

Innovative Models In Health And Housing



Prepared by Mercy Housing and
The Low Income Investment Fund
for The California Endowment and
The Kresge Foundation

Acknowledgements

The research team for this project, Joshua Bamberger, Rachel Bluestein, Kim Latimer-Nelligan, Richard Samson, and Doug Shoemaker, would like to acknowledge the generous contributions of our funders The Kresge Foundation and The California Endowment. We also greatly appreciate the support from our colleagues at the Low Income Investment Fund, as well as Val Agostino and Jessica Soske at Mercy Housing. Special thanks to Katherine Barone, LIIF New Sector Fellow.

We also acknowledge the extensive assistance provided by policymakers and practitioners we consulted during our research, including those listed below, who were extraordinarily helpful to our efforts. Finally, special thanks go to our Advisory Committee, whose knowledge and feedback guided us throughout this project. For more information, please contact Val Agostino at vagostino@mercyhousing.org or Kim Latimer-Nelligan at klatimer-nelligan@liifund.org.

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“As part of The California Endowment’s focus on addressing the social determinants of health, we believe in the importance of greater collaboration across communities, community development, housing, and health. We hope the case studies and conclusions represented in this paper help move these fields together to improve health for all communities. We also acknowledge the leadership of the Low Income Investment Fund, Mercy Housing, and all the practitioners profiled in this paper for their dedication to addressing the social determinants of health.”

Amy Chung
Director, Program Related Investments
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“To successfully reduce the growth rate of chronic health conditions and the associated cost of treatment, we must address the many factors affecting individuals’ quality of life: availability of food and housing, community and neighborhood conditions, and exposure to trauma, stress, and violence. Kresge is pleased to support the research that informed this paper exploring how non-traditional sources of capital can increase access to safe, affordable housing, with the objective of improving individual and community health. We hope this paper provides useful examples for housing developers, healthcare providers, health payers, and the public sector as we work together to meet the health and housing needs of low-income individuals.”

Kimberlee Cornett
Managing Director of Social Investment Practice
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Executive Summary

This report aims to bridge a knowledge gap between the affordable housing and healthcare fields that limits their ability to implement health and housing projects and partnerships. These two sectors have begun to realize how much they overlap, but while great work has been done to expose practitioners in both fields to information about their shared interests and common goals, the results to date have been relatively modest.

Many healthcare organizations see affordable housing as critical to the health needs of their patients and plan members, but don't know how to support the creation of housing and help them secure it. Many housing developers see that providing safe, affordable, and high quality housing to high-need individuals could deliver significant value to health partners, but aren't sure how to structure a partnership with the relevant health agencies. This document provides examples of how various healthcare and housing stakeholders have worked together to take advantage of the strengths of each sector to overcome the constraints that limit successful collaboration.

This report outlines nine case studies drawn from around the country, where the healthcare and affordable housing sectors have worked collaboratively to expand housing opportunities targeted toward individuals whose health conditions would significantly improve from service-enriched affordable housing. While acknowledging the challenges of working across sectors, and the constraints on using healthcare funding to improve the “social determinants” of health, these case studies show that there is significant opportunity to produce tangible results that improve the lives of homeless people, people living with poverty, and people living in institutions. Some of the case studies show that through coordinated statewide government legislation, healthcare

funding can be used as a catalyst to expand housing stock (e.g. Minnesota, Developmental Disability in California). We also document how focused investments from managed care agencies developed housing alternatives for people living in institutions and suffering from homelessness (e.g. San Mateo, Central California Alliance for Health) and how hospitals can use their Community Benefits Obligation to expand housing stock (e.g. Central City Concern). Three of the cases focus on providing community alternatives to institutional care (e.g. HPSM, Ohio, Developmental Disability in California) and lastly we document two communities in California (San Francisco and Los Angeles) that have used considerable local resources combined with political will to expand both scattered site and project-based housing targeting chronically homeless adults who are high users of the healthcare system.

In each of the studies presented, we try to outline how the projects developed and detail the housing and financial systems that allowed the cross-sector collaboration to become a reality. While each case is unique, one common attribute across each of the sites stands out: it required a strong leader committed to the vision that housing is an effective healthcare treatment. As Atul Gawande writes in the *New Yorker*,¹ the healthcare system was designed to “put out fires” rather than foster incremental change to improve chronic conditions. In this report we hope to show that the healthcare sector, through an investment in housing, can improve the health of a community. We also hope to show that the affordable housing sector can prioritize housing to individuals at greatest concern to the healthcare sector. While the barriers to progress may be many, these cases show that with strong vision and a common purpose, there are many solutions as well.



Introduction

This report aims to bridge a knowledge gap between the affordable housing and healthcare fields that limits their ability to implement health and housing projects and partnerships. These two sectors have begun to realize how much they overlap, but while great work has been done to expose practitioners in both fields to information about their shared interests and common goals, the results to date have been relatively modest. Many healthcare organizations see affordable housing as critical to the health needs of their patients and plan members, but don't know how to support the creation of housing and help them secure it. Many housing developers see that providing safe, affordable and high quality housing to high need individuals could deliver significant value to health partners, but aren't sure how to structure a partnership with the relevant health agencies. The public sectors of both the health and housing fields are also important stakeholders in this conundrum. Further, as several of the case studies in this paper demonstrate, even when the right partners come together with will and expertise, existing structural barriers may at times be too high to overcome.

For these reasons, many of the health and housing efforts that have occurred to date are useful trials, but relatively few point toward a long-term strategy for cross-sectoral integration. This report's goal is to share some promising efforts to expand housing opportunities funded from the healthcare sector in a multitude of ways, and to assist interested parties to move from the pilot response stage toward more systemic responses. Rather than a comprehensive scan of the field, we have profiled a handful of projects which we believe have a structure or component parts that lend themselves to greater replicability.

As our colleagues David Erickson and Doug Jutte have put it, there is not yet a market for housing and health agencies to trade in. One factor that inhibits the creation of such a market is the lack of in-depth understanding of how the other side functions beneath the level of problem statements and goals. Therefore, the case studies presented here are intentionally crafted to help practitioners of each sector better understand the financial, legal, and regulatory worlds in which the other operates.

We also hope that the case studies provide a window into the needs, capacities, and limitations of the different actors in each sector. For housing and community development practitioners, our goal is to help explain how to see the world through the eyes of private hospitals, public health systems, and managed care plans. For healthcare leaders, we hope to provide a lens into the financial and programmatic capacities and challenges of the affordable housing developer, lender, and investor communities.



Getting to know you: Affordable housing stakeholder

Unlike entitlement programs such as public education, affordable housing is not considered a legal right in the United States. Only one in four of the individuals that qualify for affordable housing benefits actually receives them.² The other three quarters of the population overcrowds, overpays, becomes homeless, or copes in some other way that often negatively impacts health. This scarcity means that there are long waitlists for affordable housing resources in most parts of the country, whether urban or rural.

In most economically vibrant cities or regions, the affordability problem is directly related to a lack of housing supply. Unlike market rate housing, affordable housing supply is less responsive to traditional supply-demand dynamics, because in most markets the rent that a lower-income household can afford is too low to support new housing production. As a result, most affordable housing production relies on public subsidy. The most important and frequently-used production subsidy is the Low Income Housing Tax Credit (LIHTC), although there are many state and local capital funding programs that also play a significant role.

While this limited supply is an important factor, the low incomes of these individuals also directly impact their ability to afford quality housing. Even in markets with relatively high vacancy rates, people who rely on social security income or work in minimum wage jobs generally earn wages too low to afford even the lowest priced housing in the market. In fact, there is no county in the United States where an individual can rent the median-priced home with a minimum wage job.³ For that reason, rental subsidies, such as Section 8 vouchers, are another major housing tool used in nearly every market in the country. As housing prices have increased, the demand for these vouchers has skyrocketed, producing long waitlists across the U.S. Subsidy programs vary, but generally the tenant spends 30% to 50% of their income on rent (or rent plus services) and the subsidy provider pays for the remainder of the rent up to a cap, the Fair Market Rent.

Rental subsidies are helpful, but are particularly important when they can provide housing to the extremely low-income populations typically of most concern to healthcare partners (seniors, people with disabilities, and people who have persistent mental health conditions).

There are three types of support or funding that are combined to provide housing to vulnerable populations: 1) capital for acquisition/development; 2) on-going services funding or in-kind service delivery; and 3) operating/rental subsidies.



Getting to know you: Health stakeholder

As Atul Gawande writes in *The New Yorker*,⁴ the healthcare system was designed to “put out fires” rather than foster incremental change to improve chronic conditions. As the main sources of illness in the US have shifted from infectious diseases and trauma to chronic conditions such as obesity, diabetes, cancer and heart disease, healthcare delivery has lagged behind in developing a system that can ideally prevent these slowly developing illnesses, or at least efficiently care for the affected individuals. In an attempt to align delivery of healthcare with today’s drivers of morbidity, there has been a shift from a fee-for-service system that prioritizes the volume of healthcare to a value-based system that prioritizes its quality. Nonetheless, hospital and other institutional-based care, which account for the majority of healthcare costs and are still mostly reimbursed on volume rather than value, continue to dominate both healthcare expenditure and policy.

Medicaid and Medicare, as the largest purchasers of healthcare services in the US, have attempted to mitigate the financial risk to the government by contracting for high-cost health services with managed-care entities that are paid based on the number of plan members enrolled, rather than based on health care service utilization. In an effort to achieve healthcare’s Triple Aim (reduce cost, improve quality, and improve access), the federal government has encouraged and supported demonstration projects with approved financial mechanisms that allow innovative healthcare models to be developed where risk and quality outcomes are intertwined.

However, the “perfect” healthcare delivery system has been hard to come by. Expanded access to insurance does not necessarily lead to improved access to the treatment that is most effective in improving health or keeping people healthy. Sometimes the system that is designed to improve quality and reduce costs for the majority of people in a state or locality can result in perverse incentives that impede the progress of more innovative programs serving discrete populations that are the highest users of the healthcare system. For example, systems that have been successful in investing in housing to reduce costs and improve outcomes are vulnerable to built-in penalties designed to limit excessive growth of the systems by restricting reimbursement to services that are deemed medically necessary. In addition, Medicaid and Medicare regulations place a high value on choice. However, a system that builds in choice and portability of benefits makes it difficult to capture savings that require longer-term continuity of enrollment to achieve a return on the investment.

Themes

Below we highlight a selection of themes that appear repeatedly throughout these case studies.

First, in many parts of our country, affordable housing is generally in short supply. This scarcity impacts the types of strategies that can be used to serve populations that need housing to improve or maintain their health. For example, the Los Angeles Department of Health Services case study demonstrates how a health agency can create a flexible subsidy program that can be used to either rent units already available in the market, or to support the development of new supportive housing. In markets where new housing needs to be created in order to effectively serve a high health-cost population, selection criteria such as preferences or set-asides become critical pieces of information for understanding how to improve access for would-be residents. Fair Housing laws can sometimes limit the ability of housing providers to align the allocation of housing units to the needs of healthcare funders, but there are generally solutions available.

In general, the economic logic of managed care systems and other forms of insurance are generally not aligned to reward the benefits of longer-term interventions. Therefore, it is useful for housing groups to consider which type of health partner to court and what type(s) of funding arrangements to seek (capital, support for services, or rental subsidy).

Second, financial leverage is a critical factor for both sectors. Both the housing and healthcare worlds have significant “mainstream” funding programs that can be tweaked or repurposed to enable agencies to partner without paying for the whole cost of a health and housing program. In the cases of the Hennepin County, Minnesota, and California case studies, a very small part of the state health budget was used to leverage hundreds of millions of dollars from other capital sources, such as the Low Income Housing Tax Credit. In addition, case management funds that are deployed in clinical or institutional settings can be repurposed to support people living independently in affordable housing.

Third, healthcare and real estate sectors operate on fundamentally different timelines and many would-be partnerships fail because they cannot overcome this disconnect. For example, driven by the LIHTC program and other financing structures, the housing industry frequently operates with 15- to 30-year term of real estate loans. However, those long-term loans do not correspond to the one- to five-year contracts typically found in agreements between States and managed care plans, or with funding streams subject to a 60-day cancellation clause such as those found in the Los Angeles Department of Health Services project. In general, the economic logic of managed care systems and other forms of insurance are generally not aligned to reward the benefits of longer-term interventions. Therefore, it is useful for housing groups to consider which type of health partner to court and what type(s) of funding arrangements to seek (capital, support for services, or rental subsidy). As the Central City Concern case study demonstrates, using community benefit dollars as a one-time up-front capital source is one way that partners have been able to overcome this timing mismatch.

Fourth, alignment of payers and cost savings is complex and can be greatly affected by risk-sharing structures among payers. The structure of the healthcare delivery system in the San Mateo example is ideal for aligning costs and benefits, but is a relatively rare structural condition. The American healthcare system has generally been structured around the idea that competition produces the lowest costs over time. While competition among insurers or providers can be an important cost-saving strategy for primary care or standardized procedures, patient mobility or “churn” often limits the willingness of health insurers or providers to pay for longer term interventions like housing as they are ultimately not the primary beneficiaries of these investments.

Fifth, we note that many good ideas are waylaid by political risk. The so-called “magnet effect” or “woodwork effect” heavily influences public perception and political support. For example, nearly every locality in the country believes that their street homeless population comes from some other place and is drawn in by generous services or a hospitable environment. In the health world, there is great fear that new benefits will induce new demand. From a political or fiscal perspective, it is difficult to demonstrate cost savings or maintain public support for investment if there is an expanding number of “consumers.” For that reason, we believe that it is critical to have a data-informed public discussion of these complex issues.

As Tom Steyer has noted, sometimes when a problem appears unsolvable, you need to make it bigger. It certainly appears that very useful interventions are not occurring because the overall structure of the health and housing sectors are not built to produce this form of collaboration.

We believe that more widespread activity depends in part on taking the problem to a different level of government than we are currently trying. For example the successful Veterans Affairs Supportive Housing (VASH) program overcomes many of the issues noted above for two reasons: 1) the VA is in effect a single payer system for eligible veterans; 2) it assumes a long-term approach by providing 15-year subsidy contracts.

In addition, as counter-intuitive as it may be, cooperation or limiting competition for certain populations (like homeless individuals) can provide a better platform for the strategies that produce real long-term cost savings. To ensure that high-cost interventions like supportive housing deliver the most costs savings, most homelessness strategies are now employing “coordinated entry” systems that match individuals to the interventions they need most. To address the high costs of emergency care for people who are homeless or unnecessarily living in an institutional setting, cooperation among private and public entities can create opportunities where competition does not.

Last but not least, we think it is critical that both housing and healthcare advocates keep the Triple Aim of Healthcare in mind when positing the benefits of this work. Certainly the expectation of cost-savings can play a critical role in shaping private and public support for investment in this space. This is particularly clear around homelessness, as the Corporation for Supportive Housing and others have built a very strong case for investments based on cost-savings from emergency rooms, shelters, jails, and other acute care facilities. However, the pent-up demand for services means that housing a high-cost patient does not always translate into system-wide cost savings. At times, newly generated savings or capacity is at risk of being quickly absorbed by new patients, as suggested by the Stygler Village case study. We need to remind ourselves that serving more people with the same amount of money is not a failure. As Josh Bamberger has noted, more traditional healthcare interventions like new cancer drugs do not have to show cost savings to be considered worthwhile-- so why should housing be subjected to this standard?

To achieve a new frame that focuses on the Triple Aim, the very transaction-oriented world of housing development will need to continue to broaden its impact language beyond the world of rent levels and fiscal cost-benefits. At the same time, the innovators in the health world will need to continue to push public and private insurers to embrace upstream, non-medical approaches to improving health.

In this report we hope to show that the healthcare sector, through an investment in housing, can improve the health of a community. We also hope to show that the affordable housing sector can prioritize housing to individuals of greatest concern to the healthcare sector. While the barriers to accomplish progress may be many, with strong vision and a common purpose, these cases show that there are many solutions as well.

Case Studies Overview

Case Study	Partners / Location	Capital Approach	Housing Approach	Health Care Approach
1. Central City Concern	Five hospital systems, nonprofit healthcare plan, project sponsor which is both an affordable housing developer and a Federal Qualified Health Center (FQHC). Portland, OR	Health providers donated \$21.5MM up front to developer under their Hospital Community Benefits Obligation.	Creation of 379 units of affordable, workforce units, as well as supportive and transitional housing, in conjunction with an FQHC.	Housing includes supportive units for people with behavioral health disorders as well as a site for an FQHC providing primary care and behavioral health services.
2. Central California Alliance for Health	Managed Care Organization (MCO), affordable housing developer. Northern California	MCO provided \$2.5MM up-front capital grant from capital investment fund.	Creation of a 90-unit mixed-use development, with 20 units set aside for homeless high-users of the healthcare system.	Targeting service-enriched housing to the homeless high users of the health system is expected to reduce utilization and improve health.
3. Chicanos Por La Causa/ United Healthcare	Managed Care Organization, Community Development Corporation. Phoenix, AZ	MCO provided a \$22MM low-interest loan.	Creation of 500 supportive housing units without using LIHTC.	Up to 20% of the units will be targeted to clients identified by the CDC as “housing insecure,” and supportive health services will be provided.
4. Health Plan of San Mateo	Managed Care Organization, housing services provider. San Mateo, CA	MCO provides ongoing funding for housing program, supporting transition of individuals from long-term care to independent supported living.	Housing services provider offers coordinated care, and supports relocation to, and stability in, independent housing or residential care facilities.	124 individuals, primarily Dual Eligible for Medicaid and Medicare, transitioned from skilled nursing facilities to service-enriched independent living. Initial results show 50% cost reduction.
5. Minnesota Group Residential Housing/ Hennepin Health	County-run Accountable Care Organization, State Government. Hennepin County, MN	State provides income supplement to homeless adults for housing and personal needs, supplemented with Medicaid and grant funds for services.	Housing navigator service combines with income supplement to reduce homelessness. The operating cost of supportive housing is partially offset by the supplement.	Over 10 years, the supplement has been used in over 1,000 units for disabled homeless adults. Accountable care agency spends a portion of savings for housing specialists to identify enriched supportive housing units for high users of healthcare services.

Case Study	Partners / Location	Capital Approach	Housing Approach	Health Care Approach
6. San Francisco Department of Public Health/ Direct Access to Housing	City Department of Public Health, Mayor's Office of Housing, affordable housing developers. San Francisco, CA	City of San Francisco designated local funding to expand supportive housing rather than using federal vouchers. Documentation of cost savings is not required, though savings were achieved.	The city moved from master-lease agreements with private owners and subsidizing the rent and operations, to contributing to up-front capital costs of housing development.	Created 1800 new units of supportive housing. Preliminary results of a randomized trial confirmed significant healthcare cost reductions were achieved for residents, primarily formerly homeless adults.
7. Los Angeles Department of Health Services/ Housing for Health	County Department of Health, affordable housing developers. Los Angeles, CA	Los Angeles allocated \$14 million annually for development, plus \$4 million in foundation funding for vouchers for supportive services and other housing-related costs.	The program supports 1200 units of new housing with a goal of 10,000 units by 2019.	A flexible housing pool is a one stop shop fiscal entity for government funds and philanthropy and provides rental subsidy and services contracts for homeless adults who are high users of public health services
8. Ohio Stygler Village/ National Church Residencies	State Department of Medicaid, State Housing Finance Agency, affordable housing developer, foundation. Gahanna, OH	State Housing Finance Agency was to provide a \$5.5MM loan to fill a project financing gap. In a Pay-for-Success type transaction, repayment source would be medical cost savings backstopped by a foundation guarantee. This transaction did not move forward.	Designed to refurbish 75 units of affordable housing for seniors, and reconfigure 75 units for assisted living for individuals who would otherwise be housed in Skilled Nursing Facilities.	Designed to produce cost savings and improved quality of life for residents by transitioning seniors and individuals in need of supportive services from institutional to residential settings.
9. California Developmental Disability Housing/ Brilliant Corners	State Department of Developmental Services, affordable housing developers. California	State contributed up to 20% of cost for acquisition and rehabilitation of housing units, while non profit developers financed the remaining 80% with conventional debt.	Housing is restricted to people with developmental disabilities. Services and operations are funded by Medicaid and SSI.	Adults with developmental disabilities are transitioned from institutional to community residential facilities, producing both cost savings and better outcomes.

Using Hospital Community Benefits to Provide Equity for Supportive Housing Development

Central City Concern, Portland, Oregon

Overview

In September 2016, five hospital systems and a non-profit healthcare plan in Portland, Oregon agreed to donate \$21.5 million to support development by Central City Concern (CCC) of 379 new affordable housing units, including supportive, respite care and transitional housing. This housing is being developed in conjunction with a 35,337 square foot healthcare facility and 1,346 square feet of commercial space/coffee shop for additional services. CCC's long history of integrating housing and clinical services to stabilize and advance the lives of its patients was a key factor in its ability to attract this level of investment. The funding helped to fulfill the Hospital Community Benefit Obligations (HCBO) required of non-profit hospital systems and is one of the largest single donations in the United States to a non-profit housing developer.

The hospital systems leveraged \$21.5 million in capital contributions into an \$81.25 million development of affordable and supportive housing linked with on-site clinical and mental health services while fulfilling their non-profit missions and meeting their obligations under the federal tax code. In addition to providing critical financial leverage, the use of HCBO as the funding mechanism overcame the problems created by differing investment horizons that can arise when the health and housing sectors attempt to collaborate. The nature of the investments as charitable donations meant that the success of the project was not dependent on documenting savings.

Background and Context

CCC is the largest provider of supportive housing in Portland as well as a primary provider of physical and behavioral health services targeting homeless adults. Since its founding in 1979, CCC has developed, operated and/or managed over 1,700 new development and scattered site units, master lease single-room occupancy hotels and renovated studio apartment buildings. The housing is a combination of Housing First units, harm reduction units (e.g. units that don't require tenants to be fully abstinent from drugs and/or alcohol to obtain and maintain housing), units for people in recovery from substance abuse requiring abstinence as part of the lease, and traditional affordable housing for low-income residents.

Operating as a provider of primary care and behavioral health services, employment services, and housing for low-income adults and families receiving Medicaid in Portland positioned CCC to develop strong and long-standing relationships with Portland-based hospital systems. In 2012, CCC was invited to be a founding member of Health Share of Oregon, a Coordinated Care Organization, and Ed Blackburn, CCC's CEO, was asked to serve on its board. Other directors of Health Share of Oregon included CEOs from healthcare systems, health plans, and county health departments. Since its inception, the governing board of Health Share of Oregon has had an interest in fostering quality care for low-income and homeless adults in the greater Portland area. Starting in 2008, CCC worked with four of the hospital systems on a recuperative care program. Under contracts renewable annually with CCC, these hospital systems discharged some of their highest healthcare cost users to a 35 unit program operated by CCC for 30-60 days of recuperative care. The program proved very successful, decreasing the



Source: Central City Concern

population's emergency room re-admittance by 90%, and saving the hospital systems significant costs. As a result of their interactions over time, a sense of trust developed among CCC and these hospital systems. The relationship among CCC and the hospital systems was further strengthened as executives of several of the hospital systems were recruited to serve as directors on the board of CCC, getting to know the organization, its mission, and its capacity.

The Community Health Needs Assessments (CHNA), required of hospital systems by the ACA, included the opportunity to prioritize social determinants of health. CCC advocated to include housing needs in the local CHNAs. The CHNAs identified access to care and housing as crucial. Hospital systems were aware of the connection between housing and healthcare but they possessed limited expertise with respect to the development or operation of housing. In addition, hospital systems were also facing increasing legislative scrutiny regarding their HCBO.

In spring 2016, Blackburn learned that Dr. George Brown, the CEO of Legacy Health, had expressed interest in investing in housing. Blackburn and Dr. Brown agreed to invite the CEOs of four other hospital systems and one managed care organization (all participating in Health Share of Oregon) for further discussion. The CEOs of all six systems (Adventist Health Northwest, Care Oregon, Kaiser Permanente Northwest, Legacy Health, Oregon Health and Science University, and Providence Health & Services- Oregon) committed to collaborate and make a transformational investment in housing. The decision to work together was aided by the prior successful collaborative experience among the hospital systems.

Although the six systems had provided CCC with a general indication of the amount of grant funding that they were willing to consider, before finalizing a grant amount, they asked CCC to develop a specific request. To meet this request, CCC engaged architectural and construction estimator assistance in order to calculate the total development costs for each of the projects. CCC then estimated the amount of funds it could obtain from traditional sources (e.g. LIHTC and state and local grants/financing) leaving a "gap" of \$21.5 million which it proposed that the six systems fund.

Discussions with two of the hospital systems that participated in this effort suggest that they see the CCC contribution as a first step with the expectation that there will be other similar HCBO funded grants for housing, as it is a good use of these funds and has both public and legislative support. When asked about the potential impact of the repeal of the ACA on grants of this type, they acknowledge that any reduction in the number of insured patients would negatively impact hospital revenues and increase the need for charity care, but their best guess at the moment is that this use of HCBO will continue.

Population Served

HCBO funds will serve several distinct populations. The largest site, the Eastside Health and Housing Center, will provide 175 units of supportive housing including 114 units for people in recovery from behavioral health disorders and 51 units of medical and mental health respite housing. In addition, 10 units will be set aside for palliative care for homeless adults at the end of life, and the ground floors will accommodate a new Federally Qualified Health Center providing primary care and behavioral health services for low-income adults and families. Stark Street Apartments will provide 153 units of permanent housing and Interstate Apartments will provide 51 units of family housing.

It is anticipated that CCC will continue to select individuals for vacant units in the supportive housing units in a manner consistent with Federal requirements when relevant, and the Eastside Housing will prioritize high users of the healthcare system who are medically or psychiatrically compromised and at greatest risk for harm on the street.

The Model

The three CCC sites will provide 379 units of permanent and short-term housing.

Combined, the grant contributions and tax credits for the project will make up 86% of the total expected development costs with only \$11.75 million (14%) needed to be financed with conventional debt. In addition, CCC is conducting a capital campaign for \$3.5 million (\$800,000 of which has been secured to date), with the goal of further reducing the debt and thus making the units more affordable to lower-income residents. Given the hospital systems' large contribution and the capital campaign, it is expected that the costs of servicing the loan and other operations of the facilities will be covered by the tenants' rent (including a possible rent subsidy) and the commercial space rent. CCC may also leverage other on-going operating support through their role as a primary care and behavioral health service provider to many of the prospective residents. Funding for these services come from a variety of sources including Medicaid billing secured through CCC's FQHC and as a full partner in Health Share of Oregon.

CCC has executed a series of funding agreements with each contributor. The initial contributions were \$50,000 from each for pre-development costs. CCC will receive four additional contributions from each contributor on each property upon the achievement of certain development milestones. With the exception of achieving the threshold for each contribution and the obligation to provide semi-annual and final reports on the projects' progress and financial status⁵ there are no other

Hospital Community Benefits Obligation

Beginning in 1956, the IRS established an expectation that all non-profit hospitals contribute some of their revenue for charity care to maintain their non-profit status.⁶ Over the past 60 years, non-profit hospitals have fulfilled this obligation primarily by providing charity care for uninsured or underinsured patients seen in their institutions or by bridging the gap between the actual cost for care and the cost reimbursed from Medicaid. In 2011, the combined HCBO across the United States was estimated to be \$62 billion. In 2009, the IRS clarified the reporting requirements necessary to document the fulfillment of this obligation by requiring that all non-profit hospitals complete a Schedule H report along

with their Form 990 IRS filings. These reporting requirements stated that most of the HCBO must be used for "community benefits" rather than "community building." Following advocacy and research that promoted housing as a healthcare intervention, the IRS clarified in 2015 that contribution to housing can be considered a "community benefit" to assist in overcoming some of the adverse "social determinants of health" rather than "community building" thereby opening up the opportunity for significantly more funding being routed to housing development to fulfill the HCBO.⁷

conditions imposed on CCC by the contributors. The funding is not subject to any risk of default nor is there any provision for a “claw back”. The hospital systems have agreed to provide funding directly to CCC rather than to the entities owning the properties to be developed (Low Income Housing Tax Credit and New Market Tax Credit partnerships). Making the contribution to CCC rather than at the individual property level, gives CCC the ability to re-allocate the funds among the three projects should the financial needs of any of the projects change.



Lessons learned, opportunities and challenges

1. Non-profit hospital systems, singly or working collaboratively, can make grants from HCBO funds to support the development of housing on a non-competitive basis.
2. Previous hospital system collaboration built the relationships that enabled the systems to respond quickly to the CCC investment opportunity. Helping traditional hospital systems to embrace housing as a means of addressing healthcare occurred over many years of discussion, including the CEO of CCC successfully developing relationships with the healthcare CEOs so their strategic orientation could include housing.
3. Changes in IRS regulations and clarification as to what constitutes a community benefit provided an opportunity for non-profit hospitals to fulfill their HCBO by donating to a housing developer.
4. Use of HCBO for housing development may be impacted if the ACA is repealed and Medicaid coverage is reduced, resulting in increased need for charity care.
5. Growing hospital system emphasis on addressing broader community health needs is moving systems to shift investments away from traditional clinical care and toward the social determinants of health.

Funding Sources for the Project (not including housing waivers)

Health system contributions
\$21.5 million

Central City Concern contribution
\$3.3 million

Total estimated cost for 3 projects
\$81.25 million

Low Income Housing Tax Credits
\$20.4 million

Grants/Soft Sources
\$16.4 million

Projections are current as of March 2017. Note total cost is net of local systems development charges and New Market Tax Credit fees.

New Market Tax Credits
\$7.9 million

Permanent Debt
\$11.75 million

Capital Investment by a Managed Care Organization

Central California Alliance for Health, Salinas, California

Overview

While the Community Benefits grants in Portland may be one of the largest capital contributions from the health system to supportive housing, it is not the only example of this type. Central California Alliance for Health (CCAH), a medium sized managed care organization covering three counties in California (Merced, Monterey and Santa Cruz), recently awarded a \$2.5 million one-time capital grant to the non-profit housing developer MidPen Housing Corporation to assist in the development (both pre-development and hard costs) of a 90 unit mixed-use development in Salinas, California.

CCAH, like the Health Plan of San Mateo (see below), is a County Organized Health System and therefore is the only Medi-Cal managed care provider in these three counties. After rollout of the Affordable Care Act, CCAH had a greater enrollment in their plan than predicted. To improve access to care for their members, CCAH created their Medi-Cal Capacity Grant Program (MCGP) funded with reserves accumulated from efficient health plan operations and cost-effective care. CCAH set aside \$116.7 million in 2016 to invest in the community to expand Medi-Cal capacity, \$79.2 million of which was set aside for capital investments. The board of

CCAH identified the need to focus the MCGP on three priority areas: 1) increasing provider capacity; 2) expanding access to behavioral health and substance use disorder services; and 3) developing and strengthening support resources for the Alliance's most medically fragile members. The investments in this last category are intended to reduce the utilization of healthcare services for the 8% of their members who were estimated to be using 75% of the healthcare resources.

One strategy to reduce demand on healthcare resources by these "eight percenters" was to invest in supportive housing for some of these high users of the healthcare system, reducing utilization and improving health for plan members who are placed in the housing facility. Working with the local housing authority (through a specific amendment to the annual Administrative Plan) which provides project-based Housing Choice vouchers for the project, MidPen Housing Corporation will set aside 20 of the 90 units identified by CCAH for homeless high users of the healthcare system. In addition to providing housing for 20 of the CCAH members who are high users of the health system, the investment is intended to encourage others in the community to make further investments in the social determinants of health to improve the population health of their community. CCAH is continuing this strategy and is expected to use the MCGP to invest in other capital projects in the next few years as part of their overall business plan to meet the Triple Aim of healthcare.

To improve access to care for their members, CCAH created their Medi-Cal Capacity Grant Program funded with reserves accumulated from efficient health plan operations and cost-effective care.

Managed Care Capital Investment to Improve Community Health

UnitedHealthcare and Chicanos Por La Causa, Phoenix, Arizona

Overview

In the Maryvale neighborhood of Phoenix, UnitedHealthcare (UHC), one of the largest managed care organizations in the United States, and Chicanos Por La Causa (CPLC), a Community Development Corporation (CDC)⁸, have partnered on a series of key community initiatives based on their shared understanding of the role that social determinants of health play in the lives of local residents. In early 2015, UHC approached CPLC to brainstorm solutions to the barriers between families and well-being and generated a breakthrough idea—to create a central hub—or “Community Connect Center”—with a single point-of-entry that addresses not only health, but also social determinants and financial stability to help clients move along a continuum from dependence to self-sufficiency. Seeing the health of the community more broadly than typical healthcare delivery systems, the two organizations began by partnering on the Maryvale Community Services Center, which provides social services as well as medical and behavioral health services. In addition UHC provided CPLC with \$22 million in capital to acquire and renovate nearly 500 rental apartments in the Maryvale neighborhood of Phoenix, Arizona.

The capital arrangement enables CPLC to acquire existing apartment complexes without the use of traditional affordable housing financing tools. This provides greater flexibility to target the use of the units to vulnerable individuals that are experiencing inadequate or unstable housing. Both parties see the lack of affordable housing as perhaps the key social determinant of health, and are working intensively with the newly housed residents on job training and other services to ensure that the units can turnover and eventually serve more people.

Background and Context

UnitedHealth Group is a large and diversified healthcare company and one of the largest insurance agencies in the United States. In addition to providing health insurance and managed care services, UnitedHealth Group has invested over \$300 million in the last ten years in Low Income Housing Tax Credits (LIHTC). CPLC is the largest CDC in Arizona and was founded in the late 1960s as a grass-roots organization to confront oppression in the Latino community in South Central Arizona. CPLC serves more than 200,000 individuals annually in Arizona, Nevada, and New Mexico and is committed to developing programs that assist clients to achieve self-sufficiency and to move away from dependence on government support.

In 2011, CPLC approached UHC to explore a collaboration to expand services offered at the Maryvale Community Services Center. This resulted in a partnership that created an electronic referral system that provided comprehensive utilization data to CPLC for UnitedHealthcare’s members and reinforced the extensive overlap between CPLC clients and UnitedHealthcare’s members. The partnership expanded further in 2015 with the creation of the myCommunity Connect pilot project, in which UHC provided funding for CPLC staff to assist clients with housing and behavioral health services. Later that year, CPLC approached UnitedHealthcare to partner on the redevelopment of 500 units of service-enriched affordable housing.

The Model

CPLC acquired and partially renovated two operating apartment complexes with 500 units in the Maryvale area solely using a \$22 million low-interest loan from UHC. Up to 20% of the units will be offered to UnitedHealthcare clients at reduced rents, with market-rate rents from the remaining apartments helping to subsidize those units and also fund supportive health services. In addition, CPLC hopes to be able to refinance the property at the end of the loan term and return UHC's investment. CPLC expects that the refinancing will be able to take advantage of a higher property value at that time due to the physical improvements to the property and increased rental revenue. UnitedHealthcare coordinated its capital partnership with CPLC with Arizona's Medicaid Agency which was supportive of the efforts to bring more affordable housing to Maryvale.

A key challenge for health and housing partnerships is overcoming the industry-specific regulations that create barriers to either investment or targeted use of resources. Within the affordable housing field, CPLC has been part of the Housing Partnership Equity Trust, an effort to use the financing tools of market-rate REITs to improve the speed and cost-effectiveness of affordable housing production.

In addition, LIHTCs are a limited resource, are highly competitive to procure, and LIHTC transactions take a significant amount of time to complete. The partnership with CLPC and UHC sought alternative capital solutions to eliminate the need to rely on LIHTC and other sources of public subsidy.

While LIHTCs are a major financial resource, the use of public funds brings regulatory prohibitions on targeting benefits to a for-profit entity. By forgoing public funding in the housing acquisition, the partners are able to target a percentage of the housing to vulnerable individuals. While this structure was critical to a partnership between two private entities, other housing groups have avoided this challenge by working with a public agency such as a county health department. In those circumstances, the use of LIHTCs has not prevented housing organizations from filling units exclusively with referrals from the public health agencies, as long as those agencies are not violating any fair housing laws by discriminating against protected classes.



Population Served

At the myCommunity Connect Center, Community Health Care Workers and housing navigators develop an individualized service plan for each client, and connect them to an array of services, including housing for those clients who have identified housing insecurities. UHC and CPLC hope the provision of housing to vulnerable clients will improve individual and community health, and further the Triple Aim of healthcare (reduced cost, better health, and improved customer satisfaction). Before and after a housing referral, CPLC and UHC's myConnections™ support residents in a variety of areas from health to employment, with the hope that community members will make economic progress in addition to improving their health.

A key challenge for health and housing partnerships is overcoming the industry-specific regulations that create barriers to either investment or targeted use of resources.

Lessons Learned

1. The unique collaboration between UHC and CPLC was predicated upon years of trust building and understanding of aligned goals for improving the health of a community.
2. The fact that both organizations had experience in both the housing and healthcare sectors improved the partnership's communication and collaboration.
3. By financing the development without use of LIHTC or other more traditional financing strategies, the project could move forward with less cost, faster and be able to prioritize limited housing resources to serve a vulnerable population.

Managed Care Leadership to Reduce Avoidable Long Term Care Costs

Health Plan of San Mateo, California

Overview

In an effort to provide less expensive, more independent alternatives to traditional nursing home services, the Health Plan of San Mateo (HPSM) created the Community Care Settings Pilot (CCSP) in 2015. CCSP is a partnership with the County of San Mateo, non-profit housing organizations and the public housing authority that provides intensive transitional case management and care coordination alongside housing services and supports. The program provides community alternatives to institutional care for HPSM members with a focus on Dual Eligible individuals through the framework of California Medi-Connect, itself a state pilot to align costs and savings between Medicaid and Medicare. As a result, the HPSM has already successfully transitioned 124 individuals from long-term care with their post-transition costs 50% lower than it was for the six months prior to moving into the community.

Case Example

Gloria Gonzalez is an 89 year old woman who has been living in an illegal in-law apartment for the past 20 years. She worked for over 40 years as a house cleaner for a number of families and companies around San Mateo and retired on a fixed income in 1993. Ms. Gonzalez was a frequent visitor to the local emergency department and has had four short inpatient stays due to poorly controlled congestive heart failure and diabetes. She was stably housed until she had a fall breaking her left hip. She had a two week stay in Mills-Peninsula hospital and was subsequently placed for six months in a skilled nursing facility. IOA and Brilliant Corners assessed her housing situation and determined that she would neither be able to safely get up the stairs to her apartment nor would the landlord be willing to make structural changes to the

apartment in order to make it accessible to Ms. Gonzales now that she needed a walker. IOA staff assisted Ms. Gonzalez to establish a medical primary care relationship and Brilliant Corners staff assisted Ms. Gonzalez in applying for and retaining housing at a new senior specific affordable housing facility that has project-based Section 8 vouchers and units set-aside for HPSM members. Ms. Gonzalez enrolled in a local Adult Day Health program where the on-site nurse administered her long-acting insulin once a day. At present, Ms. Gonzalez is doing well and has not returned to the acute hospital after her initial fall.

The case presented is a composite of cases heard by the Core group rather than an actual case to avoid disclosing protected health information about any one person.



Source: Brilliant Corners

Background and context

As of July 2016, Managed Care Organizations (MCOs) were covering the majority of Medicaid beneficiaries in 37 states⁹. In California, which has the largest Medicaid managed care population in the country with nearly 10 million beneficiaries, three quarters of Medicaid beneficiaries in the state are enrolled in an MCO. Over the last five years, California has gone further than many states, including mandating enrollment of seniors and people with disabilities into MCOs in 2011. In addition, in 2012, under the Coordinated Care Initiative (CCI), MCOs in seven counties also took responsibility for managing long-term services and supports (LTSS) including long term care in skilled nursing facilities and personal care services. The CCI also created a demonstration for individuals eligible for both Medicare and Medicaid, known as Cal MediConnect. For these beneficiaries,

Medicaid pays for long term care, Medicare premiums and cost-sharing while Medicare pays for physician services, prescription drugs, short-term skilled nursing and acute hospital care.

San Mateo County, a medium sized county just south of San Francisco and north of Silicon Valley, was one of the original pilot counties that began to enroll individuals into Cal MediConnect in April 2014. Medicaid managed care in San Mateo is delivered through the County Organized Health System (COHS) model, meaning there is only one Medicaid MCO in the county. Since HPSM is the only MCO in the county, individuals stay enrolled in the plan as long as they reside in the county and continue to qualify for services. HPSM is a local agency created by the County Board of Supervisors and its goals as a health plan align with and are in-part governed by county leadership.

In February 2013,¹² approximately 1300 HPSM members were residing in a skilled nursing facility (SNF). At that time, HPSM leadership was informed that the largest SNF in the county, Burlingame Long Term Care (BLTC), was planning to close in June 2013. HPSM staff found very limited capacity within the county to absorb the patients expected to be displaced by the closure. Initial needs assessment of SNF residents across the county revealed that anywhere from 10-30% could live independently with the right services and support in place. With these data in mind, and the incentives created by the Cal MediConnect Duals Demonstration Project, HPSM launched the Community Care Settings Pilot (CCSP) to assess the challenges and opportunities presented by these circumstances.

Snapshot on San Mateo County

Population: 765,135

Median household income: \$91,421

Population living below Federal poverty line: 16.7%¹⁰

Number of residents who qualify for Medi-Cal: 132,500 (88,775 adults and 43,725 children)¹¹

Number of residents who qualify for both Medicare and Medi-Cal: 18,172

The Model

The CCSP has three major goals: 1) provide the greatest opportunity for members to return to or stay in the community with a highest quality of life; 2) reduce utilization of long term care; and 3) generate savings for HPSM (and the State and Federal Governments) by reducing healthcare expenditures for this population.

For many of the people identified who could live more independently, the main impediment to living safely in the community was lack of an appropriate housing option connected to robust services. To meet this need, HPSM pays for intensive transitional case management and care coordination alongside housing services and supports, including identification, lease-holding and housing retention support.

A. Transitional Case Management Services: As the primary case management agency for CCSP, the Institute on Aging (IOA) staff work with CCSP participants throughout the lifecycle of the program, from referral to intake to transition from long term care settings all the way through discharge from the program. To identify participants and welcome referrals, HPSM and IOA staff work together to perform outreach to local SNFs and community-based organizations to identify individuals who would benefit from the transitional case management and housing services. After being screened and prioritized for enrollment in the program, IOA staff assess the needs of each client, including taking a detailed medical, psychiatric, and social history. After assessment, IOA staff develop an individualized treatment plan and present the case to the Core Group (see below) for final service and placement recommendations.

B. Housing Intermediary Services: As the housing services provider, Brilliant Corners is contracted by HPSM to locate low-cost, accessible apartments throughout San Mateo County and provide retention services to support housing stability over time. Housing retention services include landlord liaison, on-call supports, habitability checks, rent payment coordination, and other services. Most clients that have moved to independent housing have been placed in low-income affordable housing facilities with rent supports from project-based Housing Choice Vouchers (see below). A few clients have been supported in market rate independent housing while case managers assist clients to obtain project-based or tenant-based vouchers for longer term placement. There is no pre-determined time limit for a CCSP client to stay in market rate housing, though IOA and Brilliant Corners staff try to maximize available resources and therefore move tenants to subsidized housing as quickly as possible. In addition, Brilliant Corners coordinates and funds modifications to existing units to make them either ADA compliant or to make modifications specific to the mobility and safety needs of a particular client, such as installing grab bars, roll-in showers, and wheelchair ramps as needed.

C. Client Selection and Placement Decisions: IOA staff initially approach clients and develop an individualized treatment plan which includes client preference for housing. After assessment, IOA staff present each case to a multi-disciplinary “Core Group” of clinical staff and community agencies. The Core group comes to a consensus recommendation for one of three placement options: SNF, a Residential Care Facility (RCF), or independent housing. Brilliant Corners and IOA staff then work to identify and implement an acceptable housing option for the client as well as connect the member to primary care providers in the community, along with other services such as behavioral healthcare, IHSS, and day health programs as needed.

D. Innovative Placement Options: As CCSP rolled out, HPSM partnered with the local Housing Authority in order to explore ways to gain better access to affordable housing options. Together, they established an annual housing plan that creates a “special needs” preference for access to 10% of the units in all new HUD-funded affordable senior housing developments. 17 units have been set aside so far and the expectation is that 10% of the units in Housing Authority funded project-based units will be prioritized for CCSP clients going forward. In these developments, tenants pay 30% of their income toward rent and the remainder of the cost is covered by Section 8 project-based vouchers.

Clients who cannot live independently in their own apartments can choose assisted living in a RCF. The payment structure, assessments and other program elements for this are modeled on the State of California’s Medi-Cal Assisted Living Waiver (ALW) program, which IOA also coordinates within San Mateo County. Under this model, beneficiaries contribute 95% of their SSI/SSDI to pay for room and board, with per diem service rates added to that amount based on which service tier best fits the client’s needs. Because HPSM’s dual-eligible members are not eligible for the ALW, HPSM leverages what is known as Care Plan Optional spending to cover the cost or providing these much needed services to those members, which amounts to an annual cost of about \$1 million/year.

Initial Evaluation Results: As of October 2016, 166 clients have been engaged with CCSP in some capacity. Of these, 69 have moved into RCF, nine have moved into independent market rate housing, 24 have moved into independent affordable housing units or similar accommodations, and 22 have been able to stay in their existing residential settings following modification. Finally, 42 were withdrawn from CCSP prior to transition, either due to a change in condition, inability to identify an appropriate placement, or member choice. Spending for the six months after transition is almost 50% lower than spending for the six months prior to transition, even after including the costs of the program saving in excess of \$2 million for the 85 clients who have been in the community for at least six months post-transition.

Lessons Learned and Opportunities

1. By aligning incentives for the care of Dual Eligible individuals, CMS and state Medicaid agencies can enable health plans to invest in community solutions as an alternative to high cost institutional care.
2. By starting with a small population with known, high ongoing costs (SNF patients) a healthcare delivery system can generate considerable cost savings by offering well-coordinated and less expensive community-based options.
3. Fragmentation of the managed care market may inhibit long term investment and collaboration: While having more than one competing MCO for a specific geographic area may improve choice and contain costs for traditional medical services, the resulting churn among plan members may unintentionally undermine opportunities to capitalize on investment in long-term programs. The healthcare delivery system in San Mateo avoids this “churn” by having only one Medicaid MCO in the County.
4. Carve-outs and Program Restrictions: Various services such as mental health, housing and community-based services, and in some cases long-term care, are often carved out of managed care plans. Full integration would better align plans to serve their member needs and provide the financial resources to pay for treatment. Over the next year, HPSM will use a new 1115 Medicaid Waiver focused on integrating medical and behavioral health to innovate around other high-cost populations, including medically vulnerable homeless adults with mental health and substance use disorder, who are high users of the healthcare system.
5. Using flexible benefits and/or other funding streams to pay for client needs, health payers can utilize small amounts of funding until other mainstream funding or resources become available (e.g. providing short-term rent subsidies until a housing voucher becomes available). This strategy supports moving patients out of institutional care based on clinical condition, rather than delaying discharge until new housing can be constructed.

Clients who cannot live independently in their own apartments can choose assisted living in a RCF. The payment structure, assessments and other program elements for this are modeled on the State of California’s Medi-Cal Assisted Living Waiver (ALW) program, which IOA also coordinates within San Mateo County.



Back to Basics

Hennepin County, Minnesota

Overview

The State of Minnesota has addressed the challenge of serving high-cost users of the healthcare system in the simplest of ways: providing an income supplement to pay for housing. Low-income, homeless adults with a verified disabling condition can qualify for a state funded monthly income supplement called Group Residential Housing (GRH), consisting of up to \$891 that can be used for housing expenses (including rent). The GRH payment is sufficient to enable homeless individuals to pay rent for some market-rate units as well as for assisted housing. In combination with considerable state investment in supportive housing, as well as utilization of an Accountable Care Organization (ACO) funded housing navigator services targeting high users of the healthcare system, Hennepin County is on pace to reduce the number of chronically homeless adults to “functional zero” by the end of 2017.

Background and Context

Hennepin Health (HH), in Hennepin County (which includes the city of Minneapolis), is a county-run ACO that partners with the public hospital system (Hennepin County Medical Center-HCMC) to target high users of the healthcare system. HH has intentionally taken on a high cost population and recognized the importance of investing in services, such as housing, that positively impact the social determinants of health, and result in reduced healthcare costs overall.

ACOs are more flexible than traditional Managed Care Organizations, as savings earned through innovative programs can be returned to ACO providers or reinvested in services and community supports that are expected to improve healthcare outcomes and ultimately reduce the cost of care. CMS has allowed ACOs to have considerable flexibility and autonomy in determining how they use their earned savings.

Given the flexibility of the governance structure, there was an expectation that savings could be used to anchor affordable housing development or pay for rental subsidies targeting chronically homeless adults.¹³ Because of the on-going public investment in affordable housing through GRH, HH has not needed to use its annual shared savings investment for housing but, instead, has invested in housing navigator services.





Source: Aeon

The Model

GRH is a state funded program set forth in the base of Minnesota's General Fund budget (as opposed to a grant allocation). Typically, federal housing supports such as Housing Choice Vouchers restrict the percent of an individual benefit that can go toward housing (e.g. only 30% of SSI payment for rent). Since GRH is designed to support housing expenses, recipients retain \$97 from their GRH as a personal needs allowance with the remainder (89%) used for housing and housing related supplies and activities (see below). GRH funds can be used quite broadly for food costs, home furnishing and some transportation costs. Tenants who receive GRH also typically receive food stamps to help cover the cost of food. In-home support services can also be available for disabled tenants that need homemaker services.

Over the past ten years, GRH has been used as a resource in over 1,000 units in 104 properties. Affordable developers and service providers have been able to develop housing where the cost of operations and services can be covered by this benefit alone (at least for low or moderate need tenants). For tenants with complex mental health or medical needs, other service funding from mental health Medicaid billing or grants serving high users of the healthcare system can augment GRH to maintain funding for housing, services, and debt management of development.

The Minnesota Housing Finance Agency increases the effectiveness of GRH by using it in conjunction with financing for non-profit and for-profit developers of permanent supportive housing targeting chronically homeless adults. Between 2012 and 2016, Minnesota Housing has awarded

between \$10 million and \$80 million annually in loans to projects on a competitive basis to housing developers for hard and soft costs. Many of these loans are either offered without interest, or are structured with payments deferred until maturity. Funding priority is given to projects for preservation of federally assisted affordable housing and supportive housing targeting high users of the healthcare system, with bonus points for projects that set aside units for chronically homeless adults. This has been grafted onto a well-developed funding system for affordable housing, including HUD's Housing Choice Vouchers (Section 8), HUD's VASH for veterans, and Low Income Housing Tax Credits. Between 2011 and 2016, the state has contributed funding to develop 1,808 units of supportive housing in 111 developments.

Despite GRH's flexibility, it is insufficient to provide mental health support services at the intensive level typically seen in Assertive Community Treatment Programs to treat the chronically homeless. To address this gap, State and county healthcare agencies have made available to supportive housing providers a variety of service funding opportunities through direct billing from mental health and other county agencies. This has been done primarily through the Targeted Case Management funding allowed by Medicaid rather than through innovation grants through the Waiver programs (e.g. 1115 or 1915 Medicaid Waivers)..



The Role of Health Agencies

Given this straightforward and effective effort, healthcare organizations face a much simpler and perhaps more traditional path. In Hennepin County, the state's most populous, a mission-driven ACO, Hennepin Health, has invested in housing navigator services to help the highest users of the healthcare system take advantage of this expansion of housing stock. Using these services, many homeless adults that qualify for GRH or SSI payments have been able to secure standard market rate leases without relying on additional government financing to afford rent in the open market.

HH has chosen to use some of its shared savings to employ housing specialists and augment services in primary care clinics to assist their members to access and maintain housing during periods when their mental illness and/or substance use disorders may result in behaviors that threaten their housing stability. At the time of the writing of this paper, a centralized coordinated entry system was being rolled out that would help make recommendations for housing and help to reduce some of the systemic barriers in matching the right quality of housing and intensity of services to best serve the needs of the individual homeless adult. However, even with a fully functioning centralized intake program, housing navigators will be necessary to establish the relationships with the wide variety of private landlords and affordable housing developers.

While Hennepin County has developed a plan to reach "functional zero" for chronically homeless adults in 2017, the lack of high quality housing with enriched on-site services may be one of the factors that keep the system unstable in the long run. Nonetheless, housing navigators increase the odds of both obtaining and sustaining housing for the individuals they assist. On-going evaluation will determine if investment in this approach reduces overall healthcare costs.

Lessons Learned

1. Housing vouchers for low-income disabled adults can be an effective and less complex approach to helping homeless adults secure and maintain housing.
2. Housing navigator services can help high cost homeless adults to access supportive housing.
3. While ACOs can fund housing directly, there are disincentives to long-term operating commitments, such as individuals losing or changing their insurance.

Using these services, many homeless adults that qualify for GRH or SSI payments have been able to secure standard market rate leases without relying on additional government financing to afford rent in the open market.

From Master-Leasing to Coordinated Investment

The San Francisco Direct Access to Housing Model

Overview

Through the Direct Access to Housing program (DAH), the San Francisco Department of Public Health (DPH) has been able to secure approximately 1800 permanent supportive housing units. By helping to pioneer the Housing First model and taking control of the identification and placement of its patients into the apartments, DPH was able to overcome the most prominent barriers to getting homeless individuals into supportive housing while reducing healthcare costs. From a development perspective, a key innovation was the creation of an interagency loan committee comprised of housing, health and human services agencies that provided a one-stop shop for capital, services and operating funding.

By helping to pioneer the Housing First model and taking control of the identification and placement of its patients into the apartments, DPH was able to overcome the most prominent barriers to getting homeless individuals into supportive housing while reducing healthcare costs.

Background and Context

San Francisco is unique in California in that it is both a city and county. As a result, it carries out both public health functions (administered by counties in California) and housing finance functions (typically done by cities in California). DPH is a large health department accounting for approximately one quarter of the entire city budget and includes a major public hospital and trauma center as well as mental health clinics and twelve community-based primary care clinics. In addition, DPH contracts with community-based organizations for behavioral health services including intensive case management programs and residential and outpatient substance abuse treatment programs.

Starting in 1999, DPH began funding supportive housing directly in order to target housing toward the chronically homeless, high users of the healthcare system who were not being prioritized in the more traditional affordable housing system. Initially this was done by master leasing SRO units and gradually shifted to funding, operating and services subsidies for non-profit developed permanent supportive housing. When the program started, the city opted not to use Housing Choice Vouchers (Section 8), substituting local funds instead, in part because federal policy at that time prohibited access to housing for adults with felony convictions or active substance use.

In the mid 2000's, the program grew dramatically with the initiation of the City's first "10-Year Plan to End Homelessness." As part of that plan, DPH began partnering more directly with the City's housing department, the Mayor's Office on Housing (MOH). The City established a goal of creating 3,000 supportive housing units over the next decade, with half to come from master leasing existing housing and half from acquisition/rehab or new construction. Through this prioritization process the city increased local expenditures to expand housing through the DAH program by approximately 150 units annually between 2005 and 2012 to reach the present portfolio size of 1800 units.

The Model

The City provides local funding to pay for the operating costs of housing dedicated to its high-cost patient population. In its early years, the city mostly entered into 10-year master-lease agreements with private owners, taking control of often vacant SRO's. The cost of the renovation was paid upfront by the buildings' owners. Rent was paid by a combination of tenant contribution (50% of tenant income) and the local operating subsidy. Funding for each master lease or new building has to be approved separately by DPH, MOH, and the Board of Supervisors. Separate contracts were tendered by DPH to local behavioral health agencies to provide harm reduction-based case management services on-site within the master leased facilities.

Initially, each building set aside a number of units for one or more of a dozen local behavioral health/homeless healthcare agencies. During rent-up, or later as a unit became vacant, health department staff contacted staff at the agency for which the unit had been set aside and they would forward a qualifying client to the program to be offered tenancy. As the program grew, the buildings diversified in terms of quality of housing and intensity of on-site services,¹⁴ eventually including nine buildings (encompassing 600 units) with on-site registered nurses. With this diversification, tenant selection was centralized and a "waiting pool" was created so that the most vulnerable homeless adults could be prioritized toward available units, and there was an increased likelihood that the needs of each client could be effectively managed by the services (e.g. nursing care, intensive case management, etc.) available in each building.

The City provides local funding to pay for the operating costs of housing dedicated to its high-cost patient population.

From Master-Leasing to Development

To carry out this supportive housing expansion, MOH expanded its citywide Loan Committee to include the Human Service Agency and DPH. The Loan Committee has authority on funding priority for all new capital investments in affordable housing as well as decisions around target populations, approach to services, and operating subsidies. This multi-agency leadership structure allows for funding priorities to include an expansion of both 100% permanent supportive housing for chronically homeless adults, as well as set-asides for homeless families and seniors in more traditional affordable housing developments. As new funding sources have opened up to serve distinct populations (veterans or individuals with mental health disabilities), these priorities have been incorporated into requests for proposals by the combined agencies. This structure also provides developers with one-stop shopping for the local capital contribution on LIHTC projects, as well as services and rental subsidy commitments that increased competitiveness for State and Federal funding.

Approximately half of the 1,800 DAH units are in renovated, master leased single room occupancy residential hotels (SRO) and half are non-profit owned apartments developed with capital funding from the City's housing agencies and traditional affordable housing financing tools. Approximately one-third of the units are set aside for seniors, mostly in new construction units.

Over time, due to the increasing precision of the placement decisions and the improved quality of housing, eviction rates among the 43 buildings have fallen from 10-15% annually to approximately 3% annually, with most evictions resulting from violations to the nuisance clause of the lease (including violence, destruction of property, etc.). Unit turnover ranges from 2% annually (for mixed income, senior-specific housing) to 18% for SRO units situated in the inner-city neighborhood of the Tenderloin. Longitudinal data shows significant reduction in high-cost, institution-based services after housing with estimated decreases in healthcare costs over \$30,000 the year after tenant move-in, mostly through reductions in hospital inpatient costs.¹⁵ The city's annual per unit cost for operations and services combined ranges from approximately \$14,000 (for the initial master-leased SRO sites) to \$18,000 (for the newly built sites). Preliminary results of a recent randomized trial confirmed these initial results and showed marked healthcare cost reductions were sustained for residents.¹⁶



Lessons Learned

1. Strong, focused interdepartmental leadership is critical to developing a local, permanent supportive housing program and for sustaining production over time.
2. Local rental subsidies can be deployed in a variety of ways as housing markets shift from relative abundance to scarcity.
3. To achieve greater financial leverage and expedite housing delivery, rent subsidies and services funding should be administered in concert with capital funding decisions.
4. Using a local rent subsidy rather than federal housing choice vouchers has allowed the program to house the people in greatest need quickly, without being restricted by exclusionary federal policy. However, using exclusively local government funding leaves the program vulnerable to changes in local tax revenue and political leadership.

Strong, focused interdepartmental leadership is critical to developing a local, permanent supportive housing program and for sustaining production over time.

County Investment in Housing within a Health System

Los Angeles Department of Health Services, Housing For Health

Overview

The Los Angeles County Department of Health Services (DHS) is in the midst of undertaking one of the largest investments in permanent supportive housing in the United States. The Housing for Health (HFH) section of DHS serves as a clearinghouse for housing resources to maximize efficient use of federal and local housing dollars, incorporate philanthropic investment, and implement the priorities of the health department. Relying since inception on annual funding from the County (\$14 million in the first year), DHS has been able to report an increase in housing and improved overall health outcomes for chronically homeless adults in Los Angeles County. The majority of units are located in existing apartment buildings or master-leased single room occupancy resident hotels (SRO), although the funding is also being used to leverage new construction of supportive housing in conjunction with traditional affordable housing financial tools. HFH provides rental subsidies through an intermediary, and supportive services through contracts with a variety of behavioral health agencies.



Source: Skid Row Housing Trust

Background and Context

In January 2011, Dr. Mitch Katz began his tenure as Los Angeles County Director of DHS, the agency responsible for providing primary and institutionally-based care for all low-income residents of the county of nearly 10 million people, including an estimated 10,000 chronically homeless adults. In 2011, DHS had a budget of nearly \$4 billion (which grew to \$8 billion by 2016), owned and operated four tertiary care hospitals, and operated over a dozen community-based primary care clinics. In 2011, an estimated 60% of the people served by DHS hospitals and clinics were uninsured, with their healthcare services primarily being covered by county general funds.

With the roll-out of the Affordable Care Act (ACA) in 2014, most of the uninsured in the county qualified for Medi-Cal, California's Medicaid program, and county-funded medical services were able to generate revenue from Medicaid. Based on his earlier experience as Director of Health in San Francisco, where he saw the provision of housing lead to improving health and reducing health expenditures, Dr. Katz made a compelling case to the LA County Board of Supervisors that the overall quality of healthcare for Los Angelenos could be improved by providing housing for homeless adults. He also believed that he could provide this housing expansion without increasing county expenditures beyond 2011 levels (in part because of the increased revenue that came from the ACA expansion). The Board authorized DHS to develop 10,000 units of permanent supportive housing by the end of 2018. With an initial budget of \$18 million, \$14 million from the DHS budget, and \$4 million from the Conrad Hilton Foundation, HFH embarked on an effort to provide permanent supportive housing for chronically homeless adults in Los Angeles.



Source: Skid Row Housing Trust

The Model

The cornerstone of the HFH program is the flexible housing subsidy pool (FHSP). The FHSP coordinates local and philanthropic funding and Housing Choice Vouchers (HCV) from HUD (Housing and Urban Development). Targeting DHS clients, HFH provides rental support through either an HCV or a FHSP county funded voucher (FSHPV). This allows HFH to leverage both county and federal sources to match a homeless adult with housing and use the most appropriate voucher. Using the FHSP funds, HFH can address other barriers as well, such as first and last month deposits, furniture costs, and cost for housing to stabilize the individual while waiting for a permanent unit to become available.¹⁷ Using intermediaries to locate and contract for housing and supportive services, HFH funded 300 units in 2014 and expects to provide funding for 1200 units by the end of 2016. DHS has begun partnering with developers, the Los Angeles Housing Department (City) and housing financing agencies. Using either 4% or 9% Low Income Housing Tax Credits, a number of non-profit developers such as Skid Row Housing Trust and Meta capitalize on the rental subsidy provided by the FHSPV to develop new housing specifically targeting high-need, high users of the healthcare system selected by HFH (see insert). Although FHSPV are terminable on 30 days' notice, banks and tax credit investors appear willing to underwrite these projects, perhaps at least in part because the rental subsidies are coupled with significant capital investment from local government. To date, over 200 new units have been developed predicated upon DHS funding and another 1000 are in the pipeline expected to be occupied by 2019.

Tenant Selection

All tenants must be established DHS clients prior to referral, and must be both homeless and certified by their social worker as being disabled from either from medical or behavioral health causes. Most referrals come from social workers and case managers serving individuals in primary care clinics, behavioral health sites, hospitals and, recently, people exiting county jails. In addition, the citywide coordinated entry system uses a structured questionnaire to identify DHS clients who need supportive housing services, and refers them to HFH. The HFH intake team consists of three staff who assess each applicant by reviewing the referral packet and clinical records available in a centralized electronic medical record. Using clinical information available to the HFH staff, the clients most at risk of harm are prioritized toward housing. Following prioritization, HFH staff recommend housing in market rate units, master-lease SRO housing, or supportive housing properties. If the referred client can qualify for an HCV, the HCV is used in order to preserve more flexible local funds.



Source: Skid Row Housing Trust

The Accelerator Approach

In 2015 Mercy Housing decided to try to acquire and renovate housing by bypassing any public capital sources. Mercy Housing's decision was based on the fact that affordable housing subsidies are limited and their use can add significant time and cost to a project.

After consulting extensively with HFH staff, Mercy Housing proposed to acquire and convert 500 units to supportive housing over a five year period. Mercy Housing set two goals: 1) reduce costs to \$130,000 per unit in total development cost—well below the \$300,000 historically required to develop a new unit in LA County; and 2) reduce the development timeline from the current 3–4 years to 6–9 months.

After lining up debt and equity partners, in 2015 Mercy Housing entered into a purchase contract for a 182 unit “out of favor” tourist motel to convert it to housing with on-going rental and supportive services from FHSP. Rather than use LIHTC, this “accelerator” project hoped to combine an equity investment from Mercy Housing with mezzanine debt financing from the Kresge Foundation (Kresge) and a conventional, long-term loan from the Low Income Investment Fund (LIIF). The Kresge debt was anticipated to bear interest and be repaid in full.

Mercy projected that servicing the LIIF loan, amortizing the Kresge debt, and paying ordinary operating costs required a monthly rent of approximately \$1,400, or \$300 more than the Fair Market Rent (FMR) HFH was providing for similar units. With sufficient units already available in the market place at FMR, HFH did not want to commit to the higher rents.

The project revealed how difficult it has become to pursue non-traditional strategies to develop affordable housing. Mercy Housing was unable to avail itself of the State's property tax exemption (worth \$100 per unit per month) or density bonus laws without entering into a non-revocable 30-year deed restriction on the property. However, the long-term deed restriction is a significant deterrent to the use of private equity sources (non-LIHTC) and traditional debt. By binding the property to that use, it eliminates most exit strategies if the property were not successful as supportive housing.

In the end, the partners were unable to move forward with this structure. Mercy Housing considered developing the project using traditional 4% LIHTC with funding from HUD VASH and LA DHS, but unfortunately the hot real estate market moved too quickly and they were not able to complete the land use approval and community engagement processes before being outbid by a private buyer.

Skid Row Housing Trust is currently in the planning stage for the development of 54 studio units using a mix of FHSPV and project based Section 8 vouchers. The projected revenue using either subsidy type is identical (\$1086pu/pm) resulting in an estimated Sources and Uses as follows:

Sources

Conventional debt	\$1,957,957
Public (soft) debt.....	\$10,598,032
Grant	\$1,340,000
4% LIHTC Equity.....	\$8,300,968
Deferred Developer Fee.....	\$1,287,500
Total Sources.....	\$23,484,457

Uses

Acquisition.....	\$ 2,104,310
Hard Costs.....	\$13,032,696
Soft Costs.....	\$5,847,451
Developer Fee.....	\$1,500,000
Total Uses.....	\$23,484,457

The Role of the Housing Intermediary

HFH contracts with a non-profit, Brilliant Corners (BC), under a five year agreement to fund rental subsidies and to identify available units. Unlike other properties financed with LIHTC, there is no required long-term affordability restrictions for landlords renting associated with the program.

Clients are referred to BC, where staff assist them with choosing an available unit and with the move-in process. Clients sign a lease with the landlord, and both clients and landlords agree in writing to rules of occupancy. Rent is usually set at Fair Market Rents but can be higher to accommodate housing for people requiring special mobility access or other accommodations for their disability. Clients are expected to pay 30% of their income toward rent. DHS requires monthly placement reports and an annual audit of activities under the contract, but overall the administrative requirements imposed on the intermediary are less burdensome than those BC experiences when dealing with HUD vouchers.

Landlords were initially skeptical regarding reliance on FHSPV as the subsidies were untested and potentially short term. This perception has changed over time as landlords appreciate the program's ability to house tenants rapidly, provide move in assistance, reduce paperwork and regulatory involvement, fund rents at FMR or greater, and provide relationship management through BC.

Supportive services: HFH, through FHSP also provides contracted services at a rate of approximately \$400 per client per month for case management services. Thirteen behavioral health and supportive housing agencies provide assistance with housing application and move-in and on-site case management (counseling, assistance, eviction prevention, crisis management, obtaining benefits, linkage to psychiatric and primary care, accessing homemaker services, etc.). Every housed and pre-housed client is assigned a case manager with each case manager having no more than 20 clients at one time.

Lessons Learned

1. Focused, committed leadership capitalized on ACA expansion, to bring in significant new revenue to the county health system. This allowed LA DHS to expand housing options for homeless adults without creating a greater burden for the county budget.
2. By providing flexible funding, DHS increased the range of housing options it could use to house its homeless patients.
3. By matching a rental subsidy with supportive services, the program enhanced the likelihood of successful tenancy which is also critical to landlords and developers.
4. In contrast to HUD-funded vouchers, DHS was able to streamline the process for the locally funded vouchers, shortening the lease-up periods and reducing the administrative burden.
5. By using a housing intermediary to manage the landlord relationships and to assist with the landlord-tenant issues, HFH reduces bureaucratic red-tape and provides a consistent, known partner for landlords to help with issues that arise between landlords and tenants.
6. Reliance over time on the DHS budget setting process to continue to provide general funds leaves the program vulnerable to changes in DHS political oversight, budget priorities, and leadership.
7. The amount of subsidy limits its use to support the enhancement of services provided in connection with affordable housing that would have been created anyway. That is, the level of new affordable housing creation is still tied to the availability of tax credits.

Pay for Success Investment Targets Nursing Home Bound Seniors

Styglers Village, Ohio

Overview

The Center for Medicaid and Medicare routinely pays for nursing home care for people living with poverty. However, it is estimated that 10-20% of all seniors residing in a skilled nursing facility (SNF) could live in less restrictive environments if there were affordable alternatives to SNFs with wrap-around services.¹⁸ In 2013 an Ohio-based nonprofit, National Church Residences, attempted to leverage healthcare savings using a Pay For Success approach to pay for the development of an assisted living facility targeting seniors who could be discharged from more expensive SNFs. As the owner of Styglers Village (the Project), a 150-unit Section 8 assisted property in need of reinvestment, National Church Residences sought to use the opportunity presented by the recapitalization both to preserve 75 units as affordable housing serving seniors, and to reconfigure 75 units to create assisted living units for 75 individuals who would otherwise be housed in SNFs.

Although the project did not ultimately move forward, possibly because of the concern that the savings would not materialize due to the “woodwork effect,” the lessons learned may be valuable to others seeking to capture healthcare savings to support housing development.

Background and Context

A number of states have been given approval from CMS for 1915(c) (Home and Community-Based Services) Medicaid Waivers to experiment with using Medicaid funding to support nursing and home-maker services outside of institutions with the goal of doing so at lower cost than the cost of institutionalization. The Styglers Village initiative originated with a bipartisan effort by the State of Ohio to find savings in its healthcare expenditures. The Governor charged the Department of Health Transformation with identifying opportunities. Meetings were convened with various state agencies including the State Housing Finance Agency, and with interested philanthropic entities. National Church Residences was invited to participate in these discussions because of its institutional experience and credibility with all of the parties.

National Church Residences worked through the planning process with OHFA and the staff of the State Department of Medicaid. They anticipated receiving approval to move forward from the Director of the State Department of Medicaid in the Fall of 2013 and then approaching the State Legislature in early 2014 for inclusion of the requisite authorizing language in the 2014 Budget with construction to begin shortly thereafter. However, these last hurdles were never cleared.



The Model

National Church Residences' proposal relied on the eligible Medicaid recipients receiving an Assisted Living Waiver (ALW) in order to reside in their communities as an alternative to long-term, licensed healthcare facilities. Under the ALW, Medicaid would reimburse National Church Residences for services provided to residents enrolled in the ALW. The residents in the assisted living units at Stygler Village would continue to receive Section 8 assistance to cover rental support and use SSI support for the cost of food, etc.

National Church Residences, the Ohio Department of Medicaid, the Ohio Housing Finance Agency (OHFA), and The Kresge Foundation (Kresge) agreed to enter into a Memorandum of Understanding (MOU) establishing an arrangement similar to a Pay For Success transaction, with National Church Residences acting much like an intermediary allocating funds among the parties. The MOU established the following roles:

- National Church Residences committed that the Project would be licensed in Ohio as a Residential Care Facility (RCF) and that it would deliver health outcomes as good or better than residents typically achieve in SNFs. National Church Residences' performance would be monitored and would receive potential incentive payments upon reaching specified milestones.
- The recapitalization of the Project would employ traditional sources, 4% Low Income Housing Tax Credits, and conventional financing but these sources alone were insufficient to cover the additional development costs created by the assisted living conversion. OHFA agreed to fund this \$5.5 million gap upfront with a below-market 11-year term loan. National Church Residences planned to repay the loan over time based on savings achieved as the result of moving residents from a SNF to assisted living.
- Shifting 75 SNF residents to assisted living units was projected to reduce the cost of housing and care for these individuals by \$73 per person per day, or more than \$2 million annually. The difference between the ALW reimbursement rate and this reduced cost (the Savings) would then be available to National Church Residences for other purposes. 70% of the Savings were proposed to be used to repay the OHFA Loan, 20% of the Savings were to be remitted to the State of Ohio, and 10% were to be reserved to pay incentives to National Church Residences if it achieved quality outcome objectives. After the OHFA Loan had been paid in full, the Savings were to be divided 60% to the State of Ohio and 40% to a reserve fund which would then be available to pay National Church Residences for quality outcome incentives, and to fund additional affordable housing preservation efforts.
- Kresge agreed to guarantee payment of the OHFA Loan against the risk that some portion of the Savings would not be realized due to units being rented to individuals not qualified to receive the ALW.

The Challenge of Proving Savings

While no one can know for sure how the legislature would ultimately have reacted to the proposal, the Director of the State Department of Medicaid decided not to make the legislative request, and the effort to use ALW and OHFA funds was abandoned. Participants offer two possible explanations for this outcome: lack of departmental “bandwidth” and concern about achieving the Medicaid savings.

The time period in which this plan was under consideration coincided with the roll out of the Affordable Care Act and the possible expansion of Medicaid in Ohio. Along with other priorities, the circumstances did not, in the Director of Medicaid’s opinion, allow the Department to devote the necessary resources to the analysis, development and implementation of this new program.

Perhaps more importantly, because of its implications for other healthcare savings proposals, the Director of the Department of Medicaid was not convinced that the projected savings would actually be realized. Although the theoretical cost differential between delivering care in SNFs and RCF is objectively determinable, and while the per person per month cost difference between a SNF and an RCF is significant, the cost reductions for the entire system are realized only if the number of SNF beds or associated facility costs are actually reduced. As with other housing interventions proposed where there is more demand than supply, it is difficult to reduce healthcare costs by moving individuals to lower cost treatment options if the number of high cost treatment options (e.g. SNF beds) is back-filled from people waiting in the wings. In this case, the Director may have been concerned about the “woodwork effect” believing that the transfer of 75 patients would not result in closures or a reduction in the number of SNF beds, but would, more likely result in those SNFs or beds being occupied by new, eligible Medicaid recipients needing but not currently receiving this level of care due to the lack of openings in SNFs.

Without access to the Medicaid savings, National Church Residences was unable to obtain the OHFA Loan, and the decision was made to drop the assisted living units from the redevelopment plan. National Church Residences proceeded to apply for 9% Low Income Housing Tax Credits to develop the Project as 150 independent living units, successfully receiving an award in 2016.

Lessons Learned

1. National Church Residences’ proposed conversion of Stygler Village shows how the reduced cost of a RCF, as compared to an SNF, could generate major cost savings.
2. The use of a Pay For Success approach would have enabled health and housing agencies to accomplish a goal that neither could reach alone. The Department of Medicaid was not authorized to fund housing and OHFA could only do so if a new source of repayment were identified.
3. Foundations can be instrumental in overcoming perceived risk in innovative projects. Although National Church Residences was confident it could secure ALWs for the former SNF patients and generate cost savings on a per patient basis, OHFA conditioned its loan on receiving satisfactory financial assurance that the facilities residents would be eligible for ALWs. By guaranteeing the ALWs, Kresge enabled OHFA to offer National Church Residences a loan which it likely would not have made otherwise.
4. Relying on costs savings to pay for innovation is tricky. Comparing the rates charged at any two facilities does not necessarily capture actual savings unless it can also be shown that the higher cost facility will actually reduce staff or facility costs. Counting on closing facilities or laying off staff is problematic both because of institutional resistance and the likelihood that the now empty beds could be utilized by others not yet receiving needed care.

Along with other priorities, the circumstances did not, in the Director of Medicaid’s opinion, allow the Department to devote the necessary resources to the analysis, development and implementation of this new program.

Developmental Disability: From Institutional to Community-Based Care

State of California

Overview

In the 1990's, California made the decision to close State-run Developmental Centers (DCs) housing thousands of individuals with significant behavior and medical impairments due to developmental disabilities and relocating these individuals to small residential facilities in community-based settings. The State had previously leased some small residential facilities to house developmentally disabled individuals but this pool of housing could not meet the increased demand resulting from the DC closures, and the leased properties were always at risk of conversion to other uses as lease terms expired. In order to address this housing shortage, the State developed an innovative approach combining State funds with commercially available debt to leverage the State's ability to acquire and rehabilitate the needed housing. This new program was cost effective, significantly reducing the average annual institutional cost of \$850,000 per individual and providing the State with long-term control of the housing stock.

Background and Context

Prior to their closure, most adults in California with significant behavioral and medical impairments due to developmental disabilities were housed in State run DCs. Under the auspices of California's Department of Developmental Services a combination of State and federal health insurance programs and other public expenditures paid for room and board as well as medical, psychiatric and attendant care to maintain housing and services. By the 1960s, more than 13,500 adults were housed at five overcrowded DCs throughout the State with over 3,000 additional individuals awaiting placement.¹⁹

Considerable advocacy on the part of families of those with developmental disabilities resulted in a movement to find community alternatives to institutional care. Between the late 1960's and the present, the State has gradually closed the DCs and shifted funding to community-based housing with wrap-around services. For example, Agnews Developmental Center (Agnews) in Santa Clara, the main center for Northern California transitioned from housing 978 adults in 1978 to none by 2009. The vast majority of tenants were placed i

small homes (of between 4-15 residents) throughout the Bay Area. Along with the advocacy of families, a key motivation of this shift was cost reduction. When it was operating near capacity, the average annual cost to serve each Agnews resident was \$850,000, considerably more than the average cost for providing housing and wrap-around services in the community.

Historically, DCs housed most of this population, but some community-based housing had been leased, usually from family operators who owned one or more homes operated as Residential Care Facilities (RCFs). These providers could not meet the increased demand created by the DC closures and where leases in the community did exist, the State was always at risk that these privately-owned facilities could be lost to the system at any time should the owners pursue another use for the properties.



Source: Eugene Zelenko

The Model

Procurement regulations made it impractical for the State to purchase the properties directly in the competitive open market. Instead, the State adopted a novel strategy to provide the necessary funding through a network of state-run Regional Centers which had previously been created to oversee the housing for this population. The Regional Centers created and funded non-profits to take title to the properties, rehabilitate them and procure services²⁰ pursuant to the protocol outlined below and referred to as the “Buy-it-Once” strategy:

1. Individualized Program Plans (IPPs)/Community Placement Plans (CPPs): A specific plan outlining housing and service needs was developed for each DC resident. The IPPs were then aggregated to create Community Placement Plans (CPPs) that detailed the types and locations of housing that would be needed.
2. Request for Proposals: The Regional Centers issued requests for proposals (RFPs) to acquire the housing required by the CPPs. Bidders were the non-profit entities created by the Regional Centers.
3. Capital Contribution and Debt: The RFPs included commitments by the Regional Centers to provide capital contributions to the winning bidders to be used to partially pay for the cost of acquisition and rehabilitation of properties. Contributions were generally set at 20% of the anticipated needs (although higher amounts were offered in areas with high housing costs) and the successful bidders were required to borrow the balance of the funds with debt secured by the properties.
4. Restrictive covenants: In consideration of the State’s capital contributions, the acquiring entities executed and recorded against the property a restrictive covenant that prohibited in perpetuity its use in any manner other than to house people with developmental disabilities. The covenant is subordinate to the acquisition and rehabilitation financing, so in the event of a foreclosure lenders would be free to sell the properties without the use restriction.

5. Services and operations: Under a separate procurement, the Regional Centers retained independent for-profit or non-profit entities at each property to provide all of the necessary wrap-around services. Ongoing funding for wrap-around services and rent payments is provided by the Regional Centers to independent service providers. These funds come primarily from Medicaid through an ongoing 1915(c) Home and Community-based waiver with 62.5% of the funding from the Centers for Medicaid and Medicare and the remainder coming from the State. Room and board costs are covered by clients' SSI payment which was typically about \$1,000/month. Clients contribute their SSI payment to the service provider directly and, in turn, the service providers pay rent to the property owners which is sufficient to service the debt, to pay the cost of on-going operations including property taxes and to fund reserves for future capital needs.²¹

6. Service providers, both non-profits and more commonly for-profits, range in size from organizations that serve clients in 3-4 facilities to large institutions serving clients in hundreds of facilities across the State. Service providers are responsible for all on-site professional services including assistance with activities of daily living, such as food purchase and preparation, assistance arranging transportation to day treatment programs, hygiene assistance and overall care coordination services. There is a wide range of cost for service provider functions ranging from \$6,000 to \$15,000 per client per month for clients that need extensive assistance with ADLs (median monthly costs of approximately \$10,000/month). The rental payments are in the range of \$2,000/client/month for a 4-bedroom single family home in the San Francisco Bay Area. The amounts paid to the service providers and to the non-profit housing providers are fixed for the term of the agreements.

Population Served

As each DC was targeted for closure, the housing and service needs of the adult living in the DCs were assessed. DC staff together with a client's family, Regional Center staff and representatives from the housing and service providers would meet to develop an IPP detailing housing and service plans with the goal of achieving a successful placement for the individual in the community. The IPPs were then rolled up, creating CPPs. Regional Centers worked with housing providers, in an iterative process, to identify homes for acquisition and rehabilitation that were needed to implement the CPPs.²² In the case of Agnews, after legislative approval, Golden Gate Regional Center issued RFPs to acquire 71 existing residential properties and rehab them to meet the needs of the CPPs. Agnews, which housed over 900 individuals, was the first large DC closure. By April 2009, most Agnews residents had been placed in the community (a few were transferred to other DCs). During this period, adults with developmental disabilities who were living with their family or aging out of homes targeting youth were "deflected" from entering DCs, and were placed directly into the community as dictated by their IPPs. After closure, the Agnews property was sold with the profits contributed to the State general fund. This same approach has been used to close other DCs.

Lessons Learned

1. It is cost-effective to house the developmentally disabled population in community facilities rather than institutions.
2. The establishment of fiscal intermediaries (Regional Centers, housing providers and service providers) allows State and federal healthcare funds to be used more flexibly than when funding flows directly from government agencies.
3. State capital contributions can be leveraged with commercial debt to expand the pool of housing for the developmentally disabled.
4. State capital contributions coupled with restrictive covenants enables the State to secure long term control of a portfolio of housing.
5. Flexible capital and operating support allows housing providers to acquire a variety of housing stock that is specifically tailored to individuals.
6. Establishing fixed long-term payments for rents and services without escalations provides the State with greater certainty regarding future costs by transferring the risk of unanticipated costs and future cost increases to the providers. An unintended consequence may be that initial payments to the providers are set higher than those justified by current costs in order to protect against these contingencies.

Conclusion

This report on innovative approaches to funding health and housing initiatives and the attendant convening grew out of a collaboration between Mercy Housing and LIIF. Our two organizations have worked on both the project and policy level to pilot new approaches to funding health and housing ventures. From our vantage point, the community development, housing and health fields are increasingly coming together around shared goals and vision, however, the translation from vision to real-world practices has been harder than many had anticipated. From our efforts grew the desire to accelerate that process and give more real-world examples of success to practitioners hungry to take the next step.

The paper highlights nine case studies where healthcare, funds are used to expand permanent housing and/or prioritize housing towards people who are high users of the healthcare system. Taken together, they demonstrate the tremendous opportunity that exists today to implement partnerships even within the regulatory constraints of mainstream health and housing funding programs. The tools of affordable housing such as the Low-Income Housing Tax Credit and rental vouchers from HUD are being deployed more and more effectively to help provide homes to people whose health is dependent on stable housing. Likewise, many public health agencies and some private providers and insurers are finding ways to invest in services and occasionally in housing itself to improve the health of their patients/members. Given the size of the healthcare system (estimated at \$1.3 trillion annually), a diversion of even a small percentage of healthcare dollars can have a large impact on housing development.

The case studies share several common themes. First, most of the case studies focus on “high utilizers” of healthcare in large part because providing service-enriched housing is the most accessible financial model today for overcoming the structural obstacles and financial disincentives to cross-sectoral collaboration as the costs for this population are intensely concentrated among both people and providers making it easier for today’s payers to benefit from their investment. These case studies largely demonstrate that the progress that is being made today occurs despite the persistent prohibitions in Medicaid on spending money on rental subsidies or housing construction, the disincentives in the managed care rate-setting process that effectively penalize investment in housing.

Secondly, all the programs depend on strong local leadership that is committed and focused on improving the health of the population through expansion of housing options. This leadership is critical because neither the housing nor the health world has yet to make fundamental shifts to enable cross-sectoral work. Therefore, to make progress today despite the barriers takes courageous healthcare and community development leaders that align their missions and expand housing for the goal of improving the health of some of the most vulnerable in our communities.

Finally, many of the case studies demonstrated the importance of developing strong cross-sector relationships. Time and again, long standing relationships that build on trust, a common vocabulary and shared purpose provided fertile ground for innovation. Barriers that stymied either health or housing stakeholders, were overcome through partnership.

We shared a draft of this paper with a group of 70 health, housing, finance and philanthropy leaders at a convening held at The California Endowment to help chart a path forward. For many of us, it was an important reminder that while we haven’t cracked the code for the puzzle as a whole, there are plenty of encouraging signs. One of those signs is the participation of multiple double agents— health organizations or community development corporations with departments created specifically to implement this cross-sectoral work. It was also clear that many traditional housing and community development organizations are now able to describe themselves in the language of public health, greatly improving the chances for cross-sectoral communication.

Our two organizations have worked on both the project and policy level to pilot new approaches to funding health and housing ventures.

As the participants reflected on the paper, they noted the need for new actions in order to move forward from today's case studies:

1. Because there is so much unmet need in our communities for both medical care and housing, we need to acknowledge that our strategies may not produce short-term cost savings. The value of increased capacity in the face of unmet demand creates real value that should be recognized in evaluating the impact of housing on healthcare.
2. While nearly everyone acknowledges the importance of social and environmental determinants on the future health of young people, there are relatively few short-term cost saving opportunities that would encourage the right types of interventions today. Because of this, we need to develop a set of early or sentinel indicators that will help government, philanthropy, health and the housing sectors to coalesce around the right early interventions that positively impact child development.
3. Because there remains legitimate disagreement on whether Medicaid should pay for housing costs, it may be more useful to create silo-busting initiatives at the State and Federal levels. Examples include both traditional appropriated efforts like the HUD Veterans Affairs Supportive Housing (VASH) program which could be expanded or replicated to serve non-veterans who are homeless or individuals in skilled nursing that could live in lower-cost community settings. Other options include pay-for-success initiatives that can overcome regulatory barriers to serve a wide variety of challenging populations such as emancipating foster youth, formerly incarcerated individuals and seniors who are stuck in nursing homes due to lack of other housing options.
4. Now that there is significant understanding and action on ending chronic homelessness (aka. the "downstream"), we also need to place resources and strategies on "midstream" interventions focused on the people likely to have significant health challenges and become expensive in the future. Examples include rapid rehousing programs for people experiencing homelessness and the rapidly spreading efforts to have trauma-informed practices in schools, housing and other settings.
5. Likewise, we know that social determinants of health play a huge factor in downstream illness, but most of our health agencies are not rewarded for intervening at "upstream" locations to promote individual and population-based health. To move upstream, we likely need different structures and financial incentives than we have today. To that end, we should encourage payment reforms that enable and encourage insurers and health providers to invest in programs that attend to the social determinants of health such as housing and other community development interventions. Examples include reforming managed care rate setting to incentivize longer-term investments in housing, value-based purchasing, including housing in expenditures that are considered "medically necessary" and supporting the IRS to encourage hospitals to use community benefits funds for housing.
6. The case for innovation and reform is best made based on furthering the triple aim, not cost savings alone. However, we still need to get better data and evidence if we are going to facilitate more cross-sectoral partnerships. For example, we may know who the high utilizers of the health care system are today but few models have been developed that predict who will be high-utilizers in the future. If we want to use our healthcare dollars for housing most efficiently and with the greatest impact, we need to use better data to write the correct "housing prescriptions."

At the conclusion of the convening, David Erickson of the San Francisco Federal Reserve related Adam Smith's description of the early islands of capitalism in the sea of feudalism. He analogized this to the current moment and suggested that we need to find islands of innovative population health business models in the sea of today's healthcare practices. To make progress, we need to identify and support those seemingly isolated models where upstream investments in the social determinants translate into downstream outcomes, ideally creating alignment between investors and beneficiaries. The resulting proliferation of successful models can ultimately influence and perhaps even alter our mainstream practices.

Finally, we should recognize that in the long-term, the fields of community development, housing, and health are coalescing around shared ideas and goals. We need to continue to build a vocabulary that speaks to all three legs of the Triple Aim. If we can move beyond just cost savings to embrace quality improvement and consumer satisfaction as equally important goals, we can greatly increase the chances of moving closer to the day when the boundary between our fields stops being an impediment to improving the health of our communities.

Acronym List

ACA

Affordable Care Act

ACO

Accountable Care Organization

ADA

Americans with Disabilities Act

ADL

Activities of Daily Living

ALW

Assisted Living Waiver

BC

Brilliant Corners

BLTC

Burlingame Long Term Care

CCAH

Central California Alliance for Health

CCC

Central City Concern

CCI

Coordinated Care Initiative

CCSP

Community Care Settings Pilot

CHNA

Community Health Needs Assessment

CMS

Center for Medicare and Medicaid Services

COHS

County Organized Health System

CPPs

Community Placement Plans

DAH

Direct Access to Housing

DBHIDS

Department of Behavioral Health and Intellectual disAbility Services

DHS

(Los Angeles) Department of Health Services

DHS

Department of Health Services

DPH

(San Francisco) Department of Public Health

FHSP

Flexible Housing Subsidy Pool

FMAP

Federal Medical Assistance Percentage

FMR

Fair Market Rent

FQHC

Federally Qualified Health Center

FSHPV

Flexible Housing Subsidy Pool Voucher

GRH

Group Residential Housing

HCBO

Hospital Community Benefit Obligation

HCMC

Hennepin County Medical Center

HCV

Housing Choice Vouchers

HFH

Housing for Health

HH

Hennepin Health

HPSM

Health Plan of San Mateo

HUD

Housing and Urban Development

IOA

Institute on Aging

IPPs

Individualized Program Plans

IRS

Internal Revenue Service

LAHSA

Los Angeles Homeless Services Authority

LIHTC

Low Income Housing Tax Credit

LIIF

Low Income Investment Fund

LTSS

Long-Term Services and Supports

MCGP

Medi-Cal Capacity Grant Program

MCO

Managed Care Organization

MOA

Memorandum of Understanding

MOH

Mayor's Office on Housing

OHFA

Ohio Housing Finance Agency

RCF

Residential Care Facility

RFP

Request for Proposal

SNF

Skilled Nursing Facility

SRO

Single Room Occupancy

SSI/SSDI

Supplemental Security Income / Social Security Disability Income

VASH

Veterans Affairs Supportive Housing

Glossary

501(c)3

A type of tax-exempt nonprofit organization in the United States.

1115 Medicaid Demonstration Project

Payment vehicles that states can use to test new or existing ways to deliver and pay for healthcare services in Medicaid.

1915(c) Medicaid Waiver

Home and Community-based Waivers (aka Assisted Living Waivers) that first became available in 1983 when Congress added section 1915(c) to the Social Security Act, giving States the option to receive a waiver of Medicaid rules governing institutional care.

Accountable Care Organization (ACO)

Groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

ADA Compliant

Complies with the Americans with Disabilities Act (ADA) of 1990. The Americans with Disabilities Act of 1990 is a comprehensive civil rights act for people with disabilities

Activities of Daily Living (ADL)

Routine activities that people tend to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence.

Affordable Care Act (ACA)

A United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010. Among other aspects, for the 26 expansion states and the District of Columbia, it provides Federal funding to provide access to insurance for all people below 138% of the federal poverty level.

Affordable Housing

In general, housing for which low-income occupants are paying no more than 30 percent of their income for gross housing costs, including utilities (From HUD website).

Assertive Community Treatment Program

Multidisciplinary mental health teams that provides voluntary psychiatric care and case management in the community for people living with severe and persistent mental illness.

Assisted Living Waiver (ALW)

See 1915c waiver.

Behavioral Healthcare

Mental health and substance use treatment and services.

Capitated Rate

A payment arrangement for healthcare service providers such as physicians or managed care organizations. It pays a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

Chronic Homelessness (Federal definition)

A person who is "chronically homeless" is an unaccompanied homeless individual with a disabling condition. -who has either been continuously homeless for a year or more or has had at least four (4) episodes of homelessness in the past three (3) years that together add up to more than one year.

Coordinated Care Organization

Networks of all types of healthcare providers who have agreed to work together in their local communities for people who receive healthcare coverage under the Oregon Health Plan (Medicaid). Synonymous with Accountable Care Organization.

County Organized Health System (COHS)

A local agency created by a county board of supervisors to contract with the Medi-Cal program for offering a value-based medical service delivery system.

Dual Eligible Individuals

Single adults who qualify for both Medicare and Medicaid.

Fair Market Rents (FMR)

The 40th percentile of gross rents for typical, non-substandard rental units occupied by recent movers in a local housing market (From HUD website).

Federal Medical Assistance Percentage (FMAP)

Are the percentage rates used to determine the matching funds rate allocated annually to certain medical and social service programs in the United States of America

Federal Poverty Level

This measure, set by the U.S. government, recognizes poverty as a lack of those goods and services commonly taken for granted by members of mainstream society.

Federal Qualified Health Center (FQHC)

AKA Community Health Center (CHC) is a primary care center that is community-based and patient-directed. By mission and design, CHCs exist to serve those who have limited access to healthcare.

Fee-Based Systems

Medical reimbursement systems that pay per visit rather than per member over a set period of time.

Full Risk Provider

A medical deliver system where Medicaid contracts with another organization to assume financial responsibility for all the enrollees' medical claims and for all incurred administrative costs (including long term care).

Harm Reduction

The practice where providers work in concert with clients to help them reduce harm from drug addiction and where systems of care do not exclude clients because of on-going drug use or non-compliance with medication.

Health Home

(Aka Medicaid health home) — as defined in Section 2703 of the Affordable Care Act — offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders.

Housing Choice Voucher (HCV)

The housing choice voucher program is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. A housing subsidy is paid to the landlord directly by the local Public Housing Authority on behalf of the participating family. The family then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. Housing choice vouchers are administered locally by public housing agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program. (From HUD website)

Housing First

A homeless assistance approach that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible – and then providing voluntary supportive services as needed. Typically, it does not exclude people from housing because of on-going substance use or mental illness.

HUD VASH

A collaborative program between HUD and VA combining HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing. (From HUD Website)

Low income Housing Tax Credits 4% and 9% (LIHTC)

The low-income housing tax credit (LIHTC) program is one of the federal government's primary policy tools for encouraging the development and rehabilitation of affordable rental housing. These non-refundable federal housing tax credits are awarded to developers of qualified rental projects via a competitive application process administered by state housing finance authorities. Developers typically sell their tax credits to outside investors in exchange for equity. Selling the tax credits reduces the debt developers would otherwise have to incur and the equity they would otherwise have to contribute. With lower financing costs, tax credit properties can potentially offer lower, more affordable rents. The LIHTC is estimated to cost the government an average of nearly \$6 billion annually. (Congressional Research Service).

A 9% tax credit covers new construction projects that use additional subsidies or rehab projects that include the cost to acquire existing buildings. Partnerships that are seeking an allocation of nine percent LIHTC must submit an application to the state housing agency, which reserves a portion of total tax credits for partnerships with the best applications.

A 4% tax credit supports new construction projects without any additional federal subsidies. To obtain this type of tax credit, a partnership must first apply for tax-exempt bonds to be issued on its behalf. An allocation of bonds leads to a non-competitive application process for the tax credits. (From US Bank website)

Master Lease

The controlling lease that allows the lessee to sub-lease portions of the property for a period within the master lease's term.

Managed Care Organization (MCO)

An independent medical firm that organizes health services for a defined population as an intermediary between insurance (e.g. Medicaid) and providers and is designed to improve quality of care while containing costs.

Medicaid

A combined Federal and State healthcare program that assists low-income families or individuals in paying for long-term medical and custodial care costs. Medicaid is a joint program, funded primarily by the federal government and covers doctor visits, hospital expenses, nursing home care, home healthcare, and the like. Medicaid also covers long-term care costs, both in a nursing home and at-home care. The Federal contribution to Medicaid varies from state to state and ranges from 50.7% (Virginia) to 79.6% (Kentucky) - (From Kaiser Family Foundation website).

Medi-Cal

California's Medicaid program.

Medicare

The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease. Medicare covers some of the cost of doctor visits, hospital expenses, nursing home care (usually restricted to the first 100 days in a SNF) and home healthcare.

New Market Tax Credits

A program to attract private capital into low-income communities by permitting individual and corporate investors to receive a tax credit against their federal income tax in exchange for making equity investments in specialized financial intermediaries called Community Development Entities (CDEs).

Permanent Supportive Housing

A model that combines low-barrier affordable housing, healthcare, and supportive services to help individuals and families lead more stable lives. PSH typically targets people who are homeless or otherwise unstably housed, experience multiple barriers to housing, and are unable to maintain housing stability without supportive services (From National Healthcare for the Homeless Council website).

Public Housing

A program established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered single family houses to high rise apartments for elderly families. There are approximately 1.2 million households living in public housing units, managed by some 3,300 housing agencies (HAs). The U.S. Department of Housing and Urban Development (HUD) administers Federal aid to HAs that manage the housing for low-income residents at rents they can afford. (From HUD website).

Recuperative Care Units

Synonymous with Medical Respite - acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Medical respite care is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. (From National Healthcare for the Homeless Council website)

Residential Care Facility (RCF)

AKA Board and Care or Assisted Living Centers- non-medical facilities that provide room, meals, housekeeping, supervision, storage and distribution of medication, and personal care assistance with basic activities like hygiene, dressing, eating, bathing and transferring. This level of care and supervision is for people who are unable to live by themselves but who do not need 24-hour nursing care. They are considered non-medical facilities and are not required to have nurses, certified nursing assistants or doctors on staff.

Scattered Site Project

Refers to a form of housing in which units are scattered throughout neighborhoods or metropolitan areas. It can take the form of single units spread throughout the city or clusters of family units. (From Wikipedia).

Section 8

Section 8 of the Housing Act of 1937 (42 U.S.C. § 1437f), authorizes the payment of rental housing assistance such as housing choice vouchers to private landlords. (From HUD Website).

Single Room Occupancy (SRO)

A form of housing in which one or two people are housed in individual rooms (sometimes two rooms, or two rooms with a bathroom or half bathroom) within a multiple-tenant building. SRO tenants typically share bathrooms and/or kitchens, while some SRO rooms may include kitchenettes, bathrooms, or half-baths. Although many are former hotels, SROs are primarily rented as permanent residences. (From Wikipedia).

Single-Site or Project-Based Project

A rental project developed in one contiguous location as compared to a Scattered Site Project.

Skilled Nursing Facility (SNF)

AKA Nursing Home- A facility licensed by the state that provides 24 hour nursing care, on-site physician services, room and board, medication management and 24 hour supervision for people unable to perform routine activities of daily living.

Super-Utilizer

A subset of individuals who use considerably greater than the average amount of healthcare resources. Typically, super utilizers have multiple medical and/or psychiatric conditions and are less than 5% of the population but use more than 50% of the total healthcare resources.

Supplemental Security Income (SSI)

A nationwide federal assistance program for aged, blind, and disabled individuals with low incomes.

Triple Aim

Improving the US healthcare system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare.

Value-Based Systems

A medical reimbursement system that is organized to prioritize population-based care rather than individual-based care. Typically uses an upfront annual capitated payment system rather than a “pay as you go” system where insurance reimburses each individual visit to a hospital or medical provider.

End notes

¹ Gawande A, Tell Me Where it Hurts, The New Yorker, January 23, 2017

² Out of Reach 2016, National Low Income Housing Coalition. http://nlihc.org/sites/default/files/oor/OOR_2016.pdf

³ Ibid

⁴ Gawande A, Tell Me Where it Hurts, The New Yorker, January 23, 2017

⁵ Most of the contributors have committed to fund the initial stages out of a longitudinal study of patient performance at the projects, which will be conducted by the research division of one of the health systems. CCC has committed to cooperate in the data collection.

⁶ <https://www.nhchc.org/wp-content/uploads/2016/06/policy-brief-hospital-community-benefit.pdf>

⁷ <https://www.irs.gov/charities-non-profits/exempt-organizations-update-archive> (December 18, 2015 entry)

⁸ A community development corporation (CDC) is a not-for-profit organization incorporated to provide programs, offer services and engage in other activities that promote and support community development. CDCs usually serve a geographic location such as a neighborhood or a town. They often focus on serving lower-income residents or struggling neighborhoods. They can be involved in a variety of activities including economic development, education, community organizing and real estate development. These organizations are often associated with the development of affordable housing. (Wikipedia).

⁹ <http://kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?currentTimeframe=0>

¹⁰ Population and income data collected from US Census and American Community Survey data as of November 2016

¹¹ Based on HPSM membership figures as of November 2016

¹² Despite the initial concern, BLTC ultimately did not close and continues to provide SNF services.

¹³ Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field, Office of the Assistant Secretary for Planning and Evaluation, US Government, Health and Human Services, 8/20/2014

¹⁴ DAH buildings vary in the ratio of client to case manager from 37:1 to 16:1, neighborhood (city core to less central areas, quality of housing (renovated SRO vs. new construction), senior restricted sites vs. general population and on-site medical services.

¹⁵ Bamberger J, Dobbins SK. A research note: Long term cost effectiveness of placing seniors in permanent supportive housing. *Cityscape*. Vol 17, No 2, 2015, pp 269-277.

¹⁶ Weitzman, et al

¹⁷ FHSPVs are also available to house cohorts of the chronically homeless population that the various HUD vouchers are legally barred from serving; those with criminal histories, sex offenders and undocumented.

¹⁸ John Shen, Director of Long-term Care, State of California

¹⁹ History of Developmental Disabilities Service System in California at <http://arcanet.org/pdfs/HistoryOfSystem.pdf>

²⁰ In the Bay Area, Brilliant Corners was created as the vehicle for acquiring, rehabilitating and operating most of these properties.

²¹ Property management fees are not included in the lease payment but are paid separately under a contract between the Regional Center and the property owner.

²² During the initial expansion of housing to serve people exiting Agnews, the acquisition and rehab was financed with the support of a guaranty from the State. The Bank of America provided \$121 million in construction loans for purchase and rehab of 71 properties. These loans were ultimately repaid with proceeds from a State bond issuance. Guaranties and payoffs are no longer available in association with the new RFPs. One of the non-profits proving housing, Brilliant Corners, reports that it has been successful in obtaining 30 year fixed rate financing on terms consistent with current mortgage financing for each of its properties through commercial banks and community development finance institutions.





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