Indiana | 2020

MEDICAID SUPPORTIVE HOUSING SERVICES CROSSWALK

With Tenant Profiles

CSH

About IHCDA

The Indiana Housing and Community Development Authority's (IHCDA) mission is to provide housing opportunities, promote self-sufficiency, and strengthen communities. IHCDA promotes, finances, and supports a broad range of housing solutions, from temporary shelters to homeownership. IHCDA's work is done in partnership with developers, lenders, investors, and nonprofit organizations that use its financing to serve low and moderate-income Hoosiers. IHCDA leverages public and private funds to invest in financially sound, well-designed projects that will benefit communities for many years to come. IHCDA and CSH co-sponsor the annual Indiana Supportive Housing Institute to further strategies to end long-term and recurring homelessness. The focus of the Institute is on funding lasting solutions instead of stop-gap programs. Since the Institute began, several classes of teams (made up of developers, property management, and service providers) have completed the Institute, resulting in over 1,600 permanent supportive housing units added or under development in the state. This has helped contribute to a significant (52%) reduction in chronic homelessness in Indiana. Learn more about IHCDA's work at www.in.gov/ihcda.

About CSH

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 335,000 real homes for people who desperately need them. CSH funding, expertise and advocacy have provided nearly $1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. CSH advances solutions that use housing as a platform for services to improve the lives of the most vulnerable people, maximize public resources and build healthy communities. Visit us at www.csh.org.

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INTRODUCTION

In partnership with IHCDA, CSH conducted a Medicaid Supportive Housing Services Crosswalk (Crosswalk). Recognizing the positive effects supportive housing can have on individuals' health and well-being, housing stability, and healthcare utilization, this Crosswalk examines Indiana's Medicaid programs serving adults who would benefit most from supportive housing services. The Crosswalk concentrates specifically on Medicaid services for individuals living with disabilities including: people diagnosed with serious mental illness, people living with intellectual and developmental disabilities, people who have been diagnosed with co-occurring disorders (serious mental illness and substance use disorders), and people living with chronic illness and other disabling conditions who are eligible for Home and Community Based Services (HCBS). CSH also reviewed Medicaid benefits and services for individuals who are aging in the community and individuals with substance use disorders who are more likely to experience homelessness and be negatively affected by health disparities as a result of the social determinants of health. CSH examined Indiana's Medicaid State Plan programs and services, various HCBS programs, and certain programs operated through managed care entities (MCEs).

Programs examined include:

1) Medicaid Rehabilitation Option (MRO) [state plan services]

2) 1915(i) Adult Mental Health Habilitation (AMHH) Program services [state plan HCBS]

3) 1915(i) Behavioral and Primary Healthcare Coordination (BPHC) Program [state plan HCBS]

4) 1915(c) Community Integration and Habilitation (CIH) waiver services [HCBS]

5) 1915(c) Family Supports Waiver (FSW) services [HCBS]

6) 1915(c) Aged and Disabled (A&D) waiver services [HCBS]

7) 1915(c) Traumatic Brain Injury (TBI) waiver services [HCBS]

8) Hoosier Care Connect (HCC) [Aged, Blind, and Disabled] [managed care]

9) 1115 Healthy Indiana Plan (HIP) demonstration waiver services [managed care]

This report consists of four parts:

Part One – Connecting the Dots
Overview of key supportive housing concepts and Medicaid terminology used when discussing supportive housing and Medicaid.

Part Two – Setting the Stage
Brief review of the estimated supportive housing needs in Indiana, the social determinants of health, health and housing disparities in Indiana and key aspects of the Indiana's Medicaid program.

Part Three – Crosswalk Findings
Summary of key areas of alignment and gaps in the Crosswalk of services currently covered by Medicaid, highlights from supportive housing provider interviews, and Crosswalk findings presented through supportive housing tenant profiles.

Part Four – Next Steps
CSH's recommendations for the steps Indiana can implement to take full advantage of opportunities for Medicaid covered services to reimburse for supportive housing services.

PART ONE: CONNECTING THE DOTS

Introduction

In Indiana, a small yet noteworthy group of residents have critical, unmet housing and healthcare needs. Many of these highly vulnerable individuals are living with multiple, chronic physical and behavioral health conditions, including severe mental illness, substance use disorders and other challenges faced by Hoosiers who are aging or living with disabilities. Most have extremely low incomes and many are unstably housed, homeless, and/or cycling through multiple social service systems and institutions. Despite their frequent use of public systems such as long-term care facilities, jails, shelters, and hospitals, these individuals are not receiving the care they need; and therefore, their health and wellbeing is not improving despite significant public sector costs. Instead, they experience expensive and often preventable institutionalization, a lack of access to primary care, and a lack of integrated services addressing their co-occurring disorders and co-morbidities. While these residents represent a small percent of the total state population, their healthcare costs constitute a disproportionately large percent of Indiana's expenditures.

The homeless response system fully embraces supportive housing as a best practice for ending homelessness for those with the most need, but it does not have the resources to take this intervention to scale. A lack of sustainable services funding often delays the creation of new supportive housing units. Supportive housing service providers, who either do not bill Medicaid or are not maximizing their Medicaid billing, currently use a significant amount of flexible resources on supportive housing services that could potentially be covered by Medicaid programs. If the core list of supportive housing services were covered under Indiana's Medicaid State Plan, these flexible resources could be used to pay for housing or non-Medicaid eligible services to stretch dollars further and create more supportive housing to meet the need across the state. Medicaid reimbursement for services can allow providers to reallocate their more flexible resources to housing related activities (rental assistance and capital costs) and create more supportive housing units for a variety of populations, including those served by multiple Indiana Medicaid State Plan programs.

Key Terms and Concepts

Medicaid: Medicaid is public health insurance that pays for essential medical and medically-related services for people with low-incomes. Statutorily, Medicaid insurance cannot pay for room and board directly. Medicaid's ability to reimburse for services starts with a determination as to whether the services are medically necessary.

Medicaid Service Delivery and Reimbursement: Reimbursement for Medicaid services can be delivered in a variety of ways. States can reimburse providers directly for services in a **Fee for Service (FFS)** structure or states can contract with **managed care entities (MCEs)**. The role of MCEs is to maintain a quality network of providers of health care services, ensure that services are accessible to Medicaid members, and negotiate payment structures with their provider network. In some cases, MCEs also deliver services directly. States contract with MCEs primarily on a **Per Member, Per Month (PMPM)** basis. This shifts the financial risk onto the MCEs and while MCEs may have greater flexibility than state government to deliver services, this can also cause MCEs to limit services access so the MCE can operate within their budget. States and MCEs establish agency licensing and credentialing requirements and staff qualifications that determine which providers can receive Medicaid reimbursement. Many MCEs aim to reimburse providers within 30 days of the provider submitting a claim.

Medicaid State Plan: States and the federal government jointly finance the Medicaid program. The **Centers for Medicare and Medicaid Services (CMS)** oversee all state Medicaid plans. A Medicaid "State Plan" is the contract between a state and the federal government that determines which services are covered and how much each entity will pay for the program. All State Plans cover certain mandatory benefits as determined by federal statute. States and CMS can also agree to cover additional benefits designated as 'optional' in federal statute.[1] For example, Indiana's Medicaid Rehabilitation Option (MRO) is an optional State Plan benefit that covers a fairly broad range of recovery-oriented mental health and substance use disorder services. For CMS to approve

[1] For more detail on mandatory and optional Medicaid benefits - http://www.medicaid.gov/Medicaid-CHIP-Program- Information/By-Topics/Benefits/Medicaid-Benefits.html

optional benefits, states must meet all relevant CMS requirements. For the Rehabilitation[2] Option, the service must meet the purposes of "reducing disability and restoring function".[3] Many states use this optional rehabilitative services benefit to provide outpatient psychosocial rehabilitation services for individuals with serious mental illness and/or substance use disorders.

Medicaid Statutory Authorities: These are established mechanisms states can use to make changes to their Medicaid State Plan programs. States can apply to CMS to amend their Medicaid State Plan using a **State Plan Amendment (SPA)** or states can request for a waiver of certain provisions of the Social Security Act for specific populations. These Medicaid authorities are commonly known by their federal statutory section number. Some have particular applicability to supportive housing services and were highlighted in the June 26, 2015 CMS Informational Bulletin.[4]

- **1115 research and demonstration waivers** allow for state demonstration programs for innovative services, populations, or payment structures. 1115 waivers allow states to create, propose, and implement changes to their Medicaid programs that are unique and allow for opportunities, flexibilities and creativity that deviates (often significantly) from what traditional Medicaid statutes and rules would authorize. If successful, individual state 1115 waivers can serve as models for larger scale Medicaid improvements and permanent programs offered to all states.
- **1915(c) Waivers and 1915(i) SPAs** help states target **HCBS** for specific populations (seniors, individuals with severe or persistent mental illness, individuals with developmental disabilities, children with special health care needs, and people living with traumatic brain injuries). The focus of these services is facilitating the individual's ability to remain in the community for as long as possible, providing services to people in their own homes and communities rather than in institutions.[5] For more on Medicaid authorities for HCBS, visit the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation website.[6]

Supportive housing: Supportive housing is an evidence-based practice[7] that combines affordable housing with intensive tenancy support services and care coordination to help people who face the most complex challenges to live with stability, autonomy, and dignity. Research demonstrates that supportive housing provides housing stability, improves health outcomes, and reduces public system costs. Supportive housing is not affordable housing with resident services. It is a specific intervention that employs principles of harm reduction and consumer choice in all service delivery, and it provides specialized, housing-based tenant support services with low staff-to-client ratios. Ideally this is a 1:10 or 1:15 staff to tenant ratio.

The **housing** in supportive housing is affordable, independent, and requires a lease. It is not time-limited or transitional. It is a platform from which tenants can engage in services, as they choose, with guidance from staff. The **core services in supportive housing** are pre-tenancy (outreach, engagement, housing search, application assistance, and move-in assistance) and tenancy sustaining services (landlord relationship management, tenancy rights and responsibilities education, eviction prevention, crisis intervention, and subsidy program adherence) that help people access and remain in housing. In addition, supportive housing service providers connect tenants to clinical primary and behavioral health care services, and other community resources that help tenants to thrive. Services such as counseling, peer supports, independent living skills, employment training, end of life planning

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[2] Medicaid distinguishes between rehabilitative and habilitative services. Rehabilitative services must "involve the treatment or *remediation* of a condition that results in an individual's loss of functioning," while habilitative services assist individuals in *acquiring*, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitative services can be covered by Medicaid through a HCBS waiver or optional HCBS State Plan services. Habilitation is one of the Essential Health Benefits that must be offered when a state adopts an "Alternative Benefit Plan" to provide coverage to people who are newly eligible for Medicaid beginning in 2014. On July 15, 2013, HHS and CMS issued a Final Rule that includes requirements to ensure that Medicaid benefit packages include Essential Health Benefits and meet certain other minimum standards. This Final Rule can be found at https://www.federalregister.gov/articles/2013/07/15/2013-16271/medicaid-and-childrens-health-insurance-programs- essential-health-benefits-in-alternative-benefit#h-14.

[3] Wilkins, C., Burt, M., and Locke, G. (July 2014). A Primer on Using Medicaid for People Experiencing Chronic Homelessness and *Tenants in Permanent Supportive Housing.* Page 32. Available at: http://aspe.hhs.gov/daltcp/reports/2014/PSHPrimer.cfm.

[4] Coverage of Housing-Related Activities and Services for Individuals with Disabilities. June 26, 2015. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

[5] https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/

[6] Understanding Medicaid Home and Community Services: A Primer, 2010 Edition. Federal Medicaid Statutory Authorities. Published October 29, 2010. https://aspe.hhs.gov/report/understanding-medicaid-home-and-community-services-primer-2010-edition/federal-medicaid-statutory-authorities

[7] SAMHSA Supportive Housing Evidence Based Toolkit. https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509

and crisis supports are also routinely provided for supportive housing residents by supportive housing service providers or other community providers.

PART TWO: SETTING THE STAGE

People Experiencing Homelessness in Indiana

Every other year communities across the nation who receive Homelessness Assistance Funds from the U.S. Department of Housing and Urban Development (HUD) are required to conduct a count of people experiencing homelessness, known as the Point in Time Count (PIT). The PIT Count is held every year in Continuums of Care (CoCs) in Indiana.[8] Data from the PIT counts offer perspective on many issues, including changes in the number of people experiencing homelessness, the percent of people experiencing unsheltered homelessness, and the household and demographic makeup of individuals and families experiencing homelessness. CSH used data from the Indiana PIT counts and national reports about the data to highlight trends in the number of people in Indiana experiencing homelessness and to highlight the disproportionate representation of people of color experiencing homelessness in Indiana. Figure 1 highlights the percent changes in the number of people experiencing homelessness from 2018 to 2019 (a nearly 4% increase), and the percent change from 2010 to 2019 (a 15% decrease over 9 years).

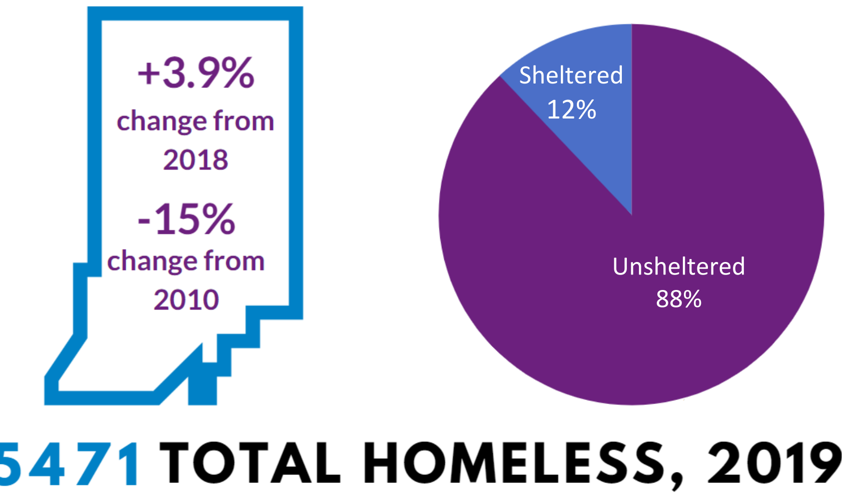


Figure 1: Results from the 2019 Indiana Point in Time (PIT) Count

Inequity in Health, Housing and the Social Determinants of Health

The Indiana State Health Assessment and Improvement Plan for 2018-2021 identified that disparities by race and ethnicity continue to exist in Indiana and in addition, highlights the State's commitment to addressing social determinants of health. The Plan features data confirming black communities in Indiana face higher rates of poverty, higher rates of chronic disease, and higher mortality rates among some of the leading causes of death (heart disease, cancer, stroke and diabetes).[9] The Plan acknowledges and defines *social determinants of health* including housing as a primary determinant.

Social determinants of health, or the places and spaces where Hoosiers live, learn, work, travel and play, are known and recognized to have a significant impact on health outcomes.[10] Lack of safe and affordable housing and housing instability can exacerbate and/or cause illness. Furthermore, the experience of homelessness is recognized as both a cause and effect of trauma and is known to make individuals more vulnerable to disease, injury, victimization, and assault. The impact of the experience of homelessness and housing instability on mental and physical health is increasingly being recognized by healthcare leaders around the nation. The health disparities reported in the State Improvement Plan highlight the poor health outcomes for racial and ethnic minority groups in Indiana. The data from Indiana also demonstrates similar trends of inequity in the black experience of housing stability and homelessness, and that data cannot be ignored.

African Americans in Indiana experience significantly higher rates of homelessness across the state. According to the U.S. Census Bureau 2018 estimates, Indiana's population is 85.4% White, 9.7% Black or African American

[8] https://www.in.gov/ihcda/indianabos/2412.htm

[9] Indiana State Health Assessment and Improvement Plan. 2018-2021. Retrieved on April 16, 2019 from: https://www.in.gov/isdh/files/18_SHA%20SHIP%20FINAL%20DOC_v5.pdf

10 The Office of Health Equity: An FSSA Commitment to Hoosier Health Outcomes. PowerPoint slide deck. Downloaded on April 17, 2019 from https://www.in.gov/fssa/files/OHE_and_SDOH_-_MAC_2.23.18.pdf

alone, 2.4% Asian alone, 0.4% American Indian, 0.01% Native Hawaiian or other Pacific Islander alone, and 2.1% two or more races. Census Bureau 2018 estimates also note that seven percent of Indiana's population is Hispanic/Latino.

Though African Americans make up about ten percent of the total population in the state, they are overrepresented among people experiencing homelessness (34.9%). In other words, among individuals experiencing homelessness in Indiana, more than one third are African American.[11] This starkly disproportionate impact spotlights the central role systemic racism has on poverty and homelessness. CSH believes supportive housing can be a lasting and equalizing force that recognizes structural racism and addresses systemic policies that maintain these disparities. Supportive housing is a part of the solution to ending homelessness for the most vulnerable, as it provides the platform for individuals to experience safety and stability, affordable housing, access to transportation, better access to healthcare, and ultimately live fuller, healthier lives.

Supportive Housing Need in Indiana

To better understand the supportive housing need across the United States, CSH staff used publicly available state and local data to predict the need across a variety of subpopulations in each state.[12] It is predicted that Indiana will need 19,423 additional units of supportive housing to meet the housing and service needs of vulnerable Hoosiers. Figure 2 highlights the supportive housing need predicted in Indiana (number of units needed) by subpopulation.[13] Older adults (65 and older referred to as Aging), individuals exiting institutions (prison, IDD institutions, and IDD and mental health residential programs), families involved in the child welfare system, people experiencing homelessness, people with substance use disorders, and transition age youth including those who are justice involved or unaccompanied, are the subpopulation groups needing the majority of new supportive housing units in Indiana. Other populations also needing the intensive services and affordable housing that supportive housing provides are families experiencing homelessness and transition age youth involved in the child welfare system. Details on the estimates presented and how these estimates were calculated for Figure 2 can be further explored on the CSH website data landing page.[14]

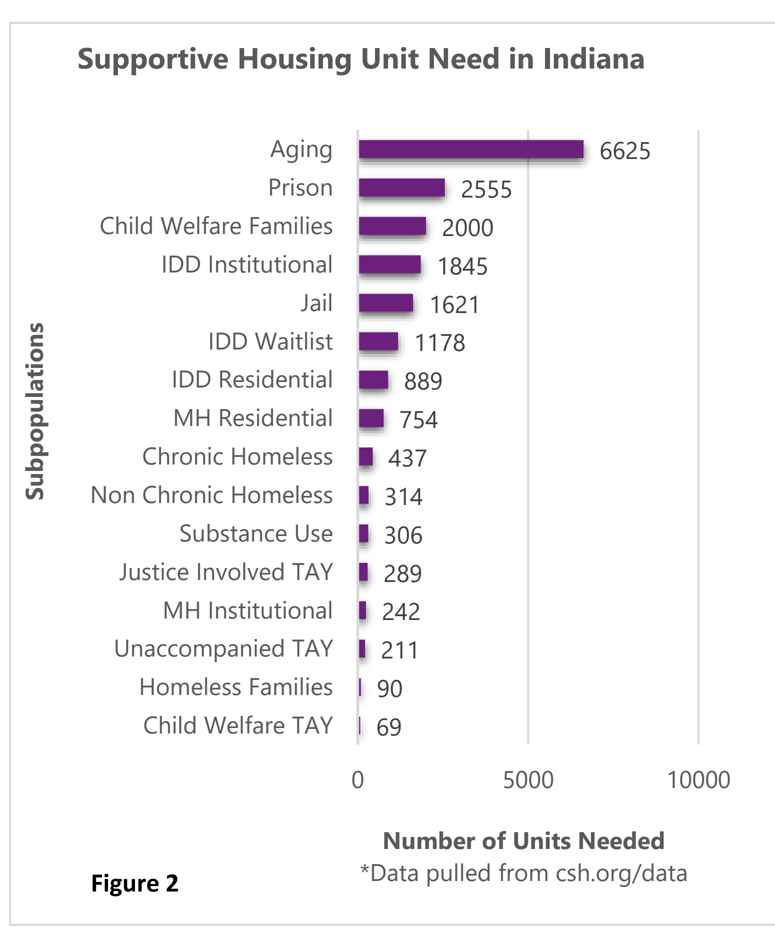


Figure 2

Supportive housing is an evidence-based practice recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) because supportive housing builds a foundation for recovery, improves the integration of behavioral and physical health care, and promotes the collaboration between treatment providers and homeless system providers. This integration can be accomplished through a variety of Medicaid authorities. For states whose Medicaid plans do not currently cover tenancy supports, CSH is broadly recommending consideration of an HCBS 1915i State Plan Amendment that covers supportive housing services for individuals

[11] Demographic Summary by Race. HUD 2018 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations. Retrieved from: https://files.hudexchange.info/reports/published/CoC_PopSub_State_IN_2018.pdf

[12] CSH Supportive Housing Needs in the United States. https://www.csh.org/supportive-housing-101/data/

[13] Find detailed data reports on the supportive housing need for each population, total figures, and research references and citations at https://www.csh.org/supportive-housing-101/data/

[14] Find detailed data reports on the supportive housing need for each population, total figures, and research references and citations at https://www.csh.org/supportive-housing-101/data/.

experiencing homelessness, aging in place, exiting institutions, and cycling in and out of emergency and crisis service systems (jails, prisons, shelters, hospitals, and detox facilities).

Indiana Medicaid and the Medicaid State Plan

Indiana Health Care Coverage Programs contain a variety of programs within and beyond Medicaid.[15] Hoosier Healthwise covers the Temporary Assistance to Needy Families (TANF) population and the Children's Health Insurance Program (CHIP) population, who have higher incomes than the TANF population. The Healthy Indiana Plan (HIP) covers low income adults, pregnant women and the adult Medicaid expansion population. The Hoosier Care Connect program covers Indiana residents who have been deemed by the state as Aged, Blind or Disabled, commonly called the ABD population. Per staff officials, February 2020 enrollment in Medicaid was 1,447,765 persons. Twenty-two percent or 320,878 remain in Fee for Service (FFS) Medicaid. Those remaining in FFS Medicaid include enrollees eligible for Medicare and Medicaid (dually eligible) and prohibited by state statute from enrolling in Medicaid managed care, enrollees who have chosen to opt out of Managed Care, enrollees who may receive HCBS services or are receiving care in a Nursing Facility as well as some other smaller enrollee populations. All other populations, including TANF and the ABD population use a Managed Care Delivery System which in Indiana is administered by organizations commonly referred to in Indiana as Managed Care Entities or MCEs.

In January 2015, through an 1115 demonstration waiver, Indiana was granted permission to implement HIP, a non-traditional Medicaid expansion. While the vehicle was an 1115 waiver, the Medicaid expansion was authorized under the Affordable Care Act and provided for expanded coverage for a new adult population with income up to 138% of the federal poverty level (FPL). Newly Medicaid eligible residents were able to access coverage effective February 1, 2015 under the plan. The Medicaid expansion population was most commonly previously uninsured, ages 19-64, and persons who were formerly not able to receive covered preventive and primary health care services, among other services. Of these, now eligible Medicaid beneficiaries, some are experiencing homelessness and/or living with substance use disorders, chronic health conditions, and undiagnosed mental illness. Newly eligible for Medicaid services, many of these individuals who are experiencing homeless or housing instability are also in need of supportive housing services.

This Crosswalk report includes a review of Indiana's Medicaid State Plan, 1115 Healthy Indiana Plan demonstration waiver, the Hoosier Care Connect, the Medicaid Rehabilitation Option (MRO), the Community Integration and Habilitation waiver {1915(c)}, the Traumatic Brain Injury waiver {1915(c)}, the Aged and Disabled waiver {1915(c)}, the Adult Mental Health Habilitation 1915(i) SPA, and the Behavioral and Physical Health Care Coordination (BPHC) 1915(i) SPA. CSH focused its analysis on these because all provide services for the highly vulnerable individuals that are most commonly served in supportive housing (people who are aging and/or living with serious mental illness, behavioral health conditions, intellectual, developmental, or physical disabilities).

Managed Care in Indiana

Indiana OMPP has contracted with four MCEs to cover the broad majority of the Medicaid population in the state including Anthem, CareSource, MDwise, and Managed Health Services (MHS). Anthem's national offices are based in Indianapolis and their plans have 32% market share in the total Medicaid market per January 2020 enrollment information. MD Wise has 20%, MHS has 17% and CareSource, the newest entrant into the market, has 6% of the Medicaid Market in Indiana.[16] All MCE's operate statewide with Anthem and MHS currently servicing the Hoosier Care Connect (ABD) population. It is likely Hoosier Care Connect will have additional MCE's operating the program. All 4 MCEs cover the Hoosier Healthwise (TANF and CHIP) and HIP (the Medicaid expansion population).

Behavioral Healthcare in Indiana

Behavioral healthcare, including a full range of mental health and addiction services in Indiana, is offered via a network of Community Mental Health Centers (CMHCs) and community providers. Standard inpatient and outpatient services are offered by qualified staff and reimbursed through MCEs or through a Fee for Service (FFS) payment delivery mechanism. Certain behavioral healthcare services for individuals with serious, persistent

[15] https://www.in.gov/medicaid/members/26.htm
[16] https://www.in.gov/fssa/ompp/4881.htm

mental illness and persons needing higher levels of behavioral healthcare supports are 'carved out' in Indiana, meaning that the MCEs do not manage these MRO resources. MRO services and the delivery system remains operating in a FFS environment. Carved out services include MRO as well as AMHH and BHPC services. MCEs are still required to coordinate care for their own members outside of specific carved out services such as MRO. Resources for those services are managed by a system of CMHCs, with each CMHC responsible for serving an exclusively designated geography or catchment area.[17] Catchment areas can span multiple counties. The MRO services require active Medicaid enrollment to access. The CMHCs are represented by a trade association called the Indiana Council.[18] CSH has completed a landscape assessment of service providers in Indianapolis who offer services supportive housing residents need and many were CMHCs. CMHC leaders talked commonly about very low rates of service, low to nonexistent financial margins, and how such limited funding inhibited their ability to innovate, reach out to vulnerable populations, or engage in the community conversations regarding ending homelessness.

Fee for Service Reimbursement in Indiana

In addition to managed care, which often reimburses through a capitated rate system (i.e. a set dollar amount per enrolled client per day/month), Indiana also operates a Fee For Service (FFS) reimbursement system primarily for beneficiaries with high cost and complex needs including HCBS services recipients, MRO services, persons who are dually eligible for Medicaid and Medicare (commonly called "Dual Eligibles"), persons in nursing homes, intermediate care facilities or state facilities, persons who choose to opt out of Managed Care, and persons who are recently enrolled in Medicaid and have not yet been assigned to an MCE.[19] Fee for service payment is based on the type of service provided and the duration of the service time. It is often calculated with a unit payment based on 15 minutes of service.

Indiana's Medicaid Authorities

Indiana, similarly to other states, uses the combination of a 1915(b)(1) and 1915(b)(4) waiver[20] to operate its managed care delivery system of the Medicaid program statewide. The state utilizes the Medicaid Rehabilitation Option support services in the CMHCs for persons with serious mental illness. The state has three 1915(c) waivers that offer services that persons who need supportive housing are commonly in need of. Those waivers cover persons who have intellectual or developmental disabilities (the Community Integration and Habilitation Waiver), persons who are aged or long term disabled (the Aged and Disabled waiver), and persons who have experienced a Traumatic Brain Injury (the TBI waiver). Indiana also uses the 1915(i) State Plan Amendment (SPA) Medicaid authority to offer its Adult Mental Health Habilitation (AMHH) program and Behavioral and Physical Health Care Coordination (BPHC) program.[21]

The state uses the HIP program to provide Medicaid to all persons aged 19-64 who are at or below 138% of the FPL, while also adding in a variety of additional requirements, including health savings account (HSAs) requirements, premiums, loss of retroactive eligibility, lock out periods and community engagement requirements (often referred to as work requirements). As of April 30, 2020, Indiana's Gateway to Work program was suspended indefinitely in response to the stay in a federal lawsuit involving Indiana Medicaid and the COVID-19 public health emergency. The suspension allows Indiana Medicaid and its Health Plan partners to focus their resources on the evolving public health crisis. If the decision is made to re-launch Gateway to Work in the future, Health Plans and other stakeholders will be engaged in the planning and implementation. However, such discussions would not begin until after the COVID-19 public health emergency is over and the federal lawsuit is resolved. [22]HSAs in Indiana are called POWER accounts and certain recipient categories (over 100% FPL, not pregnant) are required to financially contribute to these accounts or lose certain aspects of their coverage. Persons who engage in documented healthy behaviors will earn incentives to have state funds contributed to their account. Funds from these accounts can then be used to cover health care expenses. Persons who do not

[17] www.in.gov/fssa/dmha/files/DMHA_SOFs and CMHCs.pdf
[18] http://www.iccmhc.org/
[19] https://www.in.gov/medicaid/members/185.htm
[20] https://www.macpac.gov/subtopic/1915b-waivers/
[21] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/IN-Waiver-Factsheet.html
[22] This information is current as of the publication of this document. For more details visit www.in.gov/fssa/hip

comply with program requirements such as POWER account payments can be locked out of coverage or shifted from HIP Plus to HIP Basic which has a more limited service package. For persons with incomes above 100% of the FPL, lock out periods can be up to six months. It is important to note that for individuals who qualify as medically frail under federal regulation are exempt from being locked out of coverage but can be shifted from HIP Plus to HIP Basic.[23] Women who are pregnant will continue to qualify for HIP Maternity.[24] For persons with incomes below 100% of FPL, the person transitions from HIP Plus which includes dental and vision coverage to HIP Basic which does not.

The HIP program also does not include retroactive eligibility for persons who were eligible, which typically allows for provider reimbursement for services rendered up to 90 days prior to a beneficiary being enrolled in Medicaid[25]. This lack of retroactive eligibility for HIP enrollees will be a challenge for providers who work with people experiencing homelessness because it often takes longer than 90 days to engage this population. As a result, providers have little incentive to provide significant treatment and services prior to actual HIP enrollment as they will not be reimbursed for the costs incurred. Under the HIP program, Medicaid billing service providers who are serving persons who are part of the expansion populations (I.e. would not be Medicaid eligible except for the HIP program), are not able to bill for services until the person has made their first POWER account payment. For other populations, such as TANF and ABD, providers can bill for services 90 days prior to Medicaid enrollment, assuming the person was eligible in that time period.

1. 1915(c) Home and Community Based Waiver Services

Indiana has three 1915(c) waivers that provide supports to persons who meet institutional levels of care and for whom, without waiver services, could not continue to live in the community. The Indiana Aged and Disabled waiver (0210.R06.00) provides supportive services to persons who are either elderly or disabled. Within a person-centered planning process the service package can include a variety of services that are aligned with quality supportive housing including community transition and integrated health care coordination. The Indiana Community Integration and Habilitation waiver (0378.R03.00) provides supportive services to persons with developmental or intellectual disabilities. Within a person-centered planning process the service package can include a variety of services that are aligned with quality supportive housing including community transition, case management, residential habilitation and support, supportive employment, recreational therapy, and wellness coordination services. The Indiana Traumatic Brain Injury (TBI) waiver (4197.R04.00) provides supportive services to persons who have been diagnosed with a TBI. Within a person-centered planning process, the TBI service package can include a variety of services that are aligned with quality supportive housing including case management, residential based habilitation, supportive employment, behavior management, community transition and integrated health care coordination services.

2. 1915(i) Home and Community Based Services State Plan Services

Indiana has two 1915(i) programs, both with some inclusion of services for persons with serious mental illness. These persons do not need to meet institutional levels of care for 1915(i) services as they do for 1915(c) waiver services.

The Adult Mental Health Habilitation (AMHH) program for individuals with serious mental illness offer HCBS services for persons who meet the state's need-based criteria, who are age 35 and older, are enrolled in Medicaid, have an AMHH eligible diagnosis, and reside in an HCBS approved setting. AMHH services are primarily habilitative in nature, intending to support individuals in maintaining or sustaining current functioning. AMHH is designed for individuals who have achieved their functional baseline. The goal of the program is to help maintain or sustain the individual's current level of functioning and remain in the community. Medicaid members cannot receive both MRO and AMHH services at the same time. While AMHH services are habilitative, MRO services are rehabilitative, intended to support individuals in regaining functioning or skills that they once had. AMHH requires CMHC's to complete the following with potential participants: Level of Need (LON) assessment, IICP (Individualized Integrated Care Plan), crisis plan, and AMHH application. The required application includes a Residential Setting Screening Tool and Attestations from participant, staff, guardian, and psychiatrist. Services offered as part of the AMHH program include habilitation and supports, therapy and behavioral health support

[23] https://www.in.gov/medicaid/files/membereligibilitybenefitcover.pdf
[24] https://www.in.gov/fssa/hip/2463.htm
[25] https://www.in.gov/medicaid/files/member%20eligibility%20and%20benefit%20coverage.pdf

services, adult day services, respite, care coordination, supportive community engagement, addiction counseling, and medication training and support.

The Behavioral and Physical Health Care Coordination Services (BPHC) are for persons who are age 19 and over, have a BPHC eligible mental health diagnosis, resides in an HCBS approved setting and has countable income that is no higher than 300% of FPL. The goal of BPHC is to help individuals with co-existing primary healthcare and mental health care needs manage their co-existing health issues effectively. Accessing services requires the creation of an IICP, a LON plan, and a BPHC application. Care coordination is the only service provided. It consists of coordination of healthcare services to manage behavioral and primary healthcare needs. Participants who have HIP and are deemed medically frail can apply for BPHC in order to obtain care coordination services, delivered through fee for service Medicaid. Individuals can receive both BPHC and AMHH or BPHC and MRO. Overall, both AMHH and BPHC programs seek to help individuals remain in the community and receive the services that they need to remain successful. AMHH and BPHC services can only be provided by the CMHCs due to each program's respective 1915(b)(4) waiver.

3. Medicaid Rehabilitation Option

Medicaid Rehabilitation Option (MRO) provides specific services to persons who suffer from a serious mental illness, addiction, serious emotional disturbance, or other behavioral health challenge. MRO eligibility is dependent on member diagnosis and LON. If a Medicaid member qualifies for an MRO service package, an IICP must be developed to address the functional impairments that challenge a member's ability to remain in the community.[26] Like supportive housing services, MRO services can be offered in the community. However, MRO services can only be offered currently by CMHCs. MRO services include Addiction Counseling, Adult Intensive Rehabilitative Services, Behavioral Health Counseling, Case Management, Medication Training and Support, Psychiatric Services, Psychosocial Rehabilitation Services, and Skills Training and Development Services.[27]

4. 1115 HIP Demonstration Waiver

Under HIP, there is a significant new investment in addiction services to address the needs of Hoosiers who suffer from addiction challenges.[28] Previous iterations of the state's 1115 waiver included Tenancy Support Services for persons who were actively engaged in their recovery and were leaving newly developed residential treatment options to return to community settings. However, the most recent version of the waiver no longer includes those services, so while the current HIP waiver was reviewed closely, there is little to no overlap with supportive housing services.

Non-Medicaid Funding for Mental Health and Substance Use Disorder Treatment

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) awarded Indiana $1,027,624 in Federal PATH (Projects for Assistance in Transition from Homelessness) funds for FY17, the most recent publicly available data. Indiana has 12 PATH providers who offer services not covered under Medicaid. Similarly, to other states, Indiana receives from SAMHSA funding under the Substance Abuse Prevention and Treatment Block Grant (SAPT), Mental Health Block Grant (MHBG), and additional directed funds for a total statewide of $97,852,561 in FY18, the most recent publicly available data.[29] A significant portion of these funds are allocated to the CMHC system to support their general operations. These services are intended to supplement Medicaid, Medicare, and private insurance benefits.

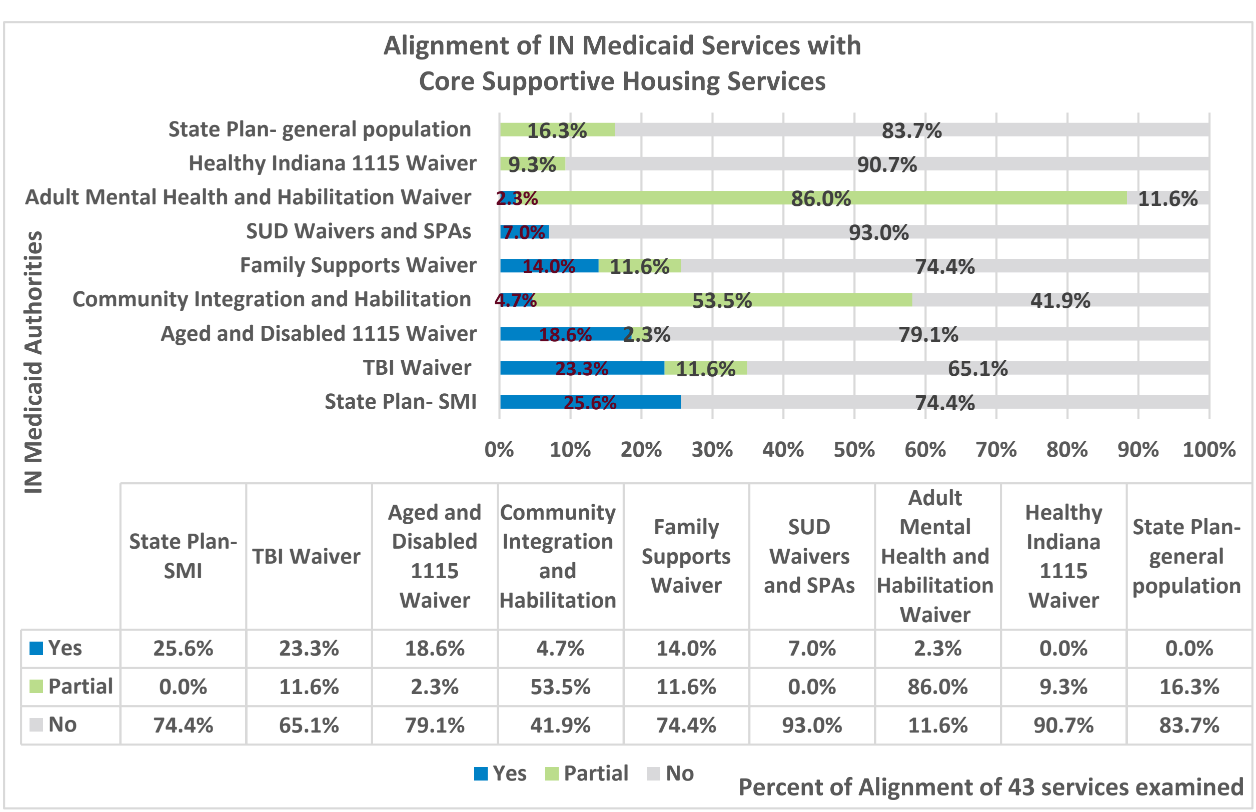
[26] https://www.in.gov/medicaid/providers/478.htm
[27] https://www.in.gov/medicaid/files/medicaid%20rehabilitation%20option%20services.pdf
[28] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf
[29] https://www.samhsa.gov/grants-awards-by-state/IN/2018

PART THREE: CROSSWALK FINDINGS

To determine the degree to which Medicaid currently pays for supportive housing services, CSH "crosswalked" 44 core services provided in supportive housing with key provisions of the Indiana State Plan and relevant Indiana Medicaid HCBS that are available to aging adults and individuals living with disabilities including intellectual and developmental disabilities (IDD), serious mental illness (SMI), substance use disorders (SUD), and high utilizers of crisis healthcare services. A listing of those services and their overlap with Indiana Medicaid services are included in Appendix A. CSH then reviewed the initial crosswalk findings with staff from OMPP, DMHA, DOA, and DDRS to confirm and clarify alignment with specific behavioral health and home and community-based services. Assistance was provided through phone consultation and written correspondence. CSH also conducted provider interviews with supportive housing providers across the state. CSH then used the crosswalk findings to create tenant profiles depicting the opportunities and barriers to Medicaid services that Hoosiers may face on their recovery journey.

Summary of Crosswalk Alignment and Gaps

The summary table in Figure 3 depicts a summary of the alignment and partial alignment identified during the crosswalk review. Details of the pre-tenancy, tenancy sustaining, and care coordination services that align or partially align with benefits offered in the Indiana Medicaid program are included in Appendix A of this report.[30]



	State Plan- SMI	TBI Waiver	Aged and Disabled 1115 Waiver	Community Integration and Habilitation	Family Supports Waiver	SUD Waivers and SPAs	Adult Mental Health and Habilitation Waiver	Healthy Indiana 1115 Waiver	State Plan- general population
Yes	25.6%	23.3%	18.6%	4.7%	14.0%	7.0%	2.3%	0.0%	0.0%
Partial	0.0%	11.6%	2.3%	53.5%	11.6%	0.0%	86.0%	9.3%	16.3%
No	74.4%	65.1%	79.1%	41.9%	74.4%	93.0%	11.6%	90.7%	83.7%

Figure 3: Summary of Alignment Identified

Supportive housing services aligned with Indiana's covered benefits and which can be accessed without barriers were tallied up and divided by the total 44 supportive housing services analyzed to create the percentages depicted in blue under the Yes category. Services that align on paper but have barriers to care in practice were tallied and divided by the total 44 services examined to make up the green bars above listed as Partial alignment. Services provided by case managers that are not formally assessed, not formally offered, or have multiple barriers in practice are also considered Partial and depicted in green above. Services not covered are depicted in grey and fall under the No category.

[30] Note: The HCBS programs included in this analysis were selected based on the appropriateness of the services and their alignment with the needs of adults in supportive housing. There are other Medicaid Waivers or HCBS in Indiana that were not included in this analysis due to the focus on supportive housing.

State Plan Gaps

Few supportive housing services align with the current Indiana State Plan. When services do align, such as with the MRO population, the current rates dis-incentivize providers from using higher skilled and high paid staff to deliver services. Even when alignment does exist, due to tight margins, limited opportunities exist to expand services or implement services flexibly to align with housing needs. Gaps in populations served and gaps in service are highlighted below and are also addressed in the Recommendations section at the end of this report. The following key gaps exist in the provision of the following supportive housing services.

1. Gaps in Populations Served

Currently, the best alignment for services with supportive housing is for people with serious mental illness using State Plan mental health services, which would include MRO services. That being said, MRO services have limited alignment with supportive housing services and therefore limited potential for increasing supportive housing development in Indiana. MRO services currently can only be provided by CMHCs. Although there are a number of CMHCs that have actively participated in providing services to tenants in supportive housing or individuals experiencing homelessness, challenges remain. The ability to engage with current or potential tenants who may not be enrolled in Medicaid or with a CMHC is a vital part of providing services in supportive housing. The lack of reimbursement for engagement and the limited ability to bill retroactively makes the practice difficult for some CMHCs to use best practices in their approach. With limited flexible funding or engagement resources, CMHCs struggle to provide on-site staff on a regular basis or to offer more accessible hours of operation either on-site or off-site. Serving the most vulnerable tenants in supportive housing requires motivated and skilled staff. CMHCs report limited cross disciplinary teams due to funding constraints and acknowledge that changes in MRO reimbursement have led to a higher utilization of life skills development staff. These are typically staff with the least amount of experience who are delivering the majority of supportive housing services when available. Barriers to delivering quality supportive housing services have been overcome when those centers have identified highly vulnerable individuals experiencing homelessness as a priority population and have invested in building their staffs' skills to deliver services with a harm reduction approach. These CMHCs have been successful by prioritizing the use of state or federal block grant funding when eligible, their own general funds, or philanthropic funding. Similarly, some CMHCs have been successful in applying for grants through SAMHSA. Unfortunately, CMHCs and other Indiana providers who have been successful with SAMHSA applications have not been able to identify funding to maintain the services delivered under these demonstration grants.

Due to difficultly in financial sustainability to deliver high quality services and engagement in supportive housing, a number of CMHCs have recently ended their participation. This has left both tenants and housing providers in a precarious situation without needed services. Others have made the decision to deliver very limited services in supportive housing. Providers are reporting that some vulnerable tenants are experiencing increased consequences, impairments, and in some cases eviction due to the sudden and dramatic end of supportive services.

Indiana, according to the 2019 PIT count, has 1,211 people with serious mental illness experiencing homelessness and 825 people with chronic substance use disorders experiencing homelessness.[31] Please note that behavioral health status is self-reported data and is commonly an undercount of prevalence. The PIT count notes a total of 5,471 persons experiencing homelessness, including 4,265 unique households.

Persons who are ineligible for MRO services would be left out of even capitalizing on this potential alignment with MRO services. Persons with HIV/AIDS and persons with primary substance use disorders without a mental health diagnosis are both commonly not able to access these services due to complications related to their multiple disabilities.

[31] https://files.hudexchange.info/reports/published/CoC_PopSub_State_IN_2018.pdf
https://files.hudexchange.info/reports/published/CoC_PopSub_State_IN_2019.pdf

2. Gaps in Services Necessary for Quality Supported Housing

Very few of the services required for quality supportive housing are available through the Indiana Medicaid State Plan. Services that commonly are available via the State Plan include care coordination, crisis support services, and skills training. Services with a focus on housing stability are commonly not available, including landlord engagement, eviction prevention, housing stabilization services, and family related supports. Per the plans reviewed, a Harm Reduction philosophy is also not noted or supported in services definitions but is a key component to success for a population suffering from a high rate of addiction.

3. Gaps in Access to HCBS Services

Persons who are receiving HCBS including those who are aging, have intellectual or developmental disabilities, or traumatic brain injury, and have a housing challenge have limited options, and services that are available to them have limited alignment with quality supportive housing. The services included, while extensive, commonly assume either a family or shared-living related setting. An increase in supportive housing for these populations and alignment of housing and services could assist to ensure improved person-centered outcomes for individuals receiving HCBS supports. The state reports that the only HCBS waiver that has an active waiting list is the family supports waiver, with 1,813 on the list.

Provider Interviews

The following section builds upon the analysis of covered supportive housing services and gaps in coverage in Indiana's Medicaid State Plan and HCBS system and presents identified gaps in practice. CSH conducted interviews with seven supportive housing providers across Indiana to understand the array of services supportive housing providers are currently offering to tenants, regardless of the funding source. CSH also surveyed these same providers about their understanding of Medicaid reimbursement of supportive housing services. The information gained during the provider interviews is useful because it highlights the valuable services supportive housing providers are currently offering tenants without Medicaid reimbursement because: those services are not currently covered in the Medicaid State Plan or HCBS; providers do not perceive the services as Medicaid reimbursable services; or the supportive housing providers are prohibited from billing for these services. This provider interview section included in the Crosswalk Report can be helpful for advocates and community leaders in support of the CMS recommended covered services for pre-tenancy and tenancy support services as well as those looking to expand provider education of the Medicaid State Plan and HCBS.

The supportive housing providers interviewed for Crosswalk represented a range of social service providers across the state. Provider interviews included a series of questions around provider perceptions of Medicaid Assistance coverage for over 80 services within 17 service categories. Providers interviewed provide services in Indianapolis, Evansville, Bloomington, and across Northwest Indiana. Not all providers interviewed had experience with billing Medicaid, and only one provider is currently billing for Medicaid Services.

Perceptions of Medicaid by Providers and Provider Recommendations

During provider interviews two key themes emerged on provider perceptions of Medicaid: 1) providers perceived they were not eligible to bill for Medicaid because they were not a CMHC; and 2) providers are currently funding services through a mix of grants and private donations. The providers interviewed included supportive service providers working in CMHCs and non-CMHC organizations. Only one provider interviewed is currently billing for Medicaid Services and that provider is a CMHC. The other providers who were not a part of a CMHC stated that they were not able to bill for services because they perceived the supportive services and tenancy stabilization services were not billable with Medicaid. The providers partnered with CMHCs, but they are not billing for a wide range of supportive services they provide from outreach and engagement to lease-up and on-going supportive services, services coordination and tenancy support services.

Supportive Housing Provider Identified Gaps in Covered Services and Reimbursement

Interview questions examined providers' understanding of the Medicaid State Plan and its coverage of services related to supportive housing. Most of the providers interviewed did not have experience with billing Medicaid for supportive housing. An assessment of supportive housing providers' perceptions of covered supportive housing services helps to inform advocates and community leaders of provider education and training needs.

In the interviews with CSH, supportive housing providers reported they did not believe and/or were unsure if the following services were covered by the Medicaid State Plan:

- Assessment;
- Outreach and In-Reach;
- Support Groups; and
- Independent Living Skills.

TENANT PROFILES

Navigating The Medicaid System for Supportive Housing Services

There are endless combinations of scenarios playing out day to day as clients seek Medicaid-covered services in Indiana. The client journeys below highlight some of the common successes and barriers clients needing supportive housing services might face, if they are eligible to receive Medicaid services under one of the following State Medicaid programs:

- Indiana State Plan: ***Services for people living with SMI***
- Indiana State Plan: ***Medicaid Rehabilitation Option (MRO)***
- Home and Community-Based Services: ***Adult Mental Health Habilitation + BPHC***
- Home and Community-Based Services: ***Aged and Disabled Waiver***
- Home and Community-Based Services: ***Traumatic Brain Injury Waiver***
- Home and Community-Based Services: ***Community Integration and Habilitation Waiver***

The tenant profile section presents realistic depictions of what the client journey for supportive housing services might look like from outreach and referral to stable tenancy and sustained support services.

MEDICAID REHABILITATION OPTION (MRO)

The Medicaid Rehabilitation Option (MRO) benefit is a part of the Indiana Medicaid State Plan and the MRO services are therefore an entitlement benefit available to any Medicaid enrollee who meets the MRO eligibility criteria (diagnostic criteria and Level of Need criteria)[32] and is able to access the services. Individuals who need aid for emotional disturbances, mental illness, and addiction may be eligible for MRO if they meet the eligibility criteria outlined. MRO services are available to "consumers and families of consumers living in the community who need aid intermittently for emotional disturbances, mental illness and addiction."[33] Eligibility for MRO services is determined by a qualifying diagnosis and a qualified LON. The qualified diagnosis is entered into the Data Asset Registry for Mental Health and Addictions (DARHMA). The qualified LON is based on the Adult Needs and Strengths Assessment (ANSA) score. Adults who score 3 or higher on the ANSA are eligible for MRO. Service packages are based on the LON. Many of the services in MRO align with critical supportive housing services if those services are specifically included in a client's individual treatment plan, deemed medically necessary, and support recovery (see chart on page 13 for alignment). This alignment makes MRO one of the clearest ways to theoretically provide Medicaid covered supportive housing services for individuals with serious mental illness, serious emotional disturbance or addiction. **The MRO services that best align with supportive housing include Adult Intensive Rehabilitative Services, Behavioral Health Counseling, Case Management, Medication Training and Support, Psychosocial Rehabilitation (Clubhouse Services) and Skills Training and Development.** Peer supports and crisis intervention services are no longer part of the MRO service packages, though remain available as a standalone state plan benefit to Medicaid enrollees. More information about the change is available here: http://provider.indianamedicaid.com/ihcp/Bulletins/BT201929.pdf.

Although many MRO services align with supportive housing services, there are also noteworthy gaps that can impact an individual's ability to remain successfully in their home. **The following journey outlines the roadmap to accessing MRO services and the areas where gaps impact access and alignment with supportive housing for a client we will refer to as "Lisa."**

Lisa's Supportive Housing Services Journey: MRO Services

Lisa is a 48-year-old woman who is currently experiencing homelessness and has been living in a shelter for the past 90 days. She has no children, no known family members and no known support systems. She is a Medicaid beneficiary living with a serious mental illness. She is experiencing schizophrenia, including delusions and hallucinations, with associated traits of paranoia. She currently is not taking any medications and has not been seen by a primary care physician in over four years. She is not aware of the case management services available to her and has difficulties engaging with staff due to her paranoia.

OUTREACH

Outreach from a case manager is a crucial component for engaging Lisa, building trust with her, and offering the services that will help Lisa access housing, remain successfully housed, and achieve the stability she wants in her life. There may be a PATH Provider who can complete the VI-SPDAT for her and assist with collecting necessary documentation including ID, birth certification and Social Security card. There are barriers during the outreach phase which include money for documentation such as ID or birth certificate if Lisa does not have these documents. Lisa will also need assistance with transportation to collect all documents.

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[32] Indiana Health Coverage Programs, Provider Reference Module, Medicaid Rehabilitation Option Services, Section 3: Diagnosis and Level of Need. Page 39. https://www.in.gov/medicaid/files/medicaid%20rehabilitation%20option%20services.pdf

[33] Indiana Application for Section 1915 (b) (4) Waiver, Fee-for Service, Selective Contracting Program, March 19, 2014. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/IN_Medicaid-Rehabilitation-Option_IN-03.pdf

REFERRAL

In order to begin the process of receiving targeted case management, Lisa would need to be connected to a CMHC at one of the 24 statewide certified CMHCs for a psychiatric assessment, an SMI Determination, a Case Management Eligibility Checklist assessment, and intake. This process and the number of steps may differ across CMHCs.

Lisa might receive this referral from a provider agency, like a local hospital or shelter. A referral from the shelter, hospital or case manager might be done over the phone or using a faxed referral form unique to each agency. There is a possibility of connecting Lisa to a Navigator for insurance. Ideally, she would also be connected by the provider agency to a Federally Qualified Health Center (FQHC) for primary care as well.

If Lisa agrees to go to a CMHC, she will have to find transportation to get there. Without a car, transportation to and from the CMHC requires a level of planning, financial resources, and social connectedness Lisa does not have. Without support in identifying and paying for transportation, Lisa's journey could end here before she receives services.

ASSESSMENT

If Lisa receives a referral to a CMHC and finds transportation to get there, her first step is to have an intake assessment. Intake includes an assessment with a master's level clinician to assess Lisa's needs and strengths and includes developing an IICP. Lisa's IICP will include an assessment of her needs, strengths, and objectives of care and how MRO services will assist Lisa with her goals for recovery and rehabilitation. During this initial intake, Lisa will meet with a case manager. She will also need to meet with a psychiatrist to determine if she has a serious mental illness or serious emotional disorder.

If a psychiatrist is not available when Lisa first arrives at the CMHC, or if the CMHC does not have open access (walk-in) appointments, Lisa will need to find a way to return for an appointment another day. Because Lisa does not acknowledge that she has a mental illness and she does not have a lot of people she can trust, she may not be inclined or able to navigate finding transportation to go to an office to meet with a psychiatrist as a precondition of receiving services.

If at the time of her intake it is determined that she does not currently have Medicaid, a navigator will assist her with applying for Medicaid during her intake appointment. Since eligibility and approval of Medicaid and MRO is not guaranteed, and to ensure Lisa does not end up incurring high out of pocket costs if not Medicaid eligible, it is likely that she will receive mostly clinic-based services until her Medicaid and MRO eligibility status is determined. Once determined Medicaid and MRO eligible, she will be assigned a case manager to provide and coordinate the MRO services for which she is eligible.

SERVICE PLANNING & PROVISON

Once Lisa is enrolled in MRO services, she will be able to receive a full continuum of care and will have access to a wide array of behavioral health services and supports to help her live safely in the community.

Lisa will have access to case management services to assist her with medical, social, educational and other service needs. The case manager from the CMHC will work with Lisa for access and coordination of care in addition to linkages to appropriate services. The case manager will work with Lisa to create an individual service plan. If Lisa and the case manager identify stable housing as an important part of Lisa's mental health recovery and as one of her goals, the case manager can work with Lisa to create a service plan that includes housing goals and interventions. This can include assisting Lisa as she searches for an apartment and applies for the apartment.

If Lisa is interested in additional clinical services, the case manager can connect Lisa to behavioral health services, including counseling and therapy. Lisa can access time-limited, structured face-to-face sessions that would allow

Lisa to work on goals identified in her IICP. The face-to-face interactions can be with the presence of family members or nonprofessional caregivers and the services must be provided to Lisa in the community. The services may be available to Lisa in her home or locations outside of the clinical setting. Since Lisa has experience and distrust in a clinical setting, the community-based services may be more comfortable to Lisa. The services will be provided at the shelter or another community location while Lisa is in the process of finding housing. There are additional barriers for Lisa to receive case management services, which include waitlists for case management spots, high turnover of case management staff, and long wait times to see a psychiatrist.

HCBS AGED AND DISABLED WAIVER

The process for an individual to receive home and community-based care services varies depending on income eligibility, all assets, and an individual's level of need based on a functional assessment identifying level of assistance and duration of impairment. In Indiana, HCBS is a term used to refer to several programs providing care in home and community-based settings, including the Medicaid HCBS Aging and Disabilities Waiver services, the Medicaid State Plan Personal Care Services, and non-Medicaid programs funded by state general funds. These non-Medicaid programs include Indiana's Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) Program, Title III of the American with Disability Act for public accommodations, the Older Hoosiers program, and Social Security Block Grant programs. Similar to Medicaid HCBS services, individuals are eligible for these state funded programs based on age or disability status, as well as their need for services based on an assessment of functional impairment and financial resources including income and assets.

David's Supportive Housing Journey: HCBS Aged & Disabled Waiver

David is 72 years old and a beneficiary of both Medicare and Medicaid. David lost his home due to a foreclosure and has most recently been renting an apartment in the same rural community he's lived in all his life. Over the past year David has been in and out of the hospital for overnight stays following a series of falls and hip surgery. During his most recent hospital stay, David received an eviction notice from his landlord after not paying rent for three months. Without returning home, David does not know if his unit is still his nor where his possessions and cat are. His daughter, who lives out of state, is encouraging David to move into a nursing facility, as she is concerned that David may have early signs of dementia and has no family nearby. David would prefer to return to his apartment and live with his cat at home. David could benefit from both supportive housing tenancy supports to help him to negotiate with his landlord, support covering the missed months of rent, and help returning to his apartment and remaining stably housed. David would also benefit from HCBS assessment to determine the level of need for help with activities of daily living, through HCBS attendant care. David is feeling pressure from his daughter to move into a nursing home but is also missing his cat. He does not want to live in an institutional setting. Supporting David to receive services at home would be both person-centered and cost-effective. The following service scenarios are intended to demonstrate how the HCBS Aged & Disabled Waiver aligns with supportive housing and the gaps in David's service needs that could be filled by supportive housing.

PRE-TENANCY SERVICES: OUTREACH & IN REACH

Outreach and in-reach supportive housing services do not align well with HCBS Aged and Disabled services, as Area Agencies on Aging (AAA) and HCBS providers do not conduct outreach prior to a referral. In reach into hospitals by ADRC/AAA staff co-locating at the hospital does not occur and hospital staff do not bill HCBS services for outreach. Hospitals can and do make referrals for HCBS assessments.

As such, David would not be assessed for HCBS during his hospital stay. Any assessments would happen after returning to his apartment without 3 months of rent for back pay or moving into a nursing facility. A hospital

discharge nurse or social worker may speak with David and identify his disinterest in moving into a nursing facility during recovery. If this happens and the hospital staff member chooses to, they can call an ADRC to refer David for an HCBS assessment.

While still at the hospital, were pre-tenancy services available at the hospital to assess and refer individuals with housing needs, David might be able to receive support to connect with homeless prevention services to assist with landlord advocacy and repayment of rental arrears to avoid eviction entirely. David could receive a referral for HCBS services while simultaneously working on moving back home after the hospital - avoiding the nursing home stay altogether. Because of limited alignment with Outreach and In-reach services, David would likely move into a nursing care facility given the lack of pre-tenancy and homeless prevention services available at Indiana hospitals.

Other care options that pose limitations for David and similar Medicaid members, include:

- Assisted Living Facilities: 140 of the 350 (40%) Assisted Living Facilities in Indiana accept Medicaid, though many will not accept Medicaid until the individual has spent down any private pay funds, meaning Medicaid is not accepted at intake. In David's scenario there is a lack of Assisted Living Facilities that accept Medicaid in rural areas. David may have an opportunity to move to a smaller urban area to a newer low-income housing tax credit development that accepts Medicaid; however, the likelihood of a hospital staff member being aware of these referral options to other urban communities is low.
- Moving in with a family member: David does not have family that have offered to take him in and this is not David's first choice.
- Adult Day Centers: Were David's daughter's concern about dementia true, David may benefit from opportunities available at Adult Day programs. There are 40 adult day programs across Indiana. These adult day centers can provide housing supports information and referrals to other community services; however, many do not accept Medicaid and are limited to private pay only.

PRE-TENANCY SERVICES: REFERRAL

Referral services for home and community based care aligns well with the importance of referrals in supportive housing; however, the referral process may occur days after David has moved into the nursing home. If, through the nursing facility move in process or during his stay, a staff member at the nursing home identifies David's desire to return to the community and his need for community based services, staff can make a call and refer David for HCBS services.

Additionally, David's desire to return to the community can be captured in Section Q of the Minimum Data Set (MDS) required by CMS for all nursing facilities receiving Medicare and Medicaid reimbursement. Findings during this assessment can trigger a referral for David to the ADRC (Aging and Disabilities Resource Center/AAA) together with a discussion of community services and housing options.

With the MDS assessment documenting David's desire to return to the community, Section Q of the MDS is shared with the appropriate AAA Options Counselor. David will now receive a visit in the nursing care facility by an HCBS Care Manager after the assessment is completed. Information is not currently available on the number of days that occur between the assessment, referral and visit.

Without pre-tenancy services to help David negotiate with his landlord to keep his unit or find a new one that is safe and affordable on his limited income, David will not be fully prepared to return to the community yet to take the next step in welcoming the HCBS Care Manager in for a home assessment. The HCBS case manager will visit David at the nursing home after receiving the referral call.

Unfortunately, David's prior landlord moved forward with the eviction and David has lost his possessions and does not know the whereabouts of his cat. It is not uncommon for individuals moving into nursing facilities to lose possessions, animals, and community connections during longer stays, making relocating back into the community a more complicated choice for those with limited income starting anew.

As David recovers from his hip surgery he no longer requires the level of care provided at the nursing care facility and he may have to pay a "liability" for continuing to stay at the nursing home facility.

PRE-TENANCY SERVICES: ASSESSMENT

There is clear potential for alignment with supportive housing best practices for the HCBS A&D Waiver for the assessment phase of pre-tenancy services. The HCBS Waiver assessment examines the home environment including the physical environment and an individual's technology needs in the home. It also assesses economic assistance needs, including housing assistance through housing vouchers.

David's housing needs not only include the physical environment and technology needs supporting his mobility, but David would also benefit from assessment questions that identify barriers to successfully remaining housed that include lease obligations and tenant responsibilities such as timely rental payments, budgeting assistance, advocacy support with landlords given his recent eviction now on his record, and help visiting apartments. David would also benefit from any move in support related to moving expenses, security deposit and first month's rent, and acquiring furniture and household items that were lost during the eviction.

David could also benefit from ongoing assistance communicating with his landlord in order to prevent future eviction scenarios like the one he just experienced and ongoing support with budgeting and activities of daily living while recovering. The current HCBS Waiver assessment does not include housing stability questions that assess barriers to remaining housed and needs related to preventing future eviction, beyond the physical environment and economic need.

PRE-TENANCY SERVICES: SERVICE PLANNING

David is unable to return to his original apartment due to his eviction. A care manager from the ADRC will work with him to create a personal care plan that can include many of the pre-tenancy and tenancy sustaining services common to supportive housing. As noted in the chart in Appendix A, if a care manager is thorough and assesses more than what is included in the formal assessment, David's need for assistance with advocacy to future landlords about his eviction history and support with budgeting and timely rental payments can be included in his plan. This care manager would also help David in planning services that will help him access financial supports through Community Transitions to cover a security deposit, utilities set up costs, and other moving costs up to $1500 over a 120-day period. If David does not have enough funding for first month's rent, furniture, and other moving costs above the $1500, a Care Manager can support him with service planning to connect with affordable housing waitlists and other community organizations.

During the assessment and service planning, David's care manager will then determine the number of service hours for which David is eligible and David will select a local service provider of his choice. At this point many days may have passed since David was ready to leave the hospital and return home. David has not yet begun receiving services from the ADRC.

If David has trouble making a decision about which provider agencies he wants for each service, the care manager can help him to select provider agencies and individuals within those agencies.

David's care manager has a case load of up to 65 clients and as such care managers are not the only ones providing home visits and supports to David. Once David has a completed assessment and service plan, David will be connected to a local provider of HCBS A&D Waiver Services. Case load sizes are worth mentioning as the term case manager and care manager can mean many different things in different programs and caseloads can also vary greatly. Best practice in supportive housing maintains that case managers should have no more than 20 clients on their caseload in order to provide flexible, in person, community-based housing support services.

His care manager is very attentive during their nursing facility visits, yet is only required to visit David in person once every three months. This means that adjustments needed to the service plan would need to be initiated by David or wait until assigned a local service provider. Wait times between assessments, service planning and

provider referral could add days or more to David's stay at the nursing facility. Had David's need and desire for living independently been addressed during his hospital stay he may have already moved in to his own supportive apartment depending on levels of landlord engagement among housing service providers.

The Care Manager helps David move back into the community. The level of support around David's eviction on his rental history and eviction prevention planning may happen, but it is dependent on the skills and level of experience of the care manager. Therefore, it does not happen on a regular basis. However, there are services available to help David avoid an eviction under HCBS such as assistance with bill paying and timely payment of rent and utilities.

TENANCY SUPPORTS: SERVICE PROVISION

If services are authorized by David's care manager and providers are available in his area to provide those needed services, David can receive the full range of tenancy sustaining services that align with covered HCBS services, which for David includes attendant care allowing the attendant care provider to visit and assist David multiple times each week with bill pay, budgeting, repair requests to the landlord or property manager and activities of daily living.

In order for these HCBS services to allow David to remain successfully in his home, care coordination for ongoing assessment and updated personal care plans must include both the care manager authorizing services and the service provider working directly with David day to day. Several services that are included in supportive housing that do not fully align with services included in the A&D Waiver include: tenant education on rights and responsibilities as a lease holder, assistance resolving disputes with landlords, property management and neighbors, advocacy and resource coordination to prevent eviction, coordination with tenant to modify housing crisis and eviction prevention plans as needs and strengths change, and the early identification of barriers to remaining housed as a key piece of assessments, service planning and re-assessments.

PART FOUR: NEXT STEPS

CSH RECOMMENDATIONS

The Crosswalk was created to provide a comprehensive look into the Indiana Medicaid funding structure with resulting recommendations to include greater alignment with necessary supportive housing services for housing created through IHCDA's initiatives. These recommendations are system-level changes that once implemented, will have high-impact on the lives of many Hoosiers. Beyond the Crosswalk, cross-sector opportunities exist to determine implementation priorities and next steps. In compiling this Crosswalk, cross-sector relationships and opportunities for greater communication and partnerships were developed. OMPP, DMHA, IHCDA, and CSH along with other key stakeholders are committed to continuing these relationships to further the implementation of the prioritized recommendations.

The State of Indiana is to be commended for its plans to improve health equity in the state, address Social Determinants of Health, and explore the impact that supportive housing can have on achieving these goals. The state is striving to create an integrated system of care that meets the health needs of the whole person and coordinates care across providers and systems to achieve better health for all residents. In order to realize the improved health outcomes and potential cost savings that result from Medicaid beneficiaries having access to supportive housing, CSH recommends the following for Indiana's leadership, government, providers, advocates, and consumers.

1. **Create a supportive housing benefit using the 1915(i) Medicaid State Plan Amendment.**
   Supportive housing services should be explicitly included in the Indiana Medicaid State Plan to align with CMS guidelines of pre-tenancy and tenancy-sustaining services included in the CMS Informational Bulletin released on June 26, 2015. Aligning these services with housing resources and priority populations should be a state priority jointly held between FSSA and IHCDA.

   In order to include these services in the State Plan, the state will need to seek a State Plan Amendment (SPA) from CMS to add a benefit to cover these services. Recent direction from CMS has indicated their willingness to consider 1915(i) SPAs that deliver tenancy support services to a targeted population for whom lack of access to supportive housing results in poor health, health inequities in our communities, and inappropriate usage of acute levels of care. As of the fall of 2019, the states of Minnesota and Michigan have been approved for a SPA that offers tenancy support services and Minnesota's is focused on people who are experiencing chronic homelessness. Indiana should review these approved SPAs and consider as potential models for their state.

   To follow this recommendation, Indiana's Family and Social Services Administration (FSSA) will need to partner with IHCDA and other housing funders and providers to align housing resources and then implement the SPA in the most effective manner. Indiana's HCBS or CMHC providers will know how to work within the HCBS delivery system, supportive housing providers know how to finance, develop and deliver quality supportive housing, and each will need to support and educate the other sector. State leadership to facilitate these learnings will be crucial.

2. **Develop state funding for tenancy support services not covered under current Medicaid authorities and for persons who are Medicaid eligible but not enrolled at the start of services.**
   To provide necessary consistent funding for Indiana supportive housing providers who serve multiple populations, CSH recommends a state funding option to cover services not covered by Medicaid, as well as coverage for services provided during gaps in enrollment or re-enrollment in Medicaid.

   The services below are essential to quality supportive housing and are not currently billable under Medicaid in Indiana.

Outreach and Engagement Services
These services ensure appropriate referrals are made to the supportive housing program for people with multiple disabilities who are the most vulnerable in the community. These persons are commonly eligible but not enrolled in Medicaid and other services.

Benefits Navigation
Persons who are the appropriate referrals for supportive housing will also need assistance to maintain continuous eligibility for benefits. While Medicaid commonly allows for 90 days of retroactive eligibility for benefits, Indiana has limited retroactive eligibility for all groups except pregnant women.[34] Commonly, persons experiencing chronic homelessness require more than the 90 days to gather documentation and prove Medicaid eligibility. Agencies should be paid for all the time and effort that benefits navigation requires for the people they serve. Therefore, state funds are needed to support benefits navigation for people experiencing homelessness and potential supportive housing residents. It should be noted other states creating tenancy supports benefits, like North Dakota, are including retroactive eligibility for benefits navigation services and, if approved, the ND 1915(i) SPA could serve as an example for Indiana to also include this retroactive benefits navigation service in their SPA submission.

Landlord Engagement, Training and Support
Engaging, educating, and supporting landlords in signing up for programs to participate effectively in supportive housing are needed services that are not commonly included in Medicaid benefit packages. These services do not directly involve the program participant but are essential for their success.

Onsite services for additional resident support
For single site buildings, providers need to both support their residents and be good neighbors in the community This commonly includes onsite staff to manage crises, offer resident support, and engage the local community. These services are not likely to be Medicaid eligible services but are essential to quality supportive housing and being a good community member.

While identifying any opportunities for these services to be covered under Medicaid, the state should develop a funding model paired with IHCDA's Supportive Housing Institute developments and other mechanisms for bringing units online that are supported by these critical services. The services could be part of a Value-Based Payment option. A Value-Based Payment option could have the potential for incentive payments for supportive housing providers that meet state determined quality metrics and can illustrate their use of evidenced-based practices. Additionally, financial resources need to be made available to provider agencies to ensure continuity of services and assistance to persons as they initially enroll or have any gaps in coverage.

3. **Capacity Building Grants for Supportive Housing providers.**
With new state funding, supportive housing providers will likely wish to become Medicaid billing entities. To make this transition, nonprofits will need capacity building grants for activities such as purchasing an electronic health record, analyzing current activities for billing potential, and additional startup costs. CSH's signature product, the Medicaid Academy, can also assist supportive housing providers to make this transition. CSH recommends the State of Indiana consider how best to leverage the knowledge and capacity of their current supportive housing network to address the needs of their priority populations.

4. **Develop Supportive Housing projects to address the opioid crisis for a sub population of those experiencing substance use issues and other disabilities.**
Indiana has prioritized addressing the opioid crisis among its citizens. CSH is recommending IHCDA and FSSA jointly develop supportive housing projects that address the supportive housing needs of a sub population of persons experiencing opioid addiction and other disabilities including mental health, HIV, and chronic physical health challenges. IHCDA would support housing costs via the supportive housing institute process and FSSA

[34] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table3 and https://www.kff.org/medicaid/issue-brief/approved-changes-in-indianas-section-1115-medicaid-waiver-extension/

would have to consider how to fund supportive services. Resources from the 2018 federal SUPPORT Act could be used for these projects. The process of cooperation between departments could be an ongoing model for joint project development between the state agencies.

5. **Develop, adopt and monitor for adherence to statewide supportive housing standards.**
   With new resources, new accountability measures should also be in place. CSH recommends the State of Indiana undertake a planning process to determine its standards for quality supportive housing. The process can allow the state to highlight its priorities and goals for increased supportive housing capacity. The planning process should be jointly held between IHCDA and FSSA so each state agency can learn more about the other's priorities and operations and the standards are jointly held by each agency. Long term fiscal sustainability for these programs will be jointly held by both offices, so the standards should be as well. Providers from both the services and housing sectors should have ample opportunity to comment upon draft standards and prepare for implementation.

   The standards should be grounded in evidenced based practices and targeted to the state priority populations. CSH's Dimensions of Quality[35] tools merge the best thinking from the SAMHSA evidenced based toolkit with HUD's Housing Quality Standards and a variety of industry standard tools for a comprehensive list of standards and a process to develop and implement those standards. The standards will build upon IHCDA's strong leadership around implementing "Housing First" program models and harm reduction services. Harm Reduction services work with persons, no matter their current behaviors or challenges, to reduce the harm associated with harmful behaviors including active addiction. Harm Reduction philosophy recognizes the worth of all individuals and that trauma, health disparities, structural racism, and other factors are highly contributory of who in our society becomes addicted and must be taken into consideration as part of the recovery process.[36] The goal of the standards is to improve outcomes in supportive housing, while delivering the right care at the right time to the people who need it most.

   The standards should be jointly held by IHCDA and FSSA and each should contribute to a process for monitoring compliance to standards. Persons with lived experience should contribute to the development of these standards. Each partner should build upon their specialized expertise to support the monitoring process. Communications regarding the standards with the various stakeholders should be a priority as well.

6. **Implement a statewide continuous training process for quality supportive housing services based upon standards developed in recommendation #5.**
   Standards, when developed, need to be supported via training for the workforce both on the roll out of standards and to ensure sustained quality supportive housing services. CMHCs that have not historically participated in supportive housing will need specialized engagement to build capacity around service models. Supportive housing providers may need training and support around any billing structures that have not historically been their method for funding services. Each sector has much to learn and much to teach in this endeavor, for example, current quality supportive housing providers could be the training partners. Given the limited services funding historically and the need for the state to lead in kicking off the standards roll out and monitoring and compliance process, CSH believes that the field will need significant training and technical assistance as the standards are rolled out. CSH recommends that the State of Indiana survey for training and technical assistance needs after this start-up period has been completed.

   An emphasis of training should include supporting a peer workforce to deliver supportive housing services. A goal for all state supportive housing projects should be an inclusion of peer support specialists in every supportive housing project statewide.

7. **Coordinate with Managed Care Entities for supportive housing projects to address those with complex health care needs. This includes new projects, as well as existing projects with tenants with complex care needs.**
   MCEs provide many of the care coordination services people who are in need of supportive housing require to effectively and efficiently meet their complex health care needs. MCEs currently have representation with

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[35] www.csh.org/quality
[36] http://www.drugpolicy.org/resource/harm-reduction-101

local Continuums of Care, homeless service programs, and supportive housing providers to coordinate care for their member's experiencing homelessness. There are ongoing opportunities to further strengthen those relationships through the development of innovative supportive housing programs for those with complex health care needs and enlist MCEs for their expertise and assistance. FSSA could request that the 2020 Performance Improvement Projects (PIPs) for Managed Care address homelessness among their members and the MCEs could work with the providers or developers of these projects to consider how to deliver on site services to their members at these projects. Best practices regarding care coordination can be disseminated to current and future supportive housing projects.

8. **Conduct regular crosswalk updates.**
   As Medicaid is a constantly evolving program, regular updates of this crosswalk should be completed every 3-5 years. A prior crosswalk was completed in 2012 and while helpful, does not reflect the current opportunities and current CMS guidance regarding tenancy supports. As continued evolution in Medicaid and services is expected over the coming years, a regular update of the crosswalk can ensure Indiana meets the current and future needs of their residents.

CONCLUSION

CSH applauds the State of Indiana and IHCDA for their efforts to increase supportive housing capacity and quality in the state of Indiana. The state has clear building blocks for better serving its most vulnerable residents who currently fall through the cracks. The recommendations in this report are in-line with the goals of the state's plan to address social determinants of health and health disparities. Leaders in Indiana know supportive housing is the solution for a subset of Medicaid beneficiaries. This report offers a thorough analysis confirming the need for a supportive housing services benefit for a subset of Medicaid beneficiaries.

IHCDA's efforts to inform and educate stakeholders state-wide about the need for supportive housing services and the potential for Medicaid to pay for those services is creating momentum for policy changes that would be beneficial to the State, providers of Medicaid services, and Indiana residents who are most in need.

Appendix A: Crosswalk Summary of IN Medicaid Benefits that Align and Partially Align with Supportive Housing Services Pre-Tenancy and Tenancy Sustaining Services

Supportive Housing Services that Align with IN Medicaid Benefits for Eligible Populations **Note: Acronyms for Benefits include Adult Mental Health Habilitation State Plan Amendment (AMHH), Community Integrated & Habilitation (CIH), Traumatic Brain Injury Waiver (TBI), Aged and Disabled 1915 (c) (A&D), Medicaid Rehabilitation Option (RHO), State Plan Serious Mental Illness (SP SMI).**		
Supportive Housing Service	**Comparable Medicaid Benefit with Potential for Alignment**	**Service as Listed in IN Medicaid Provider Manuals**
Outreach and In-Reach Services	N/A[i]	
Assessment of housing preferences and barriers related to tenancy	N/A	
Housing Service Plan	N/A	
Identification of resources to cover moving and start-up expenses	TBI Waiver and Aged & Disabled 1915(C)	**TBI:** Community Transition Services **A&D:** Community Transition Services
Assistance with move-in arrangements	TBI Waiver and Aged & Disabled 1915(C)	**TBI:** Community Transition Services **A&D:** Community Transition Services **CIH:** Community Transition Services
Assistance with collecting required documentation (i.e. birth certificate, IDs, credit history)	N/A	
Assistance with housing search and housing applications	N/A	
Early identification/intervention for behaviors that could jeopardize successful tenancy/housing retention	TBI Waiver and Aged & Disabled 1915(C)	**TBI:** Case Management, assessment and development of IICP; Behavior management (limited provider and supervisory types). **A&D:** Case Management, assessment and development of IICP; **FSW & CIH:** Case Management, Behavior Management
Ensuring housing unit is safe and ready for move-in	TBI Waiver and Aged & Disabled 1915(C), Community Integration and	**TBI/A&D:** Community Transition Services under Health and Safety assurances **CIH:** Case Management and Community Transition Services included under CCB.

	Habilitation, Family Supports Waiver	**FSW:** Case Management
Early identification/intervention for behaviors that may jeopardize housing	N Community Integration and Habilitation, Family Supports Waiver	FSW: Case Management, Behavior Management, Participant Assistance and Care CIHW: Case Management, Behavior Management, Residential Habilitation and Support
Education/training on tenant and landlord rights and responsibilities	Community Integration and Habilitation, Family Supports Waiver	FSW: Case Management, Participant Assistance and Care CIHW: Case Management, Residential Habilitation and Support
Assistance resolving disputes with landlords, property management, and neighbors	Community Integration and Habilitation, Family Supports Waiver	FSW: Case Management, Participant Assistance and Care CIHW: Case Management, Residential Habilitation and Support
Linkage with community resources to prevent eviction/ sustain tenancy	Medicaid Rehabilitation Option Community Integration and Habilitation, Family Supports Waiver	MRO: Case management services FSW/CIHW: Case Management
Ongoing training and support with activities related to household management and tenant habits	Medicaid Rehabilitation Option	**MRO:** Skills Training and Development **FSW:** Participant Assistance and Care CIHW: Residential Habilitation and Support
Development of housing support crisis plan	Medicaid Rehabilitation Option	**MRO:** Skills Training and Development; Case Management Assessment and IICP development and monitoring
Housing focused care coordination with other community providers (direct communication with other providers regarding client well-being) (hospital/jail discharge planning, housing liaison for tenant's care providers)	State Plan SMI and Medicaid Rehabilitation Option	**SP SMI:** Case Management Services **MRO: Limited Alignment-**Can be provided as Case Management for coordination of care. Does not allow for these services to be provided while member is in institutional care (hospital/jail).
Assistance with housing recertification process	N/A	

Service Coordination (arranging referrals, tracking appointments and follow-up, scheduling visits, medical transport, repairs, and appointments)	Community Integrated and Habilitation, TBI Waiver, Aged and Disabled 1915 (c)	**FSW, CIH, TBI, A&D:** Case management services for coordination of care.
Non-Emergency Transportation	Community Integrated and Habilitation, TBI Waiver, Aged and Disabled 1915 (c); IN State Plan;	**A&D:** Transportation Services **FSW:** Transportation, as specified in FSW Waiver, includes bus passes **CIH:** Transportation Services as specified in CIH Waiver, includes bus passes. **State Plan:** Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4). Limited to categorically needy populations identified by State, including "Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution (please note that the broker may only provide transportation to and from 1905(a) services)." (See limitations in a Supplement to 3.1A either a Supplement or in Attachment 3.1D) **TBI:** Transportation Services
Engagement Specialist Services	**Medicaid Rehabilitation Option**	**MRO: Peer Recovery Services**

Supportive Housing Services with Potential for Alignment with IN Medicaid Note: Acronyms for Benefits include Adult Mental Health Habilitation State Plan Amendment (AMHH), Community Integrated & Habilitation (CIH), Traumatic Brain Injury Waiver (TBI), Aged and Disabled 1915 (c) (A&D), Medicaid Rehabilitation Option (RHO), State Plan Serious Mental Illness (SP SMI).	
Supportive Housing Service	**IN Medicaid Benefit Abbreviation[ii]:** Service as listed in IN Medicaid Provider Manuals and administrative documents.
Outreach and In-Reach Services	No identified service aligns well enough to be listed as having potential.
Assessment of housing preferences and barriers related to tenancy	**AMHH:** "Assessing the individual's needs and strengths" (initial assessment not reimbursable),
Housing Service Plan	**AMHH: "**Developing an Individualized Integrated Care Plan (IICP)"; **TBI/A&D:** Case management assessment and development of individualized services plan, Community Transition Services must follow a written service plan addressing specific needs from individualized assessment, could include housing stability service needs. **MRO:** Case management assessment and development of IICP. **FSW/CIH:** Case Management requires a person-centered individualized support plan that addresses areas of community living.
Assistance with collecting required documentation (i.e. birth certificate, IDs, credit history)	**TBI/A&D:** Community Transition Services can include this assistance if following a written service plan addressing specific needs from individualized assessment that addresses housing stability service needs.
Assistance with housing search and housing applications	**TBI/ A&D:** Community Transition Services can include this assistance if following a written service plan addressing specific needs from individualized assessment that addresses housing stability service needs. **CIH:** Residential Habilitation and Support, if assistance with personal care errands include housing search errands, are medically necessary, in the needs assessment and service plan.
Early identification/intervention for behaviors that could jeopardize successful tenancy/housing retention	**AMHH:** Behavioral Health Assessment Tool ANSA, Development and submission of IICP and a Crisis Plan, Therapy & Behavioral Support Services; **MRO:**
Ensuring housing unit is safe and ready for move-in	No identified service aligns well enough to be listed as having potential.
Education/training on tenant and landlord rights and responsibilities	**AMHH:** Home and Community Based Habilitation and Support Individual Setting[37], [38]
Assistance resolving disputes with landlords, property management, and neighbors	**AMHH:** Home and Community Based Habilitation and Support Individual Setting, Therapy & Behavioral Support Services, Peer Support

[37] "Training in skills needed to locate and maintain a home, renter skills training including landlord/tenant negotiations, budgeting to meet housing and housing-related expenses, how to locate and interview prospective roommates, and renter's rights and responsibilities training." 1915(i) State Plan HCBS, State Plan Attachment 3.1-I, p.66, Retrieved from https://www.in.gov/fssa/dmha/files/3.1i.pdf.

[38] "Home and Community-Based Habilitation and Support Services are intended to focus on the maintenance of basic skills needed to live in the community." Taken from the Adult Mental Health & Habilitation Services Provider Reference Module, LIBRARY REFERENCE NUMBER: PRPR10018 PUBLISHED: SEPTEMBER 13, 2018, POLICIES AND PROCEDURES AS OF JULY 1, 2018, VERSION: 3.0, DXC Technology, p.98.

Linkage with community resources to prevent eviction/ sustain tenancy	**AMHH:** Care Coordination, referral and linkage (justification must be in assessment and IICP and demonstrate medical necessity for preventing eviction to maintain mental health goals).
Ongoing training and support with activities related to household management and tenant habits	**AMHH:** Home and Community Based Habilitation and Support Individual Setting; Peer Support;
Development of housing support crisis plan	**AMHH:** Development and submission of a Crisis Plan
Housing focused care coordination with other community providers (direct communication with other providers regarding client well-being) (hospital/jail discharge planning, housing liaison for tenant's care providers)	**AMHH:** Care Coordination, referral and linkage (justification must be in assessment and IICP)[39] and is limited to coordination with community providers when client is NOT living in an institution. Jail and hospital discharge planning while client is in jail or hospital would constitute institutional settings and AMHH cannot be provided in these settings.
Assistance with housing recertification process	**AMHH:** Home and Community Based Habilitation and Support Individual Setting under skills needed to maintain a home
Service Coordination (arranging referrals, tracking appointments and follow-up, scheduling visits, medical transport, repairs, and appointments)	**AMHH:** Care Coordination, referral and linkage, monitoring and follow-up, evaluation (justification must be in assessment and IICP). Excludes traveling with client to appointments.
Supportive Services	**AMHH:** Supported Community Engagement Services[40] **CIH:** Wellness Coordination (development, maintenance, and routine monitoring of participant's Wellness Coordination Plan.

[i] N/A signifies that no service was identified as aligning fully in the IN Medicaid benefits available to its members.
[ii] Abbreviations include: Adult Mental Health Habilitation State Plan Amendment (AMHH), Community Integrated & Habilitation (CIH), Traumatic Brain Injury Waiver (TBI), Aged and Disabled 1915 (c) (A&D), Medicaid Rehabilitation Option (RHO)

[39] Some services under AMHH allow for collateral visits, meaning services that are provided without the member present (neither face-to-face nor via telephone), on behalf of the member. The following services can be completed collaterally, with the appropriate documentation: "Home and Community-Based Habilitation and Support, Therapy and Behavioral Support Services, Addiction Counseling, Care Coordination, and Medication Training and Support), documentation provided for each encounter must include:

- All items described under General Documentation Requirements
- The persons who attended the session and their relationship with the member
- How the session addresses the member's goals
- How the service benefits the member

[40] "Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes; adult mental health habilitation"