Health and Housing Strategy for Virginians with Serious Mental Illness:

A Report to the General Assembly

Submitted by Department of Housing and Community Development – January 2019

Table of Contents

Executive Summary

Permanent Supportive Housing (PSH) is an evidence-based practice that meets the housing preferences of many individuals with serious mental illness (SMI) and demonstrates positive outcomes such as reduced hospitalizations and homelessness, increased housing stability, and improved behavioral and physical health. Data from the Virginia Department of Behavioral Health and Development Services' PSH program demonstrates positive results in all of these areas. These outcomes avoid costs associated with use of expensive systems such as psychiatric in-patient facilities, emergency departments and corrections facilities and helps the state comply with the Americans with Disabilities Act and *Olmstead*.

Both the General Assembly and Governor Northam recognize the benefits of PSH. In 2017, the General Assembly requested the Department of Housing and Community Development (DHCD) work with state agencies and other stakeholders to develop and implement strategies to expand PSH for individuals with SMI. In November 2018, Governor Northam issued Executive Order 25, recognizing Virginia's unmet housing needs and highlighting the need for PSH as a top priority.

At the request of the Deeds Commission, DBHDS assessed the need for PSH for adults with serious mental illness who need PSH to address extreme crises such as long-term homelessness, institutionalization, and frequent use of emergency services and criminal justice interventions. DBHDS's assessment established a need for 5,000 PSH units. The Administration's Interagency Leadership Team (ILT) supports efforts to address this need, consistent with the Governor's EO 25.

This report to the General Assembly by DHCD lays out in detail services and housing recommendations to continue to expand PSH to meet the long-term 5,000-unit need. Meeting this need will require leadership and commitment of state and local public and private entities to make rental units available and affordable and to provide supportive services including tenancy supports.

Annual Report on Housing Strategies for Virginians with Serious Mental Illness

The following report complies with 2017 Budget Bill language Item 108#1c - Commerce and Trade – Department of Housing and Community Development

Page 96, after line 9, insert:
"H. The Department of Housing and Community Development (DHCD) shall develop and implement strategies, that may include potential Medicaid financing, for housing individuals with serious mental illness. DHCD shall include other agencies in the development of such strategies including the Virginia Housing Development Authority, Department of Behavioral Health and Developmental Services, Department of Aging and Rehabilitative Services, Department of Medical Assistance Services, and Department of Social Services. The Department shall also include stakeholders whose constituents have an interest in expanding supportive housing for people with serious mental illness, including the National Alliance on Mental Illness Virginia, the Virginia Housing Alliance and the Virginia Sheriff's Association. An annual report on such strategies and the progress on implementation shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees by the first day of each General Assembly Regular Session."

Background

General Assembly Request

Through budget language, the 2017 General Assembly charged the Department of Housing and Community Development (DHCD) with developing and implementing strategies to increase permanent supportive housing (PSH) for individuals with serious mental illness (SMI). The General Assembly indicated that strategies could potentially include Medicaid financing and directed DHCD to include other agencies in the development of strategies, naming the Virginia Housing Development Authority (VHDA), Department of Behavioral Health and Developmental Services (DBHDS), Department for Aging and Rehabilitative Services (DARS), Department of Medical Assistance Services (DMAS), and Department of Social Services (DSS) (Item 105 H). Further, the General Assembly required DHCD to include stakeholders whose constituents have an interest in expanding supportive housing for individuals with SMI, naming the National Alliance on Mental Illness of Virginia, the Virginia Housing Alliance and the Virginia Sheriff's Association. Finally, the General Assembly required DHCD to provide an annual report on such strategies and the progress on implementation to the Chairmen of the House Appropriations and Senate Finance Committees. This report is the second DHCD report to the General Assembly in response to its charge to develop PSH strategies.

Initial Work

DHCD began this important planning process in June 2017. During the first year of this work, DHCD secured the technical assistance of the Technical Assistance Collaborative (TAC), PSH subject matter experts, and assembled and held three meetings with the “Strategy Group”, comprised of the named state agencies and stakeholders, as well as other interested parties.

DHCD also provided the General Assembly a report on first year activities. This report detailed the initial planning phase for the expansion of PSH for Virginians with SMI and outlined recommendations for expanding PSH for Virginians with SMI. The first report was provided to the General Assembly in January 2018 and can be found at: https://rga.lis.virginia.gov/Published/2018/RD12/PDF

Implementation

As described in detail in this report, during 2018 DHCD, working with state partner agencies and the Strategy Group, began to implement many of the first report recommendations. General Assembly approval of Medicaid expansion and Executive Order 25 were not anticipated by the first report; therefore, this report includes planning for how these two critical initiatives can be aligned with other recommendations to expand PSH for people with SMI.

Permanent Supportive Housing

What is PSH?

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) describes PSH as "decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible supports and services designed to meet tenants' needs and preferences.[1]" PSH is affordable rental housing that may be scattered site or single site. Support services are available to tenants but not required and PSH is not a treatment setting. PSH is a cross-system approach that requires tactical use of resources.

Housing must be safe, decent and affordable. Housing affordability is a critical issue for states working to comply with Americans with Disabilities Act of 1990, as amended (ADA) requirements because most individuals with significant disabilities rely primarily on federal Supplemental Security Income (SSI) payments that average only 20 percent of median income nationally. Nowhere in the U.S. can a person with a disability on SSI afford housing at the Fair Market Rate[2]. Affordability is created with capital to write down the cost of acquisition, development or rehabilitation of housing and rental or operating assistance to ensure tenants pay only what they can afford for rent. The tenant's limited income also means it is difficult to save for payment of a security deposit, utility hook-ups or furnishings and tenants often need assistance with these one-time costs as well.

Services are essential to assist individuals with SMI in gaining access to and transitioning to housing, and for successfully sustaining PSH. PSH programs generally provide tenancy supports to help individuals maintain successful tenancies and connect tenants with community-based organizations for health care, mental health, substance abuse (mental health and substance abuse hereafter collectively referred to as behavioral health) and other services. States have options for how to deliver and fund PSH services. It is critical to ensure services are readily available when needed and available for a long as the individual wants and needs them.

System Supports are essential, to serve as the "glue" that makes PSH work. The delivery of housing and services requires the collaboration of systems that use different language, rely on different funding sources and have different measures of accountability. Collaboration and strategic planning at multiple levels including the state, regional, and local are critical to the development and management of system supports. Each system's roles and responsibilities need to be clear and accountable at the planning stage to ensure the needed collaboration and communication is functional when programs are ready for implementation.

[1] SAMHSA (2010). Permanent Supportive Housing Evidence-Based Practices (EBP) Kit. PowerPoint Presentation: http://store.samhsa.gov/product/SMA10-4510.
[2] Priced Out 2017, Technical Assistance Collaborative.

An Evidence-Based Practice

SAMHSA has identified PSH as an evidence-based practice (EBP) for individuals with SMI. Research has shown the cost-effectiveness of the PSH model, particularly for people with extensive or complex needs such as those with co-occurring mental health and substance use disorder conditions who often experience homelessness, or who are frequent users of costly institutional and emergency care[3]. Research has also demonstrated positive impacts of PSH on housing stability, health, and behavioral health[4]. In one review of existing research studies, a consistent finding emerged that the "provision of housing had a strong, positive effect in promoting housing stability and reducing homelessness."[5]

Other federal agencies, including the Department of Housing and Urban Development (HUD), the Center for Medicare and Medicaid Services (CMS), the Department of Justice (DOJ), and the US Interagency Council on Homelessness (USICH) recognize PSH as a best practice. HUD and CMS for example, have programs or projects in place to promote PSH. HUD has provided funds annually to Continuums of Care serving chronically homeless individuals – the vast majority of whom have SMI - to expand PSH. As costs for institutional settings have grown, and alternative service approaches emerged, CMS recognized and promoted options for states to shift, when appropriate, the care of individuals in nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs) to more inclusive and less costly community-based alternatives. Initiatives such as Money Follows the Person and the Balancing Incentive Program, as well as Home and Community-Based Services (HCBS) Waivers became popular tools to assist states in reducing reliance on institutional settings. In January 2014, CMS put in place the HCBS Waiver "Settings Rule" that provided strong incentives for state Medicaid agencies and their Mental Health and Intellectual/Developmental Disabilities counterparts to develop and promote integrated community-based housing for individuals with disabilities. In June 2015, CMS issued an Informational Bulletin clarifying that while Medicaid cannot pay for room and board, the program can assist states with coverage of certain housing-related activities and services.[6] The bulletin was intended to assist states in designing Medicaid benefits, and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities, with the goal of promoting community integration for individuals with disabilities, older adults needing long-term services and supports (LTSS), and those experiencing chronic homelessness.

---

[3] Culhane, D. P. et al. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, *13*(1):107–163
Larimer, M. E. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *The Journal of the American Medical Association 301*(13):1349
Chalmers McLaughlin, T. (2010). Using common themes: Cost-effectiveness of permanent supported housing for people with mental illness. *Research on Social Work Practice*, *21*(4):404–411.

[4] Rog, D. et al. (2014). Permanent supportive housing: Assessing the evidence. *Psychiatric Services 65*(3):287-294
Padgett, et al. (2011). Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with Treatment First programs. *Community Mental Health Journal 47*(2):227–232.
Wolitski et al. (2009). Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV. *AIDS and Behavior 14*(3):493–503.

[5] Rog, D. et al. (2013). Permanent supportive housing: Assessing the evidence. *Psychiatric Services 65*(3):290.

[6] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf

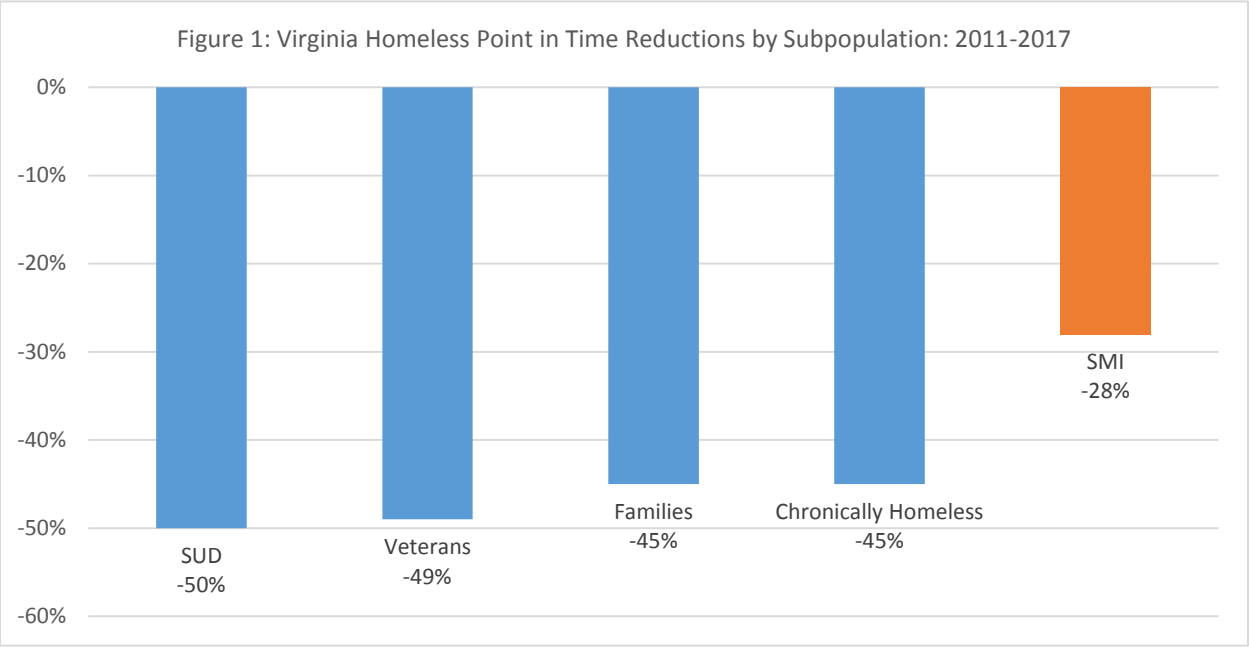
Prioritizing the housing needs of individuals with disabilities who are institutionalized or homeless is not only the most cost-effective strategy for states and the federal government, it is also a requirement of the ADA. States are increasingly moving toward expansion of PSH within their housing and services continuums because of its alignment with the ADA's integration mandate, as well as with housing preferences and choices for many individuals with SMI in particular. This is especially true where lack of availability or lack of access to such options, due in part to a history of reliance on congregate or institutional settings, seriously limits the housing choices of individuals with disabilities.

Why is a PSH Housing and Services Strategy Important for Virginia?

PSH can be a valuable tool to help the Commonwealth of Virginia address a number of public policy challenges. First, effective January 2019, Virginia will implement Medicaid expansion, affording access to health care for up to 400,000 low-income qualifying Virginia residents. Based on other states' experiences, many of these individuals will have significant chronic physical and behavioral health conditions that have previously been un-treated or under-treated due to their lack of coverage. Many of these individuals are likely to be unstably housed, adding to the myriad of needs to be addressed to improve their health. PSH can help by improving housing stability, leading to more effective use of healthcare services for this newly covered population.

Development of a housing and services strategy for individuals with SMI is also important to Virginia Medicaid because it will facilitate the timely discharge of individuals from state psychiatric beds. In 2016, Virginia sought and received approval from CMS to claim federal financial participation for up to 15 days of substance use treatment for eligible individuals' substance use disorders in certain psychiatric hospitals, including state facilities. In addition, recent federal managed care regulations now allow Medicaid to claim federal financial participation for individuals in managed care who require up to 15 days of psychiatric care in certain psychiatric hospitals. Discharging patients from the hospital back to the community is often delayed due to the lack of appropriate community-based living opportunities. Creating additional PSH capacity will assist in facilitating more timely discharges from state psychiatric hospitals and limiting Medicaid's exposure in covering psychiatric bed days.

As illustrated in Figure 1, between CY2011 and CY2017, overall homelessness in Virginia has decreased 31 percent. Homelessness among various subpopulations including people with substance use disorders, families, veterans and people experiencing chronic homelessness has decreased between 45 and 50 percent during this time period. In 2015, Virginia became the first state in the country to be certified by the U.S. Department of Housing and Urban Development to have functionally ended veteran homelessness. For people with SMI, however, homelessness decreased only 28 percent between 2011 and 2017. PSH can help the subpopulation of people with SMI exit homelessness more quickly and successfully.



Virginia's criminal justice system would also benefit considerably from additional PSH capacity. For justice system-involved individuals with SMI, and co-occurring substance use disorders (SUD), housing is critical for successful re-entry into the community and sustained recovery over time. Without safe, affordable housing and appropriate community supports, individuals with behavioral health disorders are less likely to remain in recovery and more likely to come back into contact with the criminal justice system, become re-incarcerated, or even hospitalized.

Although Virginia has made great strides to improve the ways the criminal justice system responds to the needs of individuals with behavioral health disorders, housing continues to be a significant barrier. In 2016, the General Assembly directed the Virginia Department of Criminal Justice Services (DCJS) to establish pilot programs to provide services to mentally ill inmates and evaluate the effectiveness of the programs. Six regional jails received grants to pilot a variety of approaches to better respond to incarcerated individuals with SMI including: mental health treatment for individuals while in jail, case management for re-entry planning, and short-term housing to facilitate successful re-entry. In October 2018, a final evaluation of the pilot programs was published and all six sites reported a number of challenges and lessons learned, many of which relate to re-entry, aftercare, and securing housing for inmates upon release[7]. The lack of readily accessible, affordable housing was identified as a significant barrier to re-entry for this population, even when funding for short-term rental assistance was available. Many of these individuals would certainly benefit from the long-term supports of PSH.

[7] https://rga.lis.virginia.gov/Published/2018/RD390/PDF

Assessing Cost Avoidance

A housing and services strategy is also important because national and state data suggest that PSH results in some cost avoidance.

Opportunities for Cost Avoidance for Virginia as a Result of Increased PSH Data Reflecting the National Experience

Studies demonstrate that providing supportive services and related housing interventions can help achieve significant savings by reducing avoidable emergency department (ED) visits, hospitalizations, readmissions, and other health care costs – particularly when the assistance is targeted to the most high-cost and highly vulnerable Medicaid beneficiaries experiencing homelessness.[8] Combining affordable housing with intensive services, including help finding housing, working with a landlord, accessing physical and behavioral health care, and finding employment, for a high-needs group saved an average of $6,000 a year per person in health care: 23 percent fewer days in hospitals, 33 percent fewer ED visits, and 42 percent fewer days in nursing homes.[9]

Data Reflecting Virginia Experiences

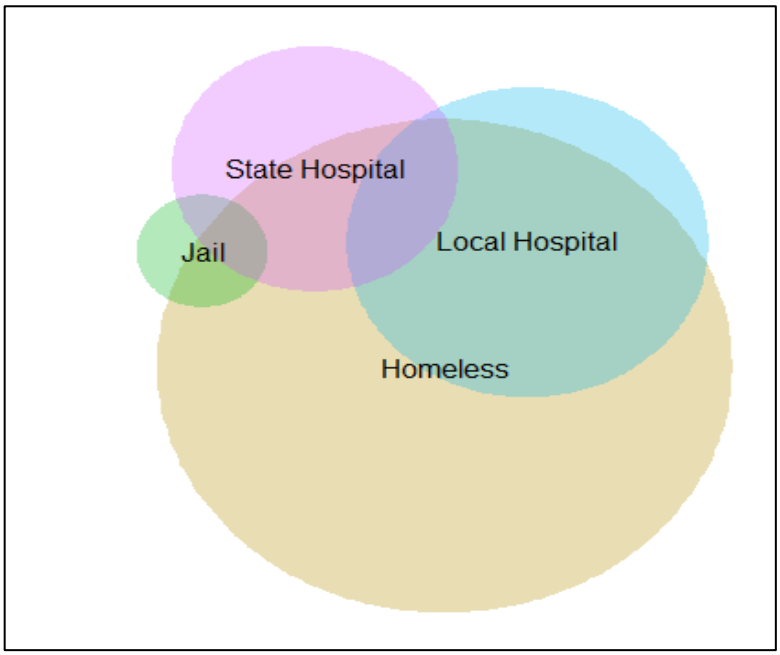
Virginia has also conducted analyses of its own PSH programs and generated findings consistent with national research. DBHDS has been operating PSH for adults with serious mental illness with targeted state general funds since 2016. In June 2018, DBHDS reported on the early experiences of individuals housed in its PSH programs across the state.

Before moving into DBHDS PSH, individuals had long histories of homelessness as well as crisis contacts and institutional care resulting in multi-system involvement, poor outcomes, and failed interventions.

[8] See The Commonwealth Fund (2014) *In Focus: Using Housing to Improve Health and Reduce the Cost of Caring for the Homeless* *http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/october-november/in-focus* and *http://aspe.hhs.gov/daltcp/reports/2011/ChrHomlr.pdf*

[9] Building the Case: Low-Income Housing Tax Credits and Health, Bipartisan Policy Center, Anand Parekh, M.D., and Caitlin Krutsick, November 2017.

Figure 2: Residential Status Six Months Before PSH Move-In (n=535)

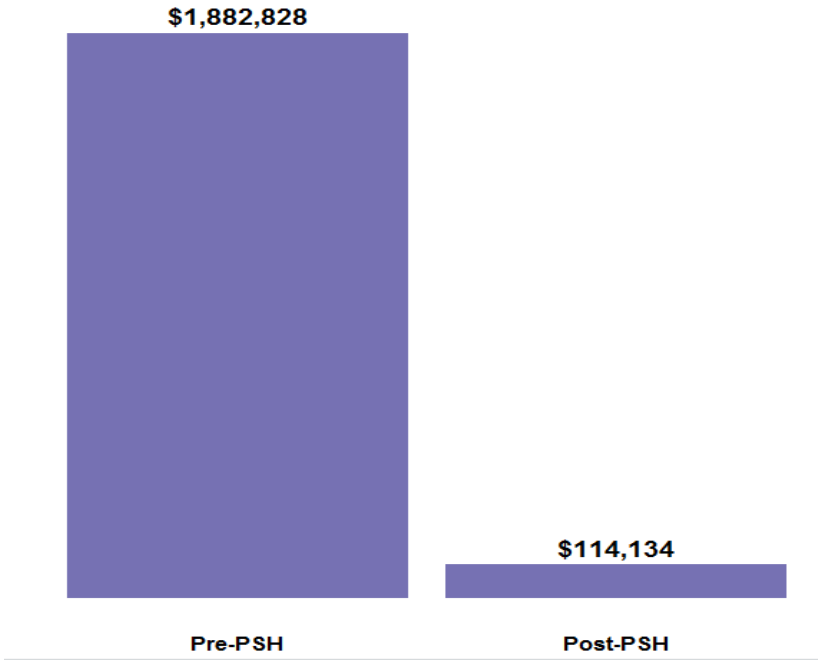


In the six months before move-in, the typical PSH participant had poor housing stability and high utilization of institutional care:

- 102 nights on the streets or in shelters
- 26 days in unstable housing
- 22 days in stable housing
- 19 days in a treatment setting
- 6 days in a correctional institution
- 4 days in a long-term care facility
- 100 individuals had a state psychiatric hospital stay with an average length of stay of 33.4 days

After move-in into DBHDS PSH, individuals experienced dramatically improved housing stability and reduced utilization of inpatient care.

Figure 3: PSH One Year Outcomes: State Hospital Cost Avoidance
(n=22)



100 individuals had a state psychiatric hospitalization in the year before PSH move-in, and 22 were in PSH for at least a year at the time of the analysis. They accounted for $1.9 million in state hospital bed day costs in one year pre-PSH, and just $114,134 in state hospital bed day costs post-PSH, representing a 94 percent cost avoidance.

- 93 percent maintained stable housing.
- 82 individuals were in a local hospital six months before or after PSH move-in. They experienced a reduction in inpatient bed days from 827 days pre-PSH to 219 days 6-months post PSH, representing a 74 percent cost avoidance.
- After one year in PSH, individuals spent 46.5% fewer days in jail.
- 167 individuals in PSH were matched to DMAS' administrative data. They had reduced Medicaid fee-for-service costs after 12 months in PSH:
    - Medicaid fee-for-service payments declined by 31 percent, totaling $501,485 in payment reductions[10].
    - Included in the overall reduction in payments is a *decrease* in inpatient and emergency department costs and an increase in outpatient and community-based care.

In 2017, nearly 18 percent of inmates incarcerated in Virginia's jails were known or suspected to be mentally ill. Of that group, 54 percent had been diagnosed with a Serious Mental Illness[11].

[10] Note that these cost savings have not been validated by DMAS.
[11] Virginia State Compensation Board, 2017 Mental Illness in Jails Report. http://www.scb.virginia.gov/docs/2017mentalhealthreport.pdf

Total cost of behavioral health treatment was estimated at approximately $16.1 million in FY17,with 76.39 percent of these costs funded by the locality, 6.27 percent funded by the state, 1.71 percent funded by the federal government, 15.43 percent by other funding sources[12]. At least four of the Jail Mental Health pilot projects allocated grant funds for "stable housing" for individuals with SMI post-release. Due to the lack of readily available affordable housing, many of the pilot sites have had to place individuals in hotels and single room occupancy units out of necessity but with few positive outcomes. Several project leads commented that dollars would be better spent and recidivism reduced if more stable housing options with support, such as PSH, were available.

Estimates of PSH Need for Virginians with SMI

By including the Supportive Housing as well as Supportive Employment benefits as part of Virginia's Medicaid expansion, the General Assembly acknowledged the important role PSH does and can play for Virginian's with disabilities, including SMI.

Table 1 provides DBHDS' estimate of additional need for PSH for Virginians with SMI. The total estimate of PSH needed to serve people with SMI who would be eligible for and benefit from PSH is 5,080. It is important to note that while many individuals with SMI would benefit from PSH, DBHDS' estimate of need below includes only those who need PSH to address extreme crises such as long-term homelessness, institutionalization, and frequent use of emergency services and criminal justice interventions.

Table 1: DBHDS Estimates of Need for PSH for Persons with SMI

Current Status of Individual	Number of Persons with SMI	Data Source
Homeless	516[13]	The State of PSH in Virginia, 2015 (Virginia Housing Alliance)
Jail	1,056	Mental Illness in Jails Report (Virginia Compensation Board, 2015)
Assisted Living Facility	824	Auxiliary Grant payments to localities (2016 Estimate of SMI based on AG recipients in one month as provided by DARS)
Unstably Housed - Top 20 percent highest utilizers of crisis and emergency services	2,684 (including 464 individuals with a state psychiatric facility stay)	Community Services Board (CSB) CCS_3 data submissions (DBHDS, 2016)

[12] Virginia State Compensation Board, 2017 Mental Illness in Jails Report. http://www.scb.virginia.gov/docs/2017mentalhealthreport.pdf

[13] The 2017 PIT for the State of Virginia (combined data from all Virginia Continua of Care) is 611 persons in shelters and 251 unsheltered persons for a total of 862 homeless individuals with SMI.

At the request of the Deeds Commission, DBHDS assessed the need for PSH by for adults with serious mental illness in these high-need categories. DBHDS' assessment established a need for 5,000 PSH units.

Progress and Accomplishments

As described above, since the submission of the 2018 report to the General Assembly, DHCD has been working with its state partners and the Strategy Group to implement the report recommendations. PSH expansion requires the identification of new or redirected resources for supports and housing as well as systemic infrastructure such as staffing, policies and procedures. Together, these all must align for successful expansion.

Expansion of PSH Support Services

Expansion of PSH Supports through 1115 Waiver

On June 7, 2018, Governor Northam signed the 2018 Virginia Acts of Assembly Chapter 2 (2018 Appropriations Act) directing DMAS to submit a Medicaid Section 1115 Demonstration Waiver seeking federal approval for new Medicaid program features "designed to empower individuals to improve their health and well-being and gain employer sponsored coverage or other commercial health insurance coverage, while simultaneously ensuring the program's long-term fiscal sustainability."

In addition to these features, through the 1115 Demonstration Waiver, the Commonwealth of Virginia will offer supportive housing and supportive employment benefits to a targeted group of high-need Medicaid members. Housing and employment supports services, such as assistance completing applications for housing or individualized job development and placement, will assist an individual with SMI with obtaining and residing in an independent community setting as well as obtaining and maintaining employment. Eligible high-need members must meet needs-based criteria and a set of required risk factors to receive the supportive housing and supportive employment benefit. The supportive housing and supportive employment benefits are expected to be phased in beginning as early as July 2020, subject to federal approval, with state authority and appropriation to fund the services, however timing and location of phase in has yet to be determined

DMAS submitted the 1115 waiver application, known as "Creating Opportunities for Medicaid Participants to Achieve Self Sufficiency" (COMPASS) waiver, to CMS on November 20, 2018. Submission of the Virginia COMPASS Waiver to CMS represents the first step in the process towards negotiations for federal approval. Negotiations on new Section 1115 Demonstration Waiver applications can be extensive, lasting many months and refining the initial policy outlined in the application. As such, timing of implementation is currently uncertain, and will be further defined as policy and related operational protocols are established through these processes.

Expansion of PSH Supports through DBHDS's PSH Program

Almost all of the new PSH units for individuals with SMI have been created through continued investment of state general funds in DBHDS' PSH program. In FY17/FY18, the DBHDS PSH program was funded at $9 million. The FY 2020 budget provides an additional $3 million to expand the DBHDS PSH program. DBHDS estimates this funding will serve approximately 900 individuals. The approximately 200 new units funded in the FY 2020 budget will be fully leased by November 2019.

The program is administered by 16 agencies – primarily CSBs. While most DBHDS PSH funds are directed to long-term rental assistance, more than thirty percent of these funds are used for housing stabilization services, one-time client assistance, or staff time to administer the rental assistance. Once the 1115 Demonstration Waiver is approved and the Medicaid housing benefits are phased in, many of these state-funded supports will be reimbursable under the waiver. It is estimated that the newly established Medicaid PSH benefit will then allow DBHDS to provide rental assistance for an additional 250 units.

Expansion of PSH Supports through the Auxiliary Grant Program

Virginia's Auxiliary Grant (AG) is an income supplement for recipients of Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals residing in an assisted living facility (ALF), in an adult foster care (AFC) home, or in a supportive housing (SH) setting through a licensed service provider that is approved by the Department of Behavioral Health and Developmental Services (DBHDS) and certified by the Department for Aging and Rehabilitative Services (DARS).

Supportive housing was added as an approved setting to the AG program in 2016 and emergency regulations for the new setting were issued in 2017 with final regulations being published on January 7, 2019 and taking effect on February 6, 2019. Supportive housing is defined as "a residential setting with access to supportive services for an AG recipient in which tenancy … is provided or facilitated by a provider licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services..." In order to be eligible for Auxiliary Grant in Supportive Housing (AGSH), individuals must be current ALF residents who meet at least the residential level of care at their first or subsequent annual assessment, are interested in supportive housing, and have been determined through an AGSH Evaluation to be able to live in supportive housing. Individuals must not require ongoing, onsite, 24-hour supervision and care or have any of the prohibited conditions or care needs described in subsection D of §63.2-1805. The AGSH program is capped at 60 individuals statewide.

DBHDS entered into AGSH provider agreements with Blue Ridge Behavioral Healthcare, Mt. Rogers CSB, and the Richmond Behavioral Health Authority in May 2017. In December 2018, AGSH programs were serving a total of 33 individuals.

Expansion of PSH Supports through State Housing Trust Fund

Up to 20 percent of the Virginia Housing Trust Fund may be used for competitive grants to help reduce homelessness. These grants may be used to provide temporary rental assistance not to exceed one year, housing stabilization services in supportive housing for chronically homeless households, and predevelopment assistance to support long-term housing opportunities for chronically homeless households. Because these grants must be applied for annually, there is some concern that providers are reluctant to request funding for on-going services. In FY18, DHCD reports that 13 projects were selected for funding through this competitive process and five of these were to existing PSH providers seeking new support services.

Expansion of PSH through Capital Investment

Given low vacancy rates and strong demand for rental housing across much of the state, it will be difficult to scale up PSH without new production of PSH units. At the state level, there are two capital programs that are primarily responsible for new affordable rental production that benefits people with SMI: the Affordable and Special Needs Housing and the Low Income Housing Tax Credit programs.

Expansion of PSH through DHCD's Affordable Housing and Special Needs Program

With the Affordable and Special Needs Housing Program (ASNH), developers can access any of four funding sources through a single application process: federal HOME and National Housing Trust (NHTF) programs as well as Virginia Housing Trust Fund (VHTF) and DHCD's PSH program. Combining the funds into one proposal process makes requesting funds significantly easier for developers, especially smaller, nonprofit developers who are more likely to be seeking these sources.

As described in Table 2 below, for 2016-2017, the total capital funding available through these four programs is just over $9 million.

Table 2: ASNH 2016-2017

Source	Amount
HOME	$3,104,622
Virginia Housing Trust Fund	$3,312,000
National Housing Trust Fund	$2,825,847
Permanent Supportive Housing	$500,000
TOTAL	**$9,742,469**

ASNH funds both homebuyer and rental housing. DHCD can only respond to those projects that apply for funding, and can fund only those projects that meet program eligibility requirements and fulfill underwriting requirements.

For the two funding rounds between 2016 and 2017, DHCD funded 38 projects, of which six were homebuyer projects; the remaining 32 were rental projects. Of the 32 projects, 7 or 22

percent were PSH projects including two group homes for people with intellectual/developmental disabilities.

A request was made to the 2018 General Assembly for an increase in Virginia Housing Trust Fund dollars; however, additional dollars were not included in the final budget.

In 2018-2019, funding for the ASNH program increased and is expected to fund two or three additional projects. The increases, however, derive solely from two federally funded programs, HOME and NHTF. While both programs did well recently, neither has had consistent federal government support; the NHTF is especially at risk.

Table 3: ASNH 2018-12019

Source	Amount
HOME	$5,784,768
National Housing Trust Fund	$4,205,306
Virginia Housing Trust Fund	$3,312,000
State Permanent Supportive Housing	$500,000
Total	**$13,802,074**

Expansion of PSH through VHDA's Low Income Housing Tax Credit Program

The Low Income Housing Tax Credit Program (LIHTC) program is considered the driver of affordable rental housing production (as well as rehabilitation) across the country. This is also the case in Virginia. In FY17, VHDA financed the development of 1,945 rental housing units, 84 percent of which were for people who are low-income, homeless, had a disability (ies) or were placed in a development with LIHTC. Since VHDA's inception in 1972, the organization has financed nearly 160,000 rental units.

Since 2015, VHDA has committed to assisting DBHDS in meeting its housing goals for people with intellectual and/or developmental disabilities under the state's settlement agreement with the U.S. Department of Justice (DOJ). This commitment has resulted in LIHTC allocations to projects in which owners committed a marketing preference for the settlement agreement population.

Since the 2018 report, VHDA has reviewed the need for PSH for people with SMI and other populations. In order to have a more significant impact, VHDA has modified its CY19 Qualified Allocation Plan to require that every development awarded LIHTC funding provide a PSH leasing preference for 10 percent of its units. Based on annualized production for the past two years, this might mean the addition of 160-200 annually for PSH.

Expansion of PSH through Rental Assistance

Rental assistance is critical to ensure PSH can serve people with disabilities who are extremely low-income (ELI), including people with disabilities whose sole source of income might be Social Security Income (SSI). Beginning in January 2019, an individual whose sole income is SSI will

receive $771 per month. The FY19 HUD Fair Market Rents for an efficiency unit range from $513 per month in Buckingham County to $1,415 in the Arlington and Alexandria[14]. Whether 67 percent of an individual's income in rural Virginia or 184 percent in the metropolitan area, these rents are unaffordable without state or federal rental assistance.

Expansion of PSH through DBHDS's PSH Program

As described above, the SFY 2020 budget provides an additional $2 million to expand the DBHDS PSH program. DBHDS estimates this funding will provide rental assistance for approximately 150 individuals with SMI. Even with this expansion, some CSBs will not have access to this resource, and no communities have been funded at a level to fully meet their assessed PSH need.

Expansion of PSH through the Mainstream Housing Choice Voucher Program

The FY17 and FY18 HUD Appropriations included a total of $400 million for new federal rental assistance under the Mainstream Housing Choice Voucher (HCV) program. Only persons with disabilities between the ages of 18 and 61 are eligible for these vouchers. In spring 2018, HUD issued a Notice of Funding Availability (NOFA) for $100 million of the $400 million appropriated to the program. Eligibility was limited to public housing agencies and the relatively few nonprofits already administering the voucher program[15]. The NOFA provided scoring incentives for agencies that agreed to prioritize persons with disabilities who were homeless, living in institutions or at risk of either condition. Scoring also favored applications that demonstrated successful partnerships with service agencies that could assist with program implementation including assisting people with disabilities to identify appropriate units, collect documentation, apply to the housing agency and to properties, move into units and connect with necessary supports.

As illustrated in Table 4 below, 10 Virginia agencies were awarded $3,443,153 to fund 412 Mainstream vouchers. VHDA was awarded 79, the largest number awarded to an agency in Virginia. Nationally no more than 99 vouchers were awarded to any single agency, even to large housing agencies such as the Housing Authority of Los Angeles County. It is to the state's advantage to have as many PHAs as possible apply and receive Mainstream funding.

[14] There are Small Area FMRs of $2,120 for an efficiency in parts of Fairfax County.
[15] This is not likely to change in subsequent Mainstream NOFAs.

Table 4: Virginia Agencies Awarded Mainstream Funding September 2018

Agency Awarded Mainstream Funding – Sept. 2018	City	Number Vouchers	Funding Awarded
Newport News Redevelopment & Housing Authority	Newport News	45	$353,295
Norfolk Redevelopment & Housing Authority	Norfolk	40	$356,616
Danville Redevelopment & Housing Authority	Danville	41	$203,019
Roanoke Redevelopment & Housing Authority	Roanoke	40	$209,645
Chesapeake Redevelopment & Housing Authority	Chesapeake	40	$317,866
Harrisonburg Redevelopment & Housing Authority	Harrisonburg	25	$178,239
Fairfax Co. Redevelopment & Housing Authority	Fairfax	55	$776,807
Arlington Co. Dept. of Human Services	Arlington	40	$463,949
People Inc. of Southwest Virginia	Abingdon	7	$22,785
Virginia Housing Development Authority	Richmond	79	$560,932
Total		**412**	**$3,443,153**

Expansion of PSH through Partnerships

While affordable housing, tenancy supports and community-based services are critical to expanding PSH for individuals with SMI, even these resources are not sufficient to ensure an expanded PSH system will be successful. State and local/regional structural systems supports are key to ensuring an effective PSH system, one that provides a fidelity-based service, targets the state's priority populations, fills units in a timely manner and maintains owner confidence by addressing tenant issues that arise.

State Level Systems

DHCD working with its partners made a number of enhancements to strengthen PSH at the state level. First, the existing interagency PSH Steering Committee was expanded to include the Department for Aging and Rehabilitation Services (DARS) and the Virginia Department of Health (VDH). All agencies were asked to identify two representatives for the steering committee. Having two representatives better ensures there is agency staff at each meeting and allows for agencies to better represent their different constituencies; for example, DBHDS staff from the Division of Behavioral Health Services and the Division of Developmental Services are now individually represented. Staff from the DBHDS Office of Forensic Services are now also included on the PSH Steering Committee. See PSH Steering Committee member list in Appendix B.

As part of this expansion, the PSH Steering Committee developed a vision statement to help ground their work together:

PSH Steering Committee Vision

All populations for whom PSH is an evidence-based practice will have access to PSH.

The PSH Steering Committee will work collaboratively across agencies and systems to:

- Advocate for the continued development of PSH, that is decent, safe, affordable, community-based housing and supports that provide tenants in the target populations with the rights of tenancy and links to voluntary and flexible supports and services.
- Braid resources to provide on-going PSH supports that meet the needs of the target populations.
- Ensure the PSH system is effective.
- Align PSH Steering Committee efforts with other related initiatives to address state priority populations for whom PSH is an evidence-based practice: people with SMI, people with developmental disabilities (DD), people experiencing homelessness.

The PSH Steering Committee is in the process of revising its existing Memorandum of Understanding to include the new partners and to address the new activities of the committee.

The PSH Steering Committee conducted a network mapping process with state partners, analyzing where there are overlapping efforts that address housing for special needs populations. As a result, the committee has developed a strategy to align/streamline state interagency work. For example, the ILT recently held coordinated meetings with the Governor's Coordinating Council on Homelessness and the PSH Steering Committee.

The Housing the SMI Population Strategy Group membership was also expanded. The goal with expansion was to enhance stakeholder input especially from the criminal justice sector. The expanded member list is in Appendix B.

The PSH Steering Committee continued working to align PSH funding, policies and systems across partner agencies. For example, with the assistance of the Innovation Accelerator Program (IAP) technical assistance (TA) provider, DBHDS' Division of Behavioral Health Services and the Division of Developmental Services are working to establish a protocol for sharing and cross-referring units developed under VHDA's LIHTC program.

Local/Regional Level Systems

DBHDS's PSH program has demonstrated the importance of local/regional housing specialists in developing and maintaining tenant-landlord relationships and ensuring their region has as an effective system in place to identify interested, eligible applicants and to assist these individuals to locate and apply for housing, including making requests as needed for reasonable

accommodations. Currently, all regions have some housing specialist capacity – however limited. DBHDS has continued to expand local PSH Program Housing Specialists to ensure all consumers in DBHDS PSH-funded programs have access to this service.

PSH Steering Committee determined an inventory of existing PSH was needed and developed an approach to compiling the inventory. This approach will provide the state with the numbers of programs, properties and units across the state, the target population and whether the program is project- or tenant-based. The initial inventory is not intended as a housing search tool – although it may eventually develop into such – but as a planning tool that could assist with developing production goals and identifying geographic gaps in PSH availability. The inventory will build on the work started by the Virginia Coalition to End Homelessness (now named the Virginia Housing Alliance) in its 2015 report[16].

Expansion of PSH through Public/Private Partnerships

Through participation in the Center for Medicare and Medicaid Services' (CMS) IAP, the DMAS, DHCD and VHDA identified potential new opportunities to leverage health care funding for capital investment in PSH. The IAP supports state Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development, and cross-state learning opportunities. DHCD and VHDA held several meetings related to exploring this opportunity. The state's TA provider, TAC, developed a brief for the state identifying some of these opportunities and how they can be leveraged. The brief is included in Appendix C.

PSH Steering Committee members have had opportunities over the last year to educate health care systems on the benefits of investment in housing. PSH Steering Committee members have also identified opportunities to provide incentives for health care system investments in housing and are currently exploring these.

Recommendations for Continued Progress

Even with the significant accomplishments over the last year, people with SMI continue to live on the streets and in shelters and languish in jails and other institutions for lack of PSH. In order to work towards meeting the identified need of 5,000 PSH units, additional capital for housing production, rental assistance to make rents affordable, and housing supports to assist tenants with SMI to live stably in the community are needed. Implementation of as many of the following recommendations as possible will be necessary to meet this need.

A Housing Supports Strategy for Virginia

Housing agencies invariably have a story about a tenant whose lease-violating behavior was unaddressed by a local service provider. A proliferation of even a small number of such experiences with tenants can negatively impact the participation of developers and property management entities in efforts to increase units dedicated to individuals with disabilities.

[16] http://vahousingalliance.org/wp-content/uploads/2015/12/State-of-Permanent-Supportive-Housing.pdf

Effective, reliable services must be in place and sustained over the long-term in order to secure and retain the support of housing providers as well as the affordable housing resources required to produce 5,000 PSH units.

Supportive Housing in the 1115 Demonstration Waiver

On November 20, 2018, DMAS submitted an 1115 Demonstration Waiver that proposes a supportive housing benefit for a targeted group of high-need Medicaid eligible members. With the waiver, Virginia will be negotiating authority to pilot a supportive housing benefit that provides Medicaid coverage for housing transition and housing sustaining services for any Medicaid member who meets expansion or current eligibility criteria and who meets the needs-based criteria for PSH and has at least one risk factor. These services, if approved by CMS and authorized and funded by the General Assembly and Administration, will be phased in across the six Medicaid regions of the state. DMAS has yet to determine the timing and locations of the phase in.

The proposed PSH benefit includes many of the services identified as eligible for Medicaid coverage in the June 26, 2015 Informational Bulletin issued by the Centers for Medicare and Medicaid Services (CMS) titled *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*.[17] This Bulletin underscores CMS' commitment to help states expand home and community-based living opportunities consistent with the Affordable Care Act, the implementation of the Home and Community Based Services (HCBS) settings final rule governing Medicaid's 1915(c) HCBS Waiver program, 1915(i) HCBS State Plan Option, as well as the ADA and the Supreme Court's decision in Olmstead v. L.C.[18] The purpose of this bulletin was to promote community integration of individuals needing LTSS by:

- Assisting states in designing Medicaid benefits;
- Clarifying which housing-related services are reimbursable under Medicaid; and
- Listing relevant authorities.

DMAS has proposed through the 1115 Waiver to pilot Medicaid coverage for the following Housing Transition Services to support an individual's ability to prepare for and transition to housing:

- Conducting a functional needs assessment that includes identifying an individual's housing preferences;
- Budgeting assistance;
- Assisting with finding/applying for housing to support the member in meeting their medical/behavioral health needs;
- Assisting with application completion;

[17] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

[18] Americans with Disabilities Act and as interpreted in the U.S. Supreme Court's 1999 decision in Olmstead vs. L.C (Olmstead). For details: Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. http://www.ada.gov/Olmstead/q&a_Olmstead.htm

- Developing an individualized community integration/housing support plan;
- Identifying resources to secure housing;
- Ensuring that housing is safe and accessible;
- Assisting with move-in details; and
- Providing transition services from a "supervised" setting to an independent living setting.

DMAS also proposes through the 1115 Waiver to pilot coverage for the following Housing Sustaining Services to support members to maintain tenancy once their housing is secured:

- Reviewing, updating and modifying the individualized plan on a regular basis with the member to reflect changes;
- Linking the member to services;
- Monitoring and following up on linkages to ensure community integration needs are addressed;
- Assisting with accessing entitlements;
- Assisting with securing supports to maximize independent living;
- Conducting assessment of individual activities of daily living skill development;
- Assisting with Landlord communications;
- Providing education on tenant rights and responsibilities, and linking the tenant to resources that will assist the member to be a "good tenant";
- Advocating for service to prevent eviction; and
- Identifying early actions or behaviors that might jeopardize housing,

The proposed benefit will not cover:

- Payment for a member's rent, room and board;
- Capital costs associated with housing development or modifications;
- Utilities or other recurring bills; or
- Leisure or recreational goods or services.

Interim Strategies to Provide Housing Supports through Medicaid

Since Medicaid expansion will occur prior to the statewide implementation of the supportive housing benefit, the Commonwealth of Virginia should consider its ability to cover many housing related services and activities using existing Medicaid covered services as an interim strategy. The availability of housing support services will help to ensure successful community integration for individuals with serious mental illness, including individuals transitioning or being diverted from institutional settings and individuals experiencing or at risk of chronic homelessness, until the Medicaid supportive housing benefit is in place.

The Services Crosswalk

The CMS IAP provided technical assistance and tools to participating states in order to link housing and health care resources, resulting in improved health care outcomes for Medicaid

beneficiaries. While not all housing related services and supports are likely to be Medicaid reimbursable for all target populations, maximizing Medicaid coverage for these services and supports can be an effective strategy to increase access to those services for Medicaid recipients and to allow states to use non-Medicaid funding sources to cover services for individuals or services not eligible for Medicaid, or to pay for housing support, such as rental assistance.

As an IAP LTSS Partnership's track participant, Virginia received the Medicaid services crosswalk, a tool intended to assist states in identifying its existing opportunities to fund housing related services and supports for target populations, using both Medicaid and non-Medicaid funding. Completing the services crosswalk has been helpful to states in identifying existing opportunities to cover housing related services and supports for each target population, gaps in coverage, and to develop an appropriate strategy for addressing gaps in coverage.

DMAS shared with TAC the completed Medicaid services crosswalk (see Appendix D). TAC reviewed the crosswalk and the Virginia Medicaid provider manuals for several rehabilitative services, collaborating with DMAS leadership on how individuals with SMI could receive Medicaid coverage for housing support services identified in the crosswalk as an interim strategy. TAC also collaborated with DBHDS staff to determine the availability of state-funded non-Medicaid services identified in the crosswalk for individuals and or services not eligible for Medicaid coverage.

TAC has identified existing opportunities for Virginia Medicaid and DBHDS to fund many of the services proposed in the housing supports benefit. Please refer to Appendix E for a detailed review of this analysis. While TAC suggests that the use of existing services can provide an interim strategy until Medicaid coverage for a PSH benefit is available, not all Housing Supports proposed under the waiver benefit will be covered, services may be limited in some communities, and additional state agency efforts and resources will be required to shape and align existing services to be effective. The most comprehensive, long-term solution to providing housing support services will be through adoption of Medicaid coverage for the PSH benefit.

Actions Necessary to Facilitate the Use of Existing Medicaid Authorities

While TAC has concluded that Medicaid does cover many housing support and housing sustaining services for Medicaid eligible members with SMI using existing direct services, such as Commonwealth Coordinated Care Plus (CCC Plus) Care Coordination (CC), Intensive Community Treatment (ICT), Targeted Case Management (TCM), Mental Health Skill-building Services (MHSS) and Peer Support, actions are required for use of these services to be effective. For this to occur, agency leadership may need to provide additional clarification to clearly identify the roles and responsibilities related to housing support services, guidance for appropriate Medicaid billing and recommendations for staff training to support these functions. DBHDS and DMAS have issued joint guidance in the past on using vocational rehabilitation and mental health support services to provide supported employment. Provider agencies must also

recognize that this approach may impact staffing levels/caseload size, as existing staff will likely need to spend more time with consumers providing assistance with accessing housing and supporting housing retention than they have historically spent.

Advantages to maximizing existing Medicaid coverage opportunities as an interim strategy include:

- This approach can occur within existing Medicaid authorities, without waiting for CMS approval;
- As such, this strategy can be implemented promptly; and
- This approach allows non-Medicaid resources to cover non-Medicaid eligible services and recipients and to provide rental assistance to more individuals with SMI.

Actions needed to promote the appropriate and effective use of existing services include:

- DMAS and DBHDS issuing joint guidance to providers for appropriate service provision and Medicaid billing;
- The assessment of provider capacity and expansion of providers/staffing where necessary; and
- Staff training in the delivery of evidence-based PSH services.

There will be challenges to plan for in implementing this approach, such as:

- There is a risk for break-down in the provision of the full array of housing support services across multiple staff/providers – there must be a clear delineation of roles and assignment of responsibilities;
- Using existing services that meet multiple recipient needs does not support dedicated staffing with expertise and focus on housing related services – staff will need clear guidance, supervision and training to effectively carry out their new duties;
- Securing the necessary Federal and state authority and funding to fully implement this benefit across the Commonwealth. This will likely be a multi-year approach as the Administration and General Assembly implement the benefit along with other state priorities;
- Additional staffing may be needed to assure the effective delivery of the new supportive housing benefit responsibilities along with existing duties; and
- Medical necessity must be met for Medicaid reimbursement, which may inhibit the long-term availability of services, especially when a tenant is doing well: terminating the services that have supported successful tenancy can result in decompensation and behaviors that could threaten tenancy

Submitting a supportive housing benefit to be piloted under the 1115 Demonstration Waiver will provide comprehensive and consistent coverage for services and supports, eligibility criteria specific for supportive housing services and eligibility criteria specifically for supportive housing providers. TAC recommends establishing eligibility criteria for providers that better align with

the knowledge and skills related to PSH, as opposed to reliance on existing services licensing standards, and establishing a parallel credentialing process. However, maximizing Medicaid coverage for existing services as an interim strategy seems to be a worthwhile investment.

Behavioral Health Redesign

DMAS and DBHDS recently partnered with the Farley Health Policy Center (FHPC) to learn about Virginia's needs, strengths, and opportunities to inform a continuum of Medicaid funded mental health services, and propose a redesigned continuum of mental health services that is trauma informed, evidence based, and focused on early intervention and prevention. The long-term vision of the redesign effort is to shift Virginia's system from one that is primarily crisis focused by investing in prevention and early intervention with mental illness. Broad goals are to keep Virginians well and thriving in their communities, reach people in environments where they already seek support such as primary care and schools, support and sustain STEP Virginia, assure Medicaid coverage and high quality behavioral health options for those eligible, and retrain and build Virginia's behavioral health workforce.

FHPC's initial analysis of data indicated that there are opportunities to improve access to services in Virginia's publicly funded behavioral health system, the outcomes of services for recipients and the rising cost of behavioral health services. Through the Behavioral Health Redesign initiative, Virginia has the opportunity to build on the strengths of agencies and programs to reshape policies that will help meet the behavioral health needs of all citizens by integrating systems and aligning efforts with greater accountability. DMAS is working in tandem with the Behavioral Health Redesign Workgroup consisting of representatives from member advocacy groups, provider associations, professional organizations, managed care organizations and state agencies.

DBHDS initiated STEP-VA in 2017, a systems change initiative intended to improve access to services, increase quality, build consistency and strengthen accountability across Virginia's public behavioral health system. Medicaid Behavioral Health Redesign will provide the network of support for STEP VA for long-term sustainability to ensure access to essential services for individuals served through the public behavioral health system. In addition, the behavioral health needs of Medicaid recipients not engaged in the public behavioral health system will be met through the system redesign. Together these transformative efforts will provide and enhance services throughout the health care continuum, meeting the needs of all populations, anticipating the following outcomes:

- Alignment of Medicaid behavioral health services with DBHDS licenses to create a continuum of evidence-based, trauma-informed, prevention-focused and cost-effective service options for members across the lifespan.
- Greater accountability through outcome measures that incentivize high quality services in least restrictive environments.
- Expanded access through a "no wrong door" approach for members across a full array of services delivered in settings where they naturally present for support.

- Expanded access to service types and therapeutic interventions that are best practices and well matched to members' level of impairment/support need.
- Inclusion of supportive housing and supported employment benefits, targeted to high risk Medicaid members with mental health conditions.

Behavioral Health Redesign is intended to address the limitations of the existing array of behavioral health services identified in Appendix E, increasing access to services, improving the quality of services, increasing value for the dollars spent on services and improving outcomes for recipients, including housing stability and retention.

Additional Options for Maximizing Medicaid Coverage for Services

Health Homes

There are additional strategies that Virginia should explore, concurrently, to expand access within the array of Housing Support services. Virginia pursued the option under the Affordable Care Act to provide a Health Home benefit for individuals with chronic health conditions, including mental health conditions. While health homes may be limited in the scope of housing support services for which they are responsible, assisting members in identifying and accessing needed supports, including housing, seems quite appropriate. Since heath homes have an identified patient cohort that tends to be within local geographical boundaries, identifying available housing resources should be less challenging for care coordinators.

DMAS and DBHDS would need to provide guidance clarifying Health Home provider responsibilities related to housing support services, and to offer training to providers/staff as needed. It would also be important to implement reporting requirements for the provision of housing services.

Managed Care Organizations

As Virginia continues to integrate behavioral health care into its Medicaid managed care contracts, the lack of affordable housing is likely becoming more impactful to the managed care organizations (MCOs). The lack of affordable housing in a community has been associated with increased visits to emergency departments, inpatient admissions, protracted discharges, unnecessary readmissions and longer stays in nursing facilities. Studies also suggest that providing supportive services and related housing interventions can help achieve significant health care savings by reducing avoidable emergency room visits, hospitalizations, readmissions, and other health care costs – particularly when the assistance is targeted to the most high-cost and highly vulnerable Medicaid beneficiaries experiencing homelessness[19].

[19] Robert Wood Johnson Foundation. *Improving Care for Medicaid Beneficiaries Experiencing Homelessness: Emerging Best Practices and Recommendations for State Purchasers*. Carol Wilkens, MPP, September 2015. Retrieved November 27, 2018 from: https://www.shvs.org/wp-content/uploads/2015/10/Improving-Care-for-Medicaid-Beneficiaries-Experiencing-Homelessness.pdf

Nationally, MCOs and health plans serving sizeable Medicaid populations are helping to create solutions that address the lack of affordable housing and support services. Some MCOs are investing "profits" from their broader health care portfolio into creating housing capacity or providing short-term rental assistance. Some health plans are funding Housing Navigators that assist members in finding and accessing affordable housing. Some plans provide "value-added services" that cover a variety of housing and tenancy sustaining services not explicitly covered by their state's Medicaid plan. The scope and amount of such investments are most impacted by:

- The Medicaid managed care contract *requirements;*
- The ability to cover additional benefits beyond those required, as these additional benefits are not covered through capitated payment made to the MCOs;
- The inclusion of performance measures that are highly corrected with stable housing;
- Performance-based incentives and/or penalties; and
- Flexibility to use alternative payment approaches.

Virginia has a number of MCOs that are known nationally for their interest and investment in affordable housing including United Health Care, Magellan and Anthem. The Commonwealth should explore opportunities to build on this experience and expertise, expanding PSH in Virginia.

Strategies that could promote MCO interest in investing in PSH include:

- DMAS should identify existing managed care contract requirements related to Housing Supports and Housing Sustaining Services;
- DMAS should also identify flexibility within the contract language that would allow for further opportunities for interested MCOs to invest resources in PSH;
- DMAS should convene the MCOs to put forward Virginia's interest in expanding PSH for members with SMI in partnership with DBHDS, explore barriers to creating housing services identified by the MCOs and engage them in identifying opportunities to expand PSH services capacity;
- DMAS should require MCOs to record the housing status for every new member and update the status at six or 12-month intervals; and
- DMAS should include performance measures related to housing stability in a future contract amendment.

In summary, there are options available to increase support for and access to various housing support and tenancy sustaining services. Alignment of these options will be important to maximize the impact of each effort, as well as the impact of all efforts combined to fill gaps without duplicating efforts. Creating additional service capacity is essential to engage housing developers and others in expanding access to affordable housing for individuals with PSH.

Planning and Training for Providers

Provider Capacity

Whether relying on existing Medicaid services or proceeding with the phase-in of the newly approved supportive housing benefit, Virginia will need to be sure there is sufficient service provider capacity in order to expand PSH. Provider capacity will be needed for both Medicaid funded services and for DBHDS funded services. If an assessment of provider capacity determines that there is a shortage of housing support services providers, DMAS and DBHDS may want to explore establishing additional provider types specifically eligible to provide the PSH benefit. Establishing a new provider type could benefit the system by engaging different experience and skill sets than currently available from providers currently participating in the Medicaid program. DMAS would need to establish a provider certification process that would assure individuals or agencies delivering the services have the skills and expertise as needed to meet the housing support needs of the target populations.

Provider Training

Both new, as well as existing providers, would benefit from training. DBHDS has historically supported providers financially to participate in PSH training. Given the expansion of PSH, the timing seems appropriate to assess the training currently available to insure it reflects the evidence-based practice of PSH. Based on this assessment, DBHDS may need to develop a new or modified training curriculum. TAC recommends that the training also address the high rates of evictions in Virginia, which exceed the national average in some communities.[20]

Housing Specialists

Housing Specialists are the "glue" that holds the housing and services components of the PSH programs together. Housing Specialists can play an important role in all aspects of PSH from identifying development opportunities to eviction prevention. Housing Specialists do play a critical role in the DBHDS PSH Program as well as in other types of PSH programs. Provider agencies funding Housing Specialist positions should receive support to assess whether any of the Housing Specialist activities are Medicaid reimbursable; where this is the case, provider agencies should receive support developing the systems and skills to bill for these activities. However, DBHDS should continue to use state funding for Housing Specialist activities that are not Medicaid reimbursable.

A PSH Housing Strategy for Virginia

In order to quickly scale up the housing component of PSH, the following three elements are key:

- **Increased capital funding**: Lack of rental housing stock and/or tight markets have inhibited use of vouchers both in rural parts of VA as well as high cost areas such as

[20]https://www.nytimes.com/interactive/2018/04/07/upshot/millions-of-eviction-records-a-sweeping-new-look-at-housing-in-america.html

Northern Virginia. Significant capital investment in affordable housing stock generally and PSH specifically is as critical, if not more so than rental assistance at this time.

- **Increased rental assistance:** Project-based rental assistance is needed to ensure new place-based PSH is affordable to people with SMI who are extremely low-income (ELI). Tenant-based rental assistance is needed because time to acquire and construct or rehabilitate affordable rental housing can be lengthy, and rental markets are more accessible in some parts of the state – and are likely to become more accessible with increased development.
- **Effective, reliable housing supports**: Many affordable housing providers are willing to discuss the possibility of PSH preferences or projects when reliable services are made available to help ensure lease compliance. While already discussed above, we cannot over-emphasize the importance of support services as the state's best selling point to engage housing agencies.

Outlined below is a strategy to secure the necessary capital and rental assistance from a variety of existing and new state and local resources.

Strategies to Increase Capital Investment in PSH

VHDA Low Income Housing Tax Credit Program

As described above, beginning with the FY19 Qualified Allocation Plan (QAP), VHDA has committed that every LIHTC project will be required to provide a leasing preference for PSH in 10 percent of units. No specific target population is named. Rather, VHDA has linked the leasing preference to populations covered by the Memorandum of Understanding (MOU) entered into by the state agencies represented on the PSH Steering Committee. Such an arrangement will allow the state to modify its target populations as needs may change over the project's compliance period. This also means the state agencies and departments serving each target population must collaborate to develop a protocol for sharing these housing units; the development of a referral protocol is discussed further below.

In CY17, VHDA ranked 1,631 units for LIHTC funding. In CY18, VHDA ranked 1,942 units for LIHTC funding. Assuming the program continues to produce units in this range, beginning in CY19, the state can anticipate that the program will make approximately 200 units available annually. It is important to note that units funded in CY19 will most likely not become available for occupancy until between January 2020 and December 2021.

Virginia Housing Trust Fund

The Virginia Housing Trust Fund (VHTF) impacts PSH growth in two ways. First, services and pre-development costs for PSH targeted to persons who are chronically homeless are funded through a competition for no more than 20 percent of the VHTF allocation, generally around $1 million.

Second, the majority of the remaining funds are combined with federal HOME and National Housing Trust funds to make up the Affordable and Special Needs Housing (ASNH) program

competition. The limited allocation of funds is shared between homebuyer and rental projects. While extra points were provided in the 2016 and 2017 competitions to projects serving special needs populations, under 25 percent of the projects included PSH.

A substantial increase in VHTF funding will be necessary for the ASNH program to contribute significantly to scaling up PSH for people with SMI. Governor Northam has included in his proposed budget an additional $14.5 million in FY 2018/2019 and $4.5 million in FY 2019/2020 to help meet the PSH and affordable housing needs in the state.

For the long-term, the state may want to consider identifying additional strategies to fund the VHTF. Other states use a variety of sources to fund housing trust funds and other capital programs. State housing trust funds are commonly funded by real estate transfer taxes, but also include funding through interest from real estate escrow or mortgage escrow accounts, and document recording fees[21]. Some states have developed PSH and affordable housing capital programs using general obligation bonds. As DHCD uses VHTF to make long-term investment of 20 or more years, bonds may be a good source of funds. At least four states fund a state housing trust fund using general obligation bonds[22]. In the last few years many states and localities have used general obligation bonds to provide funding for affordable housing development[23]. This fall, voters in at least one state and five local jurisdictions voted on the use of general obligation bonds for affordable housing development. TAC has worked with one state that has used general obligation bonds for over two decades specifically for the development of housing for people with disabilities including people with SMI and DD.

Behavioral Health and Developmental Services (BHDS) Trust Fund

Virginia has a special non-reverting fund called the Behavioral Health and Developmental Services Trust Fund. This Trust Fund consists of the net proceeds from the sale of vacant buildings and land held by DBHDS and any General Assembly appropriations to the fund. The DBHDS Commissioner administers this Trust Fund. Among other approved uses, current Virginia code allows for these funds to be used for financing of "appropriate community housing, for the purpose of transitioning individuals with intellectual disability from state training centers to community-based care." Trust Fund moneys have been used for a range of community-based services, primarily for individuals in the DOJ Settlement Agreement population. DBHDS could explore opportunities to increase funding allocations to the Trust Fund and could propose amendments to relevant code sections to add individuals with serious mental illness as a population eligible to be served in community housing financed by the Trust Fund. Some of the methods described above for the VHTF such as general obligation bonds may also be appropriate for increasing the BHDS Trust Fund.

[21] See also http://www.prezcat.org/sites/default/files/Opening%20Doors%20to%20Homes%20for%20All%20-%202016%20National%20Survey%20of%20Housing%20Trust%20Funds.pdf

[22] https://housingtrustfundproject.org/housing-trust-funds/state-housing-trust-funds/

[23] https://www.localhousingsolutions.org/act/housing-policy-library/general-obligation-bonds-for-affordable-housing-overview/general-obligation-bonds-for-affordable-housing/

Enhance Development Capacity

Increased resources alone may not be sufficient, however, to scale up PSH. DHCD staff indicated that competition for affordable housing resources is fierce and that some of the mission-driven developers who might consider PSH development do not have the capacity to produce projects that are always competitive.

TAC recommends developing active programs to increase the capacity of CSBs, nonprofit mission-driven developers and other organizations to develop PSH. This might include providing on-going education and training programs – perhaps an institute model - to strengthen housing developers' ability to successfully apply for funding to develop PSH for individuals with SMI as well as exploring mentoring models.

Another potentially effective strategy would be to pair less experienced mission-driven nonprofits or CSBs with local developers including for profit developers who have more capacity and experience. A partnership application might be more competitive for state funding and, during the process, the more experienced developers can mentor the nonprofits, who may eventually be able to compete independently.

Strategies to Secure Local Capital for PSH

As illustrated in Table 5 below, 30 cities or counties receive a direct allocation of CDBG and/or HOME funds directly from HUD. Both CDBG and HOME funds can provide capital funding for PSH. Many PSH projects require multiple sources of grants or deferred payment loans to make a project affordable. Local HOME or CDBG funding is often one of these sources. Piecing together funding for projects can be challenging. DHCD staff reported a project with 22 different funding sources! If DBHDS is able to make additional capital, rental assistance and/or supports available[24] for projects under consideration, the developer and local funders are likely to be much more receptive to creating projects.

Outreach to these local funders should be a collaborative effort, choreographed with the PSH Steering Committee. Outreach to secure city and county support for PSH is more likely to be successful when messaging from the various state services and housing agencies is clear and consistent.

[24] Either directly or through CSBs or another local entity.

Table 5: FFY18 Consolidated Plan Allocations for Virginia

Jurisdiction	CDBG Award	HOME Award
Alexandria, VA	941,853	536,873
Arlington County, VA	1,363,320	762,215
Blacksburg, VA	482,932	672,718
Bristol, VA	254,487	
Charlottesville, VA	408,417	624,013
Chesapeake, VA	1,182,627	550,827
Chesterfield County, VA	1,390,089	558,425
Christiansburg, VA	111,703	
Colonial Heights, VA	94,495	
Danville, VA	865,416	270,868
Fairfax County, VA	5,574,509	2,103,044
Fredericksburg, VA	186,790	
Hampton, VA	1,156,814	557,513
Harrisonburg, VA	559,588	
Henrico County, VA	1,692,829	897,341
Hopewell, VA	177,848	
Loudoun County, VA	1,334,299	
Lynchburg, VA	733,913	438,772
Newport News, VA	1,257,434	786,711
Norfolk, VA	4,323,842	1,278,608
Petersburg, VA	624,601	
Portsmouth, VA	1,557,075	452,783
Prince William County, VA	2,504,696	919,946
Radford, VA	165,992	
Richmond, VA	4,442,476	1,500,301
Roanoke, VA	1,732,287	606,064
Suffolk, VA	466,234	377,689
Virginia	18,289,253	10,094,628
Virginia Beach, VA	2,000,832	1,122,655
Waynesboro, VA	193,586	
Winchester, VA	231,081	615,483

There are 16 Continuums of Care (CoCs) across the state, including 15 independent CoCs and 12 local planning groups (LPGs) of the Balance of State CoC. CoCs and LPGs are tasked with creating effective community-wide emergency crisis response systems that will ensure homelessness is rare, brief, and non-recurring. This requires the coordination of federal, state, local, and private funding. Specialized resources for PSH are available from HUD for CoCs. Each CoC in Virginia has developed PSH programs available to people who are experiencing

homelessness – generally chronic homelessness – through their CoC Coordinated Entry System. Table 6 illustrates the number of new PSH projects and funding received by CoCs in Virginia for the last three HUD funding rounds[25].

Table 6: New CoC PSH Projects and Funding FY15-FY17

Funding Year	Number New PSH Projects Funded VA CoCs	Total New PSH Funding
FY17	5	$1.5 million
FY16	10	$2.7 million
FY15	9	$3.8

While not every person with SMI needing PSH is homeless, many people who are chronically homeless do have SMI or co-occurring SUD/SMI. Virginia's 2018 statewide Point-in-Time count (PIT) , a HUD requirement conducted at the local level each January, found 985 people with SMI including 699 in emergency shelters, 69 in transitional housing or safe havens and 217 persons unsheltered, living on the streets or in locations not meant for human habitation. Many of these individuals are likely to be eligible for PSH.

TAC anticipates that the FY18 HUD Appropriation will include CoC funds for the development of new PSH. DBHDS could use the availability of supports to incentivize CoCs to continue to apply for new PSH projects; supportive services funds can serve as the required "match" for these applications.

Strategies to Increase Rental Assistance for PSH

DBHDS PSH SMI Program

PSH SMI capacity is now at approximately 900 units. The Governor's budget provides $2.0 million in general funds for FY 2020 to create an additional 150 permanent supportive housing units for individuals with serious mental illness.

Growing this demonstrated successful program will be an essential component to meeting the need for 5,000 PSH units and receiving all the benefits that accrue to PSH programs including moving people from institutionalization and homelessness into housing and avoiding associated costs. A continued increase in the PSH SMI program will be especially important as the VHDA LIHTC units come on-line starting in 2020; the majority of these units will not have project-based funding and will need rental assistance to be affordable to clients.

DBHDS should also consider project-basing some portion of the PSH program. Project-basing has a number of advantages. Project-basing PSH will help to ensure clients continue to have access to housing in high cost areas such as Northern Virginia, even as rents continue to increase. Project-basing can help to provide access to housing for people with criminal

[25] Note that the new CoC projects are included in the Capital investment section of this report but that these projects could also include rental assistance.

backgrounds or poor tenancy histories who are often screened out of tax credit-funded and many other rental properties. Offering project-based PSH to rural affordable housing developments may facilitate financing for these projects. Finally, state funding does not have the targeting constraints of the federal voucher program; units can be targeted directly to people with SMI as well as other subpopulations selected by DBHDS.

If DBHDS decides to project-base some units, the agency will have to determine whether to hold some funding at the central office in order to allocate funds to CSBs or other local agencies as projects are identified or to allocate funds to a CSB or other local agency in an area where there is sufficient affordable rental housing development and demonstrated commitment to serving people with SMI.

Mainstream Housing Choice Voucher (HCV) Program

In order to ensure PSH can ride out the vicissitudes of state and federal budget cycles, and to meet the 5,000-unit need on a reasonable timeline, it is important the state balance use of state and federal resources. Congress's FY18 Appropriation for new Mainstream vouchers targeted to people with disabilities (for the first time in over ten years), provides the state with a great opportunity to continue to secure new federal PSH funds.

As described above, the state was successful in securing over 400 Mainstream vouchers for people with any disability including people with SMI. While public housing agencies cannot target these funds to benefit a specific disability[26], HUD incentivized agencies responding to the Mainstream Voucher NOFA to target these vouchers for people coming from institutions or people who are homeless, both situations that include many people with SMI or co-occurring disabilities. It is also of note that several of VHDA's HCV program agents are CSBs. This will help to ensure that people with disabilities including people with SMI are made aware of available vouchers and waiting list openings.

DBHDS should continue to work closely with all PHAs in Virginia, ensuring that PHAs, identified partners, and CSBs are aware of timeframes for the application process and the PHA's proposed process for issuing the new vouchers. If the CSB does not have the capacity to reach out to the PHA itself, DBHDS should consider assisting the CSB with the process. While these vouchers will eventually turnover and become available again, the initial issuance is a timely opportunity to secure rental assistance for individual clients.

As described above, these awards represent only 25 percent of the funds that HUD has available for the Mainstream Voucher program. HUD is expected to issue at least one more NOFA in the coming months. To the extent that this NOFA is similar to the most recent one, PHAs will be seeking local partners for their applications. If DBHDS or the CSBs can volunteer to assist the PHAs, they will be a very welcome partner; CSBs and provider agencies can provide the types of partnership activities such as identifying clients and helping them locate and move

[26] Except if approved by HUD as part of a remedial preference such as the DOJ settlement agreement.

into housing on which the previous NOFA was scored. PHAs will also be looking for assistance with funds for move-in costs such as security deposits or furnishings. Flexible funds for landlord guarantee programs for applicants who have poor tenancy histories may also help participants lease-up more quickly, one of HUD's NOFA requirements. The program does not allow disability-specific targeting. However, to the extent that a CSB or local behavioral health agency is able to assist the PHA with the activities scored in the new NOFA, their clients are more likely to benefit.

If the next Mainstream Voucher NOFA allows PHAs to target people with disabilities who are eligible for a "move-on" preference, DBHDS would benefit from reaching out to PHAs across the state to interest them in this preference. Such a preference can help to create "flow" in the system. For example, there is anecdotal evidence that some formerly homeless people living in CoC PSH units might be ready to move into their own unit, if a rental subsidy and supports were available. Encouraging these moves would free up the CoC PSH units to be able to serve people living in shelters or on the streets who do not have recent positive tenancy histories.

Discharge Assistance Program (DAP)

The Discharge Assistance Program (DAP) provides allocations of state mental health funds to CSBs and their regional planning groups. DAP has two purposes:

1. to serve individuals already discharged from state hospitals who are presently receiving services through the DAP and transition them into non-DAP funded services and supports; and

2. to serve adults in state hospitals with long lengths of stay who have been determined to be clinically ready for discharge and for whom additional funding for services and supports is required to support their placement in the community through the development, funding, implementation, and utilization review of individualized discharge assistance program plans.

DAP funds might be used more strategically to facilitate discharges into PSH, and to build PSH capacity. DBHDS should continue to examine current DAP utilization and explore strategies to align this funding with other housing initiatives for individuals with SMI such as those proposed in this report. Continued expansion of targeted rental assistance such as DBHDS's PSH and Mainstream Voucher programs provides a good opportunity for DAP to be used effectively as the short-term bridge program originally intended.

Strategies to Increase PSH through Existing Affordable Housing Programs

The production of new units and bringing new rental assistance resources into the state are the preferred strategies for expanding PSH for Virginians with SMI. However, given limitations on state and federal budgets, and the length of time for new production, increasing people with SMI's access to existing affordable housing resources is also an important strategy to meet the state's need for 5,000 PSH units.

Public Housing Agency Resources

There are 41 PHAs in Virginia. Of these, two administer only public housing units, 13 administer only vouchers, and 26 administer both the HCV and public housing programs. The PHAs in Virginia administer a total of 51,834 HCVs[27] and own and operate a total of 17,897 units of federally funded public housing[28]. PHA resources are generally made available to eligible applicants on a first-come, first-served basis but are allowed to use preferences or priorities to serve local needs or public policy priorities, as long as these are nondiscriminatory. For example, PHAs are allowed to offer preferences for people who are homeless, people with disabilities (broadly defined) and people who are institutionalized. According to the Center for Budget and Policy Priorities, 17 percent of federal rental assistance (largely housing choice vouchers but also public housing and HUD-Assisted developments) goes to single adults in Virginia who have disabilities, compared to the national average of 19 percent.

Per federal regulation (24 CFR Part 982), PHAs may not direct their resources towards people with specific disabilities, such as ID/DD and SMI, except in accordance with HUD guidance and as a HUD approved remedial preference.[29] Members of the ILT are looking at Virginia's options for housing preferences to address specific populations, like SMI, and the opportunities and implications for including such preferences in the Olmstead Strategic Plan. In the meantime, with sufficient marketing and outreach by CSBs, people with SMI can be well represented in an applicant pool even without a specific preference.

An institutionalization preference may be a useful strategy for trying to secure these resources for people with SMI. Only people with disabilities in state hospitals and ICF-IIDs, nursing facilities or other institutional settings would be eligible for such a preference. Such a preference might also be a natural fit with the DAP program discussed above.

Based on most recently publicly available data, TAC has identified a number of PHAs that have consistently underutilized their federal voucher authorization. Voucher utilization rates vary among agencies and there are different explanations for a PHA's rates. A PHA might have a low leasing rate if the per-unit cost for each family is rising or if the rents in the community are increasing. It is possible there are other explanations for the low leasing rates that mean funds are not actually available, but it would be worthwhile to explore whether there are opportunities to lease vouchers with any of these PHAs that have a lower voucher utilization.

Project-basing HCV offers DBHDS a unique opportunity to target federal funding for PSH for people with SMI. The regulations covering the project-based component of the HCV program

[27] This estimate does not include the newly awarded Mainstream Vouchers.
[28] Data from the state's IAP Housing Assessment (March 2018).
[29] HUD currently limits disability-specific preferences to HUD-approved remedial actions. According to HUD, such remedial actions must be provided in response to" Olmstead-related litigation or enforcement, including a settlement agreement, court order or consent decree, or in response to a public entity's documented, voluntary affirmative Olmstead planning and implementation efforts." https://www.hud.gov/sites/documents/PIH2012-31.PDF

(24 CFR Part 983), allow PHAs to target resources to persons needing certain services including disability-specific services. DBHDS should consider identifying PHAs already project-basing or interested in project-basing this resource and reach out to these agencies to determine whether there are opportunities to develop PSH for people with SMI. For PHAs with low leasing rates, project-basing vouchers can offer a way to improve leasing rates.

HUD Assisted Housing Resources

As illustrated in Table 7 below, there are over 22,000 units of HUD-assisted housing in Virginia that has a project-based subsidy allowing the tenant to pay only 30 percent of their income for rent. In 2013, HUD determined that it was permissible for these owners to provide a homeless or move-on preference[30]. There has been some effort in Virginia to interest owners in implementing this preference with limited success. A renewed effort led by DBHDS that includes a discussion of the array of services made available to DBHDS clients might meet with more success. Helping clients access even 1 percent of these resources will result in over 200 affordable housing options.

Table 7: HUD-Assisted Housing in Virginia

Program	Elderly	Disabled	Family	Total Properties
Section 202 w/Section 8	**679**	**817**	**0**	**1,496**
Section 202 PRAC	**2,879**	**0**	**0**	**2,879**
Section 811 PRAC	**0**	**2,941**	**0**	**2,941**
Section 8	**6,684**	**743**	**7,406**	**14,833**
Total	**10,242**	**4,501**	**7,406**	**22,149**

For a variety of reasons, Section 811 properties in some states have high vacancy rates. While these properties may have been desirable at initial development, more than 20 years later, they may be in disrepair, insufficiently accessible, too large, in a changed neighborhood or are administered by an owner or sponsor that is no longer in existence. Some of these underutilized properties may offer opportunities for reconfiguration into PSH.

Strategies to Increase PSH through Systems Supports

As described above, state and local/regional structural systems supports are key to ensuring an effective PSH system, one that provides a fidelity-based service, targets the state's priority populations, fills units in a timely manner and maintains owner confidence by addressing tenant issues that arise.

PSH Inventory

As described in the Accomplishments section of this report, the PSH Steering Committee has identified a strategy for developing a comprehensive PSH inventory. The next steps are implementation including finalizing the survey tool, identifying contact information for projects

[30] https://www.hudexchange.info/news/hud-releases-resources-on-homeless-preferences-for-multifamily-property-owners-and-agents/

and programs to be surveyed, piloting the tool, determining the data base format and surveying all identified projects and programs.

Finalize Shared Referral Protocol

In anticipation of PSH units that will be shared within and potentially across agencies and systems, DBHDS should continue to work internally as well as with VHDA and DHCD on a streamlined protocol and written policies for referring priority populations to set-asides and units with leasing preferences.

A finalized protocol should be in place no later than September 2019; however, putting a protocol in place sooner will allow DBHDS and its partners to pilot the referral process with VHDA-funded rental units that already have a leasing preference or set-aside requirement for the property. Under the DOJ Settlement Agreement, referrals of persons with I/DD to PSH resources are made through the DBHDS Central Office, but referrals of people with SMI are made at the local level through CSBs. DBHDS will work with VHDA to develop referral process protocols to ensure coordination and efficient access to available VHDA-funded rental units. The protocol should include a feedback loop to provide opportunities for the state and property owners as well as local housing agencies and the referring entities to identify issues as they arise.

It is important to note that the LIHTC units are either open to the "general" population or are targeted for elders. DBHDS will need to review the pool of potential tenants to specifically identify elders who are interested in the funded locations. Using a targeted outreach or marketing strategy will decrease the number of applicants who reject units or are rejected by the owner for lack of eligibility. TAC recommends DBHDS collaborate with CSBs and other local entities to develop strategies to market units to eligible people with SMI prior to the availability of the units.

DBHDS Cross-Disability Housing Office

The DBHDS New Organizational Structure (August 24, 2018) provides for a new cross disability Office of Community Housing. This new formation provides an excellent opportunity to continue to coordinate resources and activities across the Division of Behavioral Health Services and the Division of Developmental Services including but not limited to two areas described above - referral systems and outreach/marketing to developers. The new office reports directly to the Chief Deputy for Community Behavioral Health Services, highlighting both the importance the Administration places on housing for people as well as providing opportunities to ensure Secretariat leadership is fully aware of housing challenges and opportunities. DBHDS recently announced the selection of an Office Director with significant experience and knowledge of PSH for SMI. This will allow the work to continue seamlessly and with renewed commitment.

Joint planning: One of the important planning activities that co-location can enhance is jointly assessing, planning for and communicating the needs of DBHDS clients. PSH comes in many

forms including small and large single site, place-based, and scattered site. The state and local housing agencies that are willing to support PSH will not know what the PSH should look like, how many units, where it should be located or whether additional accessibility should be built into the program unless DBHDS lets them know. TAC has found this is not an easy task for most state services agencies but it is an important one if the agency wants to ensure the end product meets any agency requirements as well as client needs and preferences. This will also better ensure units do not sit vacant.

Working together with CSBs: Co-locating Division of Behavioral Health Services and the Division of Developmental Services housing staff will make it more efficient to share resources, ensure referrals are made in a timely manner and create and implement consistent policies. Both divisions work with CSBs and co-location may help the divisions to work collaboratively and consistently with the CSBs around housing.

Ensuring sufficient staffing: Co-location may provide for some efficiencies but the Office needs to be sufficiently staffed. The state should provide funds for additional DBHDS staffing to conduct evaluation, monitoring, and provide operational support to assure fidelity to PSH. The FY2019/2020 budget request included $300,000 to staff PSH SMI and related programs. As PSH expands, especially in LIHTC and other mainstream housing, it will be critical for the Office of Community Housingto include Housing Coordinators, staff who can act as a single point of contact at the state level for owners and managers when they are unable to resolve issues at the local level.

Training role: The new Office of Community Housing should consider developing a training program that can support efforts to help people with disabilities access affordable housing resources. Training should be made available to property owners and managers as well as CSBs and provider agencies and individuals receiving services; ideally housing and services staff will train together. Topics might include information about mental illness, developmental and other disabilities, DBHDS services and reasonable accommodation. There are many examples of such training in other states to draw on. Training can be provided by state staff or through contracts but should be provided regularly as local housing and services staff turnover frequently. Such training could be jointly funded by housing and services agencies and coordinated with DHCD and VHDA.

Continue PSH Alignment with Related Activities

The state has a number of initiatives that have some overlapping goals and strategies such as the Governor's Coordinating Council on Homelessness (GCCH), which seeks solutions to prevent and end homelessness. Over the past year, the PSH Steering Committee has worked hard to ensure committees with overlapping goals are aligned in their approaches and work collaboratively when appropriate. For example, the state has established the Interagency Leadership Team through which state agencies have been able to regularly coordinate across this project, the DOJ Settlement Agreement, and the GCCH of this coordination and

collaboration is critical. Appendix B includes additional information regarding these committees and their coordination.

Leadership Key to PSH Strategy

As described above, there are many opportunities to leverage supports, capital, and rental assistance resources to expand PSH for Virginians with SMI. No single state or federal resource will help Virginia meet the need for 5,000 PSH units. Scaling up PSH will require coordinating multiple housing and service funding mechanisms at both the state and local levels. This is a daunting task that is likely best achieved when leadership understands and is willing to support such a task. Leadership is necessary to ensure state agencies collaborate effectively. Leadership will be necessary at key points such as calling for owners to step up to serve the state's most vulnerable populations while guaranteeing that the state will provide supports to tenants and be available to owners when issues arise.

Early signs are very positive. Recent meetings of the ILT suggest that such willingness exists in Virginia. However, such leadership must be sustained over the multi-year period in which resources must be identified, programs and projects developed and then occupied by the target populations.

Conclusion

On November 15, 2018, Governor Northam signed Executive Order 25, establishing housing policy priorities to enhance the quality, availability and affordability of housing in the Commonwealth of Virginia. Permanent supportive housing was one of the three policy initiatives called out in the Executive Order. It is this leadership at the highest levels of the Executive Branch combined with support from the General Assembly that will provide the tools and momentum to ensure the state can address the supportive housing needs of people with serious mental illness, ending homelessness and institutionalization, helping these citizens of Virginia to lead stable, independent lives in their community of choice.

Appendices

Appendix A Executive Order 25

Commonwealth of Virginia
Office of the Governor

Executive Order

NUMBER TWENTY-FIVE (2018)

ESTABLISHING THE GOVERNOR'S AFFORDABLE HOUSING PRIORITIES TO ADDRESS VIRGINIA'S UNMET HOUSING NEEDS

Importance of the Issue

The sustained welfare of Virginians and the communities in which they reside depends upon the quality, availability, and affordability of housing. In recent decades, Virginia has made substantial progress in improving the quality of housing and the living environment of Virginians. However, both our urban and rural communities face a shortage of affordable housing. The high cost burden of housing, especially for lower wage earners or those with special needs, is contributing to housing instability and homelessness.

In addition to these existing needs, communities across the Commonwealth must also produce substantial new affordable housing units in order to accommodate anticipated economic and workforce growth. As the Commonwealth continues to diversify and strengthen its economy, ensuring the availability of quality, affordable housing that is proximate to employment and educational opportunities will continue to be a critical measure of community vitality and readiness for new economic investment.

To address these needs, the Commonwealth's housing initiatives should focus on enhancing Virginia's economic growth and promoting education, health, and job opportunities for all Virginians. The Commonwealth must continue to work with public and private partners to address housing instability and homelessness, provide permanent supportive housing for vulnerable populations with special needs, and expand the supply of quality, affordable housing required to meet the needs of a growing and diverse workforce. The Commonwealth must also commit to fostering inclusive communities through the deconcentration of poverty and efforts to ensure fair housing is a priority.

Establishment of the Commonwealth's Housing Initiatives

Accordingly, by virtue of the power vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, and subject to my continuing

and ultimate authority and responsibility to act in such matters, I hereby direct the Secretary of Commerce and Trade, with the assistance of the Director of the Department of Housing and Community Development and the Executive Director of the Virginia Housing Development Authority, to identify and implement actions to enable the development of quality, affordable housing with the goal of strengthening communities and fostering economic growth. I also direct the Secretary of Health and Human Resources and its agencies to partner in this effort and to identify personnel and resources to assist in the implementation of this Executive Order. The Secretary of Commerce and Trade and the Secretary of Health and Human Resources shall work with the Commonwealth's economic development and workforce development agencies on this effort.

The housing policies and actions developed pursuant to this Executive Order shall include the following:

1. Increase the supply of permanent supportive housing. This evidence-based housing model is critically important to address the most urgent areas of housing need, including programs to reduce homelessness and housing instability for vulnerable populations. The effort should bolster the ongoing inter-agency structures aimed at providing permanent supportive housing for individuals with developmental disabilities, serious mental illness, or substance use disorders, including pregnant and parenting women. The effort should also focus on individuals experiencing homelessness and individuals with other support service needs.

2. Address the shortage of quality affordable housing. The effort shall prioritize identifying and promoting policy solutions that reduce the cost of housing and provide additional affordable housing units, especially in proximity to existing and developing employment centers. The effort shall include engagement with local governments, the business community, nonprofit organizations, and other interested stakeholders. The effort should focus on coordinating economic development projects with housing production, supporting housing production technology, and supporting regional and local pilot projects that increase the supply of affordable housing units.

3. Reduce the rate of evictions across the Commonwealth. The effort shall include diversion and prevention programs that bolster housing stability for individuals and families, evaluating potential pilot programs that provide eviction relief, and counseling and education services. The Commonwealth should collaborate with stakeholders and researchers to ensure strong data collection and metrics are readily available to address this challenge, especially in communities with high eviction rates. The effort shall also prioritize policy solutions to address the underlying challenges of poverty that contribute to housing instability.

Staffing and Funding

Staffing shall be furnished by the Offices of the Secretary of Commerce and Trade and Secretary of Health and Human Resources, their agencies, and other agencies and offices as needed. Stakeholders consulted in the review and development of housing policy shall do so without compensation.

Effective Date of the Executive Order

This Executive Order shall be effective upon its signing and shall remain in force and effect unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this 15th day of November 2018.

Ralph S. Northam, Governor

Attest:

Kelly Thomasson, Secretary of the Commonwealth

Appendix B PSH Steering Committee, Strategy Group, ILT Membership

Permanent Supportive Housing Steering Committee

Name	Organization	Email
Pam Kestner	Virginia Department of Housing and Community Development (DHCD)	Pamela.Kestner@dhcd.virginia.gov
Kathy Robertson	DHCD	Kathy.Robertson@dhcd.virginia.gov
Beth Seward	Virginia Housing Development Authority (VHDA)	Elizabeth.Seward@vhda.com
Sarah Jones-Anderson	VHDA	Sarah.Jones-Anderson@VHDA.com
Kristin Yavorsky	Virginia Department of Behavioral Health and Developmental Services (DBHDS)	Kristin.Yavorsky@dbhds.virginia.gov
Jeannie Cummins	DBHDS	J.Cummins@dbhds.virginia.gov
Jana Braswell	DBHDS	Jana.Braswell@dbhds.virginia.gov
Ann Bevan	Virginia Department of Medical Assistance Services (DMAS)	Ann.Bevan@dmas.virginia.gov
Sherry Confer	DMAS	Sherry.Confer@dmas.virginia.gov
Charlotte Arbogast	Virginia Department for Aging and Rehabilitative Services (DARS)	Charlotte.Arbogast@dars.virginia.gov
Carole Pratt	Virginia Department of Health (VDH)	Carole.Pratt@vdh.virginia.gov

2018 Housing for Individuals with Serious Mental Illness Strategy Group

Name	Organization	Email
Erik Johnston	Virginia Department of Housing and Community Development (DHCD)	Erik.Johnston@dhcd.virginia.gov
Pam Kestner	DHCD	Pamela.Kestner@dhcd.virginia.gov
Kathy Robertson	DHCD	Kathy.Robertson@dhcd.virginia.gov
Daniel Herr	Virginia Department of Behavioral Health and Developmental Services (DBHDS)	Daniel.Herr@dbhds.virginia.gov
Kristin Yavorsky	DBHDS	Kristin.Yavorsky@dbhds.virginia.gov
Jeannie Cummins	DBHDS	Jeannie.Cummins@dbhds.virginia.gov
Jana Braswell	DBHDS	Jana.Braswell@dbhds.virginia.gov
Ann Bevan	DMAS	Ann.Bevan@dmas.virginia.gov
Sherry Confer	DMAS	Sherry.Confer@dmas.virginia.gov
Beth Seward	Virginia Housing Development Authority (VHDA)	elizabeth.seward@vhda.com
Sarah Jones-Anderson	VHDA	Sarah.Jones-Anderson@VHDA.com
Charlotte Arbogast	Virginia Department for Aging and Rehabilitative Services (DARS)	Charlotte.Arbogast@dars.virginia.gov
Carole Pratt	Virginia Department of Health (VDH)	Carole.Pratt@vdh.virginia.gov
Tara Ragland	Virginia Department of Social Services (DSS)	Tara.Ragland@dss.virginia.gov
Annette Kelley	DSS	Annette.kelley@dss.virginia.gov
Missy Currier	DSS	Missy.currier@dss.virginia.gov
Kendra Coleman	Virginia Department of Corrections (DOC)	Kendra.Coleman@vadoc.virginia.gov
Stephanie Beardslee	DOC	Stephanie.Beardslee@vadoc.virginia.gov
Rhonda Thissen	NAMI- Virginia	rthissen@namivirginia.org

Name	Organization	Email
Stephany Melton	NAMI- Virginia	smelton@namivirginia.org
Sim Wimbush	Virginia Housing Alliance (VHA)	swimbush@vahousingalliance.org
Sheriff Steve Draper	Virginia Sherriff's Association (VSA)	smdraper@ci.martinsville.va.us
Major Laura Hopkins	VSA	LHOPKINS@ci.martinsville.va.us
Mike Edwards	Virginia Association of Regional Jails (VARJ)	medwards@kemperconsult.com
William "Chris" Smith	VARJ	smithw@wtrj.org
Superintendent Tim Doss	VARJ	tdoss@mprsc.org
Sarah Paige Fuller	Virginia Association of Community Service Boards (VACSB)	sarah.fuller@norfolk.gov
Joy Cipriano	VACSB	JoyC@hnncsb.org
Jim Tobin	VACSB	jtobin@piedmontcsb.org
Jennifer Kelly	Virginia Hospital and Healthcare Association (VHHA)	Jennifer.kelly@uhsinc.com
Phillip Riddick	VHHA	Phillip.Riddick@uhsinc.com
Amy Clarke	VHHA	Amy.Clarke@HCAHealthcare.com
Allison Bogdanovic	Virginia Supportive Housing (VSH)	ABogdanovic@virginiasupportivehousing.org
Deidre Johnson	VOCAL – Virginia	deidre@vocalvirginia.org
Malaina Poore	VOCAL – Virginia	malaina@vocalvirginia.org
Cornel Hubbard	Magellan	cphubbard@magellanhealth.com
Michael Smith	Richmond Memorial Health Foundation	Msmith@rmhfoundation.org
Suzanne Gore	State Health Partners	Suzanne.Gore@statehealthpartners.com

Interagency Leadership Team

Housing & Supportive Services Interagency Leadership Team (ILT)

Purpose: Oversees Virginia's Plan to Increase Independent Living Options (VPIILO) which was developed in response to the Department of Justice Settlement; address any barriers to implementing the plan; ensure all of the partner agencies are working collaboratively; keep the Secretary of Health and Human Resources and the Secretary of Commerce and Trade informed of progress or issues impeding progress of implementation of the plan.

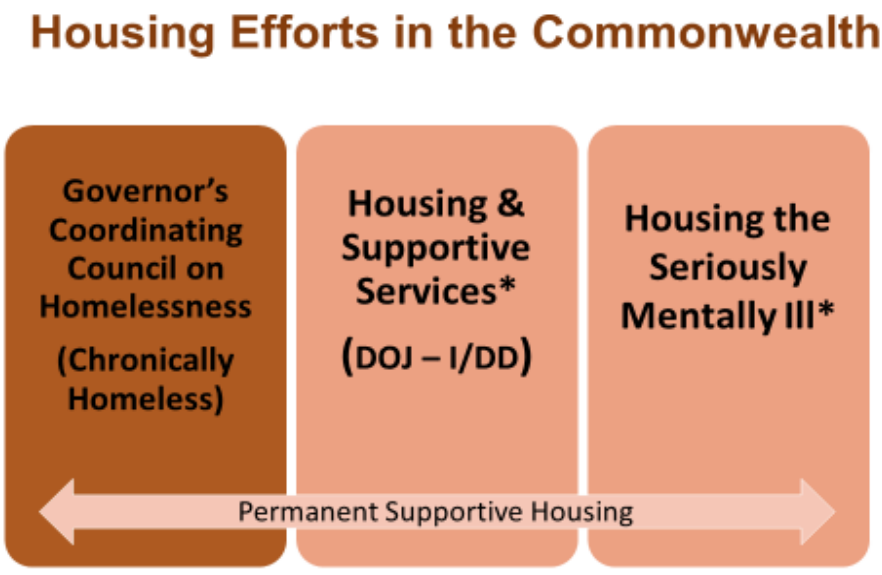
In 2017, ILT incorporated an additional focus on developing strategies to house indivduals with serious mental illness (SMI) and currently oversees the work of a state level Permanent Supportive Housing Steering Committee that has worked with a consultant to develop an annual report for the General Assembly regarding housing the SMI population and will finalize an Action Plan in 2019.

Name	Organization	Email
Susan Dewey	Virginia Housing Development Authority (VHDA)	Susan.Dewey@vhda.com
Beth Seward	VHDA	Elizabeth.Seward@vhda.com
Sarah Jones-Anderson	VHDA	Sarah.Jones-Anderson@VHDA.com
Erik Johnston	Virginia Department of Housing and Community Development (DHCD)	Erik.Johnston@dhcd.virginia.gov
Pam Kestner	DHCD	Pamela.Kestner@dhcd.virginia.gov
Kathy Robertson	DHCD	Kathy.Robertson@dhcd.virginia.gov
Hughes Melton	Virginia Department of Behavioral Health and Developmental Services (DBHDS)	Hughes.Melton@dbhds.virginia.gov
Mira Signer	DBHDS	Mira.signer@dbhds.virginia.gov
Connie Cochran	DBHDS	Connie.Cochran@dbhds.virginia.gov
Kristin Yavorsky	DBHDS	Kristin.Yavorsky@dbhds.virginia.gov
Jeannie Cummins	DBHDS	J.Cummins@dbhds.virginia.gov
Jennifer Lee	Virginia Department of Medical Assistance Services (DMAS)	Jennifer.Lee@dmas.virginia.gov
Karen Kimsey	DMAS	Karen.Kimsey@dmas.virginia.gov
Ann Bevan	DMAS	Ann.Bevan@dmas.virginia.gov

Name	Organization	Email
Kathryn Hayfield	Virginia Department for Aging and Rehabilitative Services (DARS)	Kathryn.Hayfield@dars.virginia.gov
Charlotte Arbogast	DARS	Charlotte.Arbogast@dars.virginia.gov
Norman Oliver	Virginia Department of Health (VDH)	Norman.Oliver@vdh.virginia.gov
Joe Hilbert	VDH	Joe.Hilbert@vdh.virginia.gov
Carole Pratt	VDH	Carole.Pratt@vhd.virginia.gov

Governor's Coordinating Council on Homelessness (GCCH)

Purpose: Develop and oversee implementation of state plan to effectively address homelessness; address policy issues; oversee coordination among and between secretariats and state agencies; enhance coordination and collaboration between state agencies and local organizations.



Appendix C Health and Housing Brief

Examples of Managed Care Organization and Health Care System Investments in Affordable Housing

Prepared by Sherry Lerch, Senior Consultant, The Technical Assistance Collaborative, Inc.

September 14, 2018

A lack of affordable housing in a community has been associated with increased visits to Emergency Departments, inpatient admissions, protracted discharges, unnecessary readmissions and longer stays in nursing facilities. Studies also suggest that providing supportive services and related housing interventions can help achieve significant savings by reducing avoidable emergency room visits, hospitalizations, readmissions, and other health care costs – particularly when the assistance is targeted to the most high-cost and highly vulnerable Medicaid beneficiaries experiencing homelessness.[31] Combining affordable housing with intensive services, including help finding housing, working with a landlord, physical and behavioral health care, and assistance finding employment, for a high-needs group saved an average of $6,000 a year per person in health care: 23% fewer days in hospitals, 33% fewer emergency department visits, and 42% fewer days in Nursing Homes.[32]

This growing body of research and on-the-ground experiences are leading managed care organizations (MCOs) and healthcare systems to explore solutions for improving housing stability for high cost/high risk individuals they serve.

MCOs and Affordable Housing

States are becoming more sophisticated in contracting for the administration of healthcare benefits, especially within their Medicaid programs. Whether including **performance measures and incentive payments** or moving to **value-based purchasing with shared risk**, states are expecting MCOs and ACOs to improve the overall health of members, and aligning payments with those expectations. In states using these tools, there is a direct incentive for MCOs to address the housing stability of their members. In addition, as state Medicaid agencies and MCOs assess data on the healthcare utilization of their enrollees/members, results often find that the highest utilizers of costly healthcare services are homeless/unstably housed. A number of studies have shown that **addressing housing instability reduces healthcare costs** for those members.[33]

Another incentive for for-profit MCOs to address housing stability is **the opportunity to reduce their federal tax liability**. MCOs may invest capital equity in a Low-Income Housing Tax Credit (LIHTC) financed multi-family property in exchange for tax credits which are exchanged for a dollar for dollar reduction in their federal tax obligation. This investment in LIHTCs creates new affordable rental housing

[31] See The Commonwealth Fund (2014) *In Focus: Using Housing to Improve Health and Reduce the Cost of Caring for the Homeless* *http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/october-november/in-focus* and *http://aspe.hhs.gov/daltcp/reports/2011/ChrHomlr.pdf*

[32] Building the Case: Low-Income Housing Tax Credits and Health, Bipartisan Policy Center, Anand Parekh, M.D., and Caitlin Krutsick, November 2017.

[33] Supportive Housing & Healthcare Utilization Outcomes State of the Literature. Corporation for Supportive Housing, Retrieved July 31, 2018 from CSH_supportive_housing_outcomes_healthcare_Final.pdf.

opportunities and may provide access to these units for persons with disabilities or people that are homeless dependent on the income and/or special needs targeting adopted by the developer/owner.

Challenges

There are also challenges that hinder MCOs in their decision on whether to invest in addressing housing instability that must be taken into consideration. The recently published CMS managed care regulations[34] established a **medical loss ratio** (MLR) of 15%: no more than 15% of capitation payments can be spent on non-medical care costs such as plan administrator staff salaries, overhead and profit. The regulatory established MLR limits the amount of 'profit' gained from Medicaid contracts that an MCO can choose to invest in housing. Similarly, the CMS regulations require states to regularly assess the rates paid to MCOs and to **reduce those rates when plans realize high profits**. By investing in addressing housing instability, MCOs can help to reduce healthcare costs for their members. Unless they increase spending on other eligible healthcare costs, their future reimbursement rates could be lowered as a result. A reduction in rates may create a disincentive to invest in housing over the long-run if not carefully managed. Finally, affordable housing development is often the most-needed solution to insufficient housing capacity, a key contributor to housing instability. However, housing development is a long-term investment that can require 2-3 years if not more to achieve results. State **managed care contracts are time limited and subject to competitive re-procurement**. An MCO may not be guaranteed a contract for the length of time that may be necessary to see a return on its investment in housing development; the MCO must determine that investment in housing development is a viable opportunity totally separate from their state managed care contract

Some MCOs have found success in overcoming these challenges. For example, United Healthcare (UHC) is accessing financial resources apart from their Medicaid managed care capitation revenues to invest in housing development and rental assistance, thereby avoiding limitations on available administrative funding and profit imposed by the newly established MLR. UHC has also determined that the benefits gained from investing in affordable housing outweighs the costs. Despite the challenges associated with Low Income Housing Tax Credit program, the UHC treasury team considers the tax credit market "the foundational guidebook that has allowed investors like [UHC to] have the confidence needed to invest in affordable housing," thereby playing an invaluable role in connecting the fields of health and housing.[35]

The following projects are examples of MCO investments in affordable housing and housing related services and supports.

United Healthcare

Albuquerque, New Mexico

United Healthcare partnered with Enterprise Community Investment (Enterprise) in New Mexico to provide $34 million in equity to help support the construction of five affordable-housing communities with 315 new apartments and onsite support services in Albuquerque, Deming, Gallup, Las Cruces and Santa Fe. UHC provided the **equity needed to leverage Low Income Housing Tax Credits (**LIHTC) approved by the New Mexico Mortgage Finance Authority (MFA). In

[34] Medicaid and the Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Published by the Center for Medicare and Medicaid Services, May 6, 2016. Retrieved on July 31, 2018 from https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

[35] A National Insurer Goes Local: Emerging Strategies for Integrating Health and Housing. The Urban Institute. Corianne Payton Scally, Elaine Waxman, and Ruth Gourevitch. July 2017.

the Imperial Building in Albuquerque, rents for 54 apartments are set between 30 percent and 50 percent of Area Median Income. Twenty of the apartments are not restricted under the LIHTC program but have rents that are set at about 10 percent below market prices in the area. **Fifteen of the 74 apartments will be set aside for residents with special needs** in accordance with the MFA's special needs incentive included in the qualified allocation plan (QAP).

Western Michigan

In 2017, United Healthcare invested $18.3 million to provide the **equity needed to leverage Low Income Housing Tax Credits** approved by the Michigan State Housing Development Authority (MSHDA) for the development of affordable housing. In the Jefferson Oaks project, a vacant school building and campus was transformed into 20 apartments and eight new townhome-style buildings with an additional 40 homes. **Twenty-one of the apartments are set aside for supportive housing in accordance with MSHDA's incentives in the QAP**. In the Woodlands Place Apartments project, a new 24-unit apartment community was built, with **12 units designated for people living with special needs and struggling with homelessness**. In 2016, UHC invested $16.5 million in two new affordable-housing communities in Ypsilanti and Holt.

Phoenix, Arizona

UHC provided a $22 million **low-interest loan** to Chicanos por La Causa (CLPC) to **purchase and renovate 500 rental apartments** in Phoenix, Arizona. The partnership between CLPC and UHC sought alternative capital solutions to eliminate the need to rely on LIHTC and other sources of public subsidy. By **using private funding** for the housing acquisition, the partners were able to target a percentage of the housing to vulnerable individuals. The 2- and 3-story buildings provide 177 studios, 296 one-bedroom units, 25 two-bedroom units, and 1 three-bedroom unit. Because UHC financed the entire project, it is not subject to the guidelines for target groups or income limits typically associated with government or philanthropic funding. **Up to 100 units are set aside for UHC clients at reduced rents**, and the remaining units are available to the general public at market-rate rents, helping to subsidize those units and also fund supportive health services. UHC selects potential tenants for the set-aside units from among the members of its Medicaid plan and other health plans, giving priority to members who have experienced homelessness in the past or who frequently visit emergency departments.[36].Currently, all tenants in set-aside units have an income at or below 50 percent of the area median income (AMI), and most are at or below 30 percent of AMI.[37] Referred UHC members pay rents that are approximately 50 percent lower than market-rate rents. Rents for the market-rate units, which range from $549 to $899, are below the fair market rent for the Phoenix metropolitan area and are affordable to those earning 50 percent or more of AMI. Low-income households occupy approximately 60 percent of the market-rate units.

Anthem

Anthem, Inc., is one of the largest manage care companies in the country. Currently, Anthem's **Treasury Department has invested $400 million in LIHTCs** in a variety of markets. In addition, Anthem has also made some **small grants through its Foundation for capital development** in Florida and Nevada. These grant funds have been used primarily for **short-term housing** for individuals with more complex medical needs that may need medical respite after an inpatient stay. Most of the Anthem enrollees that are in

[36] Office of Policy Development and Research, U.S. Department of Housing and Urban Development, extracted from https://www.huduser.gov/portal/casestudies/study-071818.html, July 31, 2018.
[37] Office of Policy Development Research.

these short-term respite beds are Medicare beneficiaries. In addition, Anthem has indicated that it does **underwrite operations (short-term rent or partial rent for longer periods)** on a limited basis **for its Medicaid members** in some markets. However, these funds are often from Anthem's **operating administrative budget** since capital and operating costs are not allowable service expenditures for Medicaid beneficiaries.

University of Pittsburgh Medical Center

The University of Pittsburgh Medical Center operates health plans that serve individuals with a variety of needs, in both public and private markets. In Pennsylvania, UPMC operates a healthcare plan, a behavioral healthcare plan and a plan that covers long-term services and supports within the Commonwealth's Community HealthChoices (CHC) managed care program. Unique to CHC, UPMC offers housing related support to its members.[38]

Temporary rental assistance may be available to members whose only barrier to transition from a nursing facility to the community is access to affordable housing. The benefit may provide **rental assistance for up to 24 months** for those members who have applied for a permanent subsidy program and where the subsidy is likely to become available within the 24-month period. The benefit will cover rent in the amount that would be covered under the subsidy program[39].

UPMC's CHC members may also be eligible for **enhanced community transition services -** up to a $6,000 yearly allowance to help participants who are transitioning from a nursing facility to the community. The allowance can be used on a variety of items such as **household supplies, essential furniture, general moving expenses, security deposits and other items associated with personal and environmental health and safety assurances** (This support exceeds the $4,000 lifetime maximum benefit provided by the state's fee-for-service Medicaid program.) UPMC Community HealthChoices administers this benefit in conjunction with a nursing home transition team, led by the participant, that will develop a budget for distributing these funds to support the transition to the community.

Healthcare Systems Investments in Affordable Housing

In addition to health plans investing in developing and assisting members with accessing affordable housing, healthcare systems investment in expanding housing capacity has emerged as a national trend. Homeless or unstably housed individuals are more likely to be uninsured, be hospitalized more frequently, have longer lengths of stay in the hospital, be readmitted within 30 days, and use more high-cost services. Reducing homelessness and other forms of housing instability—through case management, supportive housing (supportive services combined with housing), housing subsidies, or neighborhood revitalization—improves health outcomes, connects individuals with primary care, and reduces these high levels of utilization. When hospitals and health systems focus their resources on housing supports and case management, the cost savings can offset the expenditures by between

[38] Respondents to the CHC HealthChoices request for proposals were eligible to receive points as part of the scoring process for innovations in meeting members' needs for affordable housing.

[39] Was just implemented in Western PA in January 2018, will be in SE PA in January 2019 and in the balance of the state in January 2020.

$9,000 and $30,000 per person per year.[40] Reducing readmissions by improving care transitions is increasingly important as health care providers move toward value-based models of care.

Bon Secours, Baltimore Investment in Affordable Housing

Bon Secours Hospital in Baltimore, MD, began experiencing patient decline in the early 1990s as the neighborhood surrounding the facility deteriorated. The deteriorating conditions led to vacant properties, as many as 65% of adjacent buildings were empty, that in turn led to increased crime near the hospital. Individuals started seeking medical care at other facilities in better neighborhoods. Bon Secours purchased several of the vacant properties adjacent to the hospital, implemented a plan to **revitalize the community by developing housing units** and other community resources.

In collaboration with the community, **over the past 20 years Bon Secours has supported the development of 729 housing units**, including 119 scattered-site family units and 610 units in senior and family buildings. Through their development partners, the Health System **leveraged HUD funding and Community Development grants** when available. The affordable housing units are open to all residents of Baltimore, not just to patients of Bon Secours Health System. While the hospital does not track health data on the residents of its properties, the hospital is **seeing improved health outcomes in some patients** that are believed to be associated with their residency in the hospital's housing units.[41]

One of Bon Secours projects recently showcased by HUD, the Gibbons Apartments, opened in 2016 in Southwest Baltimore, a community that, according to the Baltimore City Health Department, scored in the bottom third of nearly 25 measures of neighborhood conditions that impact residents' health, including the built environment, education, safety, housing, and access to nutritious food.[42] The development of the Gibbons Apartments was the first stage of the redevelopment of the 32-acre site of the former Cardinal Gibbons High School. The 4-story building, which opened in 2016, consists of 24 one-bedroom, 48 two-bedroom, and 8 three-bedroom units. All the apartments are available to residents, including families and seniors, who earn between 30 and 60 percent of the area median income. The Housing Authority of Baltimore City supplies vouchers for 19 of the apartments, which are set aside for nonelderly persons with mental or physical disabilities.

The Gibbons apartments cost nearly $19.5 million to build, supported primarily with 9 percent low-income housing tax credits. Enterprise Community Investment functioned as the intermediary for the tax credits. Capital One Bank purchased the credits, and also issued a $2.5 million permanent loan for the project. Bon Secours provided the pre-development funding for architecture and environmental assessments, which needed to be completed before submitting the tax credit application. Other permanent financing included Baltimore's HOME Investment Partnerships program and a $500,000 grant from the Federal Home Loan Bank of Atlanta's Affordable Housing Program.

In addition to affordable housing, residents of the apartments have access to open space for outdoor exercise and recreation, and adjacent to Gibbons Commons, Saint Agnes Hospital runs a workforce

---

[40] Root Cause Coalition. (2016). *Housing and health: The connection, and innovative steps health systems are taking to address housing to improve health*. Washington, DC: The Root Cause Coalition. Retrieved from http://www.rootcausecoalition.org/wp-content/uploads/2016/11/White-Paper-Housing-and-Health.pdf.

[41] Health Research & Educational Trust. (2017, August). *Social determinants of health series: Housing and the role of hospitals*. Chicago, IL: Health Research & Educational Trust. Accessed at www.aha.org/housing

[42] Office of Policy Development and Research, U.S. Department of Housing and Urban Development, extracted from https://www.huduser.gov/portal/casestudies/study-071818.html, July 31, 2018.

development program. The site plan also calls for the future development of offices, retail space, and a YMCA or other recreational center. In addition to building and rehabilitating affordable rental housing, Bon Secours is offering workforce development and early childhood education programs, and the hospital is facilitating relationships among neighborhood leaders, city agencies, and faith-based institutions.[43]

St. Joseph Health, Humboldt County, California Investment in Medical Respite Beds

St. Joseph Health, Humboldt County operates two hospitals in rural northern California, St. Joseph Hospital and Redwood Memorial Hospital. The nonprofit Catholic health system has a **well-resourced community benefit department**. In addition to operating hospitals, the health system operates St. Joseph's Community Resource Centers and Open Door Community Health Centers. One of the Centers, an FQHC working with homeless individuals in the community, identified that a number of the patients they served were admitted to the hospital and experienced longer inpatient stays than medically necessary, because they were too ill or fragile to be released to the street.

To provide a less costly and more appropriate alternative, the **hospital began funding five beds** at a **transitional living facility.** Individuals without stable housing could stay in the facility for up to two weeks after leaving the hospital. The hospital also hired a nurse and a social worker to create a **Transitions Team**, that visited individuals in these medical respite beds, provided medical education and coaching, attended follow-up doctor visits with some clients and connected them with housing and other community resources.

Within its first few years after expansion, St. Joseph was able to **demonstrate a significant reduction in readmission rates and length of stay** among the population served by the medical respite program. The **return on investment** was so significant that the care transitions program has since been folded into the **hospital's operational budget**. The program has had such a positive impact that St. Joseph Health, Humboldt County recently partnered with a community foundation to **open 10 additional medical respite beds to support homeless patients after hospital discharge.**

In Summary

Housing instability is a contributing factor to high health care costs and poor healthcare outcomes for individuals with a variety of disabilities and/or chronic health conditions. The return on investment for managed care organizations and health care systems related to addressing housing instability should bring them to the table as partners in creating affordable housing options. Such partnerships would not only help to reduce healthcare costs and improve health outcomes, they would also provide opportunities for MCOs to reduce their tax burden, and for healthcare systems to maintain their non-profit status.

[43] Office of Policy Development and Research, U.S. Department of Housing and Urban Development, extracted from https://www.huduser.gov/portal/casestudies/study-071818.html, July 31, 2018.

Appendix D Services Crosswalk

Medicaid Pre-Tenancy Services

Pre-tenancy Services

1. Conducting a screening and assessment of housing preferences/ barriers related to successful tenancy
2. Developing an individualized housing support plan based on assessment
3. Assisting with rent subsidy application/certification and housing application processes
4. Assisting with housing search process
5. Identifying resources to cover start-up expenses (e.g., security deposits, furnishings, adaptive aides, environmental modifications), moving costs and one-time expenses
6. Ensuring housing unit is safe and ready for move-in
7. Assisting in arranging for and supporting the details of move-in
8. Developing an individualized housing support crisis plan"

All the above pre-tenancy services are allowable under Medicaid

Allowable Medicaid Service	Program/Target Population	Medicaid Authority	Program and/or Funding Method	Regions Where Available	Delivery Agency	Access Issues	Available Data
Transition Coordination (Members transitioning from institution to community; 1-year benefit limit)	**IDD, BH under CCC plus**	1915(c) & 1915(b)	Capitated Rate through CCC Plus	Statewide	MCO Care Coordinators	There are limited providers	
	IDD/BH under MFP (Existing Participants)	Money Follows the Person (MFP)	CMS demonstration grant	Statewide	MFP Transition Coordination (DBHDS)	MFP Sunset in 2018 (no additional enrollments beginning Jan. 1, 2018. Those with a plan can continue through the end of 2019.)	MFP report – where person came from and where they moved to. MFP has a finite number of enrollees.
"Targeted Case Management	**DD/ID**	State Plan	Fee for Service (FFS) (DD waivers and	Statewide	BHA support coordinators through CSBs	Building capacity for new DD waiver services	DBHDS/ DMAS utilization data

Allowable Medicaid Service	Program/Target Population	Medicaid Authority	Program and/or Funding Method	Regions Where Available	Delivery Agency	Access Issues	Available Data
(TCM) (Population Specific)"			those with ID not on waiver)			& housing supports will take time	
	MFP	MFP	CMS demonstration grant	Statewide	MFP Transition Coordination (DBHDS)	MFP Sunset in 2018 (no additional enrollments beginning Jan. 1, 2018)	MFP report – where person came from and where they moved to
	BH/SU	State Plan	FFS and Capitated after 12-1-18	Statewide	HIV orgs*, FQHCs, MCOs (care coordination), MHSS provided by CSBs and private providers	TCM caseloads are high. Housing services are not addressed in MHSB definition.	DBHDS & DMAS utilization data-limited to TCM claims & doesn't reflect housing screening related activities
Mental Health Skill Building Services (MHSS)	**BH/SU under state plan services**	State Plan	FFS and Capitated after 12-1-18	Statewide	HIV orgs*, FQHCs, MCOs (care coordination), TCM provided by CSBs and private providers	Housing services are not addressed in MHSB definition.	DBHDS & DMAS utilization data-limited to MHSS claims & doesn't reflect housing screening related activities
Community Guide	**IDD under DD waivers**	State Plan	FFS (DD waivers)	Statewide	Private providers including CSBs	Building provider capacity will take time	Not yet available
Supportive Housing benefit (slated no earlier than late 2019)	**SMI**	1115 Waiver	FFS and Capitated	Statewide	In development	Building provider capacity will take time	Not yet available

Medicaid Tenancy-Sustaining

Tenancy-Sustaining Services

1. Providing early identification/intervention for behaviors that may jeopardize housing, CM, MHSS
2. Education/training on the role, rights and responsibilities of the tenant and landlord
3. Coaching on developing/maintaining relationships with landlords/property managers
4. Assisting in resolving disputes with landlords and/or neighbors
5. Advocacy/linkage with community resources to prevent eviction
6. Assisting with the housing recertification process
7. Coordinating with tenant to review/update/modify housing support and crisis plan
8. Continuing training on being a good tenant and lease compliance

All the above tenancy-sustaining services are allowed under Medicaid

Allowable Medicaid Service	Program/Target Population	Medicaid Authority	Potential Funding Method	Regions Where Available	Delivery Agency	Access Issues	Available Data
Targeted Case Management (TCM) (Population Specific)	**DD/ID**	State Plan	FFS (DD waivers and those with ID not on waiver)	Statewide	Support coordinators through CSBs/BHAs	Building capacity for new DD waiver services & housing supports will take time	DBHDS/ DMAS utilization data
	MFP (Existing Participants)	MFP	CMS demonstration grant	Statewide	MFP Transition Coordination (DBHDS)	MFP Sunset in 2018 (no additional enrollments beginning Jan. 1, 2018. Those with a plan can continue through the end of 2019.)	MFP report – where person came from and where they moved to. MFP has a finite number of enrollees.
	BH/SU	State Plan	FFS and Capitated after 12-1-18	Statewide	HIV orgs*, FQHCs, MCOs (care coordination), MHSS provided by CSBs and private providers	TCM caseloads are high. Housing services are not addressed.	DBHDS & DMAS utilization data-the data is limited to TCM claims and

Allowable Medicaid Service	Program/Target Population	Medicaid Authority	Potential Funding Method	Regions Where Available	Delivery Agency	Access Issues	Available Data
							doesn't reflect housing screening related activities
Mental Health Skill Building Services (MHSS)	**BH/SU under state plan services**	State Plan	FFS and Capitated after 12-1-18	Statewide	HIV orgs*, FQHCs, MCOs (care coordination), TCM provided by CSBs and private providers	Housing services are not addressed in MHSS definition.	DBHDS & DMAS utilization data-the data is limited to MHSS claims and doesn't reflect housing screening related activities
Community Guide	**IDD under DD waiver**	State Plan	FFS(DD Waivers)	Statewide	Private providers including CSBs	Building provider capacity will take time	Not yet available
Supportive Housing benefit (slated no earlier than late 2019)	**Medicaid Expansion**	1115 Waiver	FFS and Capitated	Statewide	In development	Building provider capacity will take time	Not yet available

Other Entity Pre-Tenancy

Pre-Tenancy Services	Target Population	Funding source	How is this service paid	Service offered statewide?	Who currently provides/ delivers this service?	Are people able to access and use this service?	Data collected on access, use, effectiveness of this service
Conducting a screening and assessment of housing preferences/ barriers related to successful tenancy;	**Homeless**	HUD CoC, HOPWA*, VDH Ryan White*, CSB state and local, SAMHSA PATH, CABHI	Grant (PATH, CABHI, HUD CoC)	Yes, except PATH funded sites, CABHI-HNN, SEVHC	HIV orgs*, FQHCs, MCOs (care coordination), CoC agencies, PATH, CABHI-Norfolk, HNN	HUD CoC match requirements, administrative burden.	PACT & CABHI outcomes
Developing an individualized housing support plan based on assessment	**Homeless**	HUD CoC, HOPWA*, VDH Ryan White*, CSB state and local, SAMHSA PATH, CABHI	Grant (PATH, CABHI, HUD CoC)		HIV orgs*, FQHCs, MCOs (care coordination), CoC agencies, PATH, CABHI-Norfolk, HNN	MHSB has become more restrictive due to inappropriate utilization.	PACT & CABHI outcomes
Assisting with rent subsidy application/certification and housing application processes	**Homeless**	HUD CoC, HOPWA*, VDH Ryan White*, CSB state and local, SAMHSA PATH, CABHI	Grant (PATH, CABHI, HUD CoC)	PATH, PACT, CABHI all have designated services areas	HIV orgs*, FQHCs, MCOs (care coordination), CoC agencies, PATH, CABHI-Norfolk, HNN	MHSB has become more restrictive.	PACT & CABHI outcomes
Assisting with housing search process	**Homeless**	HUD CoC, HOPWA*, VDH Ryan White*, CSB state and local, SAMHSA PATH, CABHI,	Grant (PATH, CABHI, HUD CoC)	PATH, PACT, CABHI all have designated services areas	HIV orgs*, FQHCs, MCOs (care coordination), CoC agencies, PATH, CABHI-Norfolk, HNN		PACT & CABHI outcomes
Identifying resources to cover start-up expenses (e.g., security deposits,	**Homeless**	HUD CoC, HOPWA*, VDH Ryan White*,	Grant (PATH, CABHI, HUD CoC)	PATH, PACT, CABHI all have designated	HIV orgs*, FQHCs, MCOs (care		PACT & CABHI outcomes

Pre-Tenancy Services	Target Population	Funding source	How is this service paid	Service offered statewide?	Who currently provides/ delivers this service?	Are people able to access and use this service?	Data collected on access, use, effectiveness of this service
furnishings, adaptive aides, environmental modifications), moving costs and other one-time expenses		CSB state and local, SAMHSA PATH, CABHI, MCO		services areas	coordination), CoC agencies, PATH, CABHI-Norfolk, HNN		
Ensuring housing unit is safe and ready for move-in	**Homeless**	CABHI, PATH, VHDA, Housing Authorities, CoC, DBHDS PSH funds, HOPWA*	Grant (PATH, CABHI, HUD CoC)	Where grant funds available	DBHDS PSH providers, CABHI, PATH, CoC agencies, HOPWA*, HA's	HA inspection process can be challenging	
Assisting in arranging for and supporting the details of move-in	**Homeless**	HUD CoC, SAMHSA PATH, CABHI, HOPWA	Grant (PATH, CABHI, HUD CoC)	PATH, PACT, CABHI, have designated service areas	HIV Orgs*, FQHCs, CoC agencies, PATH, CABHI-Norfolk, HNN		PACT & CABHI outcomes
Developing an individualized housing support crisis plan	**Homeless**	SAMHSA CABHI	Grant	Parts of Hampton Roads	HNN, Norfolk CSB	Yes	CABHI Outcomes

Other Entity Tenancy Sustaining

Tenancy Sustaining Services	Target Population	Funding source	How is this service paid	Service offered statewide?	Who currently provides/ delivers this service?	Are people able to access and use this service?	Data collected on access, use, effectiveness of this service
Providing early identification/intervention for behaviors that may jeopardize housing CM, MHSB	**Homeless**	HUD CoC, HOPWA*, VDH Ryan White*, CSB state and local, SAMHSA PATH, CABHI	Grant (PATH, CABHI, HUD CoC)	Yes, except PATH funded sites, CABHI-HNN, SEVHC	HIV orgs*, FQHCs, MCOs (care coordination), CoC agencies, PATH, CABHI-Norfolk, HNN	HUD CoC match requirements, administrative burden.	PACT & CABHI outcomes
Education/training on the role, rights and responsibilities of the tenant and landlord	**Homeless**		Grants	No. Specific to grant award sites	HIV orgs, CoC agencies, PATH, CABHI-Norfolk, HNN	Limited availability, HUD CoC grants are administratively burdensome	CABHI outcomes
Coaching on developing/maintaining relationships with landlords/property managers	**Homeless**	HUD CoC, HOPWA*, VDH Ryan White*, CSB state and local, SAMHSA PATH, CABHI	Grant (PATH, CABHI, HUD CoC)	PATH, PACT, CABHI all have designated services areas	HIV orgs, CoC agencies, PATH, CABHI-Norfolk, HNN		PACT & CABHI outcomes
Assisting in resolving disputes with landlords and/or neighbors	**Homeless**	CABHI,	Grants	No. Specific to grant award sites	CoC agencies, select CSBs	Limited availability, HUD CoC grants are administratively burdensome	CABHI outcomes
Advocacy/linkage with community resources to prevent eviction	**Homeless**	SAMHSA (PATH, CABHI), HUD CoC	Grant (PATH, CABHI, HUD CoC)	PATH, PACT, CABHI all have designated services areas	HIV orgs, CoC agencies	HUD CoC match requirements, administrative burden.	PACT & CABHI outcomes
Assisting with the housing recertification process	**Homeless**	CABHI, HUD, CoC,	Grant (PATH, CABHI, HUD CoC)	Yes, except PATH funded sites. CABHI-HNN, Norfolk	HIV orgs, CoC agencies	HUD CoC match requirements, administrative burden.	PACT & CABHI outcomes

Tenancy Sustaining Services	Target Population	Funding source	How is this service paid	Service offered statewide?	Who currently provides/ delivers this service?	Are people able to access and use this service?	Data collected on access, use, effectiveness of this service
Coordinating with tenant to review/update/modify housing support and crisis plan	**Homeless**	CABHI, HUD, CoC,	Grants	No. Specific to grant award sites	CoC agencies	HUD CoC grants are administratively burdensome	PACT & CABHI outcomes
Continuing training on being a good tenant and lease compliance	**Homeless**	CABHI, HUD, CoC,	Grants	No. Specific to grant award sites	CoC agencies	HUD CoC grants are administratively burdensome	CABHI Outcomes

Appendix E Existing Coverage for Housing Transition and Housing Sustaining Services for Individuals with Serious Mental Illness, Including Individuals who are Chronically Homeless or at Risk of Chronic Homelessness

Medicaid Coverage for Housing Transition Services

TAC has identified potential opportunities for Virginia Medicaid to fund many of the services proposed in the supportive housing benefit.

Individuals with SMI

Medicaid currently provides coverage for several services that, with the provision of guidance and training, could be used to provide pre-tenancy services and supports for individuals with SMI. These opportunities are identified in the following subsections.

Commonwealth Coordinated Care Plus (CCC Plus) Care Coordination (CC) is a service available for adults with SMI who are eligible for the CCC Plus program (This includes individuals ages 65+, and adults and children with disabilities; included dual and non-dual individuals receiving LTSS (facility and community based); includes DD Waiver participants for non-waiver services). All members receive care coordination through a person-centered program design. CC may assist in educating individuals about, and connecting them to, available services and supports. In the case of housing, a CC could be trained in resources available for identifying affordable housing, referring individuals for assistance with the housing application process and connecting individuals to housing assistance.

Limitations. Care Coordinators are responsible for hundreds of plan members, which results in a "light touch," office-based service primarily through telephone contact, connecting members to services rather than providing services. CC is dependent on the services available to connect members to.

Targeted Case Management (TCM) is a service available to assist individuals whose mental health condition meets diagnostic and functional criteria. A TCM can provide an assessment of housing and supportive services needs and link individuals with available resources, services and supports. TCM can also assist an individual with, and monitor, the housing application process. TCM can *link* an individual to resources for move-in.

Limitations. Challenges for TCM to provide Housing Support services include high caseloads that may limit the amount of time a TCM has to provide the broad range of services necessary to meet client needs; and, Medicaid billing for services is limited to 30 days prior to discharge from a state hospital or jail/prison, which may not be adequate time to provide the services needed to arrange for movement into PSH.

Mental Health Skill-building Services (MHSS) is a service also targeted to individuals with SMI that may assist individuals in developing the skills necessary to locate and move into supportive housing. MHSS is intended to teach individuals how to prepare to live independently, and can

be delivered in community-integrated settings where skills are more likely to be attained and transferred.

Limitations. As it currently exists in Virginia, MHSS is delivered by private providers that are not under contract with the CSB's, nor are they part of the community-based behavioral health system that DBHDS oversees. As such, these providers may or may not have linkages to the state's housing resources, nor have they likely received training in delivering housing supports. The Community Mental Health Rehabilitative Services manual doesn't explicitly describe how this service can be used to improve skills in obtaining housing; therefore, guidance would be needed to address the development of… 'functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources' to support housing acquisition and transition.

Intensive Community Treatment (ICT) is a component of the multi-disciplinary treatment team intended for adults with SMI who are at risk of inpatient admission or homelessness and who need support and assistance in their natural environment. ICT can assist in educating individuals about, and connecting them to, available services and supports throughout the community, including housing. Some ICT teams have clear expectations that their staff are well-versed in resources available for identifying affordable housing, conducting housing needs assessments, referring individuals for assistance with the housing application process and connecting individuals to housing assistance.

Limitations. ICT teams are not available in every community; the need for the service exceeds the available capacity; reimbursement rates do not support the full costs of ICT.

Individuals who are Chronically Homeless

Chronic homelessness is not an eligibility criterion for Medicaid. Currently, an individual who is chronically homeless would need to otherwise meet a category of eligibility for Virginia Medicaid, such as Aged or Disabled. Beginning in January 2019, a childless adult whose income is at or below $16,754, which will include this population, may be eligible for Medicaid. The services previously described could be covered by Medicaid to provide Housing Support services to individuals with SMI who are chronically homeless.

Medicaid Coverage to Provide Individual Housing <u>Sustaining</u> Services

Medicaid also currently provides coverage for several services that, with the provision of guidance and training, could be used to provide individual housing sustaining services and supports.

Individuals with Serious Mental Illness

TAC suggests that a combination of TCM, MHSB and Peer Support Specialist services could provide the full array of Housing sustaining services. TCM can provide monitoring and early intervention for behaviors that may jeopardize tenancy; linking individuals with community resources to prevent eviction; assisting in dispute resolution with landlords, property managers

or neighbors should it be necessary; and coordinating with the individual to review, update, and modify their housing support plans. MHSS can provide education and training on the roles, responsibilities and rights of the tenant and of the landlord; on-going training and support in household management; and coaching on relationship-building with landlords, managers, and neighbors. Peer Support Specialists can also provide education, training and coaching support on being a good tenant. Eligibility for these services is similar, and consistent with the population intended to be served in PSH.

Limitations. As previously described, TCMs carry high caseloads, impacting their ability to provide the frequency and intensity of services needed to sustain individuals in PSH; MHSS providers may or may not be connected to community-based housing and DMAS' description of the service in the provider manual does not articulate a role for MHSS in supportive housing; and the Medicaid rate for Peer Support Specialists has not incentivized the development of service capacity.

Individuals who are Chronically Homeless

For individuals who are chronically homeless and who have a disabling SMI, CCC Plus could provide coverage for the full array of housing supports and tenancy sustaining services. Again, effective January 1, 2020, a childless adult who is homeless and whose income is at or below $16,754, could be eligible for Medicaid and may have access to the full array of housing sustaining services if risk criteria are met.

While TAC suggests that Medicaid could be used to cover most Housing Support and Housing Sustaining services for Medicaid recipients there are a few services that are essential to PSH that will not be covered by Medicaid for individuals with SMI:

1. Housing safety inspections required for rental assistance;
2. One-time move-in expenses; and
3. Administration of rental assistance.

Alternative resources will be necessary to cover these costs.

DBHDS Funded Housing Transition and Housing Sustaining Services for Individuals with SMI, Including Individuals who are Chronically Homeless

DBHDS receives funding from the General Assembly, as well as annual allocations and time-limited grants from the federal government, for services to individuals who do not qualify for Medicaid. These resources flow through the CSBs who have discretion for how the funds are spent. While the following services may be available, not all CSBs prioritize resources to support individuals in supportive housing.

Individuals with Serious Mental Illness

PSH for SMI. The Virginia General Assembly (GA) has in recent years continued to allocate funding for PSH for individuals with SMI who are being diverted from or are transitioning from a state hospital bed, and individuals who are chronically homeless or at risk of chronic

homelessness. Due to the high cost of living in many areas of Virginia, the PSH funding has been targeted for the most part to provide rental assistance (85 percent in 2016, 72 percent in 2017). However, absent the availability of essential PSH supportive services, DBHDS has issued policy that allows funded grantees to set aside a percent of their PSH funding for – administration of rental assistance, housing case management, housing stabilization services and housing peer support (15 percent in 2016, 28 percent in 2017). These services combined provide many of the Medicaid eligible housing supports and housing sustaining services. GA funding is far more flexible than Medicaid, allowing grantees to hire staff dedicated to providing housing related services and supports, as opposed to packaging together different services (such as TCM, Peer Support and MHSS).

Limitations. PSH SMI funding is limited, dependent on annual approval by the GA and every dollar spent on services is one less dollar available to support affordable housing. Maximizing Medicaid coverage for eligible Housing Supports and Housing Sustaining services would allow state general funds to cover housing costs for hundreds more individuals.

Program of Assertive Community Treatment (PACT). PACT is an evidence-based practice that promotes independent living in the community for individuals with serious and persistent mental illness. PACT services focus on treatment, rehabilitation and support services in order to reduce hospitalization, incarceration and homelessness. Services including case management, skills training in ADLs, social skills and interpersonal relationships, collaboration with others, peer counseling and direct support and advocacy to help individuals to access community resources can provide most pre-tenancy, housing support and tenancy sustaining services.

Limitations. PACT lacks sufficient service capacity to meet the level of need in Virginia, and not all individuals who want or need PSH may qualify for or choose to participate in the service.

TCM, MHSS and Peer Support. Individuals with SMI who are not eligible for Medicaid may also have access to housing sustaining services through TCM, MHSS and Peer support services that are funded through alternative resources.

Limitations. Availability of these services is limited, dependent on the amount of federal block grant, state general funds and local funding available to each CSB. In addition, most CSBs do not provide or contract for MHSS services as a result of administrative measures implemented to address quality concerns.

Individuals who are Chronically Homeless

Projects for Assistance in Transition from Homelessness (PATH). DBHDS allocates federal funds from the Projects for Assistance in Transition from Homelessness (PATH) program to 15 CSBs. While PATH funds could be used to fund pre-tenancy services, the funds are typically used to provide outreach and engagement services to homeless or at-risk persons with serious mental illness and/or co-occurring disorders.

Limitations. Funds are only allocated to 14 of the 40 CSBs. Funds are for initial transition period only; not sustaining services.

Cooperative Agreement to Benefit Homeless Individuals (CABHI) is a time-limited federal discretionary grant to DBHDS, intended to serve individuals experiencing chronic homelessness who have SMI or co-occurring mental health and substance use disorders. CABHI funds can be used for evidence-based practices, including housing support services. In Virginia, CABHI funds direct service positions in five communities. Virginia's grant was targeted to end on September 29, 2018, however the state requested and received approval for a one-year extension.

Appendix F Acronyms and Definitions

Area Median Income (AMI): For a particular jurisdiction, the median household income, adjusted for household size.

Community Development Block Grant (CDBG): Created under the Housing and Community Development Act of 1974, this program provides grant funds to local and state governments to develop viable urban communities by providing decent housing with a suitable living environment and expanding economic opportunities to assist low- and moderate-income

Consolidated Plan (ConPlan): A document written by a state or local government describing the housing needs of the low- and moderate-income residents, outlining strategies to meet these needs, and listing all resources available to implement the strategies. This document is required in order to receive some formula funded HUD Community Planning and Development funds.

Continuum of Care (CoC): A collaborative funding and planning approach that helps communities plan for and provide, as necessary, a full range of emergency, rapid rehousing and permanent supportive housing and other service resources to address the various needs of people experiencing homelessness. HUD also refers to the group of agencies involved in the decision-making processes as the "Continuum of Care."

Discharge Assistance Program: Provides supplemental funding for services and supports outside the basic array of community-based services, to assist individuals who have been discharged from state behavioral health facilities with reintegrating into their communities.

HOME: The HOME Investment Partnerships Program (HOME) provides formula grants to states and localities that communities use—often in partnership with local nonprofit groups—to fund a wide range of affordable housing activities including building, buying, and/or rehabilitating affordable housing for rent or homeownership or providing direct rental assistance to low-income people.

Homeless Management Information System (HMIS): An HMIS is a computerized data collection application designed to capture client-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness, while also protecting client confidentiality. It is designed to aggregate client-level data to generate an unduplicated count of clients served within a community's system of homeless services. An HMIS may also cover a statewide or regional area and include several Continuums of Care. The HMIS can provide data on client characteristics and service utilization.

Housing Choice Voucher Program (HCV): This program provides rental assistance to assist very low-income families, the elderly, and people with disabilities to afford decent, safe, and quality housing in the private market. It was previously known as "Section 8."

Housing First: An approach to ending homelessness that centers on providing homeless people with housing quickly and then providing services as needed. What differentiates a Housing First approach from other strategies is that there is an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing.

HUD: The U.S. Department of Housing and Urban Development (HUD) was established in 1965. HUD's mission is to increase homeownership, support community development, and increase access to affordable housing free from discrimination.

Individual Housing Transition Services: Services that support an individual's ability to prepare for and transition to housing. Transition costs may include security deposits for an apartment or utilities, first month's rent and utilities, basic kitchen supplies, and other necessities required for transition from an institution.

Individual Housing & Tenancy Sustaining Services: Services that support the individual in being a successful tenant in his/her housing arrangement and thus able to sustain tenancy. Examples may include services, such as, education/training on the role, rights, and responsibilities of the tenant and landlord, coaching on developing/maintaining relationships with landlords/property managers or, continuing training on being a good tenant and lease compliance.

Low-Income Housing Tax Credit (LIHTC): A tax incentive intended to increase the availability of affordable housing. Through state allocating agencies, (often the state's Housing Finance Agency), the program provides an income tax credit to developers for new construction or rehabilitation of low-income rental housing projects.

Managed Care Organization (MCO): A health plan with a group of doctors and other providers working together to give health services to its members. MCOs cover all state approved Medicaid services, including medical services, behavioral health services, nursing facility services and "waiver" services for community-based long term care.

Medicaid State Plan: The agreement between Virginia and the Federal government describing the policies and procedures that the state will follow in administering the Medicaid program, including those related to the methods of administration, eligibility criteria, covered services, and reimbursement methodologies.

Medicaid Waiver: An agreement between a state and the Federal government which outlines how Medicaid services and/or payment will be delivered apart from the approved Medicaid State Plan. A waiver may establish an alternative setting for services (such as in the community versus an institution), limit eligible providers, limit implementation to a part or parts of a state target a population(s) to be served and/or identify alternative payment approaches to fee-for-service reimbursement such as managed care.

National Housing Trust Fund (NHTF): A new Federal program providing capital assistance for housing development.

Non-Elderly Disabled (NED) Vouchers: Designated housing choice vouchers to enable non-elderly persons or families with disabilities to access affordable housing on the private market and/or to enable non-elderly persons with disabilities currently residing in institutional settings to transition into the community. The Mainstream Voucher program is one form of NED.

Olmstead Plan: In 1999, the Supreme Court ruled that the Americans with Disabilities Act (ADA) required states to provide services in the most integrated settings appropriate to the needs of individuals with disabilities. An Olmstead Plan is a State's document describing what strategies that state will employ within targeted timeframes to achieve this goal.

Permanent Supportive Housing (PSH): Decent, safe and affordable community-based housing targeted to individuals with disabilities and/or who are homeless or otherwise unstably housed, experience multiple barriers to housing and are unable to maintain housing stability without supportive services. PSH assures individuals the rights of tenancy and provides voluntary and flexible supports and services based on the individuals needs and preferences.

Project-Based Rental Assistance (PBRA): This term refers to a series of HUD programs that provide loans, grants, and/or renal assistance to private developers for the development and management of subsidized housing. In these programs, tenants pay 30% of their income for rent and utilities. The term is also used to differentiate between any type of rental assistance that is tied to a specific property, versus tenant-based rental assistance (see below).

Public Housing Agency (PHA): Any state, county, municipality, or other governmental entity or public body, or agency or instrumentality of these entities that is authorized to engage or assist in the development or operation of low-income housing under the U.S. Housing Act of 1937.

Qualified Allocation Plan (QAP): A Qualified Allocation Plan is the mechanism by which a state housing finance agency promulgates the criteria by which it will select to whom it will award tax credits. Each state must develop a QAP. The QAP also lists all deadlines, application fees, restrictions, standards and requirements.

Section 811 Project Rental Assistance (PRA): A Federal rental assistance program specifically for persons with disabilities that provides project-based assistance.

SMI: Serious mental illness.

SUD: Substance Use Disorder.

Supported Employment (SE): Services and supports that assist individuals with a variety of disabilities to access and maintain competitive jobs paid at competitive wages.

Supportive Housing (SH): Housing with accompanying services, which includes PSH but may also include time-limited, transitional housing programs.

Tenant-Based Rental Assistance (TBRA): Housing assistance that pays to the property owner the difference between 30% of the tenant household's income and what the owner charges for rent. The Housing Choice Voucher Program (see above) is one example of a tenant-based program. In contrast to project-based rental assistance, which is tied to a specific property, a program participant can move their tenant-based rental assistance to a different property.