MRTAHW_CSH_Categories for Recommendations-revised
Diane Louard-Michel
to:
affordable@health.state.ny.us
11/04/2011 02:57 PM
Cc:
Connie Tempel
Show Details

Kindly accept a slightly modified version of CSH's previously submitted documents. Upon closer review, I noticed a few typographical errors that would lead to misinterpretation of the barrier/recommendation. I also took the liberty of using a more consistent formatting and, in a few annotated circumstances, added clarifying language.

I hope you can accept these changes. Looking forward to a productive next meeting of the Affordable Housing Workgroup.

Sincerely,

Diane Louard-Michel

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**CURRENT BARRIERS TO SUPPORTIVE HOUSING DEVELOPMENT**

**CSH Submission to MRT Affordable Housing Workgroup**

**11/4/11**

## LAND AVAILABILITY

*SITING: Diminished supply of regularly configured lots without adverse site conditions*

Regulatory: Change building code to allow increased Floor Area for SH projects

Process: Other capital agencies follow OMH lead a do early site investigations in-house. Helps help NFP developers w/o deep pockets be more competitive and address challenge.

*SITING: Access to robust, early stage & robust predevelopment financing*

Process: Provide reimbursable capital expense line to cover early testing (soils, borings) to prescreen expensive surprises.

Policy: Increase LTVs for NY Acquisition Fund financing to allow additional funding for expenses needed to advance projects to construction

Provide low cost financing to experienced CDFIs to allow riskier on-balance sheet funding

*SITING: Community Support (NIMBY)*

Policy: Modify HPD SHLP requirement for affirmative community board support to "notice, education, best efforts". Reducing preconstruction time reduces costs.

**CAPITAL BARRIERS**

*REDUCED FUNDING FOR SH PRODUCTION*

Fedl Legislative: Increase State/local lobby for restoration/increases to threatened federal cuts

- HOME -
- HUD HEARTH/MV
- Section 202 Elderly -
- Section 811 –

State Policy: Restore OMH capital funding. This one-stop shop (coordinated capital, operating & services funding) has led to high production capacity, high capacity NFP development expertise, financially sound projects, increased NFP fiscal stability

*INCREASED COMPETITION FOR HCR CAPITAL RESOURCES* (OMH bonding moved to over subscribed HCR Integrated Housing Model)

Regulatory: Revise NYS Qualified Allocation Plan to further incentivize SH. 1) Can increase overall set-aside to SH development. 2) Can mandate every Low Income Housing Tax Credit development target 5-10% units to SH tenants. 3) Add points for targeting MRT high-cost beneficiaries, including people leaving long-term institutional care.

Policy: Address SONYMA concerns about exposure to OMH projects. (HCR stepping up integrated housing models in which OMH provides operating/services contracts to 50% SH population and HCR bonds/4% tax credits for entire project including balance for family AH production. Use DASNY to fund mixed use developments – MH housing contiguous to primary care facilities.

Process: Educate Regional Economic Development Councils on economic benefits /jobs creation derived from AH/SH development. Establish strategic priority for SH production as way to drive down Medicaid expenditures.

Formalize coordinated review process so HCR funding recommendations are informed by sister agencies with funding/oversight responsibilities for homeless, behavioral health and/or health systems.

Due to multiple capital funding applications (HCR capital, bonds) plus soft subsidies (i.e. HHAP, local sources, and 9% equity investment needs to reduce debt service load, development process can be prolonged adding to bottom line costs. Consider more frequent funding rounds or open application cycle to increase time lag between major approval processes.

Increased Financial Exposure for NFPs on LIHTC Syndications- More stringent investor requirements for developers to cover construction, operating and tax compliance risks. Due to increased need for NFPs to partner with for-profit developer/contractors with deeper pockets, promote greater transparency and more equitable distribution of risks/rewards by private and public sector investors.

Bond financed deals have automatic access to 4% LIHTC, thereby reducing some financing coordination delays. Opportunities to leverage private investment have increased (bank credit enhancement, debt and equity financing) but higher transactional fees (bond, legal, accounting) add to total development costs.

Policy: Incent 80/20 providers to accept SH referrals in 20% LI units. Recognize OMH supported housing subsidy provided critical assurances that rents would be paid and tenants BH

needs managed. Can incent new development or after-market incentive to lease to SH tenants.

HPD Mainstream programs - Encourage mixed use, mixed tenancy projects (i.e., new Livonia Ave RFP). Stipulate co-development of AH/SH and commercial uses including health care/community service supports. Recreate mini-settlement house models.

Policy: Engage NYCHA re Naturally Occurring Retirement Communities (NORCs) and right-sizing senior/disabled PHA housing. (CT– Elder Homelessness, Assisted Living spokespeople, Enterprise)

Regulatory: Assisted Living Redesign. Rethink regulations to provide more housing + services options for Medicaid eligible households who can avoid institutional care.

**OPERATING SUBSIDY/AFFORDABILITY BARRIERS**

*Concerns re Government Assurances of Reliable Rent Assistance to Extremely Low Income Households.*

Legislative: NYS/C lobbyists advocate for increased Public Housing & Section 8 Reform especially for Shelter + Care funding under HUD.

Process: Encourage State and Local Public Housing Authorities (PHAs) to collaboratively address issues in their Admin Plans that hamper ability to issue Section 8, esp. project based S8, to underwrite SH developments.

Lacking S8, NY/NY operating /service contracts have become defacto mitigant for operators and investors. Explore strategies to increase investor and SH operator confidence that reasonable apportionment between rental assistance and serviced supports can be made.

Explore with PHAs ways to prioritize limited supply of Housing Choice Vouchers to assist high-cost, frequent users of public systems and/or LTC patients able to transition to community based housing + services (After-market strategy to increase acceptance of HC/HN acceptance by affordable housing managers)

**SERVICE FUNDING / COORDINATION BARRIERS**

Policy: Most experienced state and local service funding agencies (OMH, OTDA, OASAS, Aids Institute, NYC DoHMH) review resources, explore calibrating service funding to better account for usage variations associated with disease management, health/wellness progression, and residential stability.

Service funding flat since 2006, despite increasing difficulty of targeted referrals to SH. Consider ways that Medicaid reinvestment can provide enhanced services, delivered by SH experts, especially during transition, adjustment and stabilization in SH settings.

Section 202 and PSH targeted to frail elderly can be a solution, provided they can access higher payment rates to defray costs of on-site nursing, case management and coordination with primary care entities.

Increase proximity of relevant care supports (FQHCs, CMHCs, senior centers, outpatient clinics, rehab services) and/or increased access to home health aides and Visiting Nurse services would help State avoid costs of unnecessary institutionalization.

Increase master-leasing AH units by NFP service providers in new and vacancies in existing/rehabbed private affordable housing stock.

Program Dev: Create NY/NY 4 agreement targeting highest cost/highest need Medicaid beneficiaries. Identify appropriate care models for core constituencies and develop cost-effective capital, operating and service funding models. Include scatter site and multi-year capital plan, starting with 500 several hundred units.

Link LTC alternatives to new MRT SH slots.
State DOH, City DoHMH and NYC HHC assess size, characteristics and costs of cohort that can step-down to PSH or avoid institutionalization.

Link homeless, unstably housed CIDP and MATS participants to new MRT SH slots. Recent Olmstead decisions mandate housing provision in least restrictive, most integrated settings making scatter site programs, clustered s/s and Integrated housing models most attractive. Immediate impacts for subset of unhoused new Health Homes/ Managed Care network of 975,000 identified as high cost/high need enrollees with 2 or more chronic conditions and/or a SPMI diagnosis.

**ACCESS / TARGETING BARRIERS** – No explicit targeting based on high cost/high utilizers of Medicaid. Needed to expedite access to SH by high cost Medicaid cohorts, who can't meet federal / local chronic homeless criteria and who currently lack access to rental assistance and coordinated funding for service supports.

Policy: Develop business case for housing high cost, frequent users of public systems. Use national and local data from FUSE (NYC demo- frequent users of jail and shelter, CASA

HOPE - NY/NY 3 active users program evaluation, CIBP & MATs outcome data showing significantly decreased positive outcomes for unhoused cohorts.

Expand use of predictive modeling, data matches, intercept models to identify and prioritize high cost Medicaid users lacking housing for SH intervention.

ACA and State Medicaid Redesign could be significant barrier to high-need MRT priority populations accessing housing IF fewer dollars overall available to fund capital, operating and service costs. Should explore Medicaid funded strategies to augment housing + services for high need beneficiaries.

Explore social impact investment models during 2 year transition to Health Homes, managed care enrollment of 975,000 uncovered high cost Medicaid beneficiaries.