Meeting the Need

October 2014

Permanent Supportive Housing Need Assessment & Financial Model for Ohio

CSH

The Source for Housing Solutions

About CSH

For over 20 years, CSH has led the national supportive housing movement. We help communities throughout the country transform how they address homelessness and improve people's lives. CSH develops innovative program models, provides research-backed tools and training, offers development expertise, and collaborates on public policy and systems reform. And, CSH is a certified community development financial institution (CDFI). We make it easier to create and operate high-quality affordable housing linked to services. To date, CSH has made over $300 million in loans and grants, and has been a catalyst for over 150,000 units of supportive housing. For more information, visit csh.org.

CSH wishes to thank the Ohio Housing Finance Agency which solely financed this project through Housing Investment Fund grant # 12-2038. Additional support was provided by the Ohio Department of Mental Health and Addiction Services and the Ohio Department of Medicaid.

PERMISSION REQUESTS

Permanent Supportive Housing (PSH) has given many individuals who were previously homeless or threatened with homelessness the chance to rebuild their lives. The combination of a stable housing environment and comprehensive supportive services has helped thousands of Ohioans avoid homelessness, address complex challenges, and lead more fulfilling, productive lives.

With a mission to create safe and affordable housing options, the Ohio Housing Finance Agency (OHFA) has committed significant resources to develop and preserve PSH communities since 1999. Most recently, OHFA identified PSH development as a priority in our 2015 Annual Plan and it remains an area of focus in our 2015 Qualified Allocation Plan.

We appreciate our longstanding partnership with the CSH and their dedication to advocating for Ohio's most vulnerable citizens. While we are seeing many positive outcomes from the development of PSH, there is still much work to be done. As we look to the future, Ohio must continue to look for new opportunities to reduce and ultimately end homelessness in our state. This can be achieved through the partnership, dedication, and the hard work of organizations like CSH that are committed to fighting homelessness.

OHFA will use the PSH Needs Assessment to effectively allocate our resources and increase affordable housing opportunities for veterans; seniors; persons with severe and persistent mental illness, addictions, or developmental disabilities; victims of domestic violence; youth aging out of foster care; and other special needs populations. PSH is a proven housing model that provides Ohioans with the ability to recover, succeed, and return back to their communities while reducing the overall cost of care to the state.

Doug Garver
Executive Director
Ohio Housing Finance Agency
October 2014

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INTRODUCTION

Project Purpose and Charter

Ohio believes in the effectiveness of permanent supportive housing (PSH), which combines affordable housing with services to help people overcome complex challenges, such as homelessness, mental illness, physical disabilities, and substance abuse issues. PSH is a proven solution, serving as the scaffolding for the delivery of more effective and responsive services to allow vulnerable individuals to live with stability, autonomy, and dignity.

With an inventory of nearly 14,000 units of PSH statewide, Ohio has made significant impact on ending chronic homelessness and reducing institutionalization of persons with disabilities. Local prioritization and State initiatives such as Home Choice, Returning Home Ohio and Home for Good have tested and achieved positive stable housing for vulnerable populations. Yet, the results of this PSH needs assessment will demonstrate the need for PSH continues to outpace the supply. This 2014 Needs Assessment and Financial Model on PSH for Ohio is meant to be a catalyst for continued investment and new thinking on how to finance supportive housing development, operations and services. The need for PSH continues if local communities want to reduce their numbers of persons and families experiencing homelessness or at risk of homelessness. The case for PSH continues as the state reduces its reliance upon institutional care. Overall, the need continues to create access to stable housing with services for vulnerable Ohioans leading to, recovery, health and success.

The experience of CSH and local communities, with the support of State funders, demonstrates that with specific steps a successful goal for additional PSH units can be established and realized. The steps to this process include:

- Assessing the need for PSH which is driven by the populations that need it most
- Gathering valuable input from stakeholders
- Determining a unit goal for production purposes
- Producing a financial model of the capital, operating and service costs for the unit goal
- Identifying funding gaps in the financial model and potential sources of funds to fill the gaps and
- Creating a multi-year strategy for implementation

With financial support from the Ohio Housing Finance Agency and additional support from the Ohio Department of Mental Health and Addiction Services and the Ohio Department of Medicaid, CSH was tasked to complete this process. An Advisory Group was formed to assist CSH and agreed to serve as a sounding board and provide input to CSH as they pursued the following:

Purpose: To establish a unified, state plan for developing, high quality permanent supportive housing (PSH) across Ohio that will meet the needs of defined, vulnerable populations.

Deliverables:

State Policy Statement on PSH needs assessment and development plan
PSH Unit goal
Defined vulnerable populations in Ohio that are in need of PSH
Multi-year development plan with financial model

Advisory Group Participation

CSH gratefully acknowledges the Advisory Group's assistance. We thank Doug Garver, Executive Director of the Ohio Housing Finance Agency (OHFA), Tracy Plouck, Director of Ohio Department of Mental Health and Addiction Services (OhioMHAS) and John McCarthy, Director of the Ohio Department of Medicaid for lending their support to the Advisory Group and for their participation in several of the Advisory Group's meetings.

Advisory Group Members are:

Laura Abu-Absi	*County Commissioners Association of OH*
Damon Allen	*Federal Home Loan Bank of Cincinnati*
Adam Anderson	*Mental Health & Addiction Services (OhioMHAS)*
Douglas Argue	*Coalition on Homelessness & Housing in Ohio (COHHIO)*
Doug Bailey	*OhioMHAS*
Jonathan Baker	*OhioMHAS*
Roma Barickman	*OhioMHAS*
Myia Batie	*OHFA*
Evette Bethel	*COHHIO*
Tom Bonnington	*Toledo Lucas County Homelessness Board*
Mary Butler	*Ohio Statewide Independent Living Council*
Ryan Cassell	*Community Housing Network*
Katie Colgan	*National Church Residences*
Irene Collins	*EDEN*
Jeffrey Corzine	*United Health Care Community*
Missy Craddock	*OhioMHAS*
Lori Criss	*The Ohio Council of Behavioral Health & Family Services*
Kim Donica	*OH Dept. of Medicaid*
Bill Faith	*COHHIO*
Kevin Finn	*Strategies to End Homelessness*
Ernie Fischer	*Ohio Department of Developmental Disabilities (DODD)*
Guy Ford	*OHFA*
Chris Galli	*Ohio Department of Rehabilitation & Correction (ODRC)*
Scott Gary	*Development Services Agency (DSA) and the Balance of State Continuum of Care*
Ruth Gillette	*Cleveland/Cuyahoga Co. Office of Homeless Service*
Kay Grier	*Ohio Statewide Independent Living Council*
Betsy Johnson	*NAMI-Ohio*
Rachael Jones	*Ohio Department of Veterans Services*
Jennifer Justice	*Ohio Department of Jobs & Family Services (ODJFS)*
Jim Kennelly	*Federal Department of Veteran Affairs*
Monty Kerr	*DODD*
Betsy Krieger	*OHFA*

Debbie Leasure	*OHFA*
Jody Lynch	*OhioMHAS*
Natalie McCleskey	*Stark County Regional Planning Commission*
Michelle Norris	*National Church Residences*
Lisa Patt-McDaniel	*Ohio Capital Corporation for Housing*
Amy Price	*Community Shelter Board*
Steve Randles	*Ohio Housing Authorities Conference*
Daniel Schreiber	*Office of Budget & Management (OBM)*
Kathleen Shanahan	*Montgomery County*
Sean Thomas	*OHFA*
Helen Tomic	*City of Akron*
Rick Tully	*Governor's Office*
Laurie Valentine	*ODJFS*
Cheri Walter	*Ohio Association of County Behavioral Health Authorities (OACBHA)*
Leah Werner	*OH Dept. of Medicaid*
Chris Whistler	*OBM*
Dan White	*OBM*
Sadicka White	*DSA*

Ohio's PSH Policy Framework

In 2010, the state of Ohio adopted a PSH Policy Framework that has guided a number of state resources for PSH investment. The Policy Framework defines PSH and describes the populations that are best served by PSH. The Advisory Group considered the target populations and criteria identified under the PSH Policy Framework, and determined the criteria were still applicable, and that the document holds significant relevance to guide CSH's work. Discussions at the Advisory Group meetings emphasized the need for further data collection and subsequent analysis to determine the PSH needs for additional target populations which are identified in this report.

This report is a summation of CSH's work. In the final section of this report, CSH advances a number of recommendations. CSH believes these recommendations will enable the State to expand both current PSH development efforts and effectively allocate resources for PSH for the target populations.

TARGET POPULATIONS

Who are the Most Vulnerable in Need of PSH?

State and local agencies throughout Ohio are combining efforts to develop permanent housing in the community with support services to meet the needs of a range of vulnerable populations, including individuals and families facing chronic homelessness, those at-risk of homelessness, as well as populations with disabilities leaving institutional care. With data collected from the U.S. Department of Housing and Urban Development (HUD) Homeless Management Information System (HMIS) for the nine Ohio Continuums of Care (CoC) and from various state of Ohio agencies, the PSH Needs Assessment and Development Plan targets the following vulnerable populations:

- Chronically homeless individuals and families, including homeless veterans,
- Persons leaving institutional care, including persons living in public mental health hospitals, and nursing home populations,
- Persons with mental illness released from state prisons, and
- Runaway and homeless youth.

In addition, the Ohio Department of Developmental Disabilities (DODD) has targeted transitions to community-based housing for 960 persons from State Operated Developmental Centers and Intermediate Care Facilities by 2018. Currently DODD has allocated resources for both capital development and Medicaid Waiver services for a range of community-based housing for their target populations. Follow-up and tracking on these transitions will inform and expand the strategies and resources that DODD develops for the future transitions to community-based housing, including development of permanent supportive housing for the developmental disabilities target populations.

Discussions at the Advisory Group meetings acknowledged the need for additional research to both locate the data to estimate other populations' need for supportive housing, and to assess the appropriate PSH strategies for those populations. These additional target populations which are not included in this analysis include:

- Other populations in nursing care and able to live in community-based supportive housing
- Persons in institutional care including prisons and jails challenged with alcohol and substance use disorders
- Persons in private mental health hospitals

The following section outlines the methodology that CSH uses to determine the goal for additional PSH units, and the production and financial model for the capital, operating and service costs to reach the goal. Ohio has had a strong commitment of financial resources, but to meet this next phase PSH target goal, a major expansion or reallocation is needed, especially in operating and services funding. The report also makes recommendations for stakeholders, state agencies, and Advisory Group members to consider in implementation of a multi-year PSH Production strategy.

Assumptions Used in the Numbers

The populations and data sources examined for this report were pursued in conjunction with recommendations from the Advisory Group and used to calculate the need. Data sources include homeless numbers from the nine Ohio Continuums of Care (CoCs) 2013 Point-in-Time Counts, the federal 2011 Annual Homeless Assessment Reports (AHAR), and additional data sets as provided by State agencies on Other Target Populations. With this information in hand, CSH's calculations determined that an estimated 6,360 households in Ohio are in need of PSH.

Table I highlights the data analyzed to "Estimate the Population Need for Permanent Supportive Housing." Annually, it is estimated that over 32,600 persons are homeless in Ohio, and an additional 14,350 Other Targeted Populations including persons with disabilities may be leaving institutions, including nursing homes, state prisons, and state developmental centers.

From these overall estimated population numbers, we identified the portion of each targeted population for which PSH is an appropriate housing intervention. Current best practices support a variety of housing interventions to meet the needs of the vulnerable individuals and households. Targeting existing and new PSH units for those that will benefit most from the supports will prove to be an effective utilization of valuable resources. The following assumptions of the percentage of target population best served in PSH are based on estimates of current placement rates and industry best practices:

- ✓ 95-100% of chronically homeless individuals and families,
- ✓ 32% of ex-offenders with mental illness, and
- ✓ 20% for targeted populations leaving institutional care.
- ✓ Providers in the field working with runaway and homeless youth estimate that 15-20% of this population do benefit from the combined independence, service supports and permanency (no limits on length of stay) available from PSH.
- ✓ For non-chronic homeless populations, the Advisory Group agreed (after extensive discussion) to estimate 4.7% of non-chronic homeless for PSH. This percentage reflects the prevalence of serious mental illness among the Ohio total population, based on data taken from the Ohio Housing Finance Agency's "Housing Needs Assessment 2015 Annual Report."

Discussions at the Advisory Group focused on whether this percentage was a reasonable proxy for the need for PSH among the non-chronic homeless populations, given that certain other target populations were not included in this needs assessment as noted above. Further research and identification of other target populations is included in the follow-up recommendations for this report.

Further details regarding the data sources and assumptions used to arrive at these numbers and percentages are listed in the TABLE NOTES section of this report.

Table I Estimating Population Need for Permanent Supportive Housing (PSH)					
Homeless Population					
Statewide		**Number at Point-in-Time (1)**	**Households over Course of a Year (2)**	**Assumptions for Households Benefitting from PSH**	
				% (8)	**#**
Single Adults		7,550	27,766		
	Chronic Adults	1,582	1,582	100%	1582
	Non-chronic Adults	5,968	26,184	4.7%	1231
Families (Individuals)		4,714			
Families (Households)		1,501	4,573		
	Chronic Families	24	24	100%	24
	Non-chronic Families	1,477	4,549	4.7%	214
Unaccompanied Youth		61	326	20%	65
Total Homeless		**12,325**	**32,665**		**3116**
Veterans (3) (subset of above)		*1212*	*4,181*	33%	1380
Estimated Transitions - Other Target Populations				**%**	**#**
Ex-offender (State Prison) Mental Health (4)			1528	32%	489
Public MH Hospitals			7383	20%	1477
Nursing Home Population (5)			4000	20%	800
Runaway Youth (6)			1436	20%	287
Est. Total Other Target Population					**3053**
Total Homeless and Other Target Populations Needing PSH					**6168**
		Per Year Target	**Target over Four Years**		
Developmental Disabilities					
ICF/MR (7)		150	600		
SODC (7)		90	360		
Target DD Population		240	**960**	20%	**192**

Note: The estimated counts for Other Target Populations do not include persons with substance use disorders leaving institutions, persons leaving private mental hospital, and other nursing home populations. Additional research to identify data to estimate these populations should be undertaken and incorporated into future PSH Needs Assessments.

TRANSLATING THE PEOPLE IN NEED INTO A UNIT GOAL

The next step in the PSH Needs Assessment determines the PSH Unit Goal. This PSH unit goal is based on the population need for PSH (6,360) and compares this demand with the supply of PSH currently available and under development.

Current inventory of PSH in Ohio is estimated at 13,000 units with an estimated 1,000 units in the development pipeline. These estimates are taken from inventory and funding reports from CSH, HUD Housing Inventory Charts 2013 from the nine Ohio CoCs, OHFA, and OhioMHAS of PSH units target for homeless and other target populations. Utilizing an average 1.15 turnover rate of PSH units across Ohio's nine CoCs from the HUD 2011 AHAR, CSH projects the PSH Unit Goal of 3,410 in additional new units of PSH for the targeted populations. Table II – "Estimating Permanent Supportive Housing PSH Units Needed in the Community" highlights the data points and assumptions used to arrive at the PSH unit goal.

Table II Estimating Permanent Supportive Housing (PSH) Units Needed in the Community

	Estimated Households Benefiting from PSH	% of Homeless and Other Target Populations Benefiting PSH	Estimated Existing PSH Units (1)	Estimated PSH Unit Pipeline (2)	Annual Estimated Turnover Rate (3)	PSH Units Available This Year	Estimated Total PSH Units Needed
Total Homeless and Target Populations (4)	**6,360**	**100%**	**13,000**	**1,000**	**1.15**	**2,950**	**3,410**

PSH Development Strategies

The target PSH production goal identifies a need for 3,410 new PSH units to meet projected demand from targeted populations. Based on current PSH production levels and capacity in Ohio, it is realistic to target production of this number of PSH units over a five year development period. Annual production of PSH units is targeted at 682 units per year. This production level is comparable to current capital production levels. During this time frame the state and local organizations can add to the PSH inventory to meet the needs of target populations, expand existing and explore new development strategies and partners, identify resources for operating and service funding, and continue research on community-based housing needs for additional vulnerable populations not currently targeted in this current PSH production plan.

The next step in this phase of the PSH unit production modeling is to assess the development strategies to produce the needed units. PSH Development Strategies have been identified to meet the PSH production goals based on models of development currently in use in Ohio communities: i) Leasing and ii) Build. An additional priority for Ohio communities is to expand the development and integration of PSH units within other affordable and market rate housing developments.

- **Leasing**: A leasing strategy creates units by coupling existing units in the rental housing market with rental subsidy to achieve affordability. A leasing strategy will utilize scattered site or concentration of units in both the general housing and the affordable housing inventory. Scattered or site-based units are leased by PSH provider(s) from existing housing stock and private owner(s.) No capital costs are assumed for leased units.

- **Build:** A build strategy develops PSH units through either acquisition/rehabilitation or new construction of units. Rehabilitation or new construction PSH units are site-based in property owned by PSH provider(s.) As part of the Build Strategy, the State agencies seek to further an Integration Strategy.

- **Integration**: An integration strategy incorporates aspects that are similar to each of the previous development strategies. Integrated PSH blends PSH units within developments and communities creating opportunity for additional housing choice for PSH among the broader affordable and general community. Integrated PSH units are owned by PSH or other affordable developer(s), and are either set-aside within a larger apartment building or are scattered site apartments and single-family homes in a community. Integration strategies enable leveraging of development and financial resources available for affordable housing as well as the general private rental market.

The actual development of PSH units in communities is influenced by local market conditions and available housing stock. For purposes of this statewide PSH Needs Assessment and Financial Projections assumptions must be made as to the percentage of PSH units developed under each strategy. Both the Build and the Integrated PSH units will require capital resources. No capital costs are assumed for the Leased units. For projection purposes: 1/3 of the new PSH units are assumed developed under the Leasing strategy, and 2/3

of the new PSH units are assumed to be created under the Build or Integrated strategies, requiring capital resources for development. Actual PSH unit development will change based on local market conditions, developer expertise, and community needs.

Based on data available regarding household size among the targeted populations, the production and financial model proposes that 90% of the PSH units projected for development be developed as efficiency or 1 bedroom units. Family units at 2+ bedrooms will be targeted for 10% of the new PSH units to be developed. Point-in-Time Counts in 2013 showed increases in family homelessness in two of the nine CoCs. Continued development of family units to target for those households in need of PSH is important. The Other Target Populations include generally single person households, and support the continued targeting of smaller sized PSH units.

Table III	Ohio Statewide PSH Production Strategies (1)							
	Plan Term (2): 5 years	2015	2016	2017	2018	2019		
Development Strategies and Unit Size (3)	Assumptions						Total Unit Production	
Leased Units								
Eff/One Bdrm	90%	205	205	205	205	205		1025
Two+ Bdrm	10%	23	23	23	23	23		115
Lease Production Per Year		**227**	**227**	**227**	**227**	**227**	**Total Leasing**	**1140**
Build and Integrated: Rehab/New Construction								
Eff/One Bdrm	90%	409	409	409	409	409		2045
Two+ Bdrm	10%	45	45	45	45	45		225
Build and Integrated Production Per Year		**455**	**455**	**455**	**455**	**455**	**Total Build/Integrated**	**2270**
Total Unit Production Per Year		**682**	**682**	**682**	**682**	**682**	**Total All PSH Units**	**3410**

PSH Production Plan – Costs[i] and Potential Sources

PSH projects typically need capital, operating and service funding for development and on-going successful operation. Capital is directed towards the acquisition and construction costs; rent subsidies provide supports for residents on very limited incomes to afford rents and cover building operating costs, and the service funding provides the necessary on-site service costs for residents to maintain housing. Embarking on a production plan always requires a collaborative process to invest new funds, redirect existing funds, and support and build capacity and quality.

Capital Resources

The current inventory and pipeline of nearly 14,000 PSH units in Ohio is evidence of the communities in Ohio having benefited from significant and sustained commitment of capital resources for PSH from the federal, State, and local agencies over the past two decades. Table IV- "Ohio Statewide PSH Production Development CAPITAL Resource" projects the need for capital resources necessary to produce the projected 3,410 units over the next five years of this PSH Development Plan. Per unit development costs are estimated at $173,000 based on recent OHFA PSH inventory cost certifications, and are increased at 3% annually throughout the subsequent years of the Plan. Cumulative capital costs are estimated at over $417.6 million. Note, as mentioned earlier in this report, capital expenditures are not assumed for the 1/3 PSH units (1140) created by leasing existing housing stock.

Table IV Ohio Statewide PSH Production Development CAPITAL Resources

Capital Production	Assumptions		2015	2016	2017	2018	2019		Total Capital Costs thru 2019
Estimated Per Unit Cost	3% annual escalation		$ 173,000	$ 178,190	$ 183,536	$ 189,042	$ 194,713		
Total Capital Sources Needed			$ 78,670,747	$ 81,030,869	$ 83,461,796	$ 85,965,649	$ 88,544,619		
							Total Capital Cost Needs		$ 417,673,680
Capital Production Sources									
	Annual $ (1)	Estimated % of Funding							
LIHTC Equity 9% (1)	$ 36,000,000	60%	$ 36,000,000	$ 36,000,000	$ 36,000,000	$ 36,000,000	$ 36,000,000		$ 180,000,000
HDGF (OHFA) (2)	$ 5,000,000	8%	$ 5,000,000	$ 5,000,000	$ 5,000,000	$ 5,000,000	$ 5,000,000		$ 25,000,000
OHFA Gap (OHTF)	$ 1,400,000	4%	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000		$ 7,000,000
CFEHI (OHFA/DSA) (3)	$32M/10% PSH	5%	$ 3,200,000						$ 3,200,000
County/City HOME (4)	$ 2,000,000	5%	$ 2,000,000	$ 2,000,000	$ 2,000,000	$ 2,000,000	$ 2,000,000		$ 10,000,000
HUD CoC SHP	SHP CoC Funding unlikely available for new units								
Federal Home Loan Bank (5)	$ 2,500,000	5%	$ 2,500,000	$ 2,500,000	$ 2,500,000	$ 2,500,000	$ 2,500,000		$ 12,500,000
OhioMHAS Community Capital (6)	$10MM/50% PSH	5%	$ 5,000,000		$ 5,000,000		$ 5,000,000		$ 15,000,000
Total Capital Sources Idenitified		92%	$ 55,100,000	$ 46,900,000	$ 51,900,000	$ 46,900,000	$ 51,900,000		$ 252,700,000
Capital Funding Gap		-8%	$ (23,570,747)	$ (34,130,869)	$ (31,561,796)	$ (39,065,649)	$ (36,644,619)		$ (164,973,680)

The capital projections estimate an average of $50 million per year needed for PSH development. Even with the current commitment of capital resources, additional cumulative resources of $165 million or an average of $33 million annually will be needed to carry out this PSH Production Plan.

Capital Sources Explanation
The Capital Production Resources identified in Table IV include a combination of federal and state financial sources administered by OHFA, OhioMHAS, DSA, and HUD. Resources from these agencies may be targeted for subpopulations. The Federal Home Loan Bank provides funding for supportive housing through its Affordable Housing Program. Research of past allocation by the Federal Home Loan Bank estimates $2.5 million annually targeting PSH properties in Ohio.

Resource projections for each year, and bi-annually, are assumed based on currently available funding levels. The one exception is the Capital Funding to End Homelessness Initiative (CFEHI). This program is a one-time financing resource available through spring 2015 from OHFA and DSA that is targeting housing for homeless populations. An estimated 10% of the resources (based on current applications) will likely benefit new PSH units.

A fuller description of the capital resources projected in this Plan is included in Appendix I- Explanation of Capital and Operating Sources.

Operating Resources

The major source for operation funding is typically rental income. Across all the development strategies, rental subsidies are needed to bring the PSH units within the affordability range of the target populations. The average 2014 Fair Market Rent (FMR) for different sized units with an annual inflation/escalation factor of 3% were used to estimate the projected operating subsidies needed for the 3,410 units of PSH. Persons who are homeless and those leaving institutional care, and signing a lease for the first time for PSH typically are without income to pay rent. Even those tenants with some source of income generally will still fall below an area's 30% median income. The modeling assumes conservatively that 100% of the rent is subsidized. Actual experience in PSH has shown that in later years, PSH tenants may be able to contribute to rent based on receipt of limited income from sources such as SSI, SSDI, other benefits and or employment income. The model assumes operating costs for Leasing units begin in the year of production. Operating costs for Build/Integration units are assumed to begin one year following capital production.

Operating costs are not one time costs like capital, but are repetitive in subsequent years once PSH units are brought on line. Over the course of the five year PSH Production Plan the cumulative operating needs are estimated at nearly $52 million Most significantly, once the full 3,410 PSH units are developed and occupied, the estimated annual operating costs will approach $20 million. The annual operating funding gap also increases to $13 million by year 2019. Costs associated with front desk operations are approximated at $80,000 to $100,000 per year for those PSH single-site developments. These costs are *not* included in the Table V operating cost assumptions. Funding for these costs would need to be identified in addition to the operating costs projected below, for those buildings with a concentration of PSH units.

Table V	Ohio Statewide PSH Production OPERATING Resources							
Operating Funding	**Assumptions**		**2015**	**2016**	**2017**	**2018**	**2019**	**Total**
Annual Operating Needs New Units (1)(2)	**3% escalation**		**$ 1,437,958**	**$ 4,339,044**	**$ 4,469,215**	**$ 4,603,292**	**$ 4,741,390**	
Cumulative Annual Operating Needs (3)			**$ 1,437,958**	**$ 5,777,002**	**$ 10,246,218**	**$ 14,849,509**	**$ 19,590,900**	**$ 51,901,587**
Operating - Potential Sources	**Annual $**	%						
Housing Choice Vouchers (PHAs)		68%	$977,812	$2,950,550	$3,039,066	$3,130,238	$3,224,146	$ 13,321,812
HUD/VA VASH (4)	$ 140,000		$ 140,000	$ 140,000	$ 140,000	$ 140,000	$ 140,000	$ 700,000
Ohio Housing Trust Fund (5)	**$8MM/50% PSH/biannual**		$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$ 10,000,000
Home for Good (OHFA) (6)	$ 255,000		$ 255,000	$262,650	$270,530	$278,645	$287,005	$ 1,353,830
Returning Home Ohio (ODRC) (7)	$ 902,000		$ 902,000	$ 902,000	$ 902,000	$ 902,000	$ 902,000	$ 4,510,000
Total Operating Resources			$4,274,812	$6,255,200	$6,351,596	$6,450,884	$6,553,150	
Operating Funding Gap			$ 2,836,853	**$ 478,198**	**$ (3,894,622)**	**$ (8,398,625)**	**$ (13,037,749)**	

Operation Sources Explanation

- *Housing Choice Vouchers* are permanent rental subsidies from local Public Housing Authorities (PHA.) According to CSH's pipeline tracking, a large percentage of projects that have become operational in recent years and 68% of the current pipeline of projects in predevelopment and construction have committed PHA vouchers – the majority of these commitments are project based. Therefore, we assumed this trend will continue with PHAs redirecting unused or turn over vouchers to help the projected need of PSH. The HCV are not disability specific.
- The *HUD-Veterans Affairs Supportive Housing (HUD-VASH)* program combines rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). VA provides these services for participating Veterans at VA medical centers (VAMCs) and community-based outreach clinics. Under updated HUD regulations HUD-VASH vouchers can be allocated as project based rental assistance. Recent awards to Ohio public housing authorities under HUD –VASH informed an estimate of $140,000 annual award to support new PSH units under this PSH Production Plan.
- *Home for Good* (OHFA) is a rental subsidy program established at OHFA and administered by EDEN. It is the first of its kind in Ohio, whereas four state agencies and two non-profits are partnering to provide rent subsidies to disabled persons in need of PSH but due to their criminal justice backgrounds have no access to a rental subsidy. The project is currently funded by CSH and the Ohio Department of Rehabilitation and Correction (ODRC), the Ohio Department of Medicaid and the Attorney General's office. A process evaluation on the program is being conducted by OHFA's research staff. The funds assumed in the Financial Model are based upon current availability and potential spend-downs.
- *Returning Home Ohio* (ODRC) is a reentry supportive housing project funded by ODRC and administered by CSH. CSH contracts with nonprofit PSH providers in various communities across Ohio to provide supportive housing for persons with serious mental illness (SMI) or HIV/AIDS who are leaving state prison without a housing option, or for persons homeless and within 120 days of post-release from prison who also have SMI or HIV/AIDS. The assumption is based upon a four year analysis of operational costs associated with the portfolio of Returning Home Ohio (RHO) units and upon the FY15 funding level.

Potential Operating Cost Gap Fillers

The gap in operating cost funding is a significant gap facing Ohio communities in meeting the expectations of this PSH Production Plan. Discussions with Advisory Group members and knowledge of existing resources identified the following potential Operating Cost resources for investigation to address the anticipated funding gap:

Alcohol, Drug Addiction and Mental Health Services Boards, Community Mental Health Boards and/or Alcohol, Drug Addiction Services Boards (Local Service Boards)

Local Service Boards have long invested in housing supports for their consumers – primarily as rental subsidies. At one time, the state mandated local service boards spend a portion of their state block grants on housing supports. Though that mandate no longer exits, local service boards continue to invest significantly in this area.

Among Boards' total non-Medicaid expenditures, housing supports are the lion share of their investments. Housing supports receive 47.6% of the Board's total funds compared to crisis interventions including intake and assessment at 10.3%, employment at 9.1%, bundled services at 5.8%, or any of another ten services offered. [ii] Non-Medicaid spending on housing supports specifically for permanent housing options (defined as providing full or partial rent in apartments, group homes and adult care facilities) is routine for 39 of the 53 local Boards.

Recovery Requires a Community

This new OhioMHAS/Medicaid joint program was created to support the state's Money Follows the Person (aka Housing Choice Program). Recovery Requires a Community is testing whether a source of flexible funds available to Housing Choice Transition Coordinators for people exiting nursing homes will reduce recidivisms back to nursing homes. The targeted population is people with serious mental illness – one of the populations targeted in this PSH plan. The program is experiencing demand for funds related to housing supports, such as paying past debts or short term, bridge funds for rental subsidies. The threshold for financial assistance is calculated on the potential Medicaid savings with a successful community placement after nursing home exit. This funding stream could be gap filler on operations.

Section 811 Program

In 2011, HUD updated the Section 811 Program to target capital funding and project-based rental assistance for permanent supportive housing for persons with disabilities. Funding is available competitively nationwide for states demonstrating effective partnerships between the housing finance and health and human service agencies. While not awarded resources under the first demonstration round of funding, the Ohio state agencies are aligned to compete under the current Notice of Funding. The state has applied for $11.9 million for 508 units. If awarded, the Section 811 Project Based Rental Assistance could subsidize rents for PSH units identified in this report under the Integration or Leasing Strategies. The Section 811 Program specifically supports the integration development strategy recommended based on the program requirement that no more than 25% of the units in a property can be set-aside for persons with disabilities and supported using the Section 811 rental assistance resources.

SHP CoC Program

SHP CoC Program is a HUD funded program within the McKinney Vento program and updated under the HEARTH Act for homeless services in local communities. Ohio has nine separate CoC's that administer and prioritize these funds for programs serving the homeless populations. HUD has been encouraging CoCs to shift these resources to permanent housing options, of which PSH is one. Some of the transitional housing units are meeting a local need and some may in fact be functioning as a permanent housing program. A number of the Ohio Continuums of Care have taken steps over the last several years to convert and reallocate resources from transitional housing units towards other homeless strategies. Continued efforts to shift both the physical units and the financial resources will help fill the gaps identified in the PSH Production Plan.

Services Resources

Supportive housing residents need client driven services to maintain their housing and independence. These services, listed in Appendix IV, such as outreach, engagement, independent living skills, medication management, tenancy supports and employment training are essential yet unstably financed. In order to create the 3,410 unit goal, state and local services resources must be just as intentionally secured and dedicated services resources as capital and operating resources.

CSH and other investors in supportive housing for many years have attempted to determine definitive costs to provide these housing-based services. Results of these reviews typically end with the caveat "*well, it all depends*." Differences that impact service costs per unit and thus per tenant include: Is the tenant a single adult or a family? What level of service supports does the tenant need? How are services changing over time? Does the tenant have serious behavioral health and or chronic physical health issues that require intensive interventions?

In addition, the way providers finance services varies depending on the population they serve and whether the providers receive Medicaid reimbursement. As part of this project, CSH surveyed thirty-one (31) Ohio organizations delivering services in PSH, see Appendix III. The surveys were to obtain a general indication of the level of services provided and whether the organizations receive Medicaid reimbursement. Thirteen (13) or 41% of the total solicited responded. While this was not a scientific survey, trends among the organizations informed this needs assessment and CSH's recommendations for achieving supportive housing unit creation goals.

For the purposes of this assessment and financial model, CSH also reexamined cost survey information available on Ohio PSH projects and units. The following is a summary of findings and assumptions incorporated into the PSH Financial Model. Details are contained in Appendix II - Background Information on Service Costs:

- Services costs for individuals are estimated at $8,500 per year.
    - As stated above, service costs vary based on severity of conditions and desires of the resident. Interventions such as Assertive Community Treatment (ACT), Integrated Dual Diagnosis Teams (IDDT) and in-home nursing care for people with chronic conditions is typically more expensive – providing a range of both medical and non-medical services -than housing-based case management and social support services. The estimated cost of these higher intensity housing-based case management and support services by ACT

and IDDT teams is $10,500. For purposes of the financial projections, CSH calculated the average cost of other service models at $6,500. CSH utilized $8,500, the average cost between these figures for the financial projection of service costs for the 3,410 new PSH units. Obviously, actual services costs should be determined based on the target population and individual resident needs for specific housing units.

- Service costs for all family units are estimated at $11,000 per year.[iii]
  - Though new units have been added to the pipeline for family supportive housing, Ohio lacks a source of consistent data across these projects to know for certain the cost ranges for services to families in PSH. We do know that family services are typically more expensive than those for individuals. Parenting supports, children activities, family therapy, coordinating with the education system, and engaging other systems such as child welfare are service needs for families over and above the typical services needed by individuals and often used by the adults in the family. Based upon limited information, CSH estimates families' service costs of $11,000 annually per family.

Like the operating costs, the projected service costs are not one time, but rather are on-going once the PSH units are brought on-line. Table VI – "Ohio Statewide PSH Production SERVICE Resources" identifies the annual and cumulative service costs associated with the 3,410 PSH units developed under this Plan. By 2019 the estimated annual service costs for the new PSH units will approach $28 million annually. When compared to current allocations, service resources need for new PSH units show significant gaps.

Table VI Ohio Statewide PSH Production SERVICE Resources

Service Funding Needs	Assumptions (1) (2)		2015	2016	2017	2018	2019	Total
Annual Service Needs New Units		3% escalation	$ 1,989,207	$ 6,146,651	$ 6,331,051	$ 6,520,982	$ 6,716,612	
Cumulative Service Funding Need			$ 1,989,207	$ 8,135,859	$ 14,466,909	$ 20,987,891	$ 27,704,503	**$ 73,284,370**
Services - Potential Sources	**Annual $**	**% of Funding**						
Medicaid (3)		35%-60%	$ 696,223	$ 2,474,027	$ 2,930,485	$ 3,471,160	$ 4,111,588	$ 13,683,483
HUD CoC SHP	not available for new units							
Foundations (4)		5%	$ 99,460	$ 307,333	$ 316,553	$ 326,049	$ 335,831	$ 1,385,225
Local Resources (4)		18%	$ 358,057	$ 1,106,397	$ 1,139,589	$ 1,173,777	$ 1,208,990	$ 4,986,811
Returning Home Ohio (ODRC) (5)	$ 731,000	20%	$ 731,000	$ 731,000	$ 731,000	$ 731,000	$ 731,000	$ 3,655,000
Total Service Resources Identified		**43%**	**$ 1,884,740**	**$ 4,618,757**	**$ 5,117,627**	**$ 5,701,985**	**$ 6,387,409**	**$ 23,710,518**
Service Funding Gap		**-57%**	**$ (104,467)**	**$ (3,517,102)**	**$ (9,349,283)**	**$ (15,285,906)**	**$ (21,317,094)**	**$ (49,573,851)**

Service Funding Sources Explanation

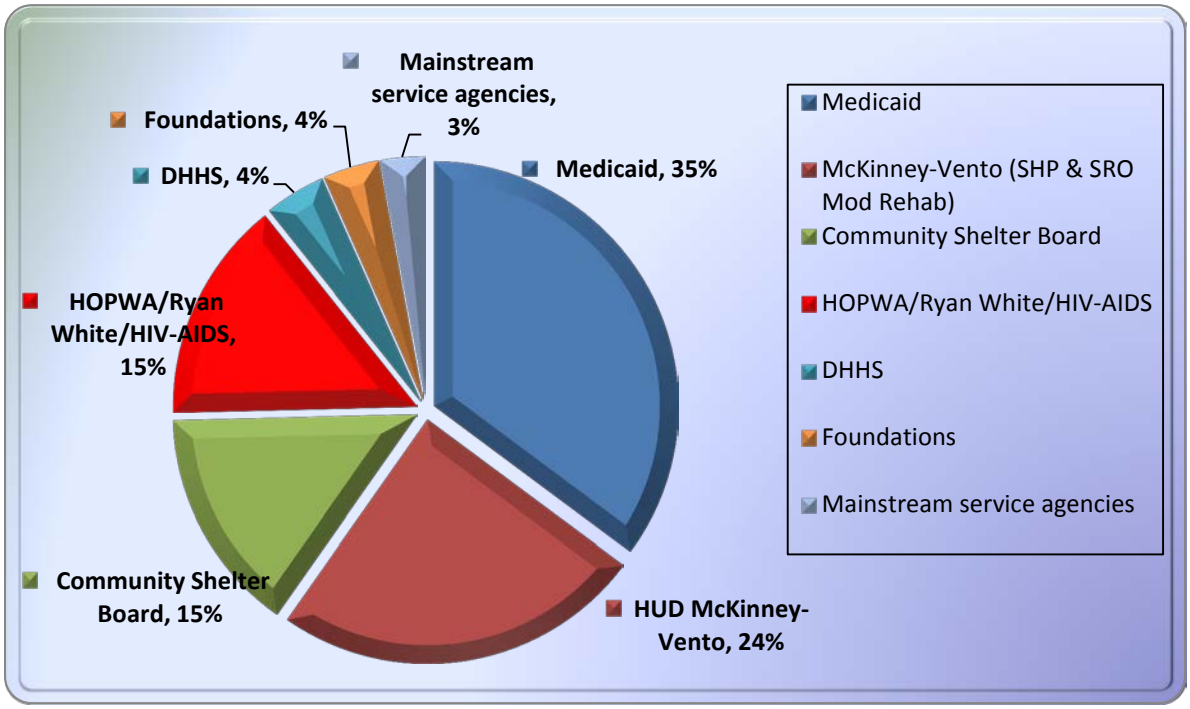
Information on the assumptions used for average service costs is provided below and in Appendix II Background on the Service Costs.

As referenced above, CSH conducted a survey in 2007 of supportive housing projects in Ohio. The survey included an analysis of the capital, operating, and service expenditures and the funding sources that paid those costs. Our follow-up general survey this year was to determine if significant changes have occurred over the last seven years on sources and uses for services.

As seen in the chart below, a third of service funding in 2007 was supplied through Medicaid eligible services. This mix appears to remain somewhat unchanged in recent years among the state's current inventory. The balance of funds in 2007 came from a variety of sources including federal Housing and Urban Development (HUD McKinney-Vento) homeless funds. Two clarifying notes to this chart: 1) Funds coming from the Community Shelter Board (CSB) for Columbus/Franklin County are public and private funds channeled through CSB available to only its portfolio of projects and 2) the sources of revenues are for *all* populations served in the surveyed supportive housing projects. Revenue sources used for single adults were not separated from revenue sources used for families in 2007 or in the 2014 surveys.

The Chart A below illustrates the *past* mix of revenue sources. It demonstrates the reliance the existing state PSH portfolio has upon HUD for services. However, HUD is no longer a service source for new PSH. This was verified in our 2014 services funding survey where respondents confirmed discontinued HUD resources. Pressure is on the Ohio Continuums of Care to continue shifting service funding away from reliance on the CoC HUD funds with the idea that those resources will be used for housing related costs. Therefore, the CSH financial model illustrates this source as no longer available. The 2014 survey of agencies confirmed the continued reliance upon local levy dollars, foundations and other state resources to finance services.

Chart A: 2007 Ohio PSH Survey on Sources of Service Funding[iv]



Medicaid for Services Funding

In Table VI, CSH assumed in the first year of the model the current Medicaid reimbursement for supportive services remains approximately a third of the total service costs, escalating to 60% of the costs by the end of the 5-year period. This escalation factor relies on the potential for Medicaid expansion for both a larger portion of the population, and future improvement and expansion of covered services. Agencies answering CSH's services financing survey indicated that they are currently able to deliver some supportive housing services to their newly Medicaid eligible clients. That change alone has likely already increased the amount of Medicaid resources being used in supportive housing but it is too early to calculate a precise percent of investment so we kept the 2015 investment at 30%. For future years, we anticipate lessons learned from several new Medicaid oriented initiatives such as Health Homes, duals eligible demonstrations, and other cost savings pilot projects will be used to improve and increase Medicaid financing of services connected to housing. In addition, these assumptions would require that providers of services in supportive housing expand their *capacity* to be Medicaid billable agencies. This capacity building could be encouraged by the state in order to take lessons learned from various initiatives to scale and ensure the new 3,410 units have adequate services financing opportunities.

Of the 2014 survey respondents, ten (10) are Medicaid billing organizations. Their Medicaid-PSH services were largely billed through behavioral health Medicaid authorities. The services these organizations received Medicaid reimbursement to deliver were consistent with some variation. While the survey does not identify why some organizations using the same Medicaid authority receive reimbursement for certain activities while others cannot, some reasons could be organizational capacity to deliver the service, flexibility given by the local service boards, and missed opportunities due to lack of communication between the local service board and the organization on the scope of reimbursable activities. Services such as initial assessment, service plan development, counseling, medication management, and independent living skills are the most common reimbursable services. Services reported as not typically reimbursed included transportation, new tenant/move in costs, support groups, job skills training and outreach.

Survey respondents also indicated that the payment model is fee for service and billed at 15 minute increments. This makes supporting staff time for activities such as: traveling between clients, supporting clients at doctor appointments, waiting in emergency rooms as the client handles anxiety (for example), and assisting with other essential but non-medical support services very difficult. Some of these challenges could be addressed by expanding allowable benefit reimbursement and changing the payment model to an outcome based case rate. There are some services that are likely not appropriate for Medicaid reimbursement and therefore should be planned for as part of state behavioral and other general resources. As mentioned above, new initiatives being carried out by the state will create lessons learned and opportunities to redesign service delivery as it relates to supportive housing. In addition, similar initiatives from other states will also inform Ohio's services financing.[v]

CSH RECOMMENDATIONS

This 2014 PSH Needs Assessment and Financial Model for Ohio is meant to be a catalyst for continued investment and new thinking on how to finance supportive housing. Based on the findings of the needs assessment, CSH shaped the following recommendations; identifying ways to move the needle forward to implementation and successfully achieving the 3,410 unit goal.

Most importantly, CSH recommends that dialogue continue among State agencies, Advisory Group members, funders, and PSH stakeholders to consider and adopt these recommendations.

Target Population Gaps

- **Addressing Additional Target Populations for PSH:** It is very clear from the discussions at Advisory Group meetings that there are significant additional populations, not currently targeted in this PSH needs assessment that should be included in future needs assessments to accurately reflect the need for PSH. The first step necessary is to conduct research to understand and collect the data available to estimate the Other Target Population need; followed by determination of the type of supportive housing strategies best suited to meet the populations' needs. Those populations identified by the Advisory Group for future assessment include:
  - residents in nursing care choosing to, and able to live in community-based supportive housing,
  - those residents transitioning from institutions with alcohol and substance abuse addictions, and
  - populations in private mental health hospitals.

- In addition, based on several pilot initiatives currently underway, the Department of Developmental Disabilities (DODD) anticipates developing a greater understanding of PSH housing models which would result in an increase of this targeted population moving from institutional facilities to PSH.

Redesigning Current Resources

- **Coordination Between Local Service Boards and Continuum of Care Resources:** Local Service Boards are highly invested in housing supports with $19.2MM spent annually on permanent housing which includes rent subsidies. However, given that HUD is shifting away from service funding, an opportunity lies with further investment of the local service boards' resources to non-Medicaid housing service supports. Balancing this increased investment with the broad demands on the local service boards' resources will be challenging. If pursued, this effort would take considerable work and direct coordination between local CoCs, agencies moving residents from institutional care, and

local service boards to ensure understanding of target population needs, that the right mix of housing subsidies and services are financed, the transition goes smoothly, and that all resources are maximized.

- **Improve Provider Medicaid Billing Capacity:** Our survey indicated some inconsistency among providers billing for Medicaid. Providers should be engaged to ensure they are maximizing Medicaid reimbursement for services, including those services that support residents in PSH. Some tenancy support services are not billable under any Medicaid authority. In addition, support is needed for organizations currently not certified as Medicaid billing entities to assist them with analyzing their current service delivery and business practices to determine if becoming certified is right for them. This would help bring federal resources to the table through the 50% Medicaid match for organizations currently relying solely on state and local services resources. This capacity building activity could also help smaller organizations who should not become Medicaid billing entities identify partners that can deliver services and receive Medicaid reimbursement. This capacity building and training will ensure that Medicaid resources are being used appropriately and state/local resources are maximized.

- **Promote Integration Strategies:** The state agencies and local organizations in Ohio are committed to expanding PSH development to include integration of units within the broader affordable housing development and market rate housing, thus leveraging a broader set of resources and development capacity. Based on existing expertise and new partnerships created under this Plan, the integration of PSH units expands opportunities to provide quality supportive housing in the community for target populations beyond this current five year PSH Production Plan. This PSH Needs Assessment Plan targets 192 residents transitioning to PSH under Ohio Department of Developmental Disabilities (DODD) community integration initiatives. Follow-up and tracking on these transitions will inform and expand the strategies and resources that DODD develops for the future transitions to community-based housing.

- **Coordination with the Ohio Department of Developmental Disabilities (DODD) Programs:** The Ohio DODD has targeted transitions to community-based housing for 960 persons from State Operated Developmental Centers and Intermediate Care Facilities by 2018. Currently DODD has allocated resources for both capital development and Medicaid Waiver services for a range of community-based housing for their target populations. Follow-up and tracking on these transitions and other special initiatives will inform and expand the strategies and resources that DODD develops for the future transitions to community-based housing, including development of permanent supportive housing for the developmental disabilities target populations.

- **Improve Targeting PSH for Vulnerable Populations**: In order to effectively target scarce resources for those who need them the most, communities throughout Ohio and around the country are implementing coordinated assessment and referral systems. These system changes enable local communities, providers and state agencies to identify those in their communities and those in institutional care most in need of, and able to benefit from permanent supportive housing, and to appropriately target a range of housing interventions to meet their needs. Continued and enhanced efforts in local Ohio communities and at state agencies involved in moving people to community-based housing to target PSH, including "moving on" strategies, can potentially free up existing PSH inventory to meet the needs of those most vulnerable populations identified in this needs assessment (and additional target populations.)

- **Advance Appropriate Transitional Housing Conversion to Permanent Housing**: Current messages from HUD under the HEARTH Regulations and annual Continuum of Care Notices of Funding instruct the local agencies to re-examine current allocation of homeless resources with a focus on creating permanent supportive housing. Transitional housing can be a vital component of a community's homeless assistance assets. Equally important, communities need to assess the effectiveness of the housing models to meet the varied needs among populations facing homelessness, as well as other targeted vulnerable populations. A number of the Ohio Continuums of Care have taken steps over the last several years to convert and reallocate resources from transitional housing units towards other homeless strategies. Continued efforts to shift both the physical units and the financial resources could reallocate those resources to help fill the gaps identified in the PSH Production Plan. CSH recommends creating a demonstration pilot with two communities whose HUD funds continue to be heavily invested in transitional housing. Work should be done to broker a pilot program to shift the investment strategies to spur new PSH units. A process evaluation could be conducted to take lessons learned.

<u>Considerations for New Resources</u>

- **Increase state rental subsidy program**: The "Home for Good", has been established in Ohio for specific populations that need PSH. In addition, Local Mental Health and Recovery Boards spend local levy funds on rental subsidies. These two resources have been used in Ohio to fill a gap due to the lack of sufficient federal rental subsidies to meet the need. States such as Illinois and New York have invested in statewide subsidies to support PSH units in a broader effort than these small and somewhat patchwork Ohio responses allow. These examples can be used to advance further investment in a more intentional manner in Ohio, especially for those populations impacting state resources in other areas.

- **Analyze Medicaid's Role in PSH Services Financing:** Based on survey respondent answers, Medicaid billing for PSH services seems confined to mental health populations. Several other populations such as those with substance use disorders, childless adults with challenges but not SSI level disabilities, and those with chronic conditions but not disabled, do not have a Medicaid benefit directed to services connected to housing. In addition, even for mental health populations, important tenancy support, management and outreach services are not reimbursable. Also, the reimbursement structure is mostly a standard fee for service arrangement. Challenges expressed by respondents indicated that their rates have been largely stagnant; they have difficulty demonstrating medical necessity for services and inconsistency among MCOs in including benefits in their plans that align with supportive housing services. Finally, our survey showed that non-Medicaid billing entities are providing the same services as those who do bill but have a much harder time finding sustainable sources of services funding. Ohio has a variety of supportive housing demonstrations that illustrate the potential cost savings to Medicaid. Therefore, it is in the state's and local service boards' interests to evaluate what services providers are able to receive reimbursement for and identify ways to improve payment mechanisms. This information can be shared across providers so that all supportive housing residents who need services can access them and their providers are paid appropriately for their work.

- This report also includes discussion of the state's efforts to transition and provide community-based housing for persons with developmental disabilities. Review of the status and capacity of the Home and Community Based Service Waiver to DD, should be reviewed so that those moving to community and PSH can have access to these resources and services.

Other Considerations

- **Improve Identification of Underutilized and Vacant PSH Units:** Each Continuum of Care is required to report in the HUD Homeless Management Information System (HMIS) regarding services and activities in their continuum. Review of these reports reveals significant variation in the utilization rates (vacancy and turnover rates) for PSH units. We recommend a further examination of those Continuums of Care with poor utilization rates at certain properties and across their system, to determine what the cause and possible solutions to improve performance or redirect resources so that these units can contribute to meeting the PSH need.

- **Support Business Modeling for Service Agencies**: Financial projections for new PSH units could benefit from additional research and present-day information across existing PSH projects on costs. The state should consider investing in a cross-section of PSH developments to verify actual service costs per unit for individuals and for families; we

also recommend that this sampling tabulate these costs in two and or three years for those tenants still remaining in PSH to determine if service costs abated over time. Our financial model is limited in acknowledging this potential to shift of resources to new tenants or those whose service needs change over time. This may be especially pertinent to the higher cost service strategies like ACT/IDDT.

END NOTES

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[i] For more information and explanations of capital, operating and services in supportive housing, check out **CSH's Supportive Housing Quality Toolkit**

[ii] Mental Health Advocacy Coalition and The Center for Community Solutions (2012) "*By the Numbers 2, Developing a Common Understanding for the Future of Behavioral Health Care, Analysis of Ohio's mental Health Non-Medicaid Spending*" Available at: *http://mhaadvocacy.org/joomla/index.php/research-materials/by-the-numbers-2*

[iii] Refer to Appendix II- Background Information on Service Costs

[iv] RWJ Taking Health Care Home initiative findings; for more information contact Oh.info@csh.org

[v] Refer to a recent CSH report "Creating a Medicaid Supportive Housing Services Benefit, A Framework for Washington and Other States, 2014. Available at http://www.csh.org/2014/08/csh-rolls-out-a-framework-for-creating-a-medicaid-supportive-housing-services-benefit/

Table Notes

Table I – Estimating Population Need for Permanent Supportive Housing (PSH)

(1) Source: HUD Homeless Assistance Programs Point-in-Time 2013 Ohio Statewide

(2) Assumption: Avg of several national multipliers and HUD AHAR OH CoC Reports 2011 (Adjusted: Tot Population less PSH +annualized PIT unsheltered)

(3) Assumption: The VA utilizes a multiplier range of 3-3.9 to annualize point-in-time counts across OH VA sites. The average multiplier used in this analysis is 3.45; 33% national estimate of chronic homelessness among veterans. US Dept. Veterans Affairs, 2014.

(4) Source: ODMH Community Linkage Database Systems Housing Placement Report 9/2012-9/2013

(5) Recovery Requires Community 2012 Analysis of Home Choice SMI Population. Estimates for identification of broader nursing home population needs require further research.

(6) Source: Reported Youth in transitional living and emergency shelter; USDHHS, Homeless & Runaway Youth - NEO-RHYMIS OH - 4/2013-3/2014

(7) DODD Target discharges from ICF/MR and SODC 2014-2018

(8) Assumptions re: % Needing PSH

* Chronic Adults and Families - 100%
* Non-chronic Adults and Families 4.7% population with serious mental illness- OHFA Needs Assessment 2015 Annual Plan
* Ex-Offender MH - estimated current placement % in PSH under Returning Home 2013-2014
* Public MH Hospitals - 20%, anecdotal information from MH hospital staff from OMHAS; and estimated recycling of 1.9 (Enterprise data - 382 admissions for 199 people)
* Nursing Home Population SMI - 20%
* Runaway Youth - 20%
* DODD estimate of DD discharges for PSH

Table II – Estimating Permanent Supportive Housing (PSH) Units Needed in the Community

(1) PSH Current Inventory Estimate based on combined CSH PSH Tracking Reports, OHFA PSH Inventory, and OhioMHAS units. OhioMHAS units are not dedicated exclusively to homeless populations.

(2) PSH Pipeline Estimate based on combined CSH PSH Tracking Reports, OHFA PSH Pipeline, and Ohio MHAS units. OhioMHAS units are not dedicated exclusively to homeless populations.

(3) Assumption: Estimated weighted average turnover rates for PSH across HUD AHAR OH CoC Reports 2011.

(4) PSH for Target DD Population over four years. Follow-up and tracking on these transitions to PSH will inform and expand the strategies and resources that DODD develops for the future transitions to community-based housing.

Table III - Ohio Statewide PSH Production Strategies

(1) PSH Production model assumes 1/3 units developed under Leasing Strategy and 2/3 developed under Build/Integrated Strategy.

Leased: Scattered or site-based units are leased by PSH provider from existing housing stock and private owner. No capital costs are assumed for leased units.

Build: Rehabilitation or new construction of new PSH units that are site-based in property owned by PSH provider

Integrated: Rehabilitation or new construction of new PSH units that are integrated in general affordable housing stock. Owned by PSH or other affordable developer

(2) Production Plan assumed at 5 years based on current development capacity and resources.

(3) Data on household size among the targeted populations suggests 90% of the PSH units projected for development be developed as efficiency/1 bedroom units. Family units at 2+ bedrooms are projected for 10% of the new PSH units to be developed.

Table IV - Ohio Statewide PSH Production Development CAPITAL Resources

(1) LIHTC Equity estimated at $.90 per LIHTC for ten years

(2) Per project investment of HDGF funding estimated at 750,000

(3) CFEHI is one time funding for shelter, transitional housing and PSH, including rehabilitation and repair of existing. Estimated

10% of total funding projected for PSH.

(4) City/County Capital funds estimated at $500,000/project for four projects per year based on OHFA review of typical PSH project financing.

(5) FHLB AIP Capital funds estimated at $500,000/project; avg. $2,500,000 awarded for Ohio in 2008-2013.

Table V- Ohio Statewide PSH Production OPERATING Resources

(1) Per unit operating costs based on average OH 2014 MSA Fair Market Rents

(2) Operating costs charged for Leasing units in year brought on line. Operating costs for Build/Integrated units assumed 1 year delay.

(3) Assumes operating costs are cumulative with costs associated with units continue to be charged in subsequent years.

(4) Annual funding based on recent award of new HUD VASH to Ohio VA Regions

(5) Funding level subject to bi-annual allocation in the legislature. Portion estimated for PSH is 50%. Can be used for operating costs in PSH

(6) Home for Good (OHFA) is a rental subsidy program established at OHFA in conjunction with three other State agencies. The funds assumed in the financial model are based upon current availability and potential spend-downs.

(7) Returning Home Ohio (ODRC) is a reentry supportive housing project funded by ODRC and administered by CSH. The proposed funding level in the financial model is based on the 2015 and a four year analysis of operational costs associated with the portfolio of Returning Home Ohio (RHO) units.

Table VI - Ohio Statewide PSH Production SERVICE Resources

(1) Per unit service costs estimated at an average $8,500.

(2) Per unit service costs increase at 3% per year.

(3) Percentage of service costs reimbursed by Medicaid is assumed at 35% of total service costs; with 15% annual increase to 60% by year 5.

(4) Estimates of percentage of service funding assumed by Foundation and Local Resources is based on Ohio PSH Survey on Sources of Service Funding in 2007 and reviewed in 2014. See detailed explanation in Appendix II- Background Information on Service Costs.

(5) Returning Home Ohio (ODRC) is a reentry supportive housing project funded by ODRC and administered by CSH. The proposed funding level in the financial model is based on the 2015 projected level and a four year analysis of operational costs associated with the portfolio of Returning Home Ohio (RHO) units.

Appendix I: Explanation of Capital and Operating Sources[1]

Capital

- **Low Income Housing Tax Credit (LIHTC)** is a program of the Internal Revenue Service that provides tax credits for projects that provide rental housing for person at or below 60% of AMI. The program is administered by the Ohio Housing Finance Agency (OHFA). Since 2005, OHFA has established a set-aside of LIHTC for permanent supportive housing developments; allocated at $4,000,000 in 2015. For purposes of this financial model, the equity raised from the allocation of LIHTC to a project is assumed at $.90 for each $1.00 of LIHTC received over 10 years.
- **Housing Development Assistance Program/Housing Development Gap Financing** is a program administered by OHFA that provides low interest loans or grants to affordable housing developers that provide housing for households at or below 50% of AMI; additional preference is given to projects that provide housing for persons at or below 35% of AMI.
- The Federal Home Loan Bank administers the **Affordable Housing Program (AHP)** which provides grants or loan dollars to nonprofits to develop housing projects affordable to households at or below 80% of AMI; 20% of the project must be affordable to households at or below 50% of AMI. The program provides competitive points to projects that serve homeless populations. Research of past allocation by the Federal Home Loan Bank estimates $2.5 million annually targeting PSH properties in Ohio.
- HUD **Supportive Housing Program (SHP)** is federal funding accessed through the Continuum of Care (CoC) process. Eligible activities include capital development, operating and rent subsidies, and some housing service funding. With reduced federal funding, allocations of SHP resources for new PSH is limited.
- **Capital Funding to End Homelessness Initiative (CFEHI)** - OHFA in collaboration with the Ohio Development Services Agency (ODSA) has created a one-time capital funding allocation of $32 million to the local Continuum of Care to assist with their strategies to end homelessness in Ohio. Funding is available 2014-2015.
- OhioMHAS **Community Capital** is a bi-annual allocation of state resources to support the development of community-based housing for persons with disabilities and populations targeted for support by OhioMHAS. The financial model assumes 50% of the $10 million bi-annual allocation would be used to support PSH for the target populations.

[1] The guidelines and regulations of the listed programs are subject to change at the discretion of the funder, applicable laws and regulations.

Operating

- **Housing Choice Voucher (HCV)**, formerly known as Section 8, is a rental assistance program that provides a direct subsidy on behalf of a tenant for rent payments. Tenants are required to pay 30% of their adjusted gross income and the HCV pays the difference. The Housing Choice Voucher program is administered by the local housing authorities across Ohio. Housing authorities have the authority to convert up to 20% of their vouchers to "project-based" which means that if a tenant leaves a unit, the subsidy remains attached to the unit.
- The **HUD-Veterans Affairs Supportive Housing (HUD-VASH)** program combines rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). VA provides these services for participating Veterans at VA medical centers (VAMCs) and community-based outreach clinics. Under updated HUD regulations HUD-VASH vouchers can be allocated as project based rental assistance.
- HUD **Supportive Housing Program (SHP)** is federal funding accessed through the Continuum of Care (CoC) process. Eligible activities include capital development, operating and rent subsidies, and some housing service funding. With reduced federal funding, allocations of SHP resources for new PSH is limited.
- The **Ohio Housing Trust Fund** provides grants to eligible applicants for homeless prevention, emergency shelter, transitional housing, direct housing and permanent supportive housing that meet the housing needs of homeless and low-income families and individuals. The financial model assumes 50% of the $8 million bi-annual allocation would be used to support PSH for the target populations.
- **Home for Good** (OHFA) is a rental subsidy program established at OHFA and administered by EDEN. It is the first of its kind in Ohio, whereas four state agencies and two non-profits are partnering to provide rent subsidies to disabled persons in need of PSH but due to their criminal justice backgrounds have no access to a rental subsidy. The project is currently funded by CSH and the Ohio Department of Rehabilitation and Correction (ODRC), the Ohio Department of Medicaid and the Attorney General's office. A process evaluation on the program is being conducted by OHFA's research staff. The funds assumed in the Financial Model are based upon current availability and potential spend-downs.
- **Returning Home Ohio** (ODRC) is a reentry supportive housing project funded by ODRC and administered by CSH. CSH contracts with nonprofit PSH providers in various communities across Ohio to provide supportive housing for persons with serious mental illness (SMI) or HIV/AIDS who are leaving state prison without a housing option, or for persons homeless and within 120 days of post-release from prison who also have SMI or HIV/AIDS. The assumption is based upon a four year analysis of operational costs associated with the portfolio of Returning Home Ohio (RHO) units and upon the PY15 funding level.

APPENDIX II - Background on the Service Costs for Ohio PSH Needs Assessment

In order to develop the estimated service costs for the PSH Needs Assessment and Financial Model several initiatives that provide services for single adults were reviewed. The tenants of each initiative examined are considered moderate to high need tenants with multiple behavioral health and primary health issues, histories of institutionalization and/or long term homelessness. One initiative, Returning Home Ohio, utilizes a mix of units –single site and scattered sites apartments - across five cities. The other initiative, Housing*first* in Cleveland & Cuyahoga County, is site-based supportive housing with 24-hour front desk support. The third initiative, or rather practice, is ACT/IDDT teams which provide an intensive, cross-disciplinary service team intervention to persons with dual diagnosis of severe mental illness (SMI) and addiction disorders. Each of these initiatives utilizes Medicaid billable services in conjunction with services reimbursed by other resources. The information from these initiatives was supplemented and compared to the state share of the average costs per single, disabled adult utilizing Medicaid. One caveat on the following table, Medicaid costs may not be entirely comparable as CSH assumed the State's Average Costs per Medicaid Client who is disabled (column 3 in Table VIa.) includes primary health care, whereas the other columns are more limited in scope.

Table VIa: Potential Service Costs in PSH for Single Adults per Unit

	CSH/ODRC Returning Home Ohio [i]	Cleveland & Cuyahoga County Housing First Initiative[ii]	The State's Average Costs per Medicaid Client who is Disabled[iii]	Average Costs for ACT/IDDT Teams in Ohio[iv]
Average Medicaid costs per person			$ 6,401	
Average for case management; service contractors; tenant assistance	$4,750	$ 6,497		
Average Medicaid Mental Health Services	$ 1,195			
Average Medicaid Substance Use Treatment	$ 534			
Total Average	**$ 6,479**	**$ 6,497**	**$ 6,401**	**$10,500**

Returning Home Ohio (RHO) and Housing*first* have evidence of tenant success in housing stability, access to recovery supports and reductions in recidivism to incarceration (RHO) and to homelessness (Housing*first*). Both are using a mix of service provisions tailored to the tenant with housing stability as a main focus.

ACT/IDDT teams require specifications to fidelity, and though often teams address homelessness and housing, this is not a required element of the model. ACT/IDDT likely has higher staff to client ratios than the other two initiatives. These teams target specific persons with serious behavioral health issues (SMI and dual diagnosed) who have not responded to more traditional service interventions and/or who are revolving between public hospitalization and community. Further, persons with SMI and dual diagnosis needing these specialized teams are approximately 20% of all consumers of a "well-functioning" mental health system.[v]

Flexible funds continue to be needed to cover the non-Medicaid costs, (such as tenant assistance, transportation and initial assessment) to provide effective services in PSH. Returning Home Ohio and OhioMHAS' Recovery Requires a Community[vi] have identified the need for flexible funds to ensure access and stability in housing. Returning Home Ohio tenant assistance is averaging $709 annually per unit. These funds often are used to pay arrears on utilities, provide optional supports such as transportation, food or other items that are not available upon move in when a new tenant is likely to have no income.

Based upon this information, CSH utilized an average service cost structure in the financial model of this report. For single adult service interventions, $8,500 is the average cost per unit.

Service Costs for Families

Service cost averages for family PSH is just as difficult to acquire. The number of PSH units dedicated to families is low. Readily available and consistent data on services rendered is nonexistent. Nationally, CSH sees service costs per unit for families on a range of $3,600 to over $15,000. Similar data and information limitations exist on these ranges for family services as described above for singles.

The Community Shelter Board (CSB) in Columbus and Franklin County regularly tracks the community's investments in its family portfolio on services and operations. The following chart provides information that is available from CSB and makes assumptions about potential Medicaid costs associated with these projects.

Table VIb: Potential Service Costs in PSH for Families per Unit

	Columbus & Franklin County Rebuilding Lives Program[vii]	The State's Average Costs per Medicaid Clients[viii]	Combined Rebuilding Lives and Medicaid Costs
Average Medicaid costs per person – same data as for single adults in Table VIa		$ 6,401	
Average Medicaid costs per child		$ 874	
Average for case management	$ 3,698		
Total	**$ 3,698**	**$ 7,275**	**$ 10,973**

Based upon this review, CSH used an average cost per unit for services in PSH for one hundred percent (100%) of families at $11,000 in the financial model of this report.

END NOTES

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[i] CSH, Ohio program www.csh.org : Nine PSH providers spending per approved budget category was analyzed for the Returning Home Ohio program years 2008, 2012, 2013 and 2014. Medicaid billable services per unit was provided by the Urban Institute's 2012 evaluation report on the Returning Home Ohio program and is available at http://www.csh.org/wp-content/uploads/2012/08/Report_Supportive-Housing-for-Returning-Prisoners_Aug12.pdf

[ii] Enterprise and the Housing*first* collaborative; costs are available at: http://www.housingfirstinitiative.org/cms__Main?name=cost-reductions

[iii] The Henry J Kaiser Family Foundation (FY2010) report is available at: http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/# and http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/ Costs are assumed to be all Medicaid costs include behavioral health and physical health care.

[iv] September 2014 Email exchange with Patrick Boyle, Director of Center for Evidence Based Practices at Case Western Reserve University (CEBP)SAMI & SE Coordinating Centers of Excellence; Annual teams range from $9,000 to $12,000 annually per 100 client team at a ratio of 1:10 staff; costs are driven by fidelity requirements of the funder and are for behavioral health treatment only.

v Bond, Gary R., Robert E. Drake, Kim T. Mueser, and Eric Latiner (2001) "Assertive Community Treatment for People with Severe Mental Illness, Critical Ingredients and Impact on Patients" Dis Manage Health Outcomes 2001:9 (3).

vi 9.9.2014 Meeting between Sally Luken, Director CSH and Adam Anderson, Manager Recovery Requires a Community, OMHAS

[vii] Community Shelter Board www.csb.org "Rebuilding Lives Funder Collaborative, Unit Cost Matrix, FY2015"

[viii] The Henry J Kaiser Family Foundation (FY2010) report is available at: http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/# and http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

APPENDIX III

CSH SURVEY:
UNDERSTANDING HOW OHIO PSH PROVIDERS USE MEDICAID

The 2014 permanent supportive housing (PSH) needs assessment project conducted by CSH for the state of Ohio presents an opportunity to improve service financing in supportive housing. Expanded supportive housing creation will be difficult if services financing is not available. With Medicaid expansion, most residents of supportive housing will have health insurance and supportive housing can help reduce/contain state Medicaid costs for these vulnerable populations.

Your answers to the following questions will give CSH an idea of the current state of Medicaid and services financing within your PSH programs. Getting this updated view of the services financing landscape, will inform our recommendations regarding increasing services capacity to meet the housing need.

Your organization has been identified as a PSH provider and/or a service provider to PSH tenants. We request your assistance in providing CSH information about services in PSH. Your answers will be aggregated to inform the PSH needs assessment. Individual organizational answers will only be shared with your prior permission. The questions are open-ended. Please type your answer and feel free to provide supplemental information. The survey is estimated to take 15 - 20 minutes. Responses are **DUE by Friday, September 5th.** If you have any questions, please contact peggy.bailey@csh.org or call at 202-715-3985 ext. 30.

Thank you in advance for taking time to complete this survey.

Contact Information (for follow up, if necessary)
Name and Title:
Organization:
Email Address:
Phone:

Survey Questions:

1. **Do you directly receive Medicaid reimbursement for any services to tenants in PSH?**

   Select: YES OR NO

If you answered no, skip to question #7.

2. **What type of Medicaid provider is your agency (mental health clinic, substance use treatment provider, FQHC, etc)? What provider qualifications do you meet (for example are you CARF accredited)?**

3. **What services do you provide within supportive housing that ARE Medicaid reimbursable?** (Feel free to copy and paste from the list on the last page of this survey. You can add additional services or change the names if necessary. Don't worry about formatting, we can sort that out.)

4. **How are you reimbursed by Medicaid? Do you have a fee-for-service arrangement or a single case rate per client? Please discuss if the rate is adequate and any other issues you would like to raise?**

5. **What services do you provide that are NOT Medicaid reimbursable?** (Feel free to copy and paste from the list on the last page of this survey. You can add additional services or change the names if necessary. Don't worry about formatting.)

6. **What sources do you use to finance these non-Medicaid billable services?**

7. **Are there differences between what is reimbursed for newly eligible vs. traditional Medicaid populations?**

After question #6, Medicaid billing agencies, can now skip to question #9

For those answering NO to Question #1, begin here.

8. **What services do you provide within supportive housing?** (Feel free to copy and paste from the list on the last page of this survey. You can add additional services or change the names if necessary. Don't worry about formatting, we can sort that out.)

9. **What funding sources do you use for supportive housing services?**

Everyone answers the following questions:

10. **Are there services your clients need but you cannot deliver due to lack of resources? Please describe these services?**

11. **What do you see as the pros and cons of Medicaid billing?**

12. **Other comments on services funding challenges or successes for your agency? Are there any service delivery partnerships you would like to tell us about?**

SUPPORTIVE HOUSING SERVICES - 2014

Housing-Based Case Management and Tenancy Supports

- **Assessment**
  - Services intake
  - Assessment-identifying client need
  - Gathering documents for eligibility determination
  - Arranging for further testing and evaluation
  - Conducting reassessments
  - Documenting assessment activities
- **Service Plan Development**
  - Service Plan Development with client
  - Writing service plan
  - Determining who should provide services
  - Obtaining signatures
  - Update and review service plan
  - Documenting service plan development
- **Referral, Monitoring, Follow-up**
  - Referrals to other ancillary services
  - Referral and related activities
  - Assist in connecting to services
  - Coordination of services identified in service plan
  - Monitoring and evaluation
  - Documenting referral, monitoring and follow-up
  - Personal advocacy
- **Medication management/monitoring**
  - Harm Reduction strategies
  - Substance abuse counseling
  - Peer counseling, mentoring
  - Education about mental illness
  - Psychotropic medication education
  - Recovery readiness
  - Relapse prevention
- **Routine medical supports, medication management, vision, dental, HIV/AIDS services**
  - Medication set-up
  - Medication coordination
  - HIV/AIDS/STD education
  - End of life planning
- **Entitlement assistance/benefits counseling**
  - Entitlement and benefits counseling
  - Application for income and food assistance
  - Application for health benefits, including Medical Assistance and specific programs funded through Medical Assistance
  - Referral to legal advocacy and assistance with appeals
  - Budgeting and financial education
- **Transportation**
  - Transportation - non-medical
  - Care manager accompaniment on appointments
- **New tenant orientation/move-in assistance**
  - Finding housing
  - Applying for housing
  - Landlord advocacy
  - Securing household supplies, furniture
  - Tenancy supports
  - Eviction prevention
- **Outreach and in-reach services**
  - Identifying and engaging with un-served, under-served individuals, and poorly-served individuals
  - Connecting individuals with mainstream services
- **Independent living skills training**
  - Nutrition education
  - Cooking/meal prep
  - Personal hygiene and self-care
  - Housekeeping
  - Apartment safety
  - Using public transportation
- **Job Skills training/education**
  - School connections
  - Access to Social Support
  - Truancy intervention
  - Access to academic support
  - Opportunities/access to GED, post-secondary training
  - Supported employment
  - Childcare (connect people to resources)
- **Domestic Violence intervention**
  - Domestic Abuse Services
  - Crisis planning, intervention
  - Child Protection assessment, follow-up
  - Referral to Legal Advocacy
  - Training in personal and household safety
  - Crisis intervention-clinic based or mobile crisis
- **Support groups Self-determination/Life satisfaction**
  - Grief counseling
  - Development of recovery plans
  - Group therapy
  - Recreation
  - Social Support
  - Community involvement/integration
  - Parenting supports and mentoring
  - Peer monitoring/support
  - Conflict resolution/mediation training
- **Respite Care**
- **Individual counseling**
- **Discharge planning**
- **Reengagement**