid spending, we firmly believe that to omit licensed clinical addiction counselors from the list of those providers eligible to bill for Outpatient Mental Health Services will only result in considerably more Medicaid expenditures due to the exorbitant cost of untreated substance abuse and addiction.

We strongly believe that the Medicaid population should have access to licensed clinical addiction counselors just as other populations who suffer from co-occurring conditions. Additionally, we feel that it would be inappropriate to disadvantage the Medicaid population by continuing to omit licensed clinical addiction counselors from the list of those professionals

³ *Fact Sheet: Dual Diagnosis*, Mental Health America website, available at <http://www.nmha.org/index.cfm?objectid=C7DF9405-1372-4D20-C89D7BD2CD1CA1B9>.

⁴ Senate Enrolled Act 96, First Regular Session 116th General Assembly (2009), available at <http://www.in.gov/apps/lsa/session/billwatch/billinfo?year=2009&session=1&request=getBill&docno=96> (Attached here as "Attachment B").

September 7, 2010

Page 4

eligible for Medicaid reimbursement for Outpatient Mental Health Services merely due to the fact that such category of providers was created at a time later than the categories of included providers already reimbursable.

For the reasons stated herein, we respectfully request the support and assistance of the Mental Health Commission in promulgating legislation that would require licensed clinical addiction counselors be added to the list of those professionals eligible for Outpatient Mental Health Services reimbursement. As our Medicaid program continues to emphasize care in the least-restrictive environment as is medically appropriate, the addition of these professionals is crucial for effective mental health care.

Sincerely,



Jean Scallon

CEO, Bloomington Meadows Hospital

cc: John Hollinsworth, Division President, Psychiatric Solutions, Inc.
Bryan Lett, CEO, Michiana Behavioral Health Center
David Bell, CEO, Valle Vista Hospital
Thomas Stormanns, CEO, Wellstone Regional Hospital
Kelly Ulreich, CEO, Columbus Behavioral Health Center for Children and Adolescents

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COMH
Meeting 3
October 27, 2010

Exhibit 5

**PRELIMINARY DRAFT
No. 3049**

**PREPARED BY
LEGISLATIVE SERVICES AGENCY
2011 GENERAL ASSEMBLY**

DIGEST

Citations Affected: IC 12-21-6.5-9.

Synopsis: Extends the commission on mental health for five years.
Extends the expiration date for the commission on mental health from
June 30, 2011, to June 30, 2016.

Effective: July 1, 2011.



A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-21-6.5-9, AS ADDED BY P.L.12-2006,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2011]: Sec. 9. This chapter expires ~~June 30, 2011~~ **June 30,**
4 **2016.**



COMH

Meeting 3

October 27, 2010

Exhibit 6



PRELIMINARY DRAFT
No. 3082

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2011 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 12-24-1-3.5.

Synopsis: Council on Evansville state hospitals. Establishes the council for Evansville state hospitals.

Effective: July 1, 2011.



A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-24-1-3.5 IS ADDED TO THE INDIANA CODE
2 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
3 1, 2011]: **Sec. 3.5. (a) The council on Evansville state hospitals is
4 established.**

5 **(b) The council consists of the following members:**

6 **(1) One (1) superior court judge having exclusive juvenile
7 jurisdiction in Vanderburgh County, who shall act as
8 chairperson of the council.**

9 **(2) The director of the division of mental health and addiction
10 or the director's designee.**

11 **(3) Two (2) members of the senate, appointed by the president
12 pro tempore of the senate. The members appointed under this
13 subdivision:**

14 **(A) may not be members of the same political party; and**

15 **(B) must represent Evansville or a surrounding area.**

16 **(4) Two (2) members of the house of representatives,
17 appointed by the speaker of the house of representatives. The
18 members appointed under this subdivision:**

19 **(A) may not be members of the same political party; and**

20 **(B) must represent Evansville or a surrounding area.**

21 **(5) Two (2) mental health providers that provide mental
22 health services in the Evansville area.**

23 **(6) One (1) member who:**

24 **(A) resides in the Evansville area; and**

25 **(B) provides services in the community, including:**

26 **(i) law enforcement services; or**

27 **(ii) children's services.**

28 **(7) The superintendent of the Evansville State Psychiatric
29 Treatment Center for Children, or the superintendent's
30 designee.**

31 **(8) The superintendent of the Evansville State Hospital, or the**



- 1 superintendent's designee.
- 2 **(9) One (1) representative of a statewide mental health**
- 3 **association.**
- 4 **(10) One (1) parent of a child who has received services at the**
- 5 **Evansville State Psychiatric Treatment Center for Children**
- 6 **and who is not associated with the Evansville State**
- 7 **Psychiatric Treatment Center for Children or the Evansville**
- 8 **State Hospital except as a consumer.**
- 9 **(c) The president pro tempore of the senate shall appoint the**
- 10 **members under subsection (b)(1) and (b)(9) and one (1) member**
- 11 **under subsection (b)(5). The speaker of the house of**
- 12 **representatives shall appoint the members under subsection (b)(6)**
- 13 **and (b)(10) and one (1) member under subsection (b)(5).**
- 14 **(d) The council has the following duties:**
- 15 **(1) Review the following:**
- 16 **(A) The mental health and addiction services available to**
- 17 **children in the Evansville area.**
- 18 **(B) The quality of the care provided to patients in a facility**
- 19 **described in section 3(a)(1) and 3(a)(2) of this chapter.**
- 20 **(C) The utilization of the facilities and the cause for any**
- 21 **underutilization.**
- 22 **(2) Determine the viability and need for the facilities**
- 23 **described in section 3(a)(1) and 3(a)(2) of this chapter.**
- 24 **(3) Provide recommendations to:**
- 25 **(A) the office of the secretary; and**
- 26 **(B) the general assembly, in electronic format under**
- 27 **IC 5-14-6;**
- 28 **concerning the council's findings under this subsection,**
- 29 **including whether the council is making a recommendation**
- 30 **under section 3 of this chapter.**
- 31 **(e) The division of mental health and addiction shall staff the**
- 32 **council.**
- 33 **(f) The expenses of the council shall be paid by the division of**
- 34 **mental health and addiction.**
- 35 **(g) A member of the council is not entitled to salary per diem or**
- 36 **traveling expenses.**
- 37 **(h) The members described in subsection (b)(7) and (b)(8) shall**
- 38 **serve as nonvoting members. The affirmative votes of a majority**
- 39 **of the voting members of the council are required for the council**
- 40 **to take action on any recommendation.**
- 41 **(i) This section expires December 31, 2013.**



COMH
Meeting

October 20, 2010
S.H.W.T.

A CONCURRENT RESOLUTION affirming the support of the commission on mental health for the mental health Medicaid quality advisory committee.

1 Whereas, The mental health Medicaid quality advisory committee was established on a
2 permanent basis at the recommendation of the commission on mental health in 2010; and

3

4 Whereas, The mental health Medicaid quality advisory committee provides vital input to the
5 drug utilization review board: Therefore,

6

7

8 SECTION 1. That the commission on mental health supports the continuation of the mental
9 health Medicaid quality advisory committee.

10 SECTION 2. That copies of this resolution be transmitted by the Secretary of the Senate to
11 the office of the secretary of family and social services.

12

COMH

Meeting 3

October 27, 2010

Exhibit 8

OFFICE OF MEDICAID POLICY AND PLANNING

*REPORT TO THE SELECT JOINT COMMISSION ON MEDICAID
OVERSIGHT, IN ACCORDANCE WITH IC 12-15-35-51(i)*

October 2010

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INTRODUCTION

Indiana statute at IC 12-15-35-51(see Attachment 1) provided for the establishment of the mental health Medicaid quality advisory committee (see Attachment 2), referred to as “Mental Health Quality Advisory Committee” or, more simply, MHQAC. This important advisory committee to the Office of Medicaid Policy and Planning (“Office”) has played a centrist role in the development and recommendation to the Office of medically cogent and reasonable coverage policy pertaining to mental health medications under the Indiana Health Coverage (IHCP) programs benefit structure.

IC 12-15-35-51(i) (see Attachment 1) requires the Office to issue a report to the Select Joint Commission on Medicaid Oversight. The report—this document—substantially recaps the important work done by the MHQAC in its advisory role to the Office regarding mental health drug coverage policy.

It is the view of the Office that, through the substantial clinical knowledge and expertise of the members of the MHQAC, both IHCP and the citizens of the State of Indiana have realized the benefits of a clinically superior and fiscally prudent mental health drug coverage policy. As part of this report, the Office would like to extend its sincerest thanks to members of the MHQAC for the time and consideration they have afforded, and continue to provide, as members of this advisory Committee. The Office welcomes all comments from the members of the Select Joint Commission regarding this report.

EXECUTIVE SUMMARY

House Enrolled Act 1325 (HEA 1325) created the Mental Health Quality Advisory Committee (MHQAC). The purpose of the committee is to develop guidelines and programs to allow open and appropriate access to mental health medications, provide educational materials to prescribers, and to promote appropriate use of mental health medications. Various tasks performed by this committee include recommending "utilization edits" (also referred to as "dose optimization edits") for mental health medications, recommending "polypharmacy edits" (also referred to as "quality edits") for specific prescribing situations that may occur with mental health medications, monitoring mental health medication prior authorization statistics related to the above-referenced edits, and reviewing various reports to develop a deeper understanding of the impact of the Committee's actions on the program.

OBJECTIVES

The objectives of this report, per statute, are to:

- 1.) Advise the Select Joint Commission on Medicaid Oversight of the MHQAC's advice and recommendations under IC 12-15-35-51.
- 2.) Provide the number of restrictions implemented under IC 12-15-35.5.7(c) and the outcome of such restrictions.
- 3.) Provide information related to the transition of individuals who are aged, blind, or disabled to the risk based managed care program.
- 4.) Provide information regarding decisions by the Office to change the health care delivery system in which Medicaid is provided to recipients.

DEFINITIONS

Behavioral Health Drugs— The terms “behavioral health drugs” and “mental health drugs” are synonymous. Both terms refer collectively to antidepressants, antipsychotics, anti-anxiety medications, and so-called “cross-indicated” drugs.

Cross-Indicated Drug—Defined in Indiana statute at IC 12-15-35.5-2 as “a drug that is used for a purpose generally held to be reasonable, appropriate, and within the community standards of practice even though the use is not included in the federal Food and Drug Administration's approved labeled indications for the drug.”

Triple A/Cross-Indicated Drugs (or “3A/Cross-Indicated Drugs”) —“Triple A/cross-indicated drugs” are “behavioral health drugs” (synonymous with “mental health drugs”).

Polypharmacy Edits—Also referred to as “quality edits”, these are claims processing system edits that are intended to prevent inappropriate prescribing situations. These edits, when encountered, require a medical necessity review via the prior authorization systems

Utilization Edits—Also referred to as “dose optimization edits”, these are claims processing system edits that identify prescribing situations inconsistent with established pharmacokinetic principles and clinical practice guidelines. The intent of the edits, some of which require prior authorization review when encountered, is to promote patient adherence to medication regimens and ensure safe, appropriate use of medications by the Indiana Medicaid population

OVERVIEW OF THE MHQAC

The advisory committee consists of the following members:

- (1) The director of the office or the director's designee, who shall serve as chairperson of the advisory committee
- (2) The director of the division of mental health and addiction or the director's designee
- (3) A representative of a statewide mental health advocacy organization
- (4) A representative of a statewide mental health provider organization
- (5) A representative from a managed care organization that participates in the state's Medicaid program
- (6) A member with expertise in psychiatric research representing an academic institution
- (7) A licensed pharmacist under IC 25-26
- (8) The commissioner of the department of correction or the commissioner's designee

The governor shall make the appointments for a term of four (4) years. The affirmative votes of a majority of the voting members appointed to the advisory committee are required by the advisory committee to take action on any measure.

The advisory committee shall advise the office and make recommendations and consider the following:

- (1) Peer reviewed medical literature
- (2) Observational studies
- (3) Health economic studies
- (4) Input from physicians and patients
- (5) Any other information determined by the advisory committee to be appropriate

The MHQAC's recommendations on all matters before it are conveyed to the Indiana Medicaid DUR Board for the Board's final determination and recommendations to the Office.

RECOMMENDATIONS OF THE MHQAC AND OUTCOMES

Mental Health Polypharmacy Edits

On January 1, 2007, six polypharmacy edits were implemented in the pharmacy claims processing systems of both fee-for-service and managed care plans. The purpose of these edits is to prevent inappropriate prescribing situations. These edits, when encountered, require a medical necessity review via the prior authorization systems. The polypharmacy edits apply to the following clinical situations:

1. Patient receiving two or more tricyclic antidepressant medications
2. Patient receiving two or more typical antipsychotic medications
3. Patient receiving three or more atypical antipsychotic medications
4. Patient receiving three or more of any antipsychotic medications
5. Patient receiving three or more benzodiazepine medications
6. Patient receiving three or more any antidepressant medications, excluding trazodone

Additional polypharmacy edits were subsequently implemented. Please refer to the Automated Prior Authorization section (page 19) of this report for additional information.

Utilization Edits

Various claims processing edits referred to as utilization edits were implemented on June 19, 2007. These edits address prescribing situations inconsistent with established clinical practice guidelines and in some instances require prior authorization when encountered. The intent of the edits is to promote patient adherence to medication regimens and ensure safe, appropriate use of medications by the Indiana Medicaid population. Utilization edits are reviewed on a quarterly basis, with updates conveyed to providers.

The polypharmacy and utilization edits were implemented consistently in both the traditional and managed care Medicaid pharmacy programs. Prior authorization criteria were developed to allow for medically appropriate prescribing circumstances. Please see Table 1 for a complete listing of mental health medications and utilization edits as of July 20, 2010.

Table 1 - Mental Health Medications and Utilization Edits

Mental Health Medication	Utilization Edit
ABILIFY 1MG/ML SOLUTION	30ml/day
ABILIFY 2MG TABLET	1/day
ABILIFY 5MG TABLET	1.5/day
ABILIFY 10MG TABLET	1/day
ABILIFY 15MG TABLET	1/day
ABILIFY 20MG TABLET	2/day
ABILIFY 30MG TABLET	1/day
ABILIFY DISCMELT 10MG TABL	2/day
ABILIFY DISCMELT 15MG TABL	2/day
ADDERALL XR 5MG CAPSULE SA	1/day
ADDERALL XR 10MG CAPSULES	1/day
ADDERALL XR 15MG CAPSULES	1/day
ADDERALL XR 20MG CAPSULES	2/day
ADDERALL XR 25MG CAPSULES	2/day
ADDERALL XR 30MG CAPSULES	2/day
ALPRAZOLAM 0.25MG TABLET	4/day
ALPRAZOLAM 0.5MG TABLET	4/day
ALPRAZOLAM 1MG TABLET	4/day
ALPRAZOLAM 2MG TABLET	4/day
ALPRAZOLAM 0.25MG ODT	4/day
ALPRAZOLAM 0.5MG ODT	4/day
ALPRAZOLAM 1MG ODT	4/day
ALPRAZOLAM 2MG ODT	4/day
ALPRAZOLAM 1MG/ML ORALCON	4ml/day
ALPRAZOLAM XR 0.5MG TABLET	1/day
ALPRAZOLAM XR 1MG TABLET	1/day
ALPRAZOLAM XR 2MG TABLET	1/day
ALPRAZOLAM XR 3MG TABLET	1/day
AMBIEN 5MG TABLET	1/day
AMBIEN 10MG TABLET	1/day
AMBIEN CR 6.25MG TABLET	1/day
AMBIEN CR 12.5MG TABLET	1/day
AMITRIPTYLINE HCL 10MG TAB	3/day
AMITRIPTYLINE HCL 25MG TAB	3/day
AMITRIPTYLINE HCL 50MG TAB	3/day
AMITRIPTYLINE HCL 75MG TAB	3/day
AMITRIPTYLINE HCL 100MG TA	3/day
AMITRIPTYLINE HCL 150MG TA	3/day
AMPHETAMINE SALTS 5MG TAB	3/day
AMPHETAMINE SALTS 7.5MG TA	3/day
AMPHETAMINE SALTS 10MG TAB	3/day
AMPHETAMINE SALTS 12.5MG T	3/day

Mental Health Medication	Utilization Edit
AMPHETAMINE SALTS 15MG TAB	3/day
AMPHETAMINE SALTS 20MG TAB	3/day
AMPHETAMINE SALTS 30MG TAB	3/day
ARICEPT 5MG TABLET	1/day
ARICEPT 10MG TABLET	1/day
ARICEPT ODT 5MG TABLET	1/day
ARICEPT ODT 10MG TABLET	1/day
BUPROPION HBR 348MG TAB SR 24H ORAL	1/day
BUPROPION HBR 522MG TAB SR 24H ORAL	1/day
BUPROPION HCL 75MG TABLET	4/day
BUPROPION HCL 100MG TABLET	4/day
BUPROPION SR 100MG TABLET	2/day
BUPROPION SR 150MG TABLET	2/day
BUPROPION HCL SR 200MG TAB	2/day
BUSPIRONE HCL 5MG TABLET	3/day
BUSPIRONE HCL 7.5MG TABLET	3/day
BUSPIRONE HCL 10MG TABLET	3/day
BUSPIRONE HCL 15MG TABLET	3/day
BUSPIRONE HCL 30MG TABLET	2/day
BUTISOL SODIUM 30MG/5 ML ELIXIR	15 ML/day
BUTISOL SODIUM 30MG TABLET	3/day
BUTISOL SODIUM 50MG TABLET	2/day
CHLORAL HYDRATE 250MG/5ML	20ml/day
CHLORAL HYDRATE 500MG/5 ML	10ml/day
CHLORAL HYDRATE 500MGCAPS	2/day
CHLORAL HYDRATE 500MGSUPP	2/day
CHLORDIAZEPOXIDE 5MG CAP	4/day
CHLORDIAZEPOXIDE 10MG CAP	4/day
CHLORDIAZEPOXIDE 25MG CAP	4/day
CHLORPROMAZINE 10MG TABLET	4/day
CHLORPROMAZINE 25MG TABLET	4/day
CHLORPROMAZINE 50MG TABLET	4/day
CHLORPROMAZINE100MGTABLET	4/day
CHLORPROMAZINE200MGTABLET	4/day
CITALOPRAM 10MG/5 ML SOLUT	20ml/day
CITALOPRAM HBR 10MG TABLET	1/day
CITALOPRAM HBR 20MG TABLET	1/day
CITALOPRAM HBR 40MG TABLET	1/day
CLOMIPRAMINE 25MG CAPSULE	2/day
CLOMIPRAMINE 50MG CAPSULE	5/day
CLOMIPRAMINE 75MG CAPSULE	3/day
CLONAZEPAM .125MG DIS TAB	3/day
CLONAZEPAM .25MG DIS TAB	3/day
CLONAZEPAM 0.5MG DIS TAB	3/day
CLONAZEPAM 1MG DIS TABLET	3/day

Mental Health Medication	Utilization Edit
CLONAZEPAM 2MG DIS TAB	3/day
CLONAZEPAM 0.5 MG TABLET	3/day
CLONAZEPAM 1MG TABLET	3/day
CLONAZEPAM 2MG TABLET	3/day
CLONIDINE HCL 0.1MG TABLET	10/day
CLONIDINE HCL 0.2MG TABLET	10/day
CLONIDINE HCL 0.3MG TABLET	8/day
CLORAZEPATE 3.75MG TABLET	4/day
CLORAZEPATE 7.5MG TABLET	4/day
CLORAZEPATE 15MG TABLET	4/day
CLOZAPINE 12.5MG TABLET	3/day
CLOZAPINE 25MG TABLET	3/day
CLOZAPINE 50MG TABLET	3/day
CLOZAPINE 100MG TABLET	6/day
CLOZAPINE 200MG TABLET	3/day
COGNEX 10MG CAPSULE	4/day
COGNEX 20MG CAPSULE	4/day
COGNEX 30MG CAPSULE	4/day
COGNEX 40MG CAPSULE	4/day
CONCERTA 18MG TABLET SA	1/day
CONCERTA 27MG TABLET SA	1/day
CONCERTA 36MG TABLET SA	2/day
CONCERTA 54MG TABLET SA	2/day
CYMBALTA 20MG CAPSULE	2/day
CYMBALTA 30MG CAPSULE	2/day
CYMBALTA 60MG CAPSULE	2/day
D-AMPHETAMINE 5MG CAP SA	2/day
D-AMPHETAMINE 15MG CAP SA	2/day
D-AMPHETAMINE SULFATE, 5MG/5ML SOLUTION	40ml/day
DAYTRANA 10MG/9 HR PATCH	1/day
DAYTRANA 15MG/9 HR PATCH	1/day
DAYTRANA 20MG/9 HOUR PATCH	1/day
DAYTRANA 30MG/9 HOUR PATCH	1/day
DESIPRAMINE 10MG TABLET	4/day
DESIPRAMINE 25MG TABLET	2/day
DESIPRAMINE 50MG TABLET	2/day
DESIPRAMINE 75MG TABLET	2/day
DESIPRAMINE 100MG TABLET	3/day
DESIPRAMINE 150MG TABLET	2/day
DEXEDRINE SPANSULES, 5MG CAPSULE	2/day
DEXEDRINE SPANSULES, 15MG CAPSULE	2/day
DEXTROAMPHETAMINE 5MG TAB	3/day
DEXTROAMPHETAMINE 10MG TAB	3/day
DEXTROAMPHET 10MG SR CAPSULE	2/day
DIAZEPAM 2MG TABLET	4/day
DIAZEPAM 5MG TABLET	4/day

Mental Health Medication	Utilization Edit
DIAZEPAM 10MG TABLET	4/day
DIAZEPAM 5MG/ML ORAL CONC	8ml/day
DORAL 7.5MG TABLET	1/day
DORAL 15MG TABLET	1/day
DOXEPIN 10MG/ML ORAL CONC	30ml/day
DOXEPIN 10MG CAPSULE	4/day
DOXEPIN 25MG CAPSULE	2/day
DOXEPIN 50MG CAPSULE	2/day
DOXEPIN 75MG CAPSULE	2/day
DOXEPIN 100MG CAPSULE	2/day
DOXEPIN 150MG CAPSULE	2/day
EDLUAR 5MG SL TABLET	1/day
EDLUAR 10MG SL TABLET	1/day
EFFEXOR XR 37.5MG CAPSULE	1/day
EFFEXOR XR 75MG CAPSULE	2/day
EFFEXOR XR 150MG CAPSULE	2/day
EMSAM 6MG/24 HOURS PATCH	1/day
EMSAM 9MG/24 HOURS PATCH	1/day
EMSAM 12MG/24 HOURS PATCH	1/day
ERGOLOID MESYL 0.5MG TAB SL	3/day
ERGOLOID MESYL 1MG TAB SL	3/day
ERGOLOID MESYLATES 1MG TAB	3/day
ESTAZOLAM 1MG TABLET	1/day
ESTAZOLAM 2MG TABLET	1/day
EXELON 2MG/ML ORAL SOLUTIO	6ml/day
EXELON 1.5MG CAPSULE	2/day
EXELON 3MG CAPSULE	2/day
EXELON 4.5MG CAPSULE	2/day
EXELON 6MG CAPSULE	2/day
EXELON 4.6MG/24 HOUR PATCH	1/day
EXELON 9.5MG/24 HOUR PATCH	1/day
FANAPT 1MG	2/day
FANAPT 2MG	2/day
FANAPT 4MG	2/day
FANAPT 6MG	2/day
FANAPT 8MG	2/day
FANAPT 10MG	2/day
FANAPT 12MG	2/day
FANAPT 1-2-4-6MG DOSEPAK	2/day
FAZACLO 12.5MG TABLET	3/day
FAZACLO 25MG TABLET	3/day
FAZACLO 100MG TABLET	6/day
FLUOXETINE 20MG/5 ML SOLUT	20ml/day
FLUOXETINE HCL 10MG CAPSUL	1/day
FLUOXETINE HCL 10MG TABLET	1.5/day
FLUOXETINE HCL 20MG CAPSUL	4/day
FLUOXETINE HCL 20MG TABLET	4/day

Mental Health Medication	Utilization Edit
FLUOXETINE HCL 40MG CAPSUL	2/day
FLUPHENAZINE 1MG TABLET	4/day
FLUPHENAZINE 2.5MG TABLET	4/day
FLUPHENAZINE 5MG TABLET	4/day
FLUPHENAZINE 10MG TABLET	4/day
FLURAZEPAM 15MG CAPSULE	1/day
FLURAZEPAM 30MG CAPSULE	1/day
FLUVOXAMINE MALEATE 25MG T	1/day
FLUVOXAMINE MALEATE 50MG T	1/day
FLUVOXAMINE MAL 100MG TAB	3/day
FOCALIN 2.5MG TABLET	2/day
FOCALIN 5MG TABLET	2/day
FOCALIN 10MG TABLET	4/day
FOCALIN XR 5MG CAPSULE	1/day
FOCALIN XR 10MG CAPSULE	1/day
FOCALIN XR 15MG CAPSULE	1/day
FOCALIN XR 20MG CAPSULE	2/day
FOCALIN XR 30MG CAPSULE	1/day
GEODON 20MG CAPSULE	2/day
GEODON 40MG CAPSULE	2/day
GEODON 60MG CAPSULE	3/day
GEODON 80MG CAPSULE	3/day
HALOPERIDOL 0.5MG TABLET	3/day
HALOPERIDOL 1MG TABLET	3/day
HALOPERIDOL 2MG TABLET	3/day
HALOPERIDOL 5MG TABLET	3/day
HALOPERIDOL 10MG TABLET	3/day
HALOPERIDOL 20MG TABLET	3/day
HYDERGINE LC 1MG CAPSULE	3/day
HYDROXYZINE 10MG/5 ML SYRU	100ml/day
HYDROXYZINE HCL 10MG TABLE	4/day
HYDROXYZINE HCL 25MG TABLE	4/day
HYDROXYZINE HCL 50MG TABLE	8/day
HYDROXYZINE PAM 25MG CAP	4/day
HYDROXYZINE PAM 50MG CAP	4/day
HYDROXYZINE PAM 100MG CAP	4/day
IMIPRAMINE HCL 10MG TABLET	2/day
IMIPRAMINE HCL 25MG TABLET	1/day
IMIPRAMINE HCL 50MG TABLET	6/day
IMIPRAMINE PAMOATE 75MG CA	1/day
IMIPRAMINE PAMOATE 100MG C	3/day
IMIPRAMINE PAMOATE 125MG C	2/day
IMIPRAMINE PAMOATE 150MG C	2/day
INTUNIV ER 1MG	1/day
INTUNIV ER 2MG	1/day
INTUNIV ER 3MG	1/day
INTUNIV ER 4MG	1/day

Mental Health Medication	Utilization Edit
INVEGA 3MG TABLET	1/day
INVEGA 6MG TABLET	2/day
INVEGA 9MG TABLET	1/day
INVEGA ER 1.5MG TABLET	1/day
INVEGA SUSTENNA 39MG PREFILLED SYRINGE	1/28 days
INVEGA SUSTENNA 78MG PREFILLED SYRINGE	1/28 days
INVEGA SUSTENNA 117MG PREFILLED SYRINGE	1/28 days
INVEGA SUSTENNA 156MG PREFILLED SYRINGE	1/28 days
INVEGA SUSTENNA 234MG PREFILLED SYRINGE	1/28 days
LEXAPRO 5MG TABLET	1/day
LEXAPRO 10MG TABLET	1/day
LEXAPRO 20MG TABLET	2/day
LEXAPRO 5MG/5 ML SOLUTION	20ml/day
LIBRITABS 25MG TABLET	4/day
LORAZEPAM 0.5MG TABLET	4/day;max quantity 120
LORAZEPAM 1MG TABLET	4/day;max quantity 120
LORAZEPAM 2MG TABLET	4/day;max quantity 120
LOXAPINE SUCCINATE 5MG CA	4/day
LOXAPINE SUCCINATE 10MG CA	4/day
LOXAPINE SUCCINATE 25MG CAP	4/day
LOXAPINE SUCCINATE 50MG CA	4/day
LUNESTA 1MG TABLET	1/day
LUNESTA 2MG TABLET	1/day
LUNESTA 3MG TABLET	1/day
LUVOX CR 100MG CAPSULES	2/day
LUVOX CR 150MG CAPSULES	2/day
MARPLAN 10MG TABLET	3/day
MAPROTILINE 25MG TABLET	3/day
MAPROTILINE 50MG TABLET	3/day
MAPROTILINE 75MG TABLET	3/day
MEPROBAMATE 200MG TABLET	4/day
MEPROBAMATE 400MG TABLET	4/day
METADATE CD 10MG CAPSULE	1/day
METADATE CD 20MG CAPSULE	1/day
METADATE CD 30MG CAPSULE	1/day
METADATE CD 40MG CAPSULE	1/day
METADATE CD 50MG CAPSULE	1/day
METADATE CD 60MG CAPSULE	1/day
METADATE ER 10MG TABLET	3/day
METADATE ER 20MG TABLET	3/day
METHAMPHETAMINE HCL 5MG TA	PA
METHYLIN 2.5MG CHEWABLE TAB	3/day

Mental Health Medication	Utilization Edit
METHYLIN 5MG CHEWABLE TAB	3/day
METHYLIN 10MG CHEWABLE TABL	3/day
METHYLIN 5MG/5 ML SOLUTION	60ml/day
METHYLIN 10MG/5 ML SOLUTIO	30ml/day
METHYLIN ER 10MG TABLET SA	3/day
METHYLIN ER 20MG TABLET SA	3/day
METHYLPHENIDATE 5MG TABLE	3/day
METHYLPHENIDATE 10MG TABLE	3/day
METHYLPHENIDATE 20MG TABLET	3/day
METHYLPHENIDATE ER 20MG TA	3/day
MIRTAZAPINE 7.5MG TABLET	1/day
MIRTAZAPINE 15MG RPD DISLV	1/day
MIRTAZAPINE 15MG TABLET	1/day
MIRTAZAPINE 30MG RPD DISLV	1/day
MIRTAZAPINE 30MG TABLET	1/day
MIRTAZAPINE 45MG RPD DISLV	1/day
MIRTAZAPINE 45MG TABLET	1/day
MOBAN 5MG TABLET	4/day
MOBAN 10MG TABLET	4/day
MOBAN 25MG TABLET	4/day
MOBAN 50MG TABLET	4/day
MOBAN 100MG TABLET	3/day
NAMENDA 10MG/5 ML SOLUTION	10ml/day
NAMENDA 5MG TABLET	2/day
NAMENDA 10MG TABLET	2/day
NAMENDA 5-10MG TITRATION P	2/day
NARDIL 15MG TABLET	6/day
NEFAZODONE HCL 50MG TABLET	2/day
NEFAZODONE HCL 100MG TABLE	2/day
NEFAZODONE HCL 150MG TABLE	2/day
NEFAZODONE HCL 200MG TABLE	2/day
NEFAZODONE HCL 250MG TABLE	2/day
NIRAVAM 0.25MG TABLET	3/day
NIRAVAM 0.5MG TABLET	3/day
NIRAVAM 1MG TABLET	3/day
NIRAVAM 2MG TABLET	3/day
NORPRAMIN 25MG TABLET	2/day
NORPRAMIN 50MG TABLET	2/day
NORTRIPTYLINE 10MG/5 ML SO	20ml/day
NORTRIPTYLINE HCL 10MG CAP	4/day
NORTRIPTYLINE HCL 25MG CAP	4/day
NORTRIPTYLINE HCL 50MG CAP	3/day
NORTRIPTYLINE HCL 75MG CAP	2/day
NUVIGIL 50MG	2/day
NUVIGIL 100MG	1/day
NUVIGIL 150MG	1/day
NUVIGIL 200MG	1/day

Mental Health Medication	Utilization Edit
NUVIGIL 250MG	1/day
ORAP 1MG TABLET	10/day
ORAP 2MG TABLET	5/day
OXAZEPAM 10MG CAPSULE	4/day;max quantity 120
OXAZEPAM 15MG CAPSULE	4/day;max quantity 120
OXAZEPAM 30MG CAPSULE	4/day;max quantity 120
OXAZEPAM 15MG TABLET	4/day;max quantity 120
PAMELOR 10MG CAPSULE	4/day
PAROXETINE HCL 10MG TABLET	1/day
PAROXETINE HCL 20MG TABLET	1/day
PAROXETINE HCL 30MG TABLET	2/day
PAROXETINE HCL 40MG TABLET	2/day
PAXIL 10MG/5 ML SUSPENSION	40ml/day
PAXIL CR 12.5MG TABLET	1/day
PAXIL CR 25MG TABLET	1/day
PAXIL CR 37.5MG TABLET	1/day
PERPHENAZINE 2MG TABLET	4/day
PERPHENAZINE 4MG TABLET	4/day
PERPHENAZINE 8MG TABLET	4/day
PERPHENAZINE 16MG TABLET	4/day
PEXEVA 10MG TABLET	1/day
PEXEVA 20MG TABLET	1/day
PEXEVA 30MG TABLET	1/day
PEXEVA 40MG TABLET	1/day
PLACIDYL 500MG CAPSULE	1/day
PLACIDYL 750MG CAPSULE	1/day
PRISTIQ 50MG TABLET	1/day
PRISTIQ 100MG TABLET	1/day
PROTRIPTYLINE 5MG TABLET	4/day
PROTRIPTYLINE 10MG TABLET	4/day
PROVIGIL 100MG TABLET	1/day
PROVIGIL 200MG TABLET	2/day
PROZAC WEEKLY 90MG CAPSULE	4/28 days
RAZADYNE 4MG/ML ORAL SOLUT	6ml/day
RAZADYNE 4MG TABLET	2/day
RAZADYNE 8MG TABLET	2/day
RAZADYNE 12MG TABLET	2/day
RAZADYNE ER 8MG CAPSULE	1/day
RAZADYNE ER 16MG CAPSULE	1/day
RAZADYNE ER 24MG CAPSULE	1/day
RESTORIL 22.5MG CAPSULE	1/day
RISPERDAL 0.25MG TABLET	2/day
RISPERDAL 0.5MG TABLET	2/day
RISPERDAL 0.5 M-TAB	2/day
RISPERDAL 1MG M-TAB	2/day
RISPERDAL 1MG TABLET	2/day
RISPERDAL 2MG M-TAB	2/day

Mental Health Medication	Utilization Edit
RISPERDAL 2MG TABLET	2/day
RISPERDAL 3MG M-TAB	2/day
RISPERDAL 3MG TABLET	2/day
RISPERDAL 4MG M-TAB	2/day
RISPERDAL 4MG TABLET	2/day
RISPERDAL CONSTA 12.5MG SYR	2/28 days
RISPERDAL CONSTA 25MG SYR	2/28 days
RISPERDAL CONSTA 37.5MG SY	2/28 days
RISPERDAL CONSTA 50MG SYR	2/28 days
RISPERIDONE 0.25MG ODT	2/day
RISPERIDONE 1MG/1ML SOLUTION	8ml/day
RITALIN LA 10MG CAPSULE	1/day
RITALIN LA 20MG CAPSULE	1/day
RITALIN LA 30MG CAPSULE	2/day
RITALIN LA 40MG CAPSULE	1/day
ROZEREM 8MG TABLET	1/day
SAPHRIS 5MG SUBLINGUAL TABLET	2/day
SAPHRIS 10MG SUBLINGUAL TABLET	2/day
SARAFEM 10MG TABLET	1/day
SARAFEM 15MG TABLET	1/day
SARAFEM 20MG TABLET	1/day
SERAX 15MG TABLET	4/day;max quantity 120
SEROQUEL 25MG TABLET	3/day
SEROQUEL 50MG TABLET	3/day
SEROQUEL 100MG TABLET	3/day
SEROQUEL 200MG TABLET	3/day
SEROQUEL 300MG TABLET	4/day
SEROQUEL 400MG TABLET	4/day
SEROQUEL XR 150MG TABLET	1/day
SEROQUEL XR 200MG TABLET	1/day
SEROQUEL XR 300MG TABLET	3/day
SEROQUEL XR 400MG TABLET	4/day
SERTRALINE 20MG/ML ORAL CO	10ml/day
SERTRALINE HCL 25MG TABLET	2/day
SERTRALINE HCL 50MG TABLET	2/day
SERTRALINE HCL 100MG TABLE	3/day
SONATA 5MG CAPSULE	2/day
SONATA 10MG CAPSULE	2/day
STRATTERA 10MG CAPSULE	2/day
STRATTERA 18MG CAPSULE	2/day
STRATTERA 25MG CAPSULE	2/day
STRATTERA 40MG CAPSULE	2/day
STRATTERA 60MG CAPSULE	1/day
STRATTERA 80MG CAPSULE	1/day
STRATTERA 100MG CAPSULE	1/day
SURMONTIL 25MG CAPSULE	1/day
SURMONTIL 50MG CAPSULE	1/day

Mental Health Medication	Utilization Edit
SURMONTIL 100MG CAPSULE	3/day
SYMBYAX 3-25MG CAPSULE	1/day
SYMBYAX 6-25MG CAPSULE	1/day
SYMBYAX 6-50MG CAPSULE	1/day
SYMBYAX 12-25MG CAPSULE	1/day
SYMBYAX 12-50MG CAPSULE	1/day
TEMAZEPAM 7.5MG CAPSULE	1/day
TEMAZEPAM 15MG CAPSULE	1/day
TEMAZEPAM 30MG CAPSULE	1/day
THIOTHIXENE 20MG CAPSULE	3/day
THIORIDAZINE 10MG TABLET	4/day
THIORIDAZINE 15MG TABLET	4/day
THIORIDAZINE 25MG TABLET	4/day
THIORIDAZINE 50MG TABLET	4/day
THIORIDAZINE 100MG TABLET	4/day
THIORIDAZINE 150MG TABLET	4/day
THIORIDAZINE 200MG TABLET	4/day
THIOTHIXENE 1MG CAPSULE	3/day
THIOTHIXENE 2MG CAPSULE	3/day
THIOTHIXENE 5MG CAPSULE	3/day
THIOTHIXENE 10MG CAPSULE	3/day
TRANLYCYPROMINE SULF 10MG	6/day
TRANXENE SD 11.25MG TABLET	1/day
TRANXENE SD 22.5MG TAB	1/day
TRAZODONE 50MG TABLET	2/day
TRAZODONE 100MG TABLET	3/day
TRAZODONE 150MG TABLET	3/day
TRAZODONE 300MG TABLET	2/day
TRIAZOLAM 0.125MG TABLET	1/day
TRIAZOLAM 0.25MG TABLET	1/day
TRIFLUOPERAZINE 1MG TABLET	2/day
TRIFLUOPERAZINE 2MG TABLET	2/day
TRIFLUOPERAZINE 5MG TABLET	2/day
TRIFLUOPERAZINE 10MG TABLET	4/day
VENLAFAXINE HCL 25MG TABLET	3/day
VENLAFAXINE HCL 37.5MG TAB	3/day
VENLAFAXINE HCL 50MG TABLET	3/day
VENLAFAXINE HCL 75MG TABLET	3/day
VENLAFAXINE HCL 100MG TABLET	3/day
VENLAFAXINE HCL 37.5MG TAB OSM 24 ORAL	1/day
VENLAFAXINE HCL 75MG TAB OSM 24 ORAL	2/day
VENLAFAXINE HCL 150MG TAB OSM 24 ORAL	1/day
VENLAFAXINE HCL 225 MG TAB OSM 24 ORAL	1/day

Mental Health Medication	Utilization Edit
VENLAFAXINE XR 150MG CAPSULE	2/day
VYVANSE 20MG CAPSULE	1/day
VYVANSE 30MG CAPSULE	1/day
VYVANSE 40MG CAPSULE	1/day
VYVANSE 50MG CAPSULE	1/day
VYVANSE 60MG CAPSULE	1/day
VYVANSE 70MG CAPSULE	1/day
WELLBUTRIN XL 150MG TABLET	1/day
WELLBUTRIN XL 300MG TABLET	1/day
ZYPREXA 2.5MG TABLET	1/day
ZYPREXA 5MG TABLET	1/day
ZYPREXA 7.5MG TABLET	1/day
ZYPREXA 10MG TABLET	2/day
ZYPREXA 15MG TABLET	2/day
ZYPREXA 20MG TABLET	3/day
ZYPREXA ZYDIS 5MG TABLET	1/day
ZYPREXA ZYDIS 10MG TABLET	2/day
ZYPREXA ZYDIS 15MG TAB	2/day
ZYPREXA ZYDIS 20MG TABLET	3/day

Mental health drugs are considered to have preferred status, in accordance with state statute IC 12-15-35-28(g)(2). Prior to the pharmacy benefit consolidation at the end of calendar year 2009, mental health health drug expenditures represented about 38.2% of total drug expenditures, equaling approximately \$120 million per year. The estimated net savings associated with implementation of the polypharmacy and utilization edits was approximately \$4.94 million for the fee-for-service (FFS) Medicaid program for calendar year 2007. Please note that the polypharmacy edits were implemented in January of 2007, whereas the utilization edits were implemented in June of 2007. As a result of these utilization edits and the edits implemented since, the annual savings would be expected to be greater.

Automated Prior Authorization System

On November 1, 2009, the fee-for-service (FFS) pharmacy program implemented an automated prior authorization (PA) tool known as SmartPA™. SmartPA™ executes real-time prior authorization decisions by utilizing highly sophisticated clinical edits supported by the member's medical and pharmacy claims data.

SmartPA™ ensures that the prescribed therapy meets Indiana-specific evidence-based criteria for appropriate use. If the criteria is met, the claim will continue through the pharmacy claims processing system. If the criteria is not met, the claim will be denied and the provider will receive notification to contact the pharmacy prior authorization vendor.

The MHQAC recommended that several polypharmacy edits be implemented within the automated prior authorization system. Please see Table 4 for a listing of these edits and their implementation dates.

Table 4. Polypharmacy Edits Implemented within SmartPA™

Implementation Date	Indiana SmartPA™ Edit
March 16, 2010	Duplicate Stimulant Therapy
March 9, 2010	Low Dose Atypical Antipsychotic Therapy
February 9, 2010	Duplicate Atypical Antipsychotic Therapy
February 9, 2010	Duplicate Typical Antipsychotic Therapy
December 8, 2009	Duplicate SSRI and SNRI Antidepressant Therapy
November 1, 2009	15 Day Trial on New Atypical Antipsychotic Therapy

Monitoring Mental Health Medication Prior Authorization Statistics

The MHQAC monitors mental health medication prior authorization statistics in order to identify any trends that could potentially have a negative impact on beneficiaries and the financial aspects of the program. Included in the monitoring is the number of utilizing members that triggered edits. Evidence to date has demonstrated that no utilizing members have been adversely impacted by the MHQAC prior authorization requirements.

PROVIDE INFORMATION RELATED TO THE TRANSITION OF INDIVIDUALS WHO ARE AGED, BLIND, OR DISABLED TO THE RISK BASED MANAGED CARE PROGRAM; OFFICE DECISIONS TO CHANGE THE HEALTH CARE DELIVERY SYSTEM IN WHICH MEDICAID IS PROVIDED TO RECIPIENTS

On December 31, 2009, patients enrolled in IHCP managed care entities (MCEs) began receiving their pharmacy benefit through the fee-for-service (FFS) Medicaid program. This initiative, referred to as the pharmacy benefit consolidation, increased the number of members receiving their pharmacy benefit under the FFS Medicaid program from approximately 280,000 to approximately 1,000,000 . The consolidation has been well received by both beneficiaries and providers of service.

CONCLUSION

The MHQAC was tasked with developing guidelines and programs that promote appropriate use of mental health medications. Various tasks performed by the Committee include recommending polypharmacy and utilization edits for mental health medications, recommending automated prior authorizations for mental health medications, monitoring mental health medication prior authorization statistics, and reviewing various reports to develop a deeper understanding of the impact of the MHQAC's activities on the Medicaid program. The polypharmacy and utilization edits recommended by the MHQAC saved approximately \$4.94 million for CY 2007. The annual savings would be expected to be greater now as a result of subsequent edits made by the MHQAC.

On December 31, 2009, patients in the Medicaid managed care entities (MCEs) began receiving pharmacy benefits through the fee-for-service (FFS) Medicaid program. This action, which increased the number of members receiving pharmacy benefits through FFS from approximately 280,000 to approximately 1,000,000 , has been well received by both beneficiaries and providers of service.

ATTACHMENT 1

IC 12-15-35-51

Establishment of mental health Medicaid quality advisory committee; members; reimbursement; duties

Sec. 51. (a) As used in this section, "advisory committee" refers to the mental health Medicaid quality advisory committee established by subsection (b).

(b) The mental health Medicaid quality advisory committee is established. The advisory committee consists of the following members:

(1) The director of the office or the director's designee, who shall serve as chairperson of the advisory committee.

(2) The director of the division of mental health and addiction or the director's designee.

(3) A representative of a statewide mental health advocacy organization.

(4) A representative of a statewide mental health provider organization.

(5) A representative from a managed care organization that participates in the state's Medicaid program.

(6) A member with expertise in psychiatric research representing an academic institution.

(7) A pharmacist licensed under IC 25-26.

(8) The commissioner of the department of correction or the commissioner's designee.

The governor shall make the appointments for a term of four (4) years under subdivisions (3) through (7) and fill any vacancy on the advisory committee.

(c) The office shall staff the advisory committee. The expenses of the advisory committee shall be paid by the office.

(d) Each member of the advisory committee who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). The member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(e) Each member of the advisory committee who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(f) The affirmative votes of a majority of the voting members appointed to the advisory committee are required by the advisory committee to take action on any measure.

(g) The advisory committee shall advise the office and make recommendations concerning the implementation of IC 12-15-35.5-7(c) and consider the following:

(1) Peer reviewed medical literature.

(2) Observational studies.

(3) Health economic studies.

(4) Input from physicians and patients.

(5) Any other information determined by the advisory committee to be appropriate.

(h) The office shall report recommendations made by the advisory committee to the drug utilization review board established by section 19 of this chapter.

(i) The office shall report the following information to the select joint commission on Medicaid oversight established by IC 2-5-26-3:

(1) The advisory committee's advice and recommendations made under this section.

(2) The number of restrictions implemented under IC 12-15-35.5-7(c) and the outcome of each restriction.

(3) The transition of individuals who are aged, blind, or disabled to the risk based managed care program. This information shall also be reported to the health finance commission established by IC 2-5-23-3.

(4) Any decision by the office to change the health care delivery system in which Medicaid is provided to recipients.

(j) Notwithstanding subsection (b), the initial members appointed to the advisory committee under this section are appointed for the following terms:

(1) Individuals appointed under subsection (b)(3) and (b)(4) are appointed for a term of four (4) years.

(2) An individual appointed under subsection (b)(5) is appointed for a term of three (3) years.

(3) An individual appointed under subsection (b)(6) is appointed for a term of two (2) years.

(4) An individual appointed under subsection (b)(7) is appointed for a term of one (1) year.

This subsection expires December 31, 2013.

As added by P.L.36-2009, SEC.2.

ATTACHMENT 2

MHQAC MEMBERSHIP BY STATUTORY DESIGNATION

MEDICAID DIRECTOR

Patricia Casanova
Director of Medicaid
402 W. Washington St., W461
Indianapolis, IN 46204
pat.casanova@fssa.in.gov

DIRECTOR (OR DESIGNEE) OF THE DIVISION OF MENTAL HEALTH AND ADDICTION

Dr. George Parker, Medical Director
Division of Mental Health & Addiction
402 W. Washington St., W353
Indianapolis, IN 46204
george.parker@fssa.in.gov

COMMISSIONER (OR DESIGNEE) OF DEPARTMENT OF CORRECTION

Position currently vacant

REPRESENTATIVE OF A STATEWIDE MENTAL HEALTH ADVOCACY ORGANIZATION

Stephen McCaffrey, President and CEO
Mental Health Association in Indiana
1431 N. Delaware Street
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smccaffrey@mentalhealthassociation.com

REPRESENTATIVE OF A STATEWIDE MENTAL HEALTH PROVIDER ORGANIZATION

James Koontz, M.D., CEO

Samaritan Center
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Vincennes, IN 47591
JKOONTZ@gshvin.org

REPRESENTATIVE FROM A MEDICAID MCO

Katherine Wentworth, JD
Vice President of Legal Affairs
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1099 N. Meridian Street, Suite 320
Indianapolis, IN 46202
kwentworth@mdwise.org

ACADEMIC INSTITUTION REPRESENTATIVE (EXPERTISE IN PSYCHIATRIC RESEARCH)

Carol Ott, R.Ph., PharmD, BCPP
Wishard Hospital
Myers Building, Room W7555
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Indianapolis, IN 46202
caott@iupui.edu

PHARMACIST LICENSED UNDER IC 25-26

Jeremy Thain
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Fort Wayne, IN 46814
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FINAL REPORT

Commission on Mental Health

COMH

Meeting 3

October 27, 2010

Subject 5

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Commission on Mental Health is established by IC 12-21-6.5 to do the following:

- (1) Study and evaluate the funding system for mental health services in Indiana.
- (2) Review and make specific recommendations regarding the provision of mental health services delivered by community providers and state operated hospitals. The review and recommendations must cover services to all age groups including children, youth, and adults.
- (3) Review and make recommendations regarding any unmet need for public supported mental health services:
 - (A) in any specific geographic area; or
 - (B) throughout Indiana.

In formulating recommendations, the commission shall consider the need, feasibility, and desirability of including additional organizations in the network of providers of mental health services.

- (4) Monitor the implementation of managed care for the mentally ill that is paid for in part or in whole by the state.
- (5) Make recommendations regarding the commission's findings to the appropriate division or department of state government.

The Legislative Council assigned the following additional responsibilities to the Commission:

- A. Issues surrounding youth suicides (SCR 3, SEA 226-2010);
- B. The flow of medical information on inmates between local units of government and the Department of Correction (SCR 3);
- C. Changes to Medicaid Rehabilitation Option (MRO) and shifts in services caused by funding changes (SCR 3);
- D. A single drug formulary for Medicaid and the Department of Correction (SCR 3); and
- E. The mental health and addiction services available to children in the Evansville area, including the following:
 - (1) quality of the care provided to patients in the Evansville State Hospital and the Evansville State Psychiatric Treatment Center for Children;
 - (2) utilization of the facilities and the cause for any underutilization; and
 - (3) viability and need for the Evansville State Hospital and the Evansville State Psychiatric Treatment Center for Children (SB 2).

II. SUMMARY OF WORK PROGRAM

A copy of this report is available on the Internet. Reports, minutes, and notices are organized by committee. This report and other documents for this Commission can be

accessed from the General Assembly Homepage at <http://www.in.gov/legislative/>

The Commission met on August 19, 2010, September 7, 2010, and October 27, 2010.

At the August 19, 2010, meeting, the Commission received a presentation from the Youth Law T.E.A.M. of Indiana, Statewide Juvenile Mental Health Screening Assessment and Treatment Pilot Project; heard a discussion of issues relating to abuse of incarcerated youth; took extensive testimony concerning the issue of teen suicide; and took testimony on the issues surrounding budget cuts to the Residential Care Assistance Program (RCAP).

At the September 7, 2010, meeting, the Commission received an update on the RCAP program issues; more information on the Youth Law T.E.A.M. program; an update on the flow of medical information between local sheriffs and the Department of Correction (DOC); an update on the issues surrounding the drug formulary used by DOC; an update on Medicaid Rehabilitation Option (MRO); and a report on plans for state operated facilities.

At the October 27, 2010, meeting, the Commission received follow-up information from the Division of Mental Health and Addiction (DMHA); a presentation on housing issues relating to individuals with mental illness; and considered legislative proposals and the final report.

III. SUMMARY OF TESTIMONY

Complete minutes for this Commission can be accessed from the General Assembly Homepage at <http://www.in.gov/legislative/>

August 19, 2010

The Commission received an update from the Youth Law T.E.A.M. of Indiana, Statewide Juvenile Mental Health Screening Assessment and Treatment Pilot Project. Ms. JuaNae Hanger and Dr. Matt Aaslma discussed the progress of the pilot project. This is the final year of the pilot project, which has expanded from five juvenile detention centers to include 14 of the 22 centers in the state. At the end of this year the project will be making a final report, including legislative proposals for future years.

The Department of Correction and the Juvenile Justice Task Force presented information on the issue of the abuse of incarcerated youth. Mr. Tim Brown, Mr. Michael Dempsey, and Dr. Andrea Hall of the DOC informed the Commission that the number of incarcerated youth has been declining over the last several years due to the availability of more services in local communities. The DOC has a zero tolerance policy for abuse. Mr. Bill Glick, Executive Director of the Juvenile Justice Task Force, discussed the impact of abuse on the mental health of youth who are abused while incarcerated. Mr. Glick reported that there is very little specific information on this issue. He stated that incarcerated children are wards of the State and that makes the

State responsible for their safety.

In response to the mandate of the Legislative Council that the Commission consider the issue of teen suicide, Senator Patricia Miller discussed legislation she had introduced in the 2010 session of the General Assembly providing for education of teachers in the prevention of teen suicide. The concept of providing training for educators on recognizing symptoms of teen suicide was supported by the Indiana State Teachers Association, the Indiana School Boards Association, the Indiana Association of School Principals, and the Indiana Association of Public School Superintendents, all of whom provided testimony. Ms. Bre England, guidance counselor at Warren Central High School, testified on the importance of training for educators on teen suicide issues. Ms. Gina Eckart, DMHA, and Dr. Joan Duwve, Indiana State Department of Health (ISDH) discussed a joint DMHA and ISDH suicide prevention survey conducted by the state. Ms. Joni Irwin, the Jason Foundation, discussed the importance of providing education for teachers in recognizing signs that a teen could be considering suicide and stressed the importance of training for educators. Ms. Colleen Carpenter provided the Commission with information on the Indiana Cares Youth Suicide Prevention Technical Assistance Center operated at Indiana University Purdue University Fort Wayne. Mr. Scott Fritz shared his experience with the loss of his child to suicide.

Ms. Faith Laird discussed the budget cuts made to the Residential Care Assistance Program (RCAP). FSSA has instituted a freeze on new admissions to the program. The current rate is \$49.35 a day which. However, due to the freeze on admissions, fewer individuals are receiving assistance. The result has been that facilities cannot fill vacant beds when someone leaves. Mr. Randall Fearnow, Krieg DeVault, reported that several facilities are in danger of closing due to the cuts. There was discussion that the loss of the RCAP alternative will put pressure on other providers who will need to pick up the slack. There was also concern that alternatives to the RCAP program are more expensive than the RCAP program.

September 7, 2010

Mr. Nick Petrone, Aging Administration of FSSA, reported that little had changed from the last meeting concerning the RCAP issue. He said that the difficult economic condition of the state has forced FSSA to redirect money to those most in need. Mr. Randall Fearnow updated the Commission on the impact on local facilities of the cuts in funding. Mr. Robert Krumweid from the Regional Mental Health Center in Lake County echoed Mr. Fearnow's comments on the negative impact of the loss of funding for RCAP, which could cause facilities to close and force individuals in need of services to return to the streets.

Ms. JauNae Hanger and Ms. Amy Karozos provided the members with additional information on the screening program. They reported that costs to the detention centers for participating are mostly related to computer costs. The success of the screening program depends not only on screening but also on the availability of adequate services in the communities.

In response to a mandate from the Legislative Council, Mr. Steve Luce of the Indiana Sheriffs' Association discussed the improvements in communication between local sheriffs and the DOC in providing medical information for inmates transferred to the DOC. Mr. Kenneth Whitker reiterated Mr. Luce's comments concerning improved communications.

In response to a mandate from the Legislative Council, Mr. Steve McCaffrey, Mental Health America of Indiana, reported on the Mental Health /Corrections Quality Advisory Committee created by legislation recommended by the Commission on Mental Health to advise the DOC on the drugs used to treat inmates with mental illness and addictions. Members have been appointed to the Committee. Representatives from Correctional Medical Services (CMS) discussed issues with using the Medicaid formulary. Their testimony centered around the use of drugs in the private sector. They expressed concern that if an expensive drug is used during incarceration but, due to cost, is not available to the individual upon release, the individual has not been given the best care.

Ms. Gina Eckart and Ms. Sarah Jagger updated the Commission on MRO. They indicated that while there were issues of timely response to providers when the program was rolled out, much of that has been worked out. Mr. Matt Brooks indicated that, for the most part, the roll out has gone smoothly.

Mr. Steve McCaffrey discussed the Lawson Select Group on Mental Health, which was formed to consider issues in moving the state toward a more integrated system of service. Additionally, Mr McCaffrey said that there has been progress made in funding for the clubhouse programs which the Commission studied in the 2009 interim.

Ms. Gina Eckart and Mr. Kevin Moore discussed plans for changes to the state hospitals. There will be major changes for Logansport and Richmond State Hospitals. No hospitals are going to be closed or privatized. Individuals with developmental disabilities who are now receiving services at Logansport and Richmond are going to be placed back in the communities. The process will begin in October of 2010. Dr. Eric Wright discussed a study of patients who left Central State Hospital when it was closed.

Ms. Hariette Rosen, National Alliance on Mental Illness (NAMI), expressed concerns that when the hospitals are downsized, there should be plans to provide that the money follows the individuals into the community programs.

October 27, 2010

Ms. Gina Eckart updated....

Ms. Sherry Seiwert and Ms. Marti Knisley....

Legislative proposals were discussed.

The final report was adopted.

IV. COMMISSION FINDINGS AND RECOMMENDATIONS

The Commission considered the following bill drafts and resolutions:

- PD 3419 Various Mental Health Issues (Adopted/Rejected)
- PD 3081 Suicide Prevention Training (Adopted/Rejected)
- PD 3049 Extends the Commission on Mental Health for Five Years
(Adopted/Rejected)
- PD 3384 Medicaid Coverage of Services of Clinical Addiction Counselors
(Adopted/Rejected)
- PD 3082 Council on Evansville State Hospitals (Adopted/Rejected)
- Concurrent Resolution Support for Medicaid Quality Advisory Committee
(Adopted/Rejected)

WITNESS LIST

August 19, 2010

Ms. JuaNae Hanger, Youth Law T.E.A.M. of Indiana
Dr. Matt Aaslma, Youth Law T.E.A.M. of Indiana
Mr. Tim Brown, DOC
Mr. Michael Dempsey, DOC
Dr. Andrea Hall, DOC
Mr. Bill Glick, Juvenile Justice Task Force
Senator Patricia Miller
Ms. Bre England, Warren Central High School
Ms. Nancy Papas, Indiana State Teachers Association
Dr. Frank Bush, Indiana School Boards Association
Mr. Gerald Mohr, Indiana Association of School Principals
Mr. John Ellis, Indiana Association of Public School Superintendents
Ms. Gina Eckart, FSSA, DMHA
Dr. Joan Duwve, State Department of Health
Ms. Joni Irwin, The Jason Foundation
Ms. Colleen Carpenter, Indiana Cares Youth Suicide Prevention
Mr. Scott Fritz, Society for the Prevention of Teen Suicide
Ms. Faith Larid, Division of Aging, FSSA
Mr. Randall Fearnow, Krieg DeVault

September 7, 2010

Mr. Nick Petrone, Division of Aging, FSSA
Mr. Randall Fearnow, Krieg DeVault
Mr. Robert Krumweid, Regional Mental Health Center in Lake County
Mr. JuaNae Hanger Youth Law T.E.A.M.
Ms. Amy Karozos, Youth Law T.E.A.M.
Mr. Steve Luce, Indiana Sheriffs' Association
Mr. Kenneth Whitker, DOC
Mr. Steve McCaffrey, Mental Health America of Indiana
Mr. John Dallas, CMS
Mr. Michael Mitcheff, CMS
Mr. Jamie Wiles, CMS
Dr. Vickie Burding, CMS
Dr. Willis Triplett, CMS
Ms. Gina Eckart, DMHA, FSSA
Dr. Eric Wright, IU Center of Health Policy
Ms. Sarah Jagger, OMPP, FSSA
Mr. Matt Brooks, Indiana Council of Community Mental Health Centers
Mr. Kevin Moore, DMHA
Ms. Hariette Rosen, NAMI

October 27, 2010

Ms. Gina Eckart, DMHA, FSSA

Ms. Sherry Seiwert, Indiana Housing and Community Development Authority
Ms. Marti Knisley, Community Support Technical Assistance Collaborative, Inc.
Senator Vaneta Becker
Mr. Steve McCaffrey, Mental Health America of Indiana

Draft

COMH
 Meeting 3
 October 27, 2010

Exhibit 9



Indiana's Permanent Supportive Housing Initiative

Permanent Supportive Housing

The Face of Homelessness in Indiana

- On any given night, approximately 8,000 Hoosiers are experiencing homelessness (2010 Point in Time Count)
 - Persons with severe mental illness account for about 28 percent of all sheltered homeless persons
 - Persons with chronic substance abuse issues make up 39 percent of sheltered adults
 - Veterans represent about 15 percent of the total sheltered adult population
 - Persons with HIV/AIDS account for 4 percent of sheltered adults and unaccompanied youth
 - Victims of domestic violence constitute 13 percent of all sheltered persons
 - 40% of heads of households were in Foster Care (2008 AHAR)

Why Permanent Supportive Housing?

For decades, communities have "managed" homelessness without addressing the underlying cause

Emergency and institutional systems are significant sources of care and support, yet they discharge people, many with disabilities, into homelessness

Government is spending hundreds of millions of dollars per year, yet homeless rates are growing

The state's \$1.9 M Emergency Shelter Grant served 18,000 unduplicated people in 2007, only 28% left shelter to permanent stable housing



What is Permanent Supportive Housing?

A cost-effective combination of permanent, affordable housing with services that help people live more stable, productive lives




Supportive Housing Types

- Buildings developed/rehabilitated as special needs housing
- Rent-subsidized apartments
- Mixed-income buildings
- Long-term set asides
- Single-family homes
- Master-leased buildings or units




PSH is for People Who:

Are experiencing long-term homelessness

- Cycle through institutional and emergency systems and are at risk of long-term homelessness
- Are being discharged from institutions and systems of care
- Without housing, cannot access and make effective use of treatment and supportive services



Housing and Services



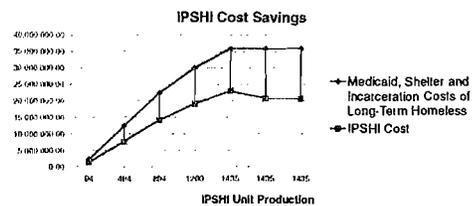
- Housing
 - Permanent:** Not time limited, not transitional
 - Affordable:** For people coming out of homelessness
 - Independent:** Tenant holds lease with normal rights and responsibilities
- Services
 - Flexible:** Designed to be responsive to tenants' needs
 - Voluntary:** Participation is not a condition of tenancy
 - Independent:** Focus of services is on maintaining housing stability

Current System is Costly and Ineffective

- To do nothing is expensive
 - The City of Indianapolis spends \$32,560 annually in the public health and criminal justice systems to respond to needs of the average homeless person with mental illness and/or substance abuse issues
- Doing nothing adversely effects multiple systems
 - Criminal Justice/ Corrections
 - Community Health Providers and Hospital
 - Housing /Neighborhoods
 - Families / Foster Care
 - Economic /Workforce Development

Bringing the costs home

Indiana Permanent Supportive Housing Initiative (IPSHI) Cost (Capital, Operating, & Services) compared to the Costs of Long-Term Homelessness Associated with Emergency Systems: Medicaid, Shelter and Incarceration



Can we really afford to do nothing?

Indiana Permanent Supportive Housing Initiative (IPSHI)

Indiana Permanent Supportive Housing Initiative (IPSHI)

- Six-year project to adopt national best practices into an Indiana model for permanent supportive housing.
- Goal of creating at least **600** supportive housing units over the three-year Demonstration Project (2008-2010)
- Establish long-term funding mechanisms and policies to create an additional **800** units (2011-2013)
- Develop new finance/funding model for PSH

IPSHI Goals

- Reduce the number of individuals and families who are experiencing long-term homeless and cycling in and out of emergency systems
- Reduce the number of individuals who become homeless after leaving state operated facilities by creating community-based housing and services
- Expand the reach of PSH to new communities
- Improve communities by ending long-term homelessness through community-based partnerships around safe, decent housing

IPSHI Achievements to Date

- IHCD dedicated staff and resources
 - 8,000,000 annually
 - Dedicated staff across the agency to achieve IPSHI goals
 - Funded the Corporation for Supportive Housing (CSH), a national non-profit, to partner on IPSHI implementation
- IHCD dedicated capital funds
 - Modified the QAP to fund supportive housing through the Low Income Housing Tax Credit Program
 - Set aside HOME and Development funds
 - Stimulus funds

IPSHI Achievements to Date

- IHCD dedicated operating Funds
 - State Admin Plan revised to project base 20% of vouchers for supportive housing projects.
 - Working with other local PHAs to project base vouchers for supportive housing
 - BOS McKinney Vento funds tied to IPSHI process

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IPSHI Achievements to Date

- Implemented PSH Institute in partnership with CSH (provides over 80 hours of in-depth training and technical assistance)
- Provided on-going technical assistance through CSH and IHCD staff
- Completed first PSH Institute in 2008 with 10 teams, 2009 with 10 teams
- Selected 8 teams for the 2010 PSH Institute bringing total units in pipeline to nearly 1000
- Linked PSH Institute Homework directly to IHCD funding applications
- Integrated the CSH Dimensions of Quality into the Institute

IPSHI Achievements to Date

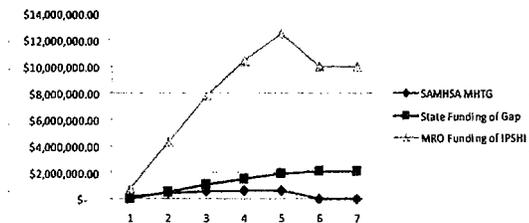
- PSH Institute teams have plans to or have created supportive housing in the following communities:

Terre Haute, Lawrenceburg, Batesville, Bloomington, Goshen, Indianapolis, Ft. Wayne, Gary, Lafayette, Muncie, New Albany, Evansville, Richmond, Huntington, Valparaiso, Michigan City, Hobart, Hammond

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IPSHI Achievements to Date

Potential Service Funding Model for IPSHI Pipeline



IPSHI Contacts

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· Lori Phillips-Steele
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Corporation for Supportive Housing (CSH)
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www.csh.org

10



Indiana Housing & Community Development Authority

COMH

Meeting 3

October 27, 2010

Exhibit 10

**Cost-Effectiveness of Permanent Supportive Housing
and Recommendations for a New Service Delivery
Model in Support of the Indiana Permanent
Supportive Housing Initiative**

from the

Indiana Housing and Community Development Authority

**30 South Meridian, Suite 1000
Indianapolis, Indiana 46204**

Last Revised May 10, 2010

Table of Contents

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Limits of Cost-Saving Data	Page 21
Bringing Permanent Supportive Housing Home for Hoosiers	Page 25
Conclusions and Recommendations	Page 26
Action Plan	Page 31
Appendix A: Recommendations for Utilizing Medicaid Rehabilitation Option (MRO) Services as the Services Platform for the Indiana Permanent Supportive Housing Initiative	Page 39
Appendix B: CSH's Dimensions of Quality	Page 50
Appendix C: IPSHI Action Plan	Page 51

This white paper was developed under the supervision of Rodney Stockment, Community Services Director at the Indiana Housing and Community Development Authority (IHCDA). Much of the content is based on the research and writing of Lauren Cooper, 2009 summer intern at IHCDA and senior at Duke University's Terry Sanford Institute of Public Policy. Additional support and comment was provided by Kirk Wheeler, Consultant to IHCDA and Manager of the Homeless Management Information System and Lori Phillips-Steele, Associate Director, Indiana Office of the Corporation for Supportive Housing. Significant contribution to the substance of the paper came from work completed by Marti Knisley of the Technical Assistance Collaborative.

Executive Summary

The intent of this white paper is to provide policy-makers, community leaders, advocates, community mental health providers and housing developers with a deeper understanding of why permanent supportive housing is a cost-effective solution to long-term homelessness and reduce long term care for individuals and families. The white paper contains an extensive literature review of the mounting evidence that permanent supportive housing is a cost-effective intervention for persons who are not only homeless, but who also face serious and persistent challenges such as mental illness, substance abuse, or HIV/AIDS and often facing periods of institutionalization in state operated facilities because more integrated community living settings are not available. The authors advocate that the evidence provided by these cost studies influence state policy to direct resources to the Indiana Permanent Supportive Housing Initiative (IPSHI).

This paper is structured in part around a separate expert position paper authored by Marti Knisley of the Technical Assistance Collaborative under contract to the Corporation for Supportive Housing. That paper, which is attached (Appendix A), defines the services required to provide true permanent supportive housing within the framework of Indiana Medicaid requirements and includes a pilot study that estimates the proportion of these services that will not be eligible for Medicaid reimbursement.

In recent years, permanent supportive housing has gained recognition as a successful combination of affordable housing and flexible services that can help individuals with special needs live more stable, productive lives. Permanent supportive housing refers to permanent housing units (typically rental apartments) linked with flexible community-based services. Permanent supportive housing is specifically intended for homeless individuals with disabilities who, but for housing, cannot access and make effective use of the treatment and services they need to stay stable; and who, but for supportive services, cannot access and maintain stable housing. By helping individuals and families move out of expensive systems of emergency and long term care and back into their own homes and communities, permanent supportive housing not only improves the lives of its residents, but also generates significant public benefits.

Background

In November 2007, IHCD led a small delegation from Indiana to the Corporation for Supportive Housing's 'Supportive Housing Leadership Forum' in Arlington, Virginia. Indiana lacked, at that time, both the local capacity to develop permanent supportive housing and the state policy to sustain quality projects. The delegation recognized that Indiana needed to establish permanent supportive housing as the center-piece for the state's efforts to end long-term homelessness. The delegation returned to Indiana committed to launching a comprehensive initiative around the production of permanent supportive housing units. At the same time, the Division of Mental Health and Addiction (DMHA) of the Family and Social Services Administration was also undergoing a transformation process to improve the delivery of behavioral health services in Indiana. Recognizing that housing is an essential part of a complete recovery model for behavioral health, DMHA invited IHCD to join their Transformation Work Group. In January 2008, IHCD, DMHA, the Transformation Work Group (TWG), the Corporation for Supportive Housing (CSH), and the Great Lakes Capital Fund launched the Indiana Permanent Supportive Housing Initiative (IPSHI), a public/private venture designed to develop a minimum of 1,400 permanent supportive housing units over six years.

Predicated on the growing evidence that permanent supportive housing is a cost-effective solution for people who face the most complex challenges, IPSHI aims to end to the cycle of chronic homelessness and institutionalization rather than merely managing its symptoms. While homelessness remains relatively invisible to the average person in most Indiana communities, chronic homelessness makes a documented and costly impact on publicly-funded systems of health, social services, and criminal justice. In fact, Indiana can no longer afford to not take action. Local scholars estimate that health care and criminal justice expenditures for the chronically homeless population in the City of Indianapolis alone range from \$3 million to \$7.8 million each year, not including the high costs of emergency shelter (Wright, July 2007).

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 included DMHA, OMPP (Office of Medicaid Policy and Planning), IHCD, and CSH. The Technical Assistance Collaborative (TAC) is providing technical assistance and consultation to this effort.

The sub-committee developed a scope of work and defined the components necessary to develop a successful permanent supportive housing model for Indiana. This committee has completed its first task, a crosswalk of the services needed in permanent supportive housing and services in the

proposed updating of the state's Medicaid Rehabilitation Option (MRO). The crosswalk identifies services that can be covered through the Medicaid Rehabilitation Option for individuals who are eligible for Medicaid, and also those services that need to be funded through other sources.

The crosswalk, as developed in partnership with the TAC and CSH, includes the role of property management in supportive housing and the link between property management and services. The Permanent supportive housing/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. We submit that the Permanent supportive housing/MRO initiative is an important element of Indiana's mental health system transformation because:

- **There is a significant body of evidence that permanent supportive housing works for people with disabilities, including those with the most severe impediments.** This is the well acknowledged "Housing First" principle which has been successful in New York and other well documented studies. 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 permanent supportive housing 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 a variety of HUD and IHCDA funded 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 are more likely to be successful in this type of housing if they have assistance in obtaining and sustaining housing, if they have a choice in housing, and if the housing is not conditioned on treatment.** This requires that a substantial stock and variety of housing be available within a jurisdiction and that disabled persons have choices among this stock. Traditional approaches, e.g. group homes, are neither faithful

to the permanent supportive housing model nor likely to promote community independence and recovery.

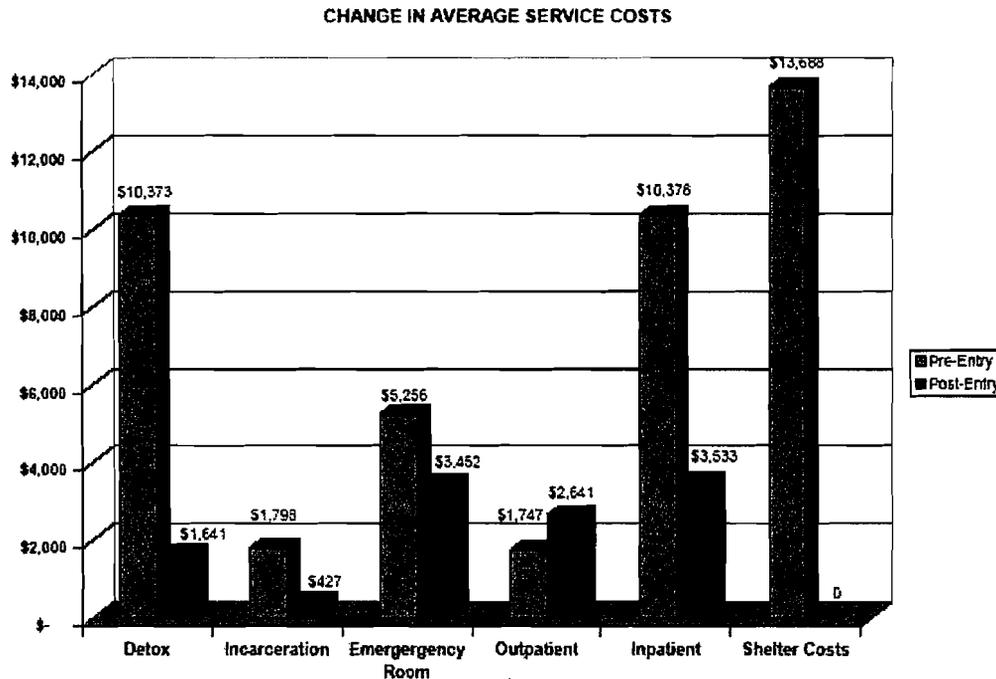
- **Services supportive of housing permanency by persons living with serious mental illness and concurrent disorders are specific to housing and available in the person's residence.** Providing services so a person can be successful in their own home is often the major determining factor in a person 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. This white paper examines data from permanent supportive housing projects across the country to identify and monetize the savings such programs can offer public service providers touched by chronic homelessness. Permanent supportive housing has been consistently associated with cost reductions across systems of emergency care, public health, mental illness and addiction treatment, and safety and corrections. For example, findings include:

- 98% reduction in emergency room visits and 62% reduction in emergency room costs (Mondello 2007)
- 95% cut in mental health inpatient hospitalizations (Moore 2006)
- 71% decrease in Medicaid reimbursement costs (Andersen 2000).
- 97% reduction in nursing home nights (Nogaski 2009)
- 84% reduction in tenants' days spent in correctional facilities (Culhane 2002)
- 87% decrease in sobering center admissions (Larimer 2009)
- 84% reduction in detoxification costs (Perlman 2006) (For more examples from Denver, see Graph #1).

GRAPH #1

Observed changes in average service costs per resident of Denver's "Housing First Collaborative," obtained by comparing service usage in the 24 months before and after entry into permanent supportive housing (Perlman 2006, page 11)



Furthermore, studies have found that the overall costs of permanent supportive housing are similar to – and often less than – the costs of allowing persons with chronic illnesses or other special needs to remain homeless. In fact, accounting for the cost of housing and services, the net savings for a Massachusetts permanent supportive housing program were estimated at \$8,949.00 per year per resident (See Graph #2) (MHSA June 2009). The same Massachusetts study reported retention rates of 84% for an average of 1.9 years housed.

The authors hope that after reading this white paper, Indiana policy-makers will take away a more complete understanding of why IPSHI is a cost-effective intervention that must be supported with more state resources to realize maximum cost savings across multiple systems.

Concretely, realization of this opportunity in Indiana requires:

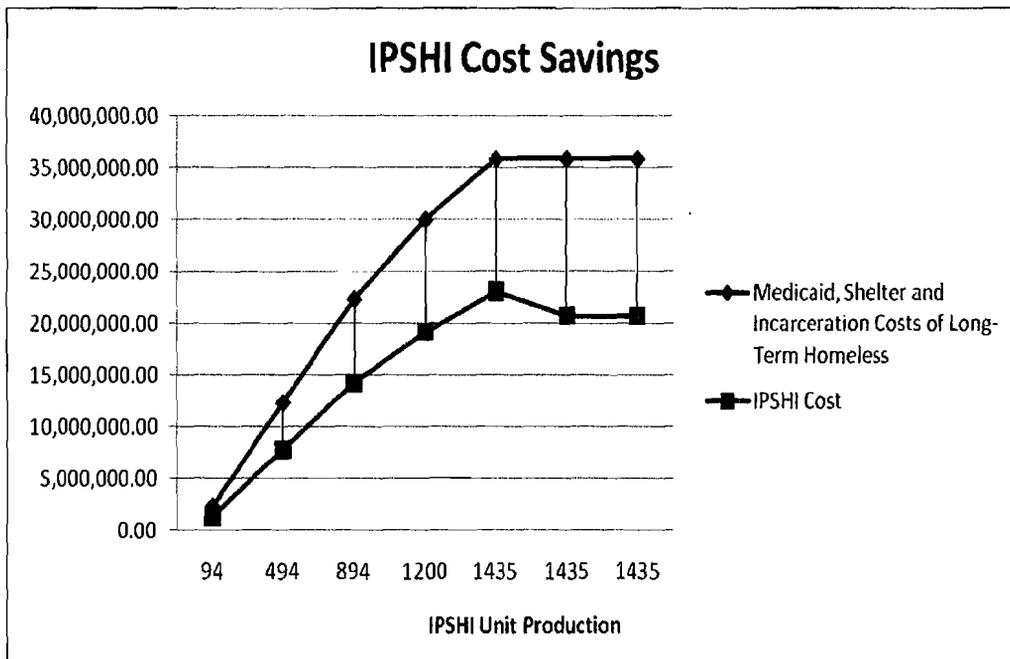
- Commitment of sufficient capital and operating funds to build and operate 1435 new units of permanent supportive housing.

- Recognition of Permanent Supportive Housing as a distinct entity within the DMHA defined Continuum of Care with particular assignment within the “service packages” for MRO eligible services.
- Additional funding of services not presently covered by Medicaid but required to allow sustainability and fidelity to the Corporation for Supportive Housing model for permanent supportive housing. It is this latter amount to which the following paragraphs refer.

Over the next five years, IHCDA has set a goal of creating 1,435 units of permanent supportive housing. The Graph #2 illustrates the cost saving that Indiana can achieve by creating the 1,435 units of permanent supportive housing over a period of seven years. IPSHI costs, including capital, rental subsidies and service costs, are compared to the cost of maintaining the current system of emergency care and incarceration. In years six and seven, IPSHI costs will be reduced as individuals recover from their mental illness and remain stably housed. **Rarely is government availed an opportunity to improve the quality of care and positive health outcomes while realizing significant cost efficiencies.**

GRAPH #2

IPSHI Cost (Capital, Operating, and Services) compared to the Costs of Long-Term Homelessness Associated with Emergency Systems: Medicaid, Shelter and Incarceration.



In order to reap the benefits of investing in permanent supportive housing, the state must also expand inter-agency coordination, overcome the challenges of “silo” funding, and remove certain barriers to resource access. **The authors estimate that by redirecting an additional \$2,302,261 annually to fund non Medicaid MRO services for persons living in permanent supportive housing, the state could realize \$15,180,417 in annual cost saving across multiple systems.** By enacting policy that directs funding to permanent supportive housing, the state will improve the delivery of behavioral and primary health services in Hoosier communities and work towards eradicating the negative impact of long-term homelessness throughout the state. Even more significant savings could be realized using permanent supportive housing as a model for community integration for individuals who remain in state operated facilities due to the current lack of community placement opportunities and for individuals who are discharged from corrections with severe mental illness and chronic addictions and at high risk of homelessness and re-offending.

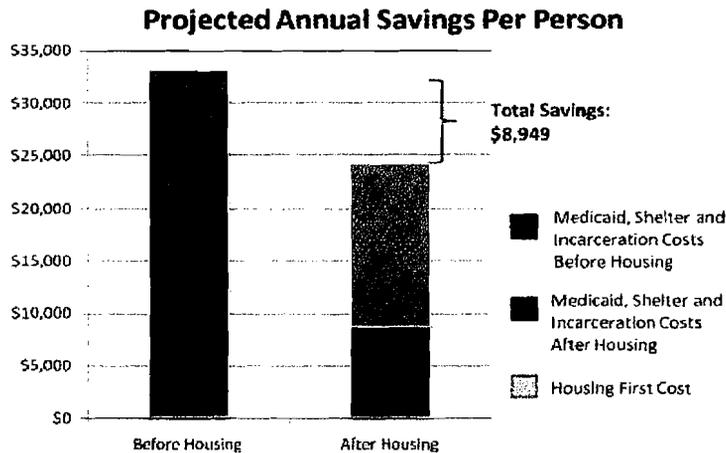
Introduction and Purpose

Background

Homelessness is often viewed as a one-dimensional issue. It is assumed that homeless persons, especially chronically homeless single persons, are a special class of social misfits who either cannot or do not wish to work and achieve stable community adjustment. However, we have increasingly found that the chronically homeless population is neither homogeneous nor one-dimensional. Research has demonstrated that the chronically homeless population includes many disabled persons who have medical, psychiatric, and/ or addiction issues that create barriers to achieving stable and fruitful recovery.

GRAPH #3

Estimated net savings, per resident, for a Massachusetts permanent supportive housing program (MHSA June 2009, page 11)



Unfortunately, when left on the streets, these persons utilize a substantial array of community resources in the form of emergency room care, public safety time, public health services, corrections time and, in many cases, continuing use of expensive emergency shelters. Research and practice have consequently shown that there are significant public costs to “doing nothing” to assist the chronically homeless population in breaking the cycle of long-term homelessness. Drawing on cost studies from across the country, this white paper will demonstrate that through coordination across multiple systems of care, permanent supportive housing offers superior cost savings and recovery outcomes when compared to alternate homeless interventions.

The National Alliance to End Homelessness supports a permanent supportive housing model, explaining “By examining the characteristics of homeless persons and the systems they interact with, (researchers) have learned that a small percentage of homeless persons...cycle between hospitals, emergency rooms, jails, prisons, and mental health and substance abuse treatment facilities. Furthermore, this small group of people, known as long-term or ‘chronically’ homeless, are very expensive to public systems of care. Permanent supportive housing can successfully provide this vulnerable population housing and services that effectively end their episodes of homelessness” (NAEH 2006). In general, permanent supportive housing has been shown to promote a sharp decline in tenants’ use of expensive emergency care services and an increase in tenants’ use of less expensive regular and preventative outpatient treatments. This results in savings across systems of emergency shelter, emergency room care, general public health care, mental illness and addiction treatment, and safety and corrections. While permanent supportive housing certainly levies costs of its own, including both the physical property costs and the operational costs of integrated social and health care services, most studies have shown that the total system savings equal or exceed the investment.

Research has also demonstrated that permanent supportive housing provides additional value to the community that exceeds basic cost-effectiveness. Permanent supportive housing encourages tenant engagement, skill building, resource access, civic participation, and leadership development. Ultimately, permanent supportive housing aims to empower tenants to be independent, responsible, and self-sufficient. Documented outcomes of this approach include improved tenant stability, increased income and employment, decreased substance abuse, and improved health care treatment. Communities with permanent supportive housing programs are also safer, more efficient, and more attractive.

IPSHI - Philosophy and Assumptions

Through the IPSHI, IHCDA and its partners have already taken steps to establish permanent supportive housing as a model for chronic homelessness recovery in Indiana. The Initiative’s primary goals are to reduce long-term homelessness, reduce the use of expensive emergency systems of care as primary homeless interventions, and improve Hoosier communities by developing high-quality permanent supportive housing projects. The Initiative intends to help

local housing developers, behavioral health providers, and homeless assistance networks develop permanent supportive housing using CSH's Dimension of Quality¹. In this model, housing is not only affordable, but a foundation for recovery from mental illness or chronic addiction. IPSHI is also intended as a platform for state agencies and private foundations to bring together elements from housing, mental health services, social services, employment, income supports and addiction treatment to foster a more holistic, collaborative recovery system.

Permanent supportive housing efforts in Indiana under IPSHI are founded on a "housing first" philosophy. In a "housing first" approach, a chronically homeless individual or family is first provided with safe, stable, and permanent housing and then offered the appropriate flexible services to allow his or her recovery into community stability and independence. Because eviction is viewed as a last resort for the sake of retention and stability, abstinence from substance use and participation in services are not conditions of tenancy. This gives participants an opportunity to end their cycle through expensive systems of emergency care by working towards recovery from a stronger foundation. Research has shown that particularly when substance abuse disorders are present, a "housing first" philosophy is a major factor in a tenant's likelihood of long-term stability. IHCDA embraces a "housing first" strategy in response to homeless individuals with mental illness and other special needs because IHCDA believes that it is cost-effective to provide permanent supportive housing as an alternative to individuals and families cycling through less effective systems of emergency care.

To date, IPSHI has developed a strong pipeline for permanent supportive housing projects and provided training and technical assistance to developers through the Indiana Permanent Supportive Housing Institute². Nevertheless, creating permanent supportive housing is a difficult endeavor. Permanent supportive housing integrates multiple housing and support service funding streams for the most vulnerable low-income households. Creating new permanent supportive housing also means changing the status quo in communities and systems of care – a change process that can be difficult.

Funding Implications

In Indiana, as in many other states, provision of permanent supportive housing is complicated by distinct funding "silos" across the structure of state government. Permanent supportive housing engages numerous public, private, and state service providers and offers benefits that span a wide range of state activities. Unfortunately, state and federal funding is not equally so flexible or

¹ The Corporation for Supportive Housing's (CSH) "Seven Dimensions of Quality for Supportive Housing" offers a self-assessment tool that measures the quality of permanent supportive housing projects by examining the physical property and linked services in the context of national best practices for a successful recovery model. For more information on the CSH Dimensions of Quality, see Appendix B.

² The Indiana Permanent Supportive Housing Institute is a comprehensive, highly interactive project development initiative for permanent supportive housing in the State of Indiana. Comprised of teams based in Indiana, the Institute provides targeted training and technical assistance to development teams working on specific supportive housing projects for persons who are homeless in Indiana.

fluid. For example, Medicaid is a major payer for supportive services in Indiana. Therefore, Medicaid policies drive how other funding sources are used, including those most frequently used for permanent supportive housing services and operations. Community-based services are most often delivered in Indiana through the MRO that is limited to Community Mental Health Centers. Not only are such services limited to persons with a demonstrated mental illness or substance use disorder, they also require that an adult be deemed disabled and display current functional impairments within the Indiana Medicaid program. Studies have found that these Medicaid eligibility processes present a barrier in homelessness services. IHEDA believes that this barrier is real in Indiana, and costly to multiple systems throughout the state. It is also true that Indiana has not historically joined permanent affordable housing with supportive services – resulting in a knowledge gap that must be addressed for real progress to be realized.

In addition to demonstrating the cost-effectiveness and positive outcomes of permanent supportive housing, this white paper examines the challenges facing permanent supportive housing providers, and their tenants, in accessing Medicaid and other funding resources. It is IHEDA's vision that the partnership to provide permanent supportive housing will engage all relevant state agencies and departments, community mental health centers, and non-profit and for-profit entities to expand housing and human service collaboration and provide cost-effective solutions to the problem of long-term homelessness. Working from IPSHI's pipeline, we recommend that new partnerships among housing and service providers be created at both the funding and direct services level. These partnerships will add value to public sector activities and help create a shared mission across the systems that serve the lowest income households with special needs.

Literature and Data Review

To understand the extent of the potential benefits Indiana could accrue from additional permanent supportive housing units, one must examine the broad reach of the public costs of homelessness. Within any state or community, homelessness – particularly chronic homelessness – puts significant pressure on a variety of housing, social service, and health care systems. Researchers found that while the chronically homeless only account for 10% of the homeless population, they consume over 50% of all homelessness resources (Kuhn 1998). This means that the continuing cycle of chronic homelessness has a disproportionate impact on housing and service providers, clogging the system and preventing providers from best serving those individuals and families who could otherwise exit homelessness relatively quickly.

Additionally, in lieu of suitable housing, many homeless individuals with chronic conditions turn to alternate social service systems to seek temporary shelter and care. Beyond emergency homeless shelters, Indiana's jails, prisons, emergency rooms, nursing homes, safety personnel, and inpatient treatment facilities currently spend significant time and money caring for chronically homeless individuals. Housing and treating the chronically homeless is not the intended function or expertise of these health and safety systems, and consequently the cycle of

homelessness creates inefficiencies that negatively impact these systems and the rest of the populations they serve. These alternate systems are also more expensive interventions relative to permanent supportive housing. The Lewin Group completed a study on the costs of serving homeless individuals in nine major US cities. The study found that the median cost of permanent supportive housing per person per day is \$30.48; compared to \$25.48 for emergency shelter, \$84.74 for prison, \$70.00 for jail, \$607 for a mental hospital, and \$1,637 for a public hospital (2004). Permanent supportive housing is not the least expensive intervention per person per day but it offers a higher likelihood of long-term recovery outcomes.

In addition to lowering the costs of emergency care and promoting long-term recovery for the chronically homeless, studies have also shown that the cost savings associated with permanent supportive housing can exceed or at least offset the expense of the program itself. In a classic report on the costs of homelessness, Dennis Culhane and his colleagues at the University of Pennsylvania's 'Center for Mental Health Policy and Services Research' tracked 10,000 homeless persons with mental illness in a case-control study in New York City (2002). The researchers tracked the service use of these persons for two years before and after placement in permanent supportive housing funded by the 1990 New York/New York (NY/NY) 'Agreement to House Homeless Mentally Ill Individuals.' The agreement provided housing linked to a variety of psychosocial services such as vocational training, group and individual therapy, and case management. To determine service usage before placement, researchers gained access to data from seven databases on psychiatric, public health, and criminal justice systems in New York. The sample of homeless persons entering NY/NY housing was matched with an equal number of control subjects who remained homeless. Special efforts were made to ensure that the control subjects had similar demographics, mental illness conditions, and levels of pre-placement service usage. The researchers compared the resulting data to determine the extent of the homeless population's shelter use, inpatient hospitalization, and time spent in jail and prison before and after permanent supportive housing placement. The study found that the chronically homeless population costs taxpayers \$40,500.00 per homeless person per year. This estimate includes the costs of emergency rooms, psychiatric hospitals, shelters, and prisons. Study findings revealed that after placement in NY/NY housing, there was an 86% drop in the number of shelter days per person, a 60% drop in state hospital use, and an 80% drop in the number of inpatient days spent in a public hospital. The housing program also cut residents' incarceration rates in half. These service reductions resulted in a per-resident cost savings of \$16,282.00 per year. Therefore, savings in the public health, emergency shelter, and corrections systems covered 95% of the cost of the NY/NY housing program, calculated at \$17,276 per person per year (Culhane 2002).

In recent years, similar or superior net savings have been recognized by a variety of other permanent supportive housing programs implemented across the country. In a San Francisco project intended to help homeless persons with mental health or substance abuse conditions, scholars Martinez and Burt estimate that the service reductions identified in the study translate

into public cost reductions of \$1,300 per resident in the first two years of enrollment, offsetting at least 10% of the estimated yearly cost of the permanent supportive housing program (2006). In a report on a Seattle permanent supportive housing project for recovering alcoholics with co-occurring conditions, the ninety-five participants had total costs of \$8,175,922 in the year prior to the study, which decreased to \$4,094,291 in the year after enrollment, with net savings of \$958.00 per participant in the first year. This is a 53% total cost rate reduction, obtained by comparing housed participants to both wait-listed controls and historical data on service usage. Total emergency costs for this sample declined by 72.95%, or nearly \$600,000.00, in the two years after the program's launch (Larimer 2009). In an analysis of a Portland, Oregon effort to reduce chronic homeless, researchers estimated pre-enrollment costs for annual health care and incarceration at \$42,075 per client. After one year in permanent supportive housing, those costs fell to \$17,199. Accounting for the investment in services and housing, totaling \$9,870, along with mainstream service use, total expenditure for the first year was \$27,069, a 36.7% or \$15,006.00 saving for the first year (Moore 2006). In Denver, Perlman found that the number of clients using emergency services such as hospitalization, substance treatment, inpatient treatment, Detox, and jail decreased by 60% in the two years following enrollment in permanent supportive housing. If housing and services were provided to all 513 chronically homeless individuals eligible in Denver, costs savings would total \$2,424,131 (Perlman 2006). In a Minnesota project to house the homeless, a cost-study discovered that a single homeless adult costs public systems almost as much as providing permanent supportive housing, with 96% of the increased costs of the housing program due to the housing itself (NCFH 2009). In Massachusetts, the cost of street homeless was calculated at \$28,436 per person per year compared to \$6,056 for those housed in the permanent supportive housing project. As previously stated in the executive summary, with before housing costs of \$33,108 and after housing costs of \$8,691 for Medicaid, shelter, and incarceration and \$15,468 for housing and services; savings in Massachusetts totaled \$8,949 per participant per year (MHSA June 2009). An Illinois permanent supportive housing report identified a 39% reduction in the total cost of services for residents in the two years after housing. This figure includes services from Medicaid, mental health hospitals, substance use treatment centers, prisons, and country jails and hospitals. Mainstream service costs decreased by almost \$5,000.00 per person for overall savings of \$854,477 over two years for the 177 participants (Nogaski 2009). In Rhode Island, a cost-study revealed savings of \$8,839 per person per year in institutional costs once enrolled in permanent supportive housing (Hirsch 2007). Analysis of a project in Maine identified \$944.00 average net savings per person per year, accounting for program investment (Mondello 2007).

Beyond net savings, permanent supportive housing offers specific benefits to a number of publicly funded systems. In particular, this white paper will discuss the savings associated with emergency shelters, emergency rooms, general public health care, mental illness and addiction treatment, and safety and corrections. In addition, this literature and data review will highlight the more general benefits of permanent supportive housing, including tenant stability, tenant independence, and community development.

Emergency Shelter Usage

A traditional response to homelessness, emergency shelters are intended to offer short-term housing to those experiencing brief and sporadic episodes of homelessness. While the emergency shelter system can effectively serve those persons with truly temporary experiences of homelessness, emergency shelters are not intended or equipped to provide the kind of care that can help individuals with special needs overcome the cycle of long-term homelessness. Consequently, emergency shelters experience significant savings and improved efficiency when chronically homeless “frequent users” are relocated to permanent supportive housing units. Permanent supportive housing not only reduces the costs of publicly-funded shelters, but also frees up shelter beds and services for the individuals and families who need only emergency, transitional, or short-term assistance.

As a combination of housing and services intended to help tenants remain stable, permanent supportive housing, theoretically, should eventually eliminate the need for chronically homeless individuals to utilize emergency shelters at all. In practice, studies have shown that once placed in permanent supportive housing, tenants’ reliance on emergency shelters does, in fact, diminish to almost zero. A cost analysis study of the permanent supportive housing project in Portland, Maine identified a 98% reduction in shelter visits among the ninety-nine tenants of the program (Mondello 2007). In a case-control study of Seattle’s 811 Eastlake “housing first” permanent supportive housing project, researchers found that after one year in permanent supportive housing, the ninety-five clients involved had reduced their emergency shelter use by 92%; from 1,870 total shelter night per year to 156 total shelter nights per year (Larimer 2009). A similar analysis of the Denver program found that placement in a permanent supportive housing program reduced emergency shelter costs by an average of \$13,600 per tenant in the two years following placement (Perlman 2006).

Emergency Room Services

Emergency shelter, while expensive on its own, is only the tip of the iceberg when it comes to the total public cost of homelessness. When seeking treatment and shelter, many homeless individuals with chronic conditions also turn to emergency room services as an alternative form of housing and care. Reviewing data from the Portland, Oregon project, Thomas Moore found that the total number of emergency visits for the thirty-nine residents of the program fell from seventy-nine visits for twenty-nine persons to seventy-five visits for ten persons in the first year housed. Moore estimates that each emergency room visit costs the public system an average of \$492.00 (2006). In a case-control cost study including two permanent supportive housing developments in San Francisco, Tia Martinez, JD and Martha Burt, PhD found that two years after enrollment, the percentage of residents with an emergency room visit in the two year period fell from 53% two years before entry to 37% two years after entry. Additionally, the total number of emergency room visits for the sample of 236 individuals in the study decreased by 56%, falling from 457 total visits two years before entry to 202 total visits two years after entry. The average number of visits per resident also decreased from 1.94 visits in the two years before

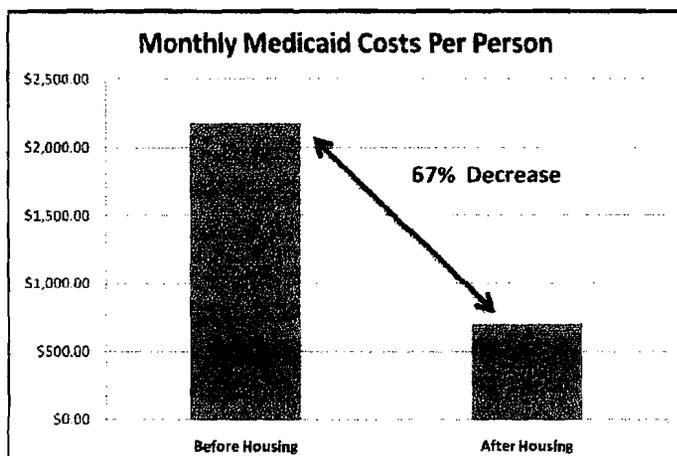
entry to 0.86 visits in the two years after entry (2006). In Illinois, emergency room usage decreased by 40% for residents in the two years following entry (Nogaski 2009). The Maine report identified a 62% reduction in total emergency room costs for its ninety-nine permanent supportive housing residents; from \$206,451 the year before entry to \$78,079 the year after entry, and a 66% reduction in participants' ambulance costs in the first year housed (Mondello 2007). A similar public health cost study from Seattle revealed that on average, tenants were 2.5 times less likely to visit the emergency room one year after enrollment in permanent supportive housing (Larimer 2009).

General Public Health Services

Public health scholars Martinez and Burt of the San Francisco permanent supportive housing study explain, "The costs associated with the health consequences of chronic homelessness fall disproportionately on municipal and state governments" (2006, page 992). Since many chronically homeless individuals suffer from a variety of co-occurring physical and psychiatric conditions, health care can be a significant public cost for this population whether they are housed or not. However, when this population remains homeless, public health costs are especially steep. Moore of the Portland, Oregon study explains, "For the most part, chronically homeless persons do not have the opportunity to do preventative health care activities prior to enrollment (in supportive housing). Only the worst of the physical problems are attended to while homeless and usually at the most expensive intervention level (ER and inpatient hospitalization). As individuals become more stabilized they are expected to utilize more health

GRAPH #4

Projected monthly Medicaid savings per resident of the Massachusetts "Home and Healthy for Good" permanent supportive housing program, confirmed by the Massachusetts Office of Medicaid (MHSA March 2009)



and dental services (if available) to deal with persistent and chronic physical health conditions and to utilize more services for minor health issues before they become major" (2006, page 9). By shifting tenants away from emergency inpatient treatment as a source of shelter and care, permanent supportive housing can put its residents in a better position to

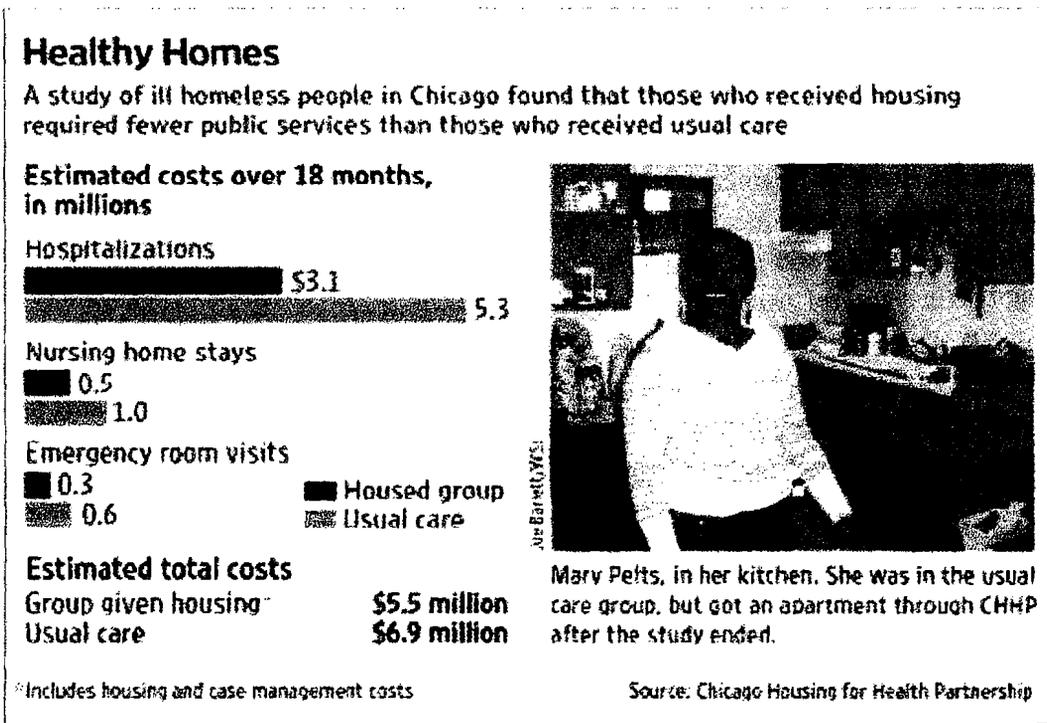
engage in more regular - and less expensive - outpatient and preventative treatments. For example, the Chicago study found that housing contributes significantly to improved HIV

prevention, management and treatment (NAHC 2008). Additional research provides strong evidence that permanent supportive housing offers health care savings to state and local governments and improves treatment outcomes for tenants.

Culhane's NY/NY study found that permanent supportive housing reduced psychiatric inpatient days by 60.8% (2002). In Portland, Oregon, Moore discovered that residents' average inpatient hospitalizations per year fell by 88% after entry into permanent supportive housing; from 1375 hospitalizations the year before the program to 155 hospitalizations the year after entry, for a sample of thirty-five participants. Moore estimates the average cost of each hospitalization at \$4,317. In the same Portland report, mental health inpatient nights fell from 355 total nights to 15 total nights for the thirty-five residents, a reduction of 95%, at an average cost of \$800 per night (Moore 2006). Mondello's project in Maine identified a 77% cut in hospital admissions after entry into supportive housing, resulting in a 59% reduction in health care costs (2007). Perlman found that two years after entry into the Denver supportive housing project, the total number of residents' inpatient hospitalizations fell by 40%, inpatient nights decreased by 80%, and overall inpatient costs were cut by 66% (2006). For Martinez's sample in San Francisco, the mean number of admissions fell from 0.34 to 0.19 per person. Total admissions fell by 44% (2006). In the Illinois study, nursing home use decreased by 97%, and inpatient days fell by 83%

GRAPH 5

Outcomes of the Chicago Housing for Health Partnership (CHHP) program, linking hospitals and permanent supportive housing units. Featured in the Wall Street Journal, March 6 2008 (Barrett 2008)



at a 25% cut in costs (Nogaski 2009). Results from Rhode Island identified a decrease in hospitalizations from 543 to 149 nights for 50 participants, resulting in an annual cost reduction from \$917,946 to \$256,131. (Hirsch 2007). For the homeless population, Medicaid is the most frequent payer for mental health and medical services. In the Connecticut Demonstration study, permanent supportive housing reduced Medicaid reimbursement per tenant using medical inpatient services by 71% (Andersen 2000).

Medicaid expenses for Larimer's sample of seventy-seven in Seattle fell 41%, or over \$1.4 million, in the first year after entry (2009). In Illinois, the number of Medicaid reimbursed inpatient psychiatric care users decreased almost 20%, and use of related services decreased over 66% for the sample of 177 (Nogaski 2009). The Massachusetts 'Home & Healthy for Good' permanent supportive housing program projected a 67% decrease in Medicaid costs per tenant of the program, from \$2,177 per person per month before housing to \$708.00 per person per month after housing. This projection was confirmed by the Massachusetts Office of Medicaid, which conducted an analysis of billing claims data to prove that chronically homeless individuals are extremely costly to the Medicaid system (See Graph #3) (MHSA March 2009).

Because of the deep connection between homelessness and public health, partnerships between hospitals and permanent supportive housing projects are a promising development. The Chicago Housing for Health Partnership (CHHP) is one such program which identifies chronically ill homeless individuals at hospitals and helps them transition into permanent supportive housing in order to maintain improved health while working towards long-term stability. CHHP Director Arturo V Bendixen explains, "Too often hospitals in our cities discharge their homeless patients to overnight shelter or other places which cannot meet their special healthcare needs. The CHHP model of service delivery provides our nation with an effective model for assisting this segment of the homeless population and saving taxpayer dollars" (Briggs 2008 page 1). This program was motivated by the fact that 32.4% of Chicago's Cook County Hospital inpatients were at high risk for homelessness. Providing 180 permanent supportive housing units, the CHHP program was able to house a high-risk segment of this population that contained 86% persons with substance abuse disorders, 46% persons with mental illness, and 34% persons with medical issues like HIV/AIDS. The housed group ended up using half as many nursing home days as their counterparts in a control group, and their overall medical expenses were significantly reduced. Patients stayed housed for up to four years and beyond, allowing them to improve their health status, find employment, and increase their independence from public health systems like emergency rooms and inpatient treatment facilities. The Wall Street Journal recently featured the CHHP program in an article on the success of permanent supportive housing as a health intervention. (See Graph #4) (Barrett 2008).

Mental Illness and Addiction Treatment

Research suggests that over 110,000 single adults with severe mental illnesses are homeless every day in the US (Culhane 2002). Understanding mental illness and addiction treatment is particularly important to understanding the chronically homeless population and their needs.

Almost every permanent supportive housing program featured in this literature review was developed to specifically target homeless individuals with severe mental illness conditions, substance abuse disorders, or some co-occurring combination. Often, these conditions are what prevent this population from exiting long-term homelessness on their own. On the other hand, some programs aimed at promoting the recovery of this population require that participants be at a certain stage of recovery or abstinence from substance use in order to receive publicly-funded housing assistance. Permanent supportive housing is different, providing a comprehensive package of both housing and services. All components of a permanent supportive housing program are meant to reinforce each other in order to support a homeless individual's holistic and lasting recovery. If individuals do continue to struggle with their addictions or conditions while housed, "housing first" approaches dictate that service interventions be employed, on-site, to work with the resident in an effort to avoid eviction and a continued cycle through homelessness systems and treatments. Since permanent supportive housing programs strive to overcome the challenges of mental illness and addiction with their tenants on-site, mainstream treatment services reap important benefits as permanent supportive housing programs take on much of the responsibility of caring for this population while simultaneously reducing this population's need for care.

In Seattle, Larimer found that total sobering center admissions for residents of the permanent supportive housing program fell by 87% in the first year of housing, from 6,432 admissions one year before entry to 837 admissions one year after (2009). Moore identified a 93% decrease in alcohol and drug treatment inpatient nights for residents of the Oregon project, falling from 3905 nights to 243 nights for the thirty-five participants in the first year, with each visit costing an average of \$100.00 (2006). In the Denver study, Perlman found that incarceration costs were cut by 76% after the first two years of housing.(2006).

Safety and Corrections Services

Studies have also consistently demonstrated that permanent supportive housing can cut public costs for corrections and safety. Chronically homeless persons living on the street tend to have frequent contact with public safety and police personnel. Even more expensive, many homeless persons go through cycles of arrests and jail or prison time as a result of their presence on the street or their efforts to secure food and shelter. Once released from correctional facilities, individuals re-entering the community without housing, employment or other resources usually continue on through the same cycle of chronic street homelessness, returning to the same points of contact with public safety services and correctional institutions again and again.

Notably, Culhane's study found that the NY/NY program reduced days in a correctional facility by 84% (2002). Mondello identified a 62% reduction in incarcerations and a 66% reduction in police contacts in Maine (2007). Perlman found that incarceration costs were cut by 76% after the first two years of the Denver study (2006). For the Portland, Oregon study, incarceration days decreased by 94% after one year in housing, falling from 1478 days the year before entry to 74 days the year after entry for the thirty-five participants. The average daily cost for each day

was estimated at \$115.00 (Moore 2006). Larimer discovered that total county jail bookings decreased by 45% in the year after entry into the Seattle housing project. Total county jail days for the same study fell by 42% (2009). A 38% cost reduction was identified for jails in the Rhode Island report. For all fifty participants, jail bookings fell from 919 nights to 149 nights in the first year housed (Hirsch 2007).

Tenant Stability

Of course, the savings offered by permanent supportive housing have no practical value without high levels of program retention. In order to truly end long-term homelessness for this population, permanent supportive housing must offer long-term stability. Evaluations of the permanent supportive housing projects reviewed in this white paper reveal that tenants do remain in permanent supportive housing long enough to substantially reduce their use of mainstream services and recognize the theoretical benefits of the program. The Minnesota study found that while tenants had only spent sixty-four days in their own housing in the 180 days before entry into the program, they spent 144 days in their own housing in the 180 days after entry (NCFH 2009). The Massachusetts study reported a retention rate of 84% stability. Out of 388 residents, 244 remained housed for an average of 1.9 years, 92 moved to other permanent supportive housing, 32 went back to homelessness, 10 were incarcerated, 12 died, and 18 were lost in the system (MHSA June 2009). In San Francisco, 81% of tenants remained housed at least one year, 63% remained housed at least 2 years, and 48% remained housed at least 3 years (Martinez 2006). In Larimer's report on Seattle, 66% remained housed one year (2009). In Denver, 80% of residents remained housed for six months, and 77% remained housed for two years (Perlman 2006).

Beyond retention, another important aspect of stability involves tenants' maintenance of an improved health and wellness condition. Without this kind of mental and physical stability, residents cannot be expected to utilize the services available to help them become more responsible and independent tenants and citizens. Perlman found that in the Denver program, 50% of residents had improved their mental health status, 64% reported improved quality of life, and there was a 15% decrease in substance abuse (2006). For tenants recovering from substance use in Seattle's project, Larimer found that mean number of drinks per day fell from 15.7 at entry to 14 at six months, 12.5 at nine months, and 10.6 at one year. This occurred in a "housing first" approach without abstinence requirements. The number of self-reported days of drinking to intoxication per month for the same sample fell from 28 at entry to 15 at six months, 20 at nine months, and 10 at one year housed (Larimer 2009).

Tenant Independence

While stability is certainly an important ingredient in ending the cycle of chronic homelessness, the lasting value of permanent supportive housing lies in its potential to help tenants achieve eventual independence from the program and other forms of public assistance. Although

permanent supportive housing is still a fairly new model for treating homelessness, preliminary outcomes have certainly shown that permanent supportive housing can equip many tenants with the resources to substantially decrease their reliance of public systems of assistance. In Maine, residents increased their income by 69% (Mondello 2007). In Denver, average income increased from \$185.00 per month at entry to \$431.00 per month two years after entry (Perlman 2006).

Community Development

Beyond savings in the social service sector and the increased stability and independence of tenants, permanent supportive housing offers general benefits that entire communities can appreciate. Eradicating the presence of chronic and street homelessness promotes community development outcomes with high universal value. In the Connecticut Demonstration, permanent supportive housing increased neighborhood property values for eight of the nine projects reviewed (Andersen 2000). The Furman Center study in New York City revealed a net increase in nearby property values within 1000 feet of a permanent supportive housing development over a five year period (Furman Center, 2008.) In Seattle, Larimer's study compared the six month periods before and after the launch of the permanent supportive housing program to discover that the Downtown Seattle Association's Metropolitan Improvement District reported a 21% decrease in the number of calls for the county sobering unit van (Mondello 2007). No community desires for homelessness to threaten the safety and appeal of its streets. By reducing street homelessness (Larimer 2009), permanent supportive housing is a win-win for both the community and the residents of the program.

Limits of Cost-Study Data

The preceding literature and data review is intended to provide an overview of the current body of research on permanent supportive housing as a solution to long-term homelessness. While merits such as cost-effectiveness and successful outcomes are the foundation for massive national support for the permanent supportive housing treatment model, there are certainly limits to the data and important issues that must be addressed as the housing community continues to refine this model for chronic homelessness recovery.

Capturing All Relevant Costs

As reflected in this white paper, most studies on the service reductions associated with permanent supportive housing are limited to systems of emergency shelter, emergency rooms, public health care, mental illness and addiction treatment, and safety and corrections. There is also limited working knowledge on the benefits accrued through tenant stability, tenant independence, and community development. While savings in these realms have proven significant, there may be other categories of both savings and costs that have yet to be rigorously examined. For example, the costs and savings associated with outcomes such as new income, employment, taxes paid, reductions and increases in public assistance, court time, use of alternative subsidized housing (such as section 8 vouchers), public health insurance costs, food

subsidies, academic or trade skills education, encounters with child protective services, loss of property, harm caused to others, and family-related improvements have yet to be thoroughly explored.

In addition to capturing all categories of costs and savings, there is also the question of utilizing accurate and reliable statistics on cost data. In many cases, emergency rooms and health care providers do not itemize their billing for indigent care. By lumping this kind of care for the homeless into different parts of the different budgets, the data offered by these systems may not provide a complete picture of the actual public dollars spent on care for this population. Exploring permanent supportive housing projects and cost studies in countries with more socialized medical systems or more detailed billing practices would be an interesting start to more accurately understanding the full costs of emergency health care for the homeless.

There is also only limited research on how to make a permanent supportive housing project as cost effective as it can be. The programs studied in the literature review represent a variety of states, each which calculate a different cost for the housing and services provided through their respective permanent supportive housing offerings. We know that on the whole, permanent supportive housing tends to be a cost-effective model. However, as programs continue to emerge, it will be useful to understand best practices for cost efficiency within any certain program. For example, developers can save money by using a scattered-site model that identifies apartments or units already available for rent on the market (Bazelon Center 2009). This would be a much less expensive alternative to developing a new building, but it may not suit the needs of certain specially targeted projects.

Lack of Long-Term Data

As evidenced in the literature review, most studies on permanent supportive housing are fairly recent. While the timeliness of this literature and data increases its relevance and credibility, the limited window of analysis does limit how far we can measure the long-term outcomes of these programs. This is particularly important because permanent supportive housing is approached as a solution for truly long-term homelessness. Before entry into the permanent supportive housing programs reviewed in this white paper, tenants averaged up to 8.6 years homelessness (Moore 2006). Most studies included in this literature review, however, only offer results for a one to two year period since the programs in question were so recently established. This leads to the question; as these permanent supportive housing programs continue, will mainstream service use continue to decline? Will service use increase in some areas and fall in others? Scholars have suggested that the costs of programs may actually peak at the beginning, and as the program continues, costs will fall and even higher levels of savings could be realized. In regards to the Portland, Oregon permanent supportive housing project, Thomas Moore, PhD notes, "Experience suggests that the first year of treatment is the most expensive. Based on this, it is highly recommended that further studies, over a greater period of time, be undertaken to

demonstrate the on-going cost savings...as clients remain stabilized in the community over multiple years” (2006 page i). Moore goes on to explain that in studies on recovery from alcoholism, costs do not usually drop significantly until the third year. It is quite possible this could also be a trend in supportive housing costs. The California study featured a fairly substantial five year window. The authors emphasized that significant reductions like a 62% decrease in inpatient days, 64% cut in inpatient admissions, and 69% reduction of inpatient charges did not materialize until the second year of the program (Linkins 2008). They believed this was the case because tenants experienced a delay in accessing Medicaid treatment needs, such as surgery that had been necessary for quite some time, but could not be funded until enrollment was completely processed.

In a related question, as long-term recovery treatment helps tenants improve their physical and mental health and stability, how will permanent supportive housing programs address the potential “graduation” of participants into independent living? What forms of public assistance will remain necessary, and how will the provision and delivery of those services be managed?

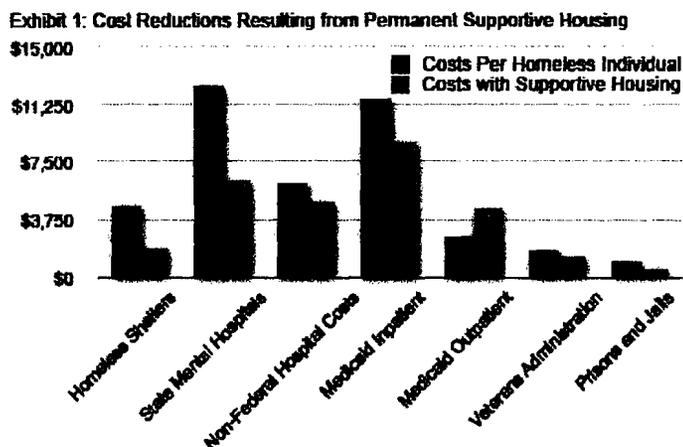
Translating Theoretical Cost Savings

While cost analysis studies identify high levels of savings in the public sector, it is important to note that the cost savings estimated in these reports may not lead to actual monetary reductions in the budget for individual public service agencies. For example, a prison or homeless shelter has already set the parameters of its physical building capacity and salaried staff. It would likely take years of very significant service reductions for these providers to be able to actually eliminate costs like space, capital investments, or staff. While some of the benefits of permanent supportive housing are so significant that they may realistically lead to a cost reduction as extreme as closing or downsizing certain emergency shelters, it is unlikely that savings could lead to the shutdown or downsizing of an established jail or prison that also serves a variety of other populations besides the homeless. However, the costs savings and service reductions in these arenas can certainly improve efficiency and operation within the existing system. Larimer of the Seattle report explains, “In addition to real dollar savings, reduced use of other services by the study population has implications for improved service delivery; greater access to care for other individuals; and increased ability of police, judicial, and jail personnel to focus of issues of higher priority to public safety” (2009 page 1356). In this way, while the savings identified may not always translate into dollar-for-dollar budget cuts, they are certainly of high value to the social service realm and the community at large.

Along the same lines, one concern in establishing funding streams for permanent supportive housing addresses the idea that the savings recognized in one system may not be compensated back to another. For example, the corrections system may accrue many benefits from permanent supportive housing, but that does not necessarily mean the corrections system is assisting with the costs of the program. From the perspective of the state, there are certainly net savings to be realized from permanent supportive housing, but potential individual developers will likely not

GRAPH #6

While some service use does increase after housing, total costs of services usually fall as tenants switch from more expensive emergency care to less expensive regular care (NAEH 2006, page 4)



be able to absorb all the costs of investment. Culhane explains, “The challenge facing proponents of a national strategy to increase the supply of supportive housing will be to determine how costs can be paid for in one area (for housing or housing support services), when the bulk of the savings from the intervention will accrue elsewhere (state mental health services, Medicaid, etc.)” (Culhane 2002) The NY/NY housing program reviewed by Culhane was so successful in achieving

and measuring savings because organizers in New York put together a complete “package” of federal, state, and city resources to pay for the operating and service costs of the program. Participation from all relevant parties is therefore required for such comprehensive success. This is why it is so vital to establish collaborative partnerships and lines of communications between all systems involved in the effort to end long-term homelessness. By working together to look at the big picture, more substantial savings and outcomes can be planned and achieved.

Another common question about the savings associated with permanent supportive housing deals with the reality that while inpatient and emergency service usage decreases when housed, outpatient and prevention treatment usage tend to increase. Many critics wonder if these changes offset one another to result in no actual net benefit to systems of health care. As discussed in the literature review, the pattern of switching from crisis care to regular care is real and usually perceived as an important signal of healthy recovery and stability. The Minnesota study is one study that identified this change in service usage, noting that tenants used less detox, inpatient, and corrections services and more pharmacy and outpatient services (NCFH 2009). It is important to recognize that while actual service *use* may remain roughly the same, the resulting *costs* do not. Regular and preventative treatments tend to be much less expensive than intensive emergency care. For an example of the cost savings promoted by changing trends in service usage, see Graph #5 from the National Alliance to End Homelessness (NAEH 2006 page 4).

Medicaid Enrollment and Barriers to Efficiency

As previously stated, services for mentally ill homeless persons are very closely tied to processes for determining Medicaid eligibility. As an important funding stream for permanent supportive

housing, Medicaid is an important factor in the kind of treatment tenants will receive and how that treatment will be funded and categorized. When this funding is difficult to access, the potential for recovery through permanent supportive housing is severely limited and delayed. Specific to Indiana, local scholar and dean of Indiana University's School of Public and Environmental Affairs Eric Wright, PhD explains "There is a need for projects to help people more quickly access mainstream subsidies such as disability determination and Medicaid eligibility. Determination of disability would lead to a consistent source of income, while a determination of Medicaid eligibility would lead to better mental and physical health care... Administrative barriers often restrict access to mainstream programs and decrease the likelihood that homeless people will apply for the programs" (Wright September 2007). Without timely access to Medicaid eligibility and enrollment, it will be difficult for permanent supportive housing programs to maximize savings and tenant outcomes.

A recent analysis of the relationship between existing Medicaid Rehabilitation services and the services needed under a Permanent Supportive Housing model reveals substantial opportunity to serve the needs of long-term homeless persons within the medical necessity guidelines for Medicaid. These services include skills training related to the location, procurement and maintenance of safe, affordable housing, development of appropriate skills for budgeting, negotiating and maintaining one's own home and nurturance of skills for community integration and assimilation. Additionally, case management is indicated to assess, coordinate and monitor the person in his/her pursuit and sustaining of appropriate housing.

There are some necessary supports that do not fit neatly into current Medicaid Rehabilitation guidelines. These include but are not limited to providing liaison services between the supported person and the landlord/property manager; building familiarity with and skill in negotiating tenancy requirements; developing an appropriate housing stock such that applicants are not placed on waiting lists which could be detrimental to their recovery and stability and provision of 24 hour back up to avoid situations which might lead to eviction. These services must somehow be funded if the permanent supportive housing model is to enjoy success in Indiana.

Bringing Permanent Supportive Housing Home for Hoosiers

There is reason to believe that the cost savings and positive outcomes of permanent supportive housing outlined in this literature review could also be recognized in Indiana. In Indianapolis, the Coalition for Homeless Intervention and Prevention (CHIP) contracted with Dr. Eric Wright and the Indiana University Purdue University Indianapolis Center for Health Policy to estimate the public health care and criminal justice-related expenditures of serving homeless individuals who are "frequent users" of public services. The study included ninety-six individuals over three years (2003-2006), concluding that Marion County and the City of Indianapolis expend between \$5,912 and \$15,560 each year in the public health and criminal justice sectors to respond to the needs of the average homeless person with mental illness or substance abuse issues (Wright, July 2007). Many of the individuals in the study also faced significant mental health or substance

use-related challenges. The homeless census estimates approximately 500 individuals fit into this category annually in Indianapolis, suggesting an annual cost of between \$3 million and \$7.8 million to Marion County and the City. These costs are associated only with public health and criminal justice related expenses and do not include shelter and other emergency services, which could substantially increase these cost estimates.

CHIP also contracted with Wright to study the impact of the 'Action Coalition to Ensure Stability' (ACES) pilot program. ACES served chronically homeless individuals with co-occurring mental illness and substance abuse disorders. Analysis of the ACES program demonstrated a 75% reduction in public health care costs when compared to participants' medical charges before enrollment in the program. These charges accounted for a \$9,000 cost reduction for each of the forty-nine clients studied. When extrapolated to the entire 121 clients who participated in the program, estimated savings exceed \$1 million (Wright 2006).

While Indiana-specific data is limited to these two reports, the body of research on permanent supportive housing demonstrates that permanent supportive housing offers a humane and cost-effective solution to long-term homelessness. In the words of Culhane, "The emergency assistance system is not appropriate as a source of long-term housing and services for families and individuals in need." (2008). This is just as true in Indiana as in the other states that have recognized massive benefits from permanent supportive housing development. In the Indiana cost studies, Dr. Wright found that for Indianapolis, the average number of inpatient visits per homeless person in a period of 3.5 years was seventy-three. The average cost of inpatient care per person over those 3.5 years was \$11,772. This totals \$1,130,122 in health care costs for the ninety-six Indianapolis participants studied. Dr. Wright also found that criminal justice encounters for the ninety-six intensive users totaled \$599,525 for a 3.5 year period (Wright 2006). These statistics emphasize that Indiana is already paying a high cost to manage the cycle of chronic homelessness. Dr. Wright explains, "Expanding access to (permanent supportive housing) programs - and coordinating this type of care with existing housing and social services - would help provide better care for this high-need population and reduce the financial stress on our criminal justice and public healthcare system" (Wright September 2007). Based on the savings demonstrated by other states, developing additional permanent supportive housing in Indiana could cut these costs and promote a more effective approach to long-term, recovery-based treatment.

Conclusion and Recommendations

In the words of Culhane, a clear leader in research on permanent supportive housing, "Among advocates for the homeless in the US, a truism has long held that homelessness is more expensive to society than the costs of solving the problem" (Winter 2008). By reviewing the body of literature and data on permanent supportive housing, this white paper has intended to demonstrate that permanent supportive housing is a cost-effective, humane, and sustainable

intervention that could bring significant benefits to Indiana's homeless population and public service system.

In 2008, the US Department of Housing and Urban Development (HUD) estimated that there had been an 11.5% decline in chronic homelessness since 2005, or a drop of 20,000 persons. HUD attributes this decline to the funding of 60,000 units of permanent supportive housing since 2001 through the McKinney-Vento permanent housing set-aside (Culhane, December 2008). This point is emphasized by nationally recognized reductions in homelessness in many of the states with permanent supportive housing programs featured in this white paper. According to data from the National Alliance to End Homelessness, in recent years Denver has reduced homelessness by 11.5% in metro regions, including a reduction in street homelessness from 1,000 to 600 persons. Philadelphia and Pennsylvania have reduced street homelessness by over half, Portland has housed 660 of its 1,600 chronically homeless persons, and San Francisco has reduced homelessness by 28% and street homelessness by 40% (NAEH 2006). It is time for Indiana to fall in line, acknowledging that there are high costs to 'doing nothing,' to re-direct the cycle of chronic homelessness and following national trends to establish permanent supportive housing as the working model for treating chronic homelessness (Graph #2). While IPSHI has developed a focused coalition of support and a strong pipeline of projects, research has shown that the combination of housing and services makes permanent supportive housing a success. IHCD has already committed substantial capital and operating resources to the IPSHI. In order for Indiana to realize the full potential of supportive housing through IPSHI, policy-makers must implement recovery based services, find additional supportive service funding for permanent supportive housing and streamline the process for procuring such funding.

The IPSHI represents an attempt to apply national best practices to the issues of chronic homelessness in Indiana. The goals of the Initiative include:

- Extend the reach of supportive housing to new communities
- Increase the capacity and number of nonprofits providing supportive housing at the local level
- Improve the connection between behavioral health services and housing systems
- Reduce the number of individuals and families who experience long-term and chronic homelessness

To achieve these goals, the initiative is divided into two phases. The first phase is the Demonstration Project (2008 – 2010) and the second phase is the Expansion Project (2009 – 2013). The Demonstration Project (2008 – 2010) includes the following strategies: 1) launch the Corporation for Supportive Housing's Permanent Supportive Housing Institute (Institute) to provide the training and technical assistance needed to bring supportive housing on-line, 2) the development of an Indiana service delivery model using CSH's Dimensions of Quality in Supportive Housing, and 3) the development of financial models and multi-agency funding strategies for housing and services. There is a goal of producing a minimum of 500 units during

the first phase. During the second phase, the Expansion Project, IHCDA and its partners will create an additional 600 units, evaluate the first phase and the permanent supportive housing projects that have come on line, develop best practices based on the outcome of evaluation activities, and establish new target units.

There has been significant achievement to-date on IPSHI strategies. IHCDA has made a multiple year commitment to the Institute to train and develop teams who can create supportive housing projects that meet the parameters for permanent supportive housing. IHCDA has redistributed resources to ensure the financial feasibility of supportive housing including the project based Housing Choice Vouchers, streamlining of the application process, set-asides of HOME Investment Partnership funds and Low Income Housing Tax Credits, creating a pool of funds for pre development activity and technical assistance at all phases of project development. As a result of this commitment, to date, there are nearly 700 units in the pipeline.

In March of 2008, as a result of IHCDA and DMHA talking about how to work together to implement IPSHI, 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 addressing service funding to support the model. The sub-committee includes DMHA, OMPP, IHCDA, and CSH. The Technical Assistance Collaborative (TAC) is providing technical assistance and consultation to this effort.

The sub-committee met in September 2008 to discuss the IPSHI housing goals; the State's Transformation Plan; the State's work to re-define Medicaid Rehabilitation Option (MRO) covered services and financing and delivery of mental health services; narrowing the gap between the number of units of supportive housing and the services needed and what can be covered under Medicaid and what needs to be covered through other funding sources – either because of enrollment/eligibility guidelines or because the services are not coverable.

The sub-committee developed an agreed upon scope of work and the components necessary to develop an Indiana model. The first task completed was a service delivery crosswalk of the services needed in permanent supportive housing. The crosswalk was aligned with CSH's Dimensions of Quality and includes a description of the role of property management in supportive housing. It identifies those services which can be covered through Medicaid Rehabilitation Option as defined by the Finance and Delivery Transformation work for individuals who are eligible for Medicaid and those services which need to be funded through other sources. It also includes the role of property management in supportive housing and the link between property management and services. Although important to a discussion about funding, this crosswalk has emerged as a fidelity model for what is needed to make supportive housing successful and recognized as a key component of the State's Recovery Model.

In June 2009, the workgroup decided that 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 work group decided to utilize the organizations participating in the Institute to demonstrate the feasibility of this model as the MRO initiative is getting underway. The goal is to align the Expansion phase of the IPSHI with the roll out of Medicaid and MRO changes occurring in July 2010 (Appendix A).

The efficacy of using MRO services as the principal service resource for permanent supportive housing 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. 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 Community Mental Health Centers in Indiana can help make supportive housing possible and successful for consumers. If strategically pursued, permanent supportive housing 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 community mental health centers on how to build capacity and proceed to implement permanent supportive housing; (2) assure Medicaid eligibility for eligible residents of Permanent Supportive Housing is pursued in a timely fashion; (3) assure regulatory and implementation support of permanent supportive housing; (4) assure community mental health centers can meet MRO standards and achieve fidelity to permanent supportive housing simultaneously; and (5) assure community mental health centers can cover costs associated with effectively implementing permanent supportive housing.

There are three types of costs associated with implementing the program

1. The first is the cost to providers of building capacity to deliver services. Judging from key informant interviews, the IHCDA-CSH Indiana Supportive Housing Institute appears to be an excellent venue for assisting providers to build capacity and is recommended as one approach to accomplish this recommendation. **IHCDA is committed to the training and ongoing monitoring necessary to provide the training and guidance necessary to build and maintain service capacity, as well as developing and maintaining quality permanent supportive housing.**
 2. The second cost is the direct services cost for interventions for consumers who are not or have not yet 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
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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 permanent supportive housing recipients to gain access to Medicaid benefits. Some of the residents who are otherwise eligible for permanent supportive housing may not meet Indiana Medicaid medical necessity requirements, e.g. those with a primary substance abuse disorder. **Based on the Crosswalk study, these initial and/or non-eligible services will account for about 25% of the service costs at any given time.** To achieve this level of efficiency, DMHA and OMPP need to be full partners with IHCD and CSH in assuring providers have the tools and support to meet MRO standards with fidelity to quality supportive housing models.

3. 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 permanent supportive housing. This includes active coordination of the roles and responsibilities of both services staff and property managers or landlords. While the services in the Medicaid Rehabilitation Option can be utilized as the primary service model for people in permanent supportive housing, there are costs for providers to deliver high quality services, particularly for people who have not had stable housing, beyond what is reimbursable in the MRO. However, these costs can be identified and incorporated into a single adjustable rate based on cost, or can be packaged into a single definable “service pack” to be used concurrently with MRO services. If state funds are available for this purpose, Indiana can benefit tremendously from the housing and services resources that come with permanent supportive housing.

GRAPH #7 Permanent Supportive Housing Costs Over Seven Years: Total of 1,400 Units of Permanent Supportive Housing

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
IPSHI Pipe Line Units	94	494	894	1200	1400	1400	1400
MRO Service Cost	819,052.08	4,304,380.08	7,789,708.08	10,455,984.00	12,198,648.00	9,758,918.40	9,758,918.40
Non MRO Service Cost	170,452.08	895,780.08	1,621,108.08	2,175,984.00	2,538,648.00	2,030,918.40	2,030,918.40
Housing Costs	564,000.00	2,964,000.00	5,364,000.00	7,200,000.00	8,400,000.00	8,400,000.00	8,400,000.00
IPSHI Costs (MRO Service + Non MRO Service + Housing)	1,553,504.16	8,164,160.16	14,774,816.16	19,831,968.00	23,137,296.00	20,189,836.80	20,189,836.80
Estimated Cost of Long-Term Homeless on Emergency Systems of Care	2,538,000.00	13,338,000.00	24,138,000.00	32,400,000.00	37,800,000.00	37,800,000.00	37,800,000.00
Cost Savings to State	984,495.84	5,173,839.84	9,363,183.84	12,568,032.00	14,662,704.00	17,610,163.20	17,610,163.20

The TAC/CSH report (Appendix A), presents clear evidence that while permanent supportive housing will require state agencies to “change the way they do business” and reallocate funds to this new strategic initiative, the state will benefit both in the realization of cost savings across multiple systems and an improved efficacy in the delivery of services. Permanent supportive housing has three primary costs: capital, operating and service. Graph 7 illustrates the costs for the IPSHI if 1,400 units are developed over a seven year time frame. As this graph illustrates, the primary service funding mechanism is Medicaid MRO. The Medicaid costs are not “new” but simply more closely identified with the permanent supportive housing units they support. In this approach, the state would be required to redirect \$2,030,928.40 annually by year six; however, the authors estimate that the state could realize cost savings of \$17,610,163 over the “cost of doing nothing.” Clearly, this would be an effective use of state resources and increase the quality of life in Hoosier communities.

The authors believe that implementing this funding along with the attached action plan (Appendix C) will put Indiana in a position to provide national leadership on how a small state can develop and implement a recovery based service delivery model within permanent supportive housing. If the recommendations outlined within this paper are implemented, Indiana will realize cost savings across multiple public and private sectors and the state will improve the effectiveness of its community based behavioral health services. It should be noted that the IHADA commitment to this effort will produce substantial economic development, including the creation of several hundred new construction jobs over a five year period. Additionally, all 1435 new units are expected to add to the tax base of their local communities.

Action Plan

In order to fully operationalize permanent supportive housing in Indiana and fully realize the cost savings described in this white paper, there are a number of steps that must be taken (Appendix C). First, IPSHI and its partners must develop a State Housing Policy that clearly specifies the need for permanent supportive housing in Indiana for homeless individuals and families experiencing homelessness and individuals leaving state operated facilities at risk of homelessness. Second, add permanent supportive housing to the Division of Mental Health and Addiction Continuum of Care. Third, develop a financial strategy and commitment for closing the service funding gap for the IPSHI units as they are developed. Four, develop strategies to ensure that Medicaid eligibility is pursued in a timely fashion. Five, identify and support the training and capacity building needs required as the State moves from traditional residential models to supportive housing.

By expanding the impact of IPSHI to include permanent supportive housing for individuals leaving group homes, state hospitals and nursing homes, the State can realize even greater systems savings. This strategy should be built on the foundation that has been created through IPSHI by identifying the financial impact and savings; identifying the sources of funding for

development, operating and services; and, developing a strategic plan for implementing permanent supportive housing as a response to more costly residential care models.

As clearly demonstrated in this white paper, permanent supportive housing is a cost effective intervention by helping individuals and families move out of expensive systems of emergency and long term care and back into their own homes and communities. Permanent supportive housing not only improves the lives of its residents, but also generates significant public benefits. By enacting policy cited in this paper that directs funding to permanent supportive housing, the state will improve the delivery of behavioral and primary health services in Hoosier communities and work towards eradicating the negative impact of long-term homelessness throughout the state.

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Appendix A

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

May 1, 2010

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

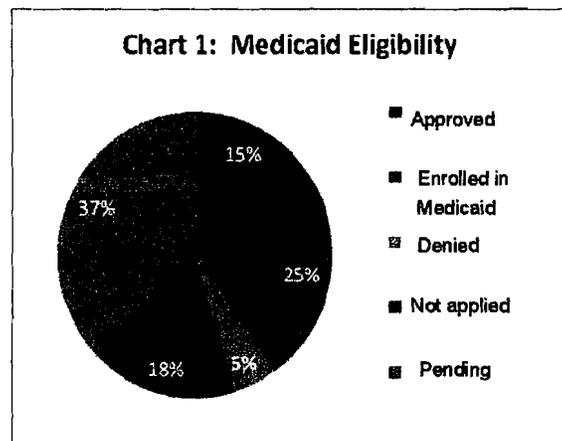
Table 1 depicts the eligibility of a cross section of persons from four CMHC IPSHI caseload (N=40) for SSI/SSDI and Medicaid who had entered the program in 2009. This analysis was conducted to determine the percentage of people on each agency’s caseload who have applied for benefits, the status of their 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. IHCD 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 IHCD-ISH 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 IHCD and ISH 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 IHCD 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 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.

Appendix B

CSH Dimensions of Quality

Defining the Seven Dimensions of Quality for Supportive Housing

Through communication with supportive housing tenants, providers, funders, and other stakeholders - and through involvement in successful supportive housing projects around the country - CSH has identified the following Seven Dimensions of Quality for supportive housing.

Dimension #1: Administration, Management, and Coordination

All involved organizations follow standard and required administrative and management practices, and coordinate their activities in order to ensure the best outcomes for tenants.

Dimension #2: Physical Environment

The design, construction, appearance, physical integrity, and maintenance of the housing units provide an environment that is attractive, sustainable, functional, appropriate for the surrounding community, and conducive to tenants' stability.

Dimension #3: Access to Housing and Services

Initial and continued access to the housing opportunities and supportive services is not restricted by unnecessary criteria, rules, services requirements, or other barriers.

Dimension #4: Supportive Services Design and Delivery

The design and delivery of supportive services facilitate access to a comprehensive array of services, are tenant-focused, effectively address tenants' needs, and foster tenants' housing stability and independence.

Dimension #5: Property Management and Asset Management

Property management activities support the mission and goals of the housing and foster tenants' housing stability and independence, and appropriate asset management strategies sustain the physical and financial viability of the housing asset.

Dimension #6: Tenant Rights, Input, and Leadership

Tenant rights are protected within consistently-enforced policies and procedures, tenants are provided with meaningful input and leadership opportunities, and staff - tenant relationships are characterized by respect and trust.

Dimension #7: Data, Documentation, and Evaluation

All involved organizations reliably capture accurate and meaningful data regarding the effectiveness, efficiency, and outcomes of their activities, and use this data to facilitate, and improve, the performance of those activities on an ongoing basis.

Seven Dimensions of Quality for Supportive Housing: Definitions and Indicators is available at:

<http://www.csh.org/index.cfm?fuseaction=Page.ViewPage&PageID=4435>

Appendix C

IPSHI Action Plan

Below are the recommended steps to operationalize the fidelity model and implement the cost savings described in this white paper:

- 1) Supportive Housing Policy/Plan
 - Develop a State Housing Policy/Plan (determine compatibility of TWG's adoption of supportive housing and the development of a State Housing Policy)
 - Identify roles of each stakeholder and a clearly defined charter agreement including tasks and completion dates
 -
- 2) DMHA Continuum of Care
 - Incorporate supportive housing definition into the DMHA Continuum of Care
- 3) Develop a financial strategy and commitment for closing the funding gap for IPSHI units as they are developed (addressing the need for funding between now and July 2011 and reallocated State funds beginning July 2011)
 - Identify the capital, operating, and service costs associated with developing and operating supportive housing;
 - Identify the resources designated for capital and operating (in other words, demonstrate the resources committed by IHCDA);
 - Create a timeline for units coming on line;
 - Determine the level of funding needed to pay for services defined in the crosswalk including Medicaid and non-Medicaid eligible expenses (use the results from the recent analysis of needed services for people to access and sustain permanent supportive housing);
 - Develop the process for allocating the resources (i.e., a state supported rate or fee) with a focus on providing incentives and financial support to centers to implement supportive housing;
 - Identify cost savings to the system; and,
 - Incorporate the financial strategy into the State Housing Policy and request for a service funding commitment.
- 4) Develop a strategy for ensuring Medicaid eligibility is pursued in a timely fashion.
 - Review Medicaid application process to identify barriers to homeless persons who apply for Medicaid;
 - Review sample of Medicaid denials to determine most often cited reason for denial of cases;
 - Provide additional training for DDS/Medicaid eligibility staff on co-occurring disorders cases;
- 5) Capacity Building and Training

- Identify the policy and cultural shifts required as the State moves from traditional residential models to supportive housing;
 - Use the identified “shifts” as the foundation for on-going capacity building and training;
 - Develop and provide capacity building for centers interested in expanding supportive housing options;
 - Continue Supportive Housing Institutes and further integrate crosswalk into the supportive housing institute sessions.
 - Integrate supportive housing and the crosswalk in trainings on new MRO packages
 - Develop and provide capacity building trainings for centers interested in expanding supportive housing.
 - Provide on-going support and training once projects are operational
- 6) Develop a strategy for deinstitutionalization from group homes, state hospitals and nursing homes. The strategy will include housing placement plans and development of supportive housing.
- Incorporate the financial impact of decreasing State Hospital beds
 - Incorporate the financial impact and possibility of Group Homes closing
 - Include CSH and IHCDA in planning for the shift from a Group Home model to supportive housing
 - Share examples from other states of the impact of closing Group Homes without a supportive housing strategy in place
 - Work with CSH and IHCDA to develop a strategy for increased funding for operating and services
 - Work with CSH and IHCDA to establish housing set-asides for deinstitutionalization
 - Include CSH and IHCDA in planning for the shift from a Group Home model to supportive housing

COMB

McKinney 3

October 20, 2010

Exhibit 11

PSH: Challenges and Opportunities

Background:

- In '80s PSH created for people with psychiatric and developmental disabilities
- PSH approach evolved and resources shifted: homeless persons became major recipients
- Housing funding became focus of attention
- McKinney became major source of funding; now \$2 billion annual appropriation; administered by HUD
- This growth result of demonstrated success



PSH: Challenges and Opportunities

Challenges:

- HUD as major funder---services are typically grant funded, non-sustainable and outside mainstream systems
- Other challenges with housing and services systems not matching up well (consumer eligibility, housing and services requirements-not compatible)
- Today housing funding more predictable and attainable than services funding



PSH: Challenges and Opportunities

Opportunities:

- HUD and HHS beginning to recognize need to channel more resources into mainstream programs
- Legislation (811 Reform) requires mainstream services funding
- States beginning to seek opportunities to take supportive housing to scale using combination of federal and state resources



PSH: Indiana Opportunity

- IPSHI has taken major steps to secure housing resources and build services capacity
- IPSHI has taken first step to explore services opportunities
- The primary opportunity is to build on State's efforts to improve the finance and delivery system of mental health services through re-defined Medicaid Rehabilitation Option (MRO) covered services



PSH: Indiana Opportunity

- IPSHI developed a Crosswalk which integrates MRO recovery based model with CSH dimensions of quality in supportive housing
- It serves as a guide for aligning MRO eligible services with the services needed in supportive housing
- Using crosswalk IPSHI conducted a feasibility study to identify potential for using MRO as the principle services resource for supportive housing



Technical Assistance Collaborative, Inc.

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PSH: Indiana Opportunity

- Results indicate MRO services can work as a principle resource for supportive housing in Indiana
 - There are two gaps between what resources are needed for supportive housing and what the MRO program covers based on this initial review
 - The first gap is “one-time” cost of services as people who are homeless are moving into housing if they are not already Medicaid eligible
 - The second is a 5% gap between costs and revenues to providers for providing PSH if MRO only resource after start up.



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PSH: Indiana Opportunity

The challenge now:

- Find ways to minimize or eliminate gap:
 - This includes expanding efforts to secure benefits as quickly as possible
 - Be prepared to take advantage of 2014 Medicaid eligibility changes
- Convert existing resources to PSH
- Take advantage of state (IHCDA) and federal housing (811) opportunities

