BARRIERS AND SOLUTIONS

FOR DEVELOPING HOUSING AND ENSURING ADEQUATE SERVICES

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ACL's focus is OMH funded and licensed housing therefore, most of the comments in this brief will be limited to this housing. However, ACL, SHNNY and others have had conversations that lead us to similar conclusions about the systems in which our, overlapping, providers work. Therefore, some of what is in this paper is a re-iteration of what was sent in by SHNNY. However, we agree with all of their positions even though we did not incorporate all of them.

GENERAL:

- **BARRIER:** The most obvious barrier to developing more housing is the lack of money

  SOLUTION: Short of the state and city coming up with more money, they can privatize and re-invest. When the state began operating services many years ago it augmented a small non-profit community of providers. Today there are a robust number of non-profits in every part of the state that do the exact same work as the state (and city) in many program types. Also, it is a conflict for the same entity to provide oversight to programs with which they compete for consumers and resources. There is no longer a need for the state (or city) to provide services.

  - Privatize the following and re-invest the savings in housing:
    - State Operated Community Residences (See ACL Report)
    - NYC operated shelters;
    - State operated MH clinics;
    - Others to be identified.
  - Re-Invest
    - We echo the BHO workgroups recommendations to re-invest Medicaid and non-Medicaid savings that are a result of the BHO and HH initiatives into Housing and social supports.

- Invest:
    - Add language to Phase-Two BHO contracts that require them to re-invest some of the money that they save into housing, as they did in PA.
- Exempt Income
    - "Exempt income" is income that providers earned in residential settings for Medicaid reimbursable restorative services that is above the income limit that OMH imposes. OMH is taking back 50% of the amount that is above OMH's limit. There is an outstanding lawsuit – ACL is suing OMH to bar them from taking back legitimately earned, and much needed, Medicaid revenue. However, if OMH wins the current lawsuit that allows them to take this money back, NY should re-invest the $38 million currently at issue, as well as future exempt income, into housing.

INTERAGENCY COORDINATION/REGULATORY REFORM

Providers must use an array of funding sources to bring a project on-line greatly adding to time and expense. Anything that adds unnecessarily to building costs results in fewer units being built for the money. For example, experienced developers of OMH housing will say that HCR projects costs are considerably higher and much less efficient than OMH's.

- **BARRIER:** Responsibility for supportive housing development and management is dispersed across multiple State agencies, making it difficult to design and implement a cohesive development and service strategy. Building standards are different in state agencies that jointly fund projects:
    - The providers think that some building standards are expensive, time-consuming and unnecessary:
    - Multiple agency application processes for capital, operating and service funding delay development and increase risk**.** Even when capital funding is secured, service and operating funds may not be assured upon opening. Assembling such financing lengthens development times, and creates uncertainty that increases costs and risks to both developers and government agencies.
    - Capital financing from multiple agencies creates duplicative, inefficient and sometimes contradictory oversight of development and construction**.** While HCR, DASNY, and NYC HPD are all capable of providing construction oversight, there is no need to have all involved in every project.
    - The new Consolidated Funding Application (CFA) and Regional Economic Development Councils (REDC) add a new layer of review that may hinder the State's supportive housing development**.** Affordable housing developers must now apply

for HCR capital funds through the new CFA process that includes review by one of ten REDCs. While this new structure is likely to improve the effectiveness of regional economic development initiatives, it may further delay the affordable housing development process. Proposals for supportive housing in particular may be disadvantaged when judged in an economic development context by REDC members unfamiliar with the State's social service and Medicaid strategies and priorities.

- Providers serve individuals in supportive housing sites that are dually funded by HUD McKinney Vento and OMH where criteria differ. This is especially true with referrals from OMH psychiatric centers, where policies and criteria are not always in alignment.

SOLUTION: The State should establish a position in the Governor's office with authority to coordinate supportive housing efforts across agencies.
This position would lead a council of reps from HCR, OMH, OTDA, OASAS, DOH and OPWDD that would work together to:

- Establish and monitor supportive housing unit production goals;
- Streamline capital development processes;
- Simplify contract management;
- Ensure effective asset management;
- Establish placement priorities;
- Evaluate the effectiveness of service models;
- Identify and redirect new and existing resources for development, operations and services;
- Review all state agency standards and make them uniform to the extent possible;
- Review standards that add considerable cost to projects and remove them, within reason;
- Identify ways to coordinate and/or consolidate funding application procedures to reduce development time;
- Appoint one lead agency to oversee the design, construction and development processes for each project;
- Establish safeguards that prioritize supportive housing in the CFA REDC process;
  - Educate all the REDCs on the economic and social benefits of supportive housing
  - Police REDCs for unwarranted NIMBY obstruction
  - Increase the HCR Supportive Housing Set-Aside of federal Low Income Housing Tax Credits to $6 million, or to a level that ensures robust production of supportive housing by HCR.
  - Continue to exempt funding for special needs housing at other agencies (OMH, OPWDD, OTDA and OASAS) from the CFA REDC process.

- Try to limit the role of attorneys so that fees do not reach in the millions for individual projects.

A coordinator located in the Governor's office would be able to direct a cohesive statewide supportive housing policy, while allowing agencies to retain control over day-to-day budgeting and management of their supportive housing stock, service programs and client populations.

BARRIER: 45 and 90 day bed hold regulations that hold beds for person's hospitalized from an OMH Community Residences result in underutilized beds, decreased access, and financial loss to the providers.

SOLUTION: Short term step-down beds could be developed and used, freeing up the CR beds for those who need them. Those hospitalized could be put to the top of the wait list for the next bed at the CR.

SITING & ACQUISITION:

- **BARRIER:** Suitable building sites are in short supply**.** This makes it difficult to site new supportive housing residences, and often adds to costs and development delays as developers contend with additional problems when they build on less desirable sites.

  SOLUTION: Identify vacant land owned by the State, NYCHA, HHC and other localities and entities that can be allocated to supportive housing capital development**.**

- **BARRIER:** Proposed supportive housing residences often face misinformed opposition from some members of the community. This NIMBYism can cause delays, increase costs, and sometimes stop development, or reduce the number of units included in a project.

  SOLUTION: The Governor's Office can provide the leadership necessary to facilitate the successful siting of new residences. State agencies have a strong track record supporting proposed residences in the face of community opposition. The Governor's Office can respond to occasional political pressures to stop the development of specific supportive housing residences by educating community members and elected leaders about the benefits of supportive housing both to tenants and communities. In addition to State efforts, NYC HPD can work with providers to redesign its community outreach

process to make it more predictable and to shorten the time it takes to site new residences.

ACCESS and ELIGIBILITY:

- **BARRIER:** It is not clear whether units set aside in HCR-financed housing for people with special needs continue to house people with special needs, or house the most vulnerable individuals in those special needs cohorts.

  SOLUTION: Survey the existing HCR affordable housing stock to ensure that units built to serve people with special needs are indeed occupied by people with the disabilities identified for those units.

  While we may find that buildings are indeed meeting requirements in this area, those that are found to be housing fewer people with special needs than indicated in financing agreements will need to prioritize new vacancies for vulnerable people identified by the State. State agencies serving people with special needs will need to prioritize and facilitate referrals of appropriate tenants.

- **BARRIER:** We do not know how many people need housing. Although we know that there are 600,000 or 700,000 people with high needs, or that are on SSI, the vast majority of these people do not need subsidized housing. The Campaign for Mental Health Housing identified approximately 35,000 additional units that might be needed for those with chronic mental illnesses, which included the 4500 in adult homes.

  SOLUTION: Create a statewide wait list. Develop numerical targets and a long-range development plan to adequately house everyone in need.

- **BARRIER:** Information on State and local supportive housing resources is compartmentalized and incomplete so that those most in need, or their helpers, are not able to access information**.**

  SOLUTION: The State should develop a database that captures all supportive and other housing resources for people with special needs in one location**.** Such a tool could track development and occupancy, while compiling data across agencies to help inform State policy decisions and strategy.

ENSURE SERVICE and BUILDING MAINTENANCE ADEQUACY

- **BARRIER:** Supportive housing residents have increasingly complex service needs that must be met to keep residences safe and effective**.** At the same time, service and operating funds have remained flat or have been cut. It is important to note:

  - Low salaries for entry level positions make retention a challenge and reduce opportunities for staff training and development.
  - OMH Supported Housing stipends are well behind inflation. In some areas of the state, up to 90%, or more, of Supported Housing stipends now go toward rent and utilities. The expectation was that SH staffing ratios were to be 1 to 15. The reality in some areas is 1 – 30 or worse.
  - Supported Housing contracts are often with localities that pay late – up to a year.
  - Congregate OMH licensed residential programs are budget-based, **not cost-based**, are 17% behind inflation and grossly understaffed but are expected to serve those who are very symptomatic and near hospitalization. Staffing levels have not been re-visited since 1984. There is one person on evening and weekend shifts where all medications are supervised, meals need to be made and Medicaid paperwork needs to be done. It is becoming untenable. These are not re-based, there is no rate appeal and they have never been part of any statutory automatic rate increase.
  - NY/NY III service contracts remain at 2006 rates; NY/NY III rent subsidies no longer cover rent levels required by tax credit underwriting; funding for new residences is scarce.
  - OTDA NYSSHP has not had a COLA for 6 years; providers in the city received a 17% cut last year that erased the value of the previous COLA.
  - McKinney-Vento funding has made no increases to SHP after the initial awards, many of which were made 17 years ago.
  - Providers can no longer depend on Section 8 and Advantage subsidies and are being asked to rent to homeless referrals with no income.
  - HASA and OASAS contract payments are often 8 to 12 months late.

SOLUTION: Identify ways to increase and stretch service and operating funds**.** With funding streams flat or cut, and promised payments delayed or not made at all, the quality of services will suffer without some funding increases. These are needed. However, an effort should be made to find efficiencies.

- Explore re-investment strategies mentioned in the first section of this paper to re-invest into services that are attached to housing,
- Find a way to take back contracts from localities that have lengthy payment records.
- OMH should have regional contracts for Supported Housing. Providers that are in both low rent and high rent areas could move the money to where it is most effective, even adding beds for the same dollars in some cases.
- Direct more project-based and tenant-based Section 8 vouchers to supportive housing residences. The largest source is NYCHA; HCR, HPD and other authorities also control Section 8 funds.
- The State can engage with philanthropic foundations to explore opportunities to create a pilot program of social impact investment bonds that would pay for operations and services in supportive housing. Investing foundations would receive market rate or close to market rate returns only if the subsidies were measured to reduce Medicaid and other public costs. In this way, the State would only pay for success, after that success is achieved.

NEW PROGRAMS:

BARRIER: The state has not made a concerted effort to do what the MRT is trying to do now, i.e. reduce the use of some high cost programs and re-invest in lower cost alternatives.

- Providers do what they can to hold people to forestall hospitalizations, particularly if a person is in supported housing and can go into a CR for a few days to get that extra support. However, this is not really allowed, nor is it reimbursed.
- Some clients remain in a high level of care, not because they need that level of support, but because they are poor and cannot afford to live anywhere else. Providers are barred from, and would not want to, discharge people prematurely to settings that are sub-par or that would result in people cycling back to high cost services or homelessness.
- OMH transitional programs are subject to constitutional due process regulations so that discharging someone, even when the person no longer needs the level of support that the program offers and a suitable placement is available, can be difficult and time consuming keeping those in true need of the service from getting in.

SOLUTION: Re-Invest and create new alternatives to help individuals transition from high cost services and programs to lower cost services and programs.

- Create an OMH stipend program, with little to no supports, to ensure that there are enough stipends for people who no longer need the support of a CR or traditional Supported Housing.
- Convert some transitional OMH beds into crisis residences that can provide alternatives to psychiatric hospitalization. This would require a higher level of support than is provided now but the cost would be offset by reducing hospitalizations and re-admissions.
- Provide respite care opportunities for homeless people leaving hospitalizations**.** By upgrading additional Respite Centers to a Medicaid level of funding, the State can create temporary settings that remain less expensive than detox or medical hospitalization, with better outcomes at achieving placement into permanent housing.

BARRIER: Many of the high-cost Medicaid user population, because of intractable behavioral issues caused by substance abuse and untreated psychiatric problems, remain homeless, in shelters or cycle through emergency rooms because they lack a stable place to live.

SOLUTION: Create a workgroup of providers and government to apply what we've learned in successful housing and service programs (e.g., Housing First) for homeless and/or marginally housed people with chronic illnesses. In particular, consider new financial models to support "low-threshold" models of long-term transitional and "gateway" housing, some coupled with intensive clinical, medical and personal care services.