
Affordable, Accessible Housing: Who's Responsibility is it Anyway?
Presentation to APHA 11/7/10
MFP
MONEY FOLLOWS THE PERSON
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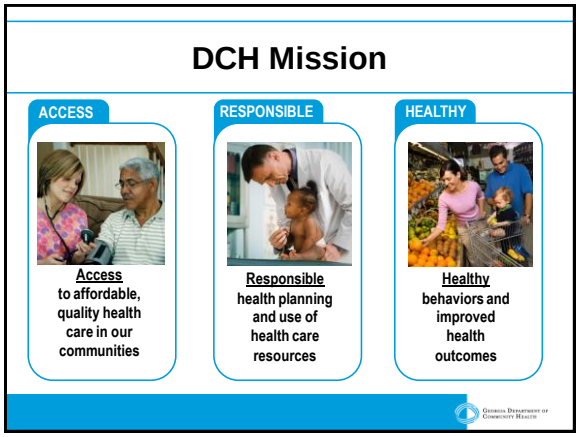
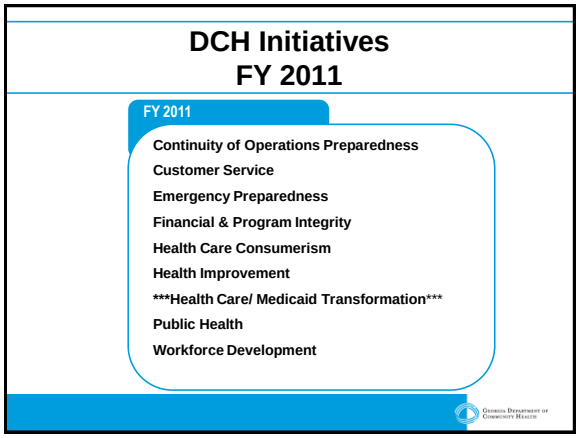

DCH Mission
ACCESS
Access to affordable, quality health care in our communities
RESPONSIBLE
Responsible health planning and use of health care resources
HEALTHY
Healthy behaviors and improved health outcomes


DCH Initiatives FY 2011
FY 2011
Continuity of Operations Preparedness
Customer Service
Emergency Preparedness
Financial & Program Integrity
Health Care Consumerism
Health Improvement
Health Care/ Medicaid Transformation
Public Health
Workforce Development

Overview of Presentation

- Theory-Participation as Outcome
- Rationale-Medicaid Transformation
- Background-Money Follows the Person (MFP)
- Problem-barriers to participation in built environments (housing)
- Methodology
- Preliminary results
- Discussion and next steps

Theory--Social Model of Disability

- Hahn's theory on the institutional creation of disability (social attitudes, environment, public policy) (Hahn, 1985, 1993)
- People with disabilities encounter barriers in society (physical and attitudinal), (Gray and Hahn, 1997)
- Barriers decrease participation in community and quality of life (Stark, Hollingsworth, Morgan, & Gray, 2007)

Theory—Environmental Contexts of Disability

- WHO-International Classification of Function (ICF)
  - Disability as universal human experience
  - functioning and disability occur in social and environmental context
  - Importance of participation
  - Barriers to participation
    - Barriers in the built environment-housing

Rationale: Why Transform Medicaid? Economic Drivers (Slide 1 of 5)

- Medicaid consumes 20% or more of state's budgets
- Elderly and disabled beneficiaries
  - represent 25% of Medicaid population
  - account for more than 65% of spending
- Medicaid Long Term Care-
  - consumes 30% of state's Medicaid budgets
  - Of this 30%, 68% is spent on institutional care, leaving only 32% to cover all HCBS (CMS)
  - Medicaid is growing faster than any other state expense

Why Transform Medicaid? Market Drivers (Slide 2 of 5)

- 54.1 million people in the U.S. have a disability (2000 Census, cited in Dowrick & Keys, 2001)
- Demand goes off the chart for Long Term Care
  - 77 million 'Baby Boomers' hit retirement age
  - Americans are living longer
    - by 2020 the number of people age 85+ will increase by more than 40% (US Census)
    - With aging comes changes in function
    - Increased need for Long Term Care services

Why Transform Medicaid? Market Drivers (Slide 3 of 5)

- Persons wishing to remain at home and/or leave Nursing Facilities and other state institutions are faced with-
  - Limited options for HCBS
  - Lack of funding for HCBS (Medicaid bias)
  - National shortage of home health providers/ direct service workforce
  - **Severe shortage of affordable, accessible and integrated housing**

Why Transform Medicaid? Policy Drivers (Slide 4 of 5)

- Medicaid Bias
  - Medicaid pays nearly 50% of all Nursing Facility bills
  - Entitlement is to institutional care
  - Institutional care more costly than Home and Community Based Services (HCBS)
- Legal/regulatory requirements
  - ADA (1990) and the Olmstead v LC (1999) decision
  - Beneficiary given 'choice' of where services are delivered
  - Services must be delivered in 'most integrated setting'

Why Transform Medicaid? Policy Drivers (Slide 5 of 5)

- Deficit Reduction Act of 2005
  - Created and Funded Money Follows the Person (MFP)
- Support in both major political parties
- States slow to shift to HCBS and away form institutional care

MFP
MONEY FOLLOWS THE PERSON

Background: Money Follows the Person (MFP)

- Created by Deficit Reduction Act (DRA)
- Largest demonstration in history of CMS
- $1.7 Billion in funding available to states to
  - Shift spending away from institutional and toward HCBS
  - Develop policy and infrastructure to support growth of HCBS
- 35,000 people targeted for deinstitutionalization
  - Older adults and people with all types of disabilities
- Reauthorized by the Patient Protection and Affordable Care Act (2010) until 2016 with no cost extension to 2020

States Participating in MFP

- Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin

How MFP Works

- Each state developed an Operational Protocol
  - How-to instructional for it's rebalancing plans
  - If CMS approved the OP, the state received a higher Federal Medical Assistance Percentage (FMAP) for services provided by the state to MFP participants
- OP addressed
  - Quality of services and quality of life of MFP participants
  - Continuation of services after discharge and after MFP
  - The use of institutional cost savings to rebalance LTC

Why MFP is Different Through MFP States Received…(Slide 1 of 2)

- 90/10 (Federal/State) Enhanced FMAP to offset costs related to deinstitutionalization
- Supplemental Services—one time services not usually covered by Medicaid
  - Housing coordination assistance to-
    - Locate affordable and accessible housing
    - Build better relationships with local housing officials, housing providers (personal care homes etc) and landlords
    - coordinate HCV applications and environmental modifications
    - coordinate housing assistance (e.g. security deposit, roommates)

Why MFP is Different Through MFP States Received…(Slide 2 of 2)

- Supplemental Services Cont.
  - community integration assistance from MFP Transition Coordinators (paid staff) and community agencies (e.g. CILs, AAA/ADRCs and DD Regional resources,)
    - to identify health services in the community and obtain supplies and equipment
    - to identify and access local transportation options
    - to increase participation in community activities
    - to improve health outcomes

Georgia's MFP Initiative

Money Follows the Person Initiative

The Money Follows the Person Initiative began as a five-year grant award to shift Medicaid Long-Term Care from its emphasis on institutional care to home and community-based services (HCBS). In 2005, before Georgia received the MFP grant, the State's long-term care expenditures were $1.5 billion with 70% expended on institutional care. The goal of the MFP grant is to increase the percentage of HCBS to just over 40% by the end of the grant or December 2011. MFP was created as part of the Federal Deficit Reduction Act of Fiscal Year 2006. Georgia MFP of over $36 million will operate through December 2011. Through healthcare reform, Georgia will now be able to access additional funds to continue the grant through 2016.

Georgia's MFP: A Cross-Agency and Cross-Sector Initiative

A Cross-Agency and Cross-Sector Initiative

MFP is a joint effort between the Georgia Department of Community Health (DCH), the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia Department of Human Services, Division of Aging Services (DHS/DAS). The Georgia Department of Community Affairs (DCA), the state housing finance authority had joined the initiative to transition 618 Georgians over four years from institutional settings to the community through Georgia's waiver programs, which include;

•The Independent Care Waiver Program (ICWP)

•The Services Options Using Resources in a Community Environment program (SOURCE)

•The Community Care Services Program (CCSP)

•The New Options Waiver (NOW) and Comprehensive Waiver (COMP)

Goals of MFP in Georgia

- Medicaid-eligible persons receive support for HCBS in settings of their choice
- Increase use of HCBS waiver services
- Encourage self-direction of personal support services (PSS)
- Increase the ability of the State to provide HCBS
- Eliminate barriers in State law, State Medicaid Plan and State budgets that prevent or restrict the flexible use of Medicaid funds

Six Georgia MFP Benchmarks

1. Transition 618 persons to HCBS waivers
2. Increase HCBS expenditures related to LTC each year
3. Reduce the number of DD beds in State ICFs by the end of the demonstration
4. Increase the rate of successful transition each year
5. Establish trusted, visible, reliable Point-of-Entry system
6. Increase the number of participants choosing self-directed Personal Support Services (PSS)

Georgia MFP Services (Slide 1 of 2)

- Peer Community Support
- Trial Visits with Personal Support Services or PCH
- Household Furnishings
- Household Goods and Supplies
- Moving Expenses
- Utility Deposits
- Security Deposits

Georgia MFP Services (Slide 2 of 2)

- Skilled Out-of-Home Respite
- Caregiver Training
- LTC Ombudsman
- Equipment and Supplies
- Vehicle Adaptations
- Environmental Modifications
- Transition Support
- Transportation

Planning for Transition under Georgia MFP

- Outreach and Recruiting
- Screening and Referral
- Person-Directed Planning & Circle of Friends
- Transition assistance to locate-
  - accessible and affordable housing
  - community transportation options
  - community healthcare, equipment & supplies
- Quality of Life Survey and LTCO services
- Continuation of services post MFP

Georgia MFP Transition Team

- MFP participant
- Transition Coordinator (TC)
- Circle of Friends, family members, friends, etc.
- NF discharge planner
- waiver case manager
- Providers and other individuals as requested by participant or deemed necessary
- Long Term Care Ombudsman

GA MFP Individualized Transition Plan (ITP)

- Person-Directed Planning and the ITP:
  - existing supports/strengths
  - goals, needs, and barriers
  - supports needed to live in the community
  - what MFP will provide (services)
  - waiver service needs
  - action steps/tasks for transition and who is responsible for each
  - budget
  - signatures

What Happens After Discharge?

- 365 days of MFP services from discharge date
- Waiver services begin on date of discharge
- Transition Coordinators make monthly contact
- Waiver case managers follow regular waiver procedure for contact
- LTCO may make face-to-face visits at 1, 6, and 12 months
- Quality of Life survey is conducted by surveyor at 12 and 24 months post-discharge

MFP & Housing: 3 Qualified Residences Defined by DRA

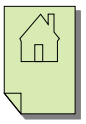
- A home owned or leased by the individual or the individual's family member,
- An apartment with an individual lease, with lockable access and egress, which includes living, sleeping, bathing and cooking areas over which the individual or the individual's family has domain and control
- A residence, in a community based residential setting, in which no more than 4 unrelated individuals reside

Problem: Housing (Built Environment) as Barrier to Participation

- Community housing not designed to meet the needs of older adults and people with disabilities
- Participation in community is impacted by how people are able to use (and not use) their environments
- Lack of housing is a barrier to participation
- Access to affordable, accessible and integrated housing is needed to increase community participation of people leaving institutions

Housing Crisis
Current Housing Volatility (Slide 1 of 3)

- State Housing Finance Authority (HFA) balancing wide variety of housing needs
  - Maximizing spread of limited housing funds, localities must create gap financing, family housing competes with special need/elderly housing
- Homeownership declining due to subprime lending market fallout
  - Affordable rental units taken by families; loss of supply
- Aging out of LIHTC and Housing Subsidies
  - Private owners converting to condos; loss of critical mass of affordable units
- Increase in real estate and housing costs
  - Pricing out of very-low income participants, based on HUD 50% AMI housing affordability rule
  - Lack of rental housing at 30% AMI, subsidies not serving very-low income



Housing Crisis (Slide 2 of 3)

- Lack of **accessible, affordable**, **integrated** housing
  - Landlords refuse to rent/sell to people with disabilities, disenfranchised-difficulty filing Fair Housing Complaints
  - Rules requiring accessible multifamily units (5-1-1) not updated since 1970; disability larger % of population
  - Modifications charged to renter; renter can't afford them
- Architectural Barriers
  - Segregated designs (stairs, narrow doorways, small bathrooms with step-in showers/tubs), not designed for 'aging in place'
  - Segregated funding of congregate housing (HUD 811/202)

Housing Crisis (Slide 3 of 3)

- What MFP participants in Nursing Facilities (NF) face:
  - If home owned, need costly environmental modifications
  - Housing and furnishings lost during extended stay in NF
  - no money for security deposits for housing, social security benefit (SSI/SSDI) used to pay NF stay (very-low income)
  - Long waiting list for project-based rental assistance units, no way to track MFP participants on waiting lists
  - Limited waiver slots and limited funding for personal services and supports (PSS)
  - need 2 or 3 bedroom unit for live-in attendant and/ or family
  - Need access to public transportation/ paratransit

The Housing Crisis… So What and Who Cares?

- No one transitions without **housing**!
- The lack of affordable, accessible and integrated housing has the potential to render MFP and Medicaid Transformation **outcomes unattainable!**
- Planning **where** and **how** people transition is as important as planning for the HCBS services needed!

Methods: Meeting the Challenge

- Environmental Context of Public/ Community Health
  - 'Community participation' as measureable Long-Term Care Outcome
- Partnerships for…
  - Economic (real estate) Development
  - Market Development
  - Policy Development
    - Top Down and Bottom Up Strategies

'Top Down' Development Strategies Services (Slide 1 of 4)

- Systematic Strategic Partner Development
  - Cross-agency/sector service partners
  - cross-disability advocacy groups
  - housers (housing providers, financers, developers, etc.)
  - transportation providers
  - community partners
- Develop mission, vision & actionable goals
- Identify dedicated staff to act as cross-agency liaisons
  - Cross-cultural communication between 'service providers' and 'housers'

'Top Down' Development Strategies Services (Slide 2 of 4)

- Needs Assessment/Analysis of Service Capacity
  - What? Determine HCBS Waiver Capacity/Slot Funding
  - Who? Identify service system inputs
    - MDS 30, Section Q and ADRCs, MFP and Olmstead lists
    - Community Agencies--AAA, CILs, PHAs, Peer Support Networks, Behavioral Health, homelessness initiatives, etc.
    - Transitions by population (OA, PD/ABI, DD, MH)
  - Where? Facilities from which transitions occur
    - Nursing Facilities and Intermediate Care Facilities (ICFs)
    - State hospitals and Psychiatric Residential Treatment Facilities
    - Determine geographically where people are resettling

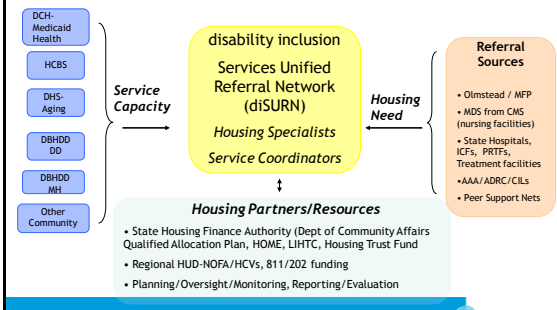
'Top Down' Development Strategies Housing (Slide 3 of 4)

- Who?
  - State Housing Finance Authority
    - Qualified Allocation Plan (QAP), Consolidated Plans, HOME, CDBG, LIHTC, HOPWA, Housing Trust Fund
  - Public Housing Authorities (PHAs)-vouchers, PBRA
  - Community Development Agencies
    - ConPlans, CHDOs, NSP, ARRA, City Planners
  - Federal Resources-HUD 811/202, NoFA /HCVs

'Top Down' Development Strategies Housing (Slide 4 of 4)

- What-Analyze housing finance tools & mechanisms
  - Resources for development of subsidized housing
  - Resources for development of affordable housing
  - Review of housing finance program guidelines and administrative rules, analysis of impediments to fair housing
- Where
  - Available Inventory, statewide registry
  - Type (single/multifamily, group, permanent supportive housing)
  - Improve information systems about housing

Georgia's 'Top Down' Approach diSURN



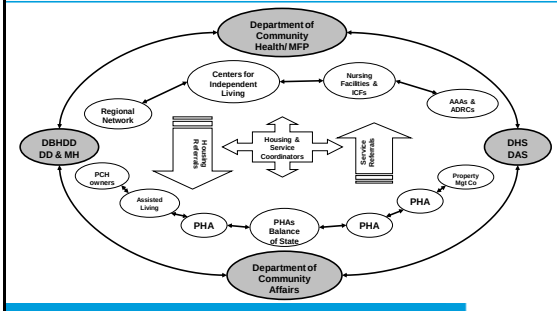
'Bottom Up' Development Strategies Outreach to 'Housers' (Slide 1 of 3)

- Develop relationships with 'housers'
  - State Housing Finance Authority
    - Disability Housing Coordinator
    - balance of state HCVs
    - www.georgiahousingsearch.org and tools behind public interface
  - Metro Public Housing Authorities (PHAs)
    - HCV/Sec 8 vouchers, project-based housing
  - Personal Care Homes, Host Homes
  - Assisted Living Centers
  - Permanent Supportive Housing (a la Housing First)
  - Property Management Companies-TBRA

'Bottom Up' Development Strategies Outreach to Participants (Slide 2 of 3)

- Housing searches begin early in transition process
  - Complete a housing needs assessment
    - Accessibility, need for environmental modifications
    - Identify assets-
      - MFP and HCBS environmental mod service funds
      - Individual Development Accounts
      - Low-Cost Loans, PASS or Medicaid Buy-in for folks who will return to work
  - Conduct housing search
    - Use local tools-GA Housing Search, United Way
    - Use local agency assistance, AAA, CILs, etc.
  - Identify type of housing needed
    - Affordable (non-subsidized and subsidized)
    - Housemate and roommate match services
    - Public Housing (HCV and project-based)
    - Get folks on waiting lists at projects

'Bottom Up' Development Strategies Graphic (Slide 3 of 3)



Housing Development Strategy Guiding Principles (Slide 1 of 2)

- Collaborations will be unique to stakeholders involved
  - Centralized transition referral access point with regional partners in different regions of the state
  - No 'right way' to develop and implement
  - Unique administrative and regulatory structures
  - Housing and services strategy development will depend on current funding available and future appropriations
- Focus on subsidy programs as bridge to community

Housing Development Strategy Guiding Principles (Slide 2 of 2)

- Create and expand access to affordable, accessible and integrated housing for all populations-
  - sustainable infrastructure
  - Include both short and long term action steps
  - Clear objectives around housing model types and number of units
  - Reliance on subsidized housing tools will not yield critical mass
  - Focus on existing programs, make new linkages, alternative uses
  - Focus on long term strategies to sustain housing after MFP
- Consistency across access points-every door is a right door
- Continuous outreach and education of cross sector agencies, organization and providers

Preliminary Results: diSURN

- Initiated Cross-sector Partnerships
  - Lead Medicaid Agency (DCH)
  - Hired MFP Housing Specialist
  - Sister service agencies (DBHDD and DHS/DAS)
- Partnership with state housing finance authority
  - Hired Disability Housing Coordinator
  - Provided 100 housing choice vouchers (balance of state)
  - Convener of metro Public Housing Authorities (PHAs)
- Obtained technical assistance (AHP)
  - Six metro PHAs applied for 615 Category I, 310 Cat II
- Promoted 'Visitability' for rehab (NSP) and new construction of both single/multi-family housing

Discussion/Next Steps (Slide 1 of 2)

- Convene diSURN partners, negotiate MOUs
- Develop referral process for new NoFA Cat II HCVs
- Develop diSURN mission, vision and key objectives
- Conduct assessment of service capacity
  - Total numbers transitioning by population, referral sources
  - Geographic distribution of transitions
  - Continuum of housing needed from permanent supportive housing, group settings, to single occupancy rental units

Discussion/Next Steps (Slide 2 of 2)

- Conduct assessment of housing finance policy/tools
  - Housing resources available-QAP, HOME, CDBG, LIHTC, etc
  - Increase number of HCVs in metro areas
- Create unified referral process
- Determine unmet need for additional housing
  - Analysis of Impediments to Fair Housing
  - Creation of affordable, accessible and integrated housing units
- Implement new home ownership initiatives

Resource List

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Resource List

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