



Taking Integrated Permanent Supportive Housing (PSH) to Scale: The Louisiana PSH Program

Program Design, Implementation Lessons & Policy Implications

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Introduction

Louisiana's 3,000 unit Permanent Supportive Housing (PSH) Program is the nation's first large scale cross-disability, integrated PSH initiative to include sustainable funding for both housing and supportive services. PSH is an evidence-based, cost-effective approach that combines permanent affordable rental housing with voluntary, flexible and individualized services aimed at assisting the most vulnerable people with disabilities to live in the community. Integrated PSH approaches maximize community integration by providing a small set-aside of PSH units within affordable rental properties that primarily assist households without disabilities.

Louisiana's PSH program, which was modeled after a similar program created in North Carolina, was a critical part of the state's *Road Home* hurricane recovery plan following hurricanes Katrina and Rita in 2005. The program has had national policy significance due to several unique features that set it apart from most communities' PSH approaches which rely on a provider-by-provider strategy to develop and manage access to PSH units. Through state-level policy and partnerships that systematically offer access to a pipeline of integrated affordable housing units, and local infrastructure for outreach and service coordination, Louisiana has created an innovative and replicable PSH approach that is sustainable with mainstream affordable housing and services funding.

To date, the program has provided housing for over 2,300 of the most vulnerable people with disabilities across Louisiana's Gulf Coast region. Housing retention rates are high and average monthly Medicaid costs per person have been reduced. State and federal housing and human service officials, national, state, and local homeless and disability advocates, PSH experts, philanthropy and local service partners each played a

critical role in this success. This brief discusses key program design features, implementation lessons, and implications of Louisiana's experience for national PSH policy.

As states are under more pressure to decrease reliance on expensive institutional care and to comply with the U.S. Supreme Court's 1999 *Olmstead* decision affirming the right of people with disabilities to live in the most integrated setting appropriate to their needs, systems-level PSH approaches can offer states the opportunity to increase community living options for people with disabilities. Louisiana's PSH approach is aligned with these and other important policy goals including preventing and ending homelessness, and has already been successfully tested by other states including North Carolina, Pennsylvania and New Mexico.

Implementing PSH at scale requires certain essential building blocks be in place. Partnerships between state housing and health and human service agencies must be forged to create a new system of integrated housing opportunities aligned with appropriate supportive services to help people get and keep housing, and to ensure priority populations get served. This type of systems-level approach, in which providers no longer own or control housing, also requires a new way of organizing the outreach and referral process and for ensuring essential PSH services are available to maintain tenancies.

These state-level partnerships are similar to those required by the new HUD Section 811 Project Rental Assistance option which leverages mainstream affordable housing development resources and has the potential to create thousands of new integrated PSH opportunities each year. State-level partnerships also position states to take advantage of provisions in the Affordable Care Act (ACA) - such as the Health Home demonstration for individuals with chronic conditions, the

Rebalancing Incentive Program, the Community First Choice option, and changes to the 1915(i) home and community-based services State Plan option – which create new opportunities to implement promising and highly cost-effective supportive housing policies by leveraging Medicaid.

State agency partners were not the only players critical to Louisiana's success. Homeless and disability advocates came together and urged the federal and state government to take the required policy and funding actions necessary for the program's success. Local service partners enthusiastically adopted new PSH management responsibilities and the community-based PSH services model. Finally, TAC, a national nonprofit with extensive PSH expertise and prior experience working in Louisiana before Katrina and Rita, provided on-the-ground policy and program support through generous grants from the Melville Charitable Trust and the Robert Wood Johnson Foundation.

State-Level Partnerships

State agency partnerships provided the overall framework for Louisiana's successful PSH program design. Housing and human service officials from the Louisiana Departments of Health and Hospitals (DHH) and Children and Family Services (DCFS), the Louisiana Office of Community Development (OCD) and the Louisiana Housing Finance Agency (LHFA) were critical to making the cooperative policy decisions that led to the development of a production strategy for the creation of integrated affordable PSH units, a targeting policy to ensure the most vulnerable people with disabilities had access to those units, and a services approach that would be sustainable through Medicaid and other mainstream services resources.

Perhaps the most critical partnership was between the state's Office of Community Development (OCD) and the LA Department of Health and Hospitals (DHH). OCD was given overall responsibility for PSH program administration and became the Louisiana Public Housing Authority in order to administer federal housing subsidies tied to the program. OCD was also charged with overseeing time-limited Community Development Block

Grant (CDBG) disaster recovery funds for PSH services administered by DHH through a written cooperative agreement. The agreement also made DHH responsible to establish and implement the targeting policy, local infrastructure for outreach, referral and supportive service delivery, and a services sustainability plan.

PSH Unit Development

Louisiana's housing production strategy is based on a model pioneered by the State of North Carolina in which a state-level partnership between the Housing Finance Agency and the Department of Human Services produced policy to require 10% of the housing units in every new federal Low Income Housing Tax Credit (LIHTC) property to be reserved for PSH tenants. In a similar fashion, the Louisiana Housing Finance Agency (LHFA), in partnership with DHH, created a policy to 'set-aside' at least 5% of all units in new rental properties financed with LIHTCs. The result is a pipeline of nearly 1,200 high quality PSH units integrated in affordable rental properties created using the existing mainstream affordable housing production system.

In order to make PSH units affordable to extremely low-income households and to ensure the remainder of the 3,000 units would be secured through scattered-site leasing in the private rental market, Louisiana state officials and PSH advocates worked tirelessly for two years to ensure housing subsidies would be available for the program. Finally, in 2008 Congress appropriated funding for 2,000 Section 8 Project-Based vouchers (PBVs) & 1,000 Shelter Plus Care (S+C) subsidies specifically for Louisiana's PSH program.

The increased number of individuals with disabilities experiencing homelessness or who were at risk of homelessness following the 2005 hurricanes compelled the state to take immediate action while Congress considered the request for the 3,000 PSH rental subsidies. To address this need, the Department of Children and Family Services (DCFS), OCD and DHH created a temporary bridge rent subsidy program approach that provided immediate housing and services to over 400 homeless and at-risk households who were

later seamlessly transitioned to permanent PSH subsidies and services.

Program Eligibility & Targeting

Louisiana's *Road Home* hurricane recovery plan defined a cross-disability target population for PSH that included people with mental illnesses, substance use disorders, developmental disabilities and chronic health conditions, as well as frail elders and youth aging out of foster care. DHH worked with PSH advocates to further define eligibility among this cross-disability population to include extremely low-income households determined to be in need of the supportive services offered by the PSH program, and to devise a formal targeting policy that ensured the most vulnerable people with disabilities would be served.

In contrast to the policies that typically determine who gains access to units in homeless and disability provider-run PSH models, Louisiana created a highly centralized, state policy driven system which targets all of the state's PSH priority populations, including people with disabilities who are either homeless or at-risk of homelessness and people living unnecessarily in institutions or at-risk of institutionalization, in one initiative.

PSH Services Design

Louisiana's PSH approach required that new local PSH services infrastructure be developed to manage outreach, referral and service coordination functions which are typically handled by project owners or providers in a provider-driven PSH system. Borrowing from North Carolina's program design, DHH designated six entities to serve as Local Lead Agencies (LLAs) responsible for managing these activities. In Louisiana, the LLAs are local human service authorities responsible for mental health, substance use and developmental disabilities services, or regional DHH program offices responsible for either mental health or aging and adult services. Each LLA is responsible to manage local PSH infrastructure activities across all eligible disability groups, and an allocation of supportive service funds commensurate with the number of new PSH units

expected in their service region to 'replace' housing lost or destroyed by the hurricanes.

The LLAs manage outreach, make referrals to available PSH units, and contract for PSH supportive services, utilizing a community-based 'Housing First' philosophy which also builds strong relationships with private developers and landlords. PSH services are voluntary, individually tailored and flexible, focused on helping households get and keep housing, available 24/7 to respond to periods of crisis or increased needs, and leverage other community-based services to meet tenant needs.

Extensive training and technical assistance provided to the LLAs and local service providers was critical to ensure consistent service model implementation and to develop the staff skills and knowledge necessary to assist persons to get housing, utilize services, and achieve stable housing and recovery.

Program Outcomes

Data indicates Louisiana's program has been successful in several key areas. First, the state's PSH targeting policy has been effective in prioritizing those most in need of PSH for entry into the program. DHH examined program data nearly two-thirds of the way through leasing and found that 58% of those entering the program were homeless or at risk of homelessness at program entry, and that 10% had been institutionalized or at risk of institutionalization. Successful efforts to increase the number of institutional referrals are underway.

Second, the program has experienced an extremely low turnover rate with less than 5% of PSH tenant households exiting the program. The use of effective housing retention and eviction prevention strategies is strongly emphasized with PSH service providers. Housing sponsors and managers actively support this approach.

Third, as seen in **Figure 1**, the number of people being served who have a **single** diagnosis of either mental illness, substance use disorder or development disability is low. In fact, the program is serving individuals and

families with complex and multiple conditions. A limitation of this data, which is based on Medicaid claims for all PSH household members, is that it under-represents the number of people with primary substance use disorders being served, since Louisiana did not have a substance use benefit in its Medicaid program until very recently.

Figure 1: Diagnoses for All PSH Household Members Based on Medicaid Claims Data

Diagnosis	N	Primary Diagnosis	Single Diagnosis
DD	282	8.7%	.7%
MH	1,515	46.6%	5.1%
SA**	65	2%	.2%
Health Related	981	30.2%	30.2%
None/Other	407	12.5%	-
Total	3,250	100%	36.2%

Finally, **Figure 2** shows a 24% reduction in average monthly Medicaid costs per person served in PSH households. These costs reductions are largely attributable to reductions in institutional costs for people who were previously in long-term care or developmental disability facilities or who were receiving inpatient mental health care.

Figure 2: Medicaid Cost Savings for All PSH Household Members

Diagnosis	N	Pre	Post	% Decrease
DD	244	\$1,927	\$1,497	22%
MH	1,185	\$1,190	\$939	21%
SA	44	\$2,289	\$2,206	4%
PH	717	\$791	\$513	35%
Overall	2,402	\$1,088	\$828	24%

Services Sustainability

The disaster recovery CDBG grant funds awarded to DHH in 2008 included funds for the start-up of the LLAs and funds for PSH services as described above. DHH committed to "sustaining" services as the CDBG funds were depleted.

DHH considered a number of options to sustain these services and conducted reviews in 2009 and 2010 to analyze the demographics, types of benefits, and potential service and support needs of individuals being made eligible for PSH. These reviews revealed that over 80% of the tenants are likely to be eligible for Medicaid, and the majority of tenants will have behavioral health services needs. A significant number of individuals will be eligible for home and community-based services (HCBS) because they either have an intellectual disability or qualify for long-term care. The reviews also revealed there is a significant overlap between the interventions individuals were receiving in the PSH program and services included or proposed in the Medicaid State Plan and Waivers.

DHH and TAC examined options for retaining the successful PSH program approach embedding PSH service requirements into coverable Medicaid services. Their assessment led to DHH modifying the program design to enable DHH to sustain the program with a minimum investment of scarce state resources.

This design includes: (1) an updated governance structure for planning, policy setting, budgeting, managing, monitoring and reporting on performance and outcomes. A PSH Executive Management Council was named in 2011 with representation from OCD and DHH including the DHH Deputy Secretary, the state's Medicaid Director, Assistant Secretaries of Behavioral Health, Developmental Disabilities and Aging and Adult Services, and PSH management staff; (2) a management structure to permit DHH to conduct outreach, eligibility determination, services assignment, tracking and reporting, support for tenant-landlord liaison services and management of contingency funds for move-in assistance; and (3) PSH services interventions embedded into key Medicaid coverable services and

services coverage for individuals not eligible for the Medicaid services with embedded interventions.

PSH interventions are now embedded into Assertive Community Treatment (ACT), Intensive Case Management (ICM) and Community Psychiatric Support and Treatment (CPST) services covered in the state's Medicaid program. This was made possible when the state applied and was granted approval from CMS in 2011 for these services in an 1915(i) Medicaid State Plan. PSH service interventions will also be embedded into multiple HCBS coordination services. Services arrangements will be made with substance abuse service providers in the near future.

DHH elected to contract with their new Statewide Management Organization (SMO) selected by DHH in 2011 to manage and contract for Medicaid and state funded behavioral health services to manage the PSH program. This unique arrangement will be bolstered by inter-office agreements within DHH to assure the program sustains its cross-disability focus. Combining comparable service and management approaches into one program structure and making arrangements for provision of unique services for each disability group ensures PSH resources can be available to a greater number of people.

DHH also recognizes the need for non-Medicaid funds to cover management and services costs not coverable by Medicaid, and will utilize remaining disaster recovery funds for these purposes. The services for non-eligible Medicaid recipients will be the same as those for Medicaid recipients. These new 'sustainable' management and services arrangements go into effect in state fiscal year 2013.

Lessons Learned

There are many lessons learned from Louisiana's PSH program. Medicaid and disability services program leaders are successfully learning how to develop a sustainable statewide community integrated PSH model. Their approach is consistent with that contemplated in the Frank Melville Supportive Housing Investment Act enacted in 2011 to replace the moribund federal Section 811 program. The state took careful steps to create a cross-disability management approach, and to implement a housing targeting policy that assures individuals exiting institutions, such as hospitals, jails and nursing homes, or who are homeless, get priority access to housing and services to live successfully in the community and in their own home. All of this has been accomplished while the state is re-balancing Medicaid and other federal funds to assure PSH program sustainability. Louisiana has demonstrated a large scale cost-effective model for PSH.

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