LEGISLATIVE BUDGET AND FINANCE COMMITTEE

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

The Impact of Housing on Health

House Resolution 2023-66

October 2024

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For the ninth straight year the National Legislative Program Evaluation Society (NLPES) awarded the Legislative Budget and Finance Committee with a Certificate of Impact. The Certificate of Impact is presented to legislative offices that produce evaluations or audit reports that resulted in documented public policy changes, program improvements, dollar savings, or other public impacts.

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REPORT SUMMARY

Objectives

- *To develop background information and data relating to housing conditions.*
- *To review health-related housing initiatives across the nation and any other information or data deemed necessary or appropriate.*
- *To perform an analysis of whether there are Medicaid health expenditures related to unmet housing needs.*
- *To develop an analysis of the health care cost savings achievable through addressing unmet housing needs.*
- *To perform an analysis of the efficacy of interventions to address unmet housing needs, improve health outcomes, and reduce healthcare expenditures.*
- *To make any recommendations as to any appropriate action.*

Report Overview

This study is in response to House Resolution 2023-66, adopted by the House of Representatives on June 26, 2023, and adopted by the LBFC officers as a staff project on October 18, 2023. HR 2023-66 requires the Legislative Budget and Finance Committee (LBFC) to conduct a study and issue a report concerning the impact of housing on health in Pennsylvania.

This report was far-reaching. Although the primary focus of the study dealt with the Department of Human Services and its role in Medical Assistance and housing supports, our research led us to other governmental agencies, such as the Department of Community and Economic Development, the Pennsylvania Housing Finance Agency, the Department of Military and Veterans Affairs, and the US Department of Housing and Urban Development. We interviewed and met with numerous private organizations, including nonprofits providing direct assistance with housing and housing supports, hospitals and healthcare systems, Pennsylvania's managed care organizations, the state's continuums of care, academic researchers, and other experts in the field.

All these entities are working toward ensuring that the homeless, those at risk for homelessness, and low-income individuals and families can live in safe, affordable housing with the appropriate healthcare and supports to address their physical and behavioral health needs. From our research, however, it appears these stakeholders lack a single, overarching entity to coordinate funding streams, promote data sharing, and mitigate the challenges of this multifaceted issue in the interest of a collaborative goal. To address this, we recommend that:

1. **The General Assembly and Governor's Office convene a working group of public and private partners to address all issues surrounding the intersection of housing and health to determine the best uses of available resources, encourage coordination and data sharing among entities to maximize the impact of all services and supports, and determine the best interventions and best practices.**

In this report, we also recommend that:

2. **DHS should develop health-centered outcome measures and key performance targets for housing-related services within the MA program to ensure that state and federal Medicaid spending is being efficiently used to improve the independence and health of MA participants.**

3. **Healthcare and housing stakeholders from across the commonwealth should collaborate and engage in new data-sharing partnerships that will provide the insights needed to benefit the shared goal of improving the health and well-being of Pennsylvanians.**

4. **DHS continue to proactively engage stakeholders throughout the Keystones of Health waiver demonstration period, emphasizing statewide coordination.**

5. **DHS collaborate with managed care organizations (MCOs), community-based organizations (CBOs), and other Keystones of Health stakeholders to develop guidelines to mitigate the impact of transitioning off waiver rental assistance in situations where housing stability may not be achieved.**

6. **DHS collect data to assess potential healthcare cost savings and healthcare outcomes realized from housing support during the Keystones of Health waiver demonstration period.**

7. **The General Assembly consider requiring DHS to report findings on healthcare cost savings experienced during the waiver period to the legislature.**

8. **The General Assembly consider allowing all counties the flexibility to increase the amount of the maximum allowable fee for the optional affordable housing trust fund commensurate with their current recording fees and subsequently index the fee maximum for inflation.**

Background

According to the Department of Human Services (DHS), "Access to safe, quality, affordable housing and the services necessary to maintain stable housing constitutes one of the most basic social determinants of health.

Securing housing requires a package of supportive services that cover and facilitate the housing search, transition into stable housing, and maintenance of that situation, as each step in the process can constitute a significant barrier to housing stability."

This reasoning has recently led to an increased focus on housing and its impacts on health nationally and in the commonwealth.

Social Determinants of Health (SDOH) and Health-Related Social Needs (HRSN)

Although sometimes used interchangeably, there are distinctions between SDOH and HRSN within the healthcare industry. SDOH refers to broad environmental conditions, while HRSN are specific to the individual.

SDOH are conditions in which a person is born, grows, works, lives, and ages, and the broader set of forces and systems shaping their conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems. The Centers for Medicare and Medicaid Services (CMS) defines HRSN as "an individual's unmet, adverse social conditions that contribute to poor health."

This study focuses on housing instability, an SDOH and an HRSN, and its impacts on health.

Housing Instability

Housing instability can be defined as:

- ***Homelessness:*** individuals/families experiencing a total lack of shelter or residing in transitional or emergency shelters.
- ***Lack of affordable housing:*** households experiencing severe rent burden, overcrowding, eviction or foreclosure, and frequent moves.
- ***Poor housing conditions:*** includes many issues, such as structural issues (leaks, insulation, heating, and cooling issues) and exposure to allergens (mold, pests, chemicals, asbestos).

Various factors can impact housing instability, including:

- ***Cost Burden***: A household is cost-burdened if more than 30 percent of its income is spent on housing. A household that spends more than 50 percent on housing is said to be severely cost-burdened.
- ***Lack of Affordable Housing***: Pennsylvania has a shortage of over 260,000 affordable and available rental homes for

extremely low-income renters, with 41 available per 100 renter households.

- ***Eviction***: Evictions pose a barrier to Pennsylvanians accessing stable housing opportunities and are one of the most common causes of homelessness.

The Intersection of Health and Housing

Poor health can be a determinant of homelessness, and homelessness can contribute to poor health. A Health Affairs article stated that although there are no randomized controlled trials to prove a correlation, there is evidence to suggest that poor health is associated with an elevated risk of homelessness and that "compared to low-income populations with housing, people experiencing homelessness have a higher prevalence of acute and chronic physical and mental health conditions and higher mortality rates."

Types of Housing Services

Many organizations exist to assist those experiencing homelessness and those at risk of homelessness, including street outreach, different types of shelters, housing supports, home remediation or modifications, medical and behavioral health care, eviction assistance, tenancy support, and case management services.

Continuums of care (CoCs), generally considered the "gateway" to home and housing services, can provide access to many services, including many nonprofit organizations that provide services and support.

Cost Savings from Better Housing

Throughout our work on this report, we have sought health cost savings realized through Medical Assistance (MA) recipients receiving better housing and necessary supportive services. Robust outcomes data is limited on this topic; however, some qualified evidence of cost savings has emerged in recent years. We discuss several studies conducted in Pennsylvania in Section III of this report and further elaborate on how innovative programming for Pennsylvania's MA populations may reduce healthcare spending.

Homelessness in Pennsylvania

The McKinney-Vento Homelessness Assistance Act authorized the United States Department of Housing and Urban Development (HUD) to conduct a Point-in-Time Count (PIT), which counts sheltered and

unsheltered people experiencing homelessness. The PIT count takes place annually on a single night in January.

Pennsylvania had 9,334 homeless households and 12,556 homeless individuals in 2023. In addition to many homeless persons having health issues, of the 12,556 homeless individuals in the state, many have other extenuating circumstances, including severe mental illness, chronic substance abuse, HIV/AIDS, and can be victims of domestic violence or veterans.

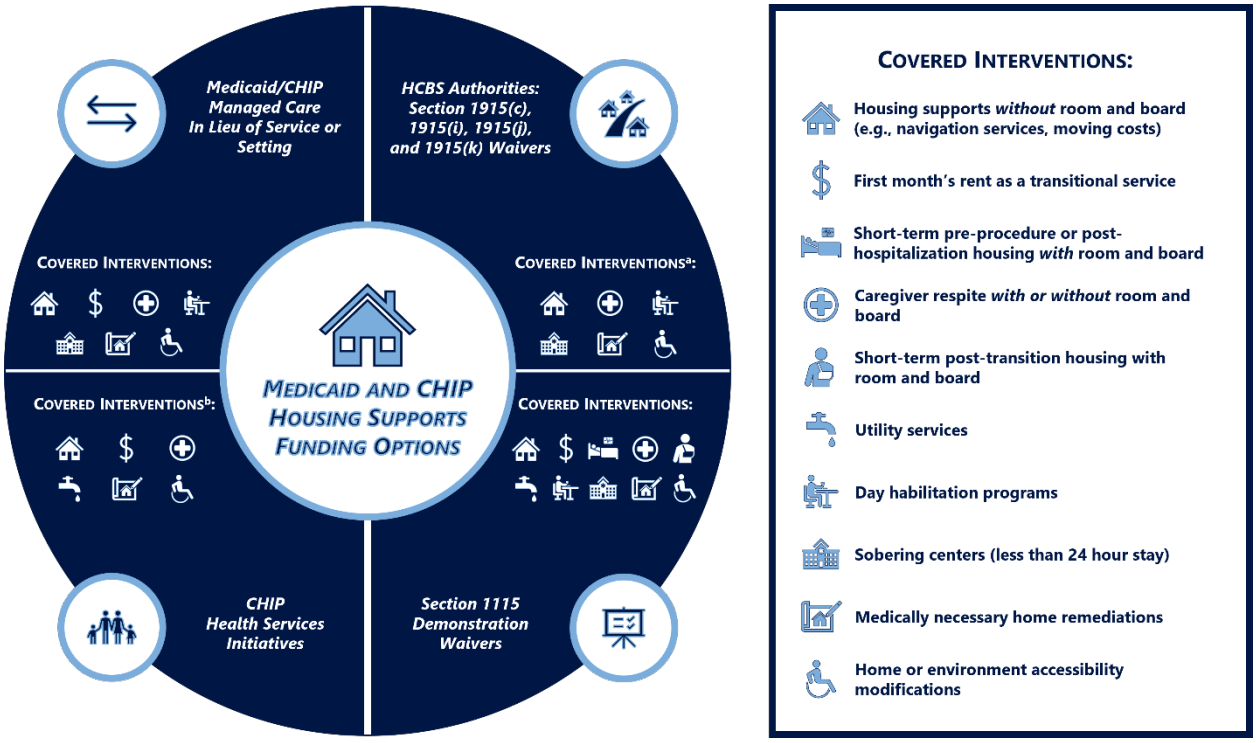
Medical Assistance and Housing

Guided by HR 66, we were tasked with determining how Medicaid expenditures are currently dedicated to unmet housing needs and examining whether those housing interventions have effectively improved health outcomes and reduced healthcare costs in the commonwealth.

Available Mechanisms for States to Use Medicaid Funding on Housing Supports

We provide an overview of the most recent guidance the CMS has distributed to states regarding SDOH and HRSN interventions in Medicaid waivers and state plan amendments. CMS has approved 10 distinct housing interventions covered under four Medicaid and CHIP authorities.

Medicaid and CHIP Housing Support Funding Options



Source: Developed by LBFC staff from information obtained from the Centers for Medicare and Medicaid Services.

Federal financial participation has historically been unavailable for room and board outside specific institutional settings. However, new guidance from CMS related to HRSN interventions has allowed states to test strategies that would have previously been unallowable.

Medical Assistance Programs with Impacts on Housing

We review the current initiatives within the DHS MA programs that provide housing supports. Many housing supports are spread across the service arrays of the MA managed care program, known collectively as HealthChoices, but some services are still paid under a fee-for-service (FFS) program.

We found that the implementation of the commonwealth's long-term services and supports (LTSS) managed care program, Community HealthChoices (CHC), resulted in the absorption of several service types into the administrative costs of managed care organizations (MCOs), leading to a significant decline in claims billing. Targeted housing

supports claims totaled $504 million during the CHC rollout between CYs 2018 to 2020 but declined to $155.8 million in 2021 and 2022. Within DHS's Office of Developmental Programs (ODP), which oversees intellectual and developmental disability services, spending on housing-related services was more straightforward, totaling over $12.2 billion for the five years.

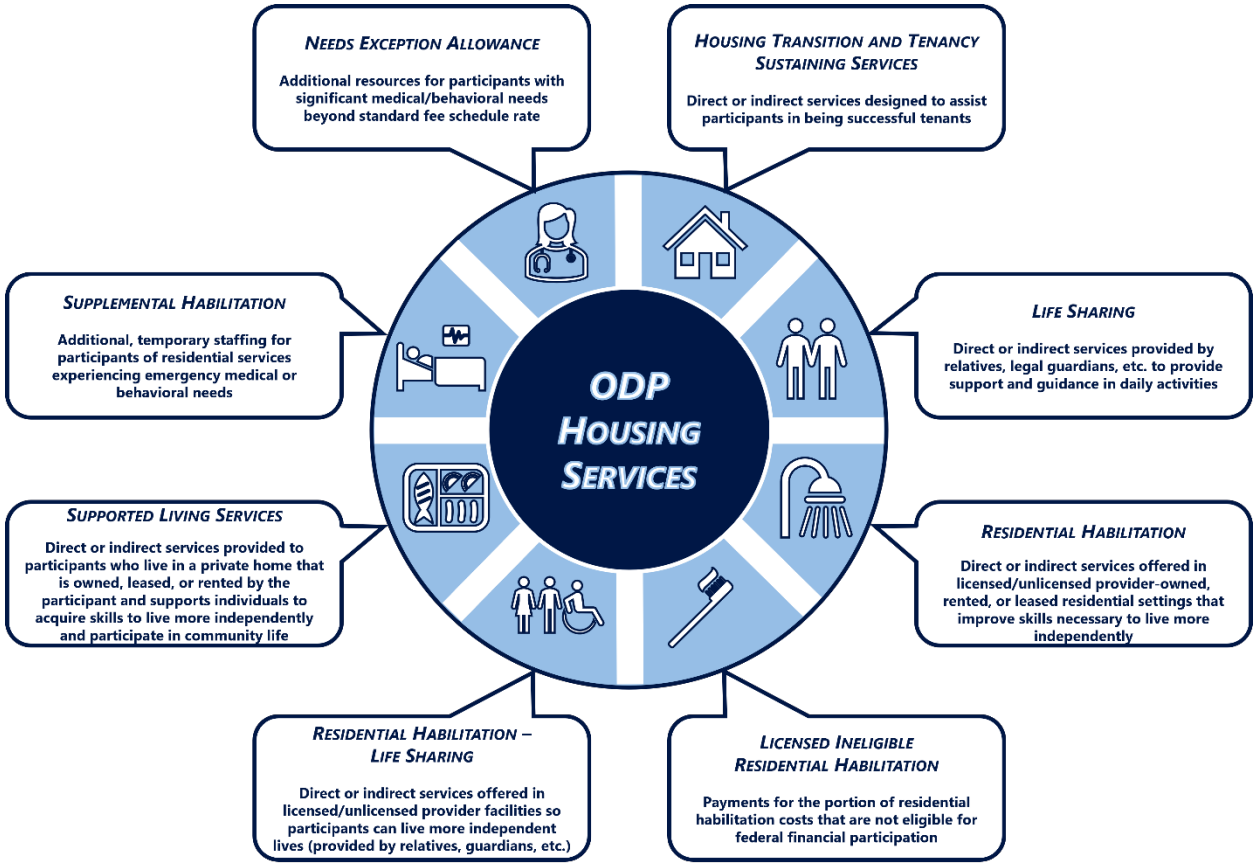
In recent years, DHS has introduced new programs—Community-Based Care Management (CBCM) and Value-Based Purchasing (VBP)—that require MCOs to work with community-based organizations that offer various services, such as housing. However, a reoccurring issue with many of the current housing-related supports in the MA program was a lack of measurable outcomes data, which prevented us from thoroughly assessing the initiatives' impacts on health and costs.

Office of Long-Term Living (OLTL). According to DHS, OLTL provides many services designed to help keep beneficiaries in, or return them to, a community setting. Our review focused on a featured subset from OLTL's array of supports:

- ***Community Transition Services:*** One-time expense for a participant transitioning from an institution (e.g., nursing facility) or other provider-operated living arrangement to a private residence.
- ***Home Adaptations:*** Physical changes to a participant's private residence to ensure health, welfare, and safety and enable the participant to have more independence in the home.
- ***Residential Habilitation Services:*** Services designed to assist a participant in acquiring the basic skills needed to maximize independence in daily living and fully participate in the activities of community life.
- ***Service Coordination:*** Functions necessary to facilitate a participant's transition from an MA-funded institution (e.g., nursing facility) to supportive housing in a community-integrated setting.

Office of Developmental Programs (ODP). ODP within DHS oversees intellectual and developmental disability services. Much like OLTL, many services are designed to maximize participant independence in a home or community setting. ODP services are paid using fee-for-service rates.

ODP Housing-Related Services and Payments[a]

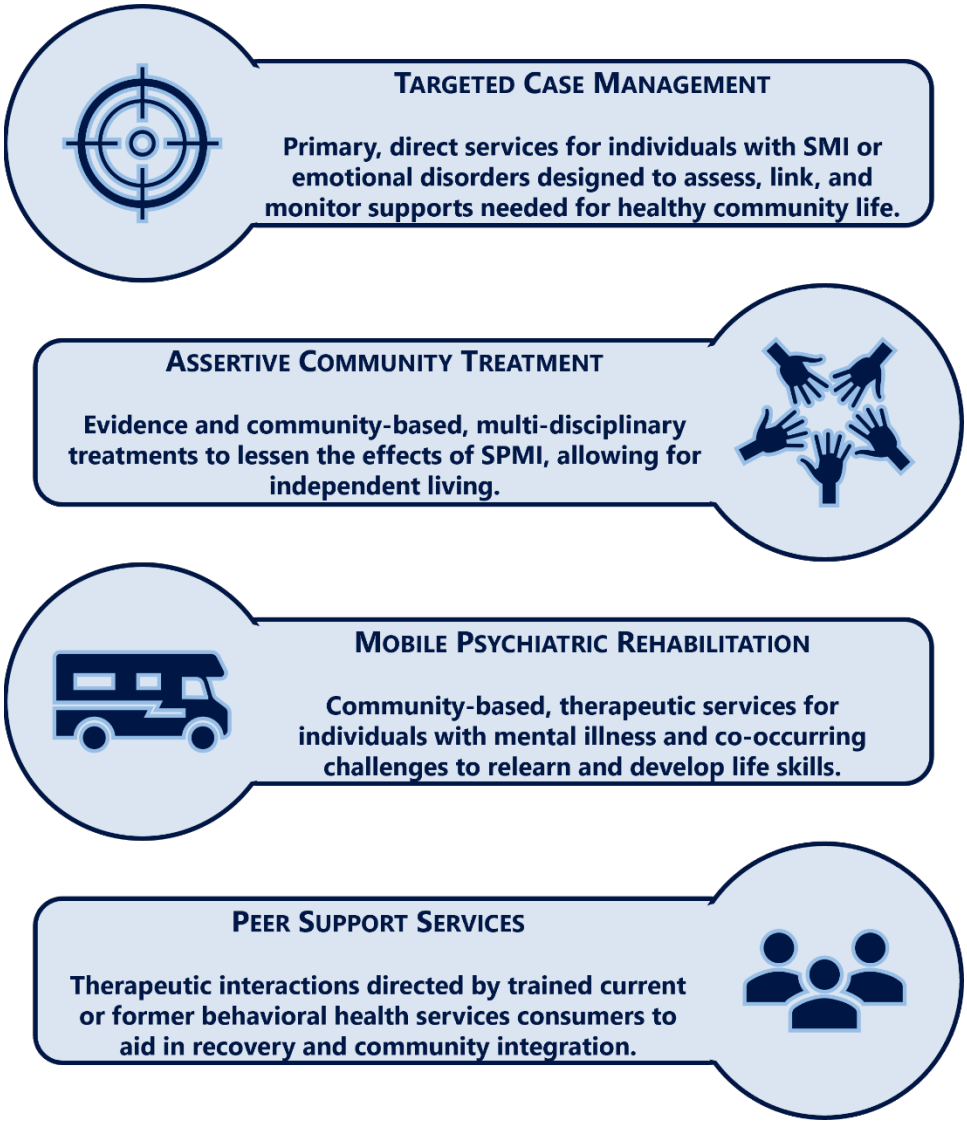


[a] Note: This summary has been simplified for illustrative purposes.

Source: Developed by LBFC staff from information obtained from DHS.

Office of Mental Health and Substance Abuse Services (OMHSAS). Within DHS, OMHSAS oversees the provision of behavioral health and substance abuse services for the MA program. The office informed us that there are four services with housing-related activities within its current MA-funded service array.

Housing-Related Services Offered by OMHSAS[a]



[a] Note: This summary has been simplified for illustrative purposes.

Source: Developed by LBFC staff from information obtained from DHS.

Initiatives to Address Social Determinants of Health and Health-Related Social Needs

In addition to the housing supports offered in the service arrays of its program offices, DHS has also started implementing initiatives to address SDOH and HRSN, including housing. These initiatives, Community-Based Care Management, Value Based Purchasing, and MCO

Revenue Sharing Plans (RSPs), are designed to be flexible enough to meet specific population needs.

CBCM, VBP, and RSP are at Various Stages within the MA Managed Care Program

	 Community-Based Care Management	 Value Based Purchasing	 MCO Revenue Sharing Plans/Reinvestment[a]
	Partnerships between MCOs and Community-Based Organizations (CBOs), hospital/health systems, or providers that use preventative services to mitigate SDOH barriers, reduce health disparities, and improve maternal and child health.	Agreements between MCOs and providers that link provider payments to the value of services provided while improving care quality, efficiency of services, reducing costs and can address SDOH barriers.	Agreements between DHS and MCOs or primary contractors allowing entities to keep half of excess revenue beyond allowable 3% profit threshold, if remaining revenue is invested in projects to support provider networks, address HRSN, advance health equity, or engage in community development.
Physical HealthChoices	✓	✓	***New in 2023***
Behavioral HealthChoices	✓	✓	✓
Community HealthChoices		✓	***New in 2024***

[a] The program utilizing excess revenues for Behavioral HealthChoices is called reinvestment, described by DHS as "capitation revenues from DHS and investment income which are not expended during an agreement period by the primary contractor may be used in a subsequent agreement period to purchase start-up costs for State Plan services, development or purchase of in lieu of and in addition to services or non-medical services, contingent upon DHS prior approval of the primary contractor's reinvestment plan."

Source: Developed by LBFC staff from information obtained from DHS.

Impacts of Housing Programs on Health Outcomes and Costs for Medical Assistance Participants

Throughout this study, we were able to engage several researchers and public health professionals who have been studying the impacts of housing on healthcare outcomes and costs for the better part of the last decade. This section outlines several of their key findings while high-lighting challenges for future consideration. We first contextualize the concept of "cost savings," which is more appropriately defined in the healthcare industry as "containing" costs from increasing further by re-ducing the use of more expensive services. Much of the research in this

discussion comes from the University of Pittsburgh Medicaid Research Center (MRC), which most recently documented MA cost savings of $162 per member, per month for permanent supportive housing (PSH) participants the year after leaving the program. However, Pitt MRC's research is still caveated by data limitations and time constraints.

Other Non-MA Funded DHS Programs and Initiatives

DHS has several other programs that MA does not fund to assist the homeless. Like those funded with Medicaid dollars, many of these programs assist individuals with developing and maintaining the skills needed to live in the community. However, unlike their MA counterparts, these DHS programs often support individuals in finding and maintaining stable housing.

- ***Projects for Assistance in Transition from Homelessness (PATH):*** A grant program that aims to reduce or eliminate homelessness for individuals with serious mental illness and substance abuse disorders who are experiencing homelessness or are at risk of becoming homeless. PATH is funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health.
- ***Homeless Assistance Program (HAP)****:* A state program administered by DHS that assists individuals and families experiencing or at risk of homelessness. HAP operates in all 67 counties and offers various supportive services, including case management, emergency shelter, bridge housing, supportive housing, and rental assistance.
- ***Permanent Supportive Housing (PSH)****:* A housing intervention strategy that combines affordable housing with supportive services to address the needs of chronically homeless individuals. PSH aims to assist individuals who face challenges such as very low incomes, persistent physical or mental health issues, or are consistently homeless or at risk of homelessness.
- ***Low-Income Home Energy Assistance Program (LIHEAP):*** This federal program, administered and partially funded by the US Department of Health and Human Services, assists eligible low-income households with heating and cooling energy costs, bill payment assistance, energy crisis assistance, weatherization, and energy-related home repairs.

Recommendations

We recommend that:

1. **DHS should develop health-centered outcome measures and key performance targets for housing-related services within the MA program to ensure that state and federal Medicaid spending is being efficiently used to improve the independence and health of MA participants.**

2. **Healthcare and housing stakeholders from across the commonwealth should collaborate and engage in new data-sharing partnerships that will provide the insights needed to benefit the shared goal of improving the health and well-being of Pennsylvanians.**

Keystones of Health

Recent CMS guidance regarding HRSN interventions in Medicaid waivers has allowed states to test new strategies to improve coverage and care for beneficiaries. Pennsylvania is also attempting to use this opportunity to improve access to housing with DHS's submission of the "Bridges to Success: Keystones of Health for Pennsylvania" Section 1115 demonstration waiver application to CMS in January 2024. The department requests a five-year demonstration period from January 1, 2025, to January 1, 2030.

Keystones of Health Waiver Overview

Using CMS guidelines and other states' best practices, the department employed an evidence-based HRSN framework to generate cost savings, enhance social supports, reduce unnecessary or avoidable healthcare utilization, and improve health-related outcomes for designated populations.

As proposed, DHS will develop services and benefits focusing on four key HRSN areas. However, our report focuses on housing supports, which are services to assist participants without stable housing in finding and keeping a place to live.

DHS proposes four housing supports and expects to impact 6,700 members over the five years of the demonstration. These supports will consist of services designed to work alongside community, local, and state-run programs:

1. ***Pre-Tenancy, Transition Navigation, and Case Management Supports:*** Supports connecting participants to navigation and case management services, including local housing specialists for pre-tenancy and transition services. These specialists will assist participants with local, state, and federal program applications (covering application fees, form completion, etc.) and help beneficiaries find and maintain stable housing.
2. ***One-Time Transition Start-Up Services:*** Single-use services to cover moving costs and other transitional needs, including but not limited to application fees, inspection fees, fees to obtain necessary identification, security deposits, first month's rent, utility activation fees, movers, relocation expenses, pest control, and the purchase of household goods and furniture.
3. ***Rental Subsidies for Up to Six Months:*** Payment of rental subsidies, including rental and temporary housing assistance, for up to six months.
4. ***Tenancy Sustaining Services:*** Provide assistance and guidance to participants, including tenant rights education and eviction mitigation support.

For housing support in Keystones of Health, DHS has listed two hypotheses it will attempt to prove over the five-year waiver period. First, the department will test the theory that expanding housing supports will reduce homelessness, homeless recidivism, and housing instability of individuals. Secondly, DHS will examine the statement that improvements in housing stability will improve access to recommended or preventive care. DHS is working to determine methods to measure waiver outcomes.

With the waiver's pending status, projecting potential costs for Keystones of Health is challenging. The waiver costs are intended to be budget neutral, and DHS included estimates in its waiver application.

1115 Demonstration Waivers in Other States: HRSN Waiver Framework

In December 2022, CMS released guidance for addressing HRSN under Section 1115 waivers. Through the 1115 waivers, CMS has allotted states the flexibility to design and improve their programs for Medicaid beneficiaries through clinically appropriate and evidence-based HRSN services and supports, care delivery transformations (including data sharing), and performance measurements.

As of February 2024, eight states have approved 1115 waivers under the new HRSN framework, which covers certain evidenced-based housing and nutrition services for specific high-need populations that include high-risk children, high-risk pregnant individuals, individuals who are

homeless or at risk of becoming homeless, individuals with SMI or SUD, and individuals experiencing high-risk care transitions (including transitions from institutional care or hospitals for people with disabilities and older adults) designed to mitigate the negative health impacts of unmet HRSN.

The states are:

- Arizona.
- Arkansas.
- California.
- Massachusetts.
- New Jersey.
- New York.
- Oregon.
- Washington.

All states approved under the new 1115 HRSN framework have an identified target population, which includes health needs criteria and social risk factors. Because these states are still in various implementation stages, we could not report any results of their demonstration waivers.

Recommendations

We recommend that:

1. **DHS continue to proactively engage stakeholders throughout the Keystones of Health waiver demonstration period, emphasizing statewide coordination.**

2. **DHS collaborate with managed care organizations (MCOs), community-based organizations (CBOs), and other Keystones of Health stakeholders to develop guidelines to mitigate the impact of transitioning off waiver rental assistance in situations where housing stability may not be achieved.**

3. **DHS collect data to assess potential healthcare cost savings and healthcare outcomes realized from housing supports during the Keystones of Health waiver demonstration period.**

4. **The General Assembly consider requiring DHS to report findings on healthcare cost savings experienced during the waiver period to the legislature.**

US HUD and PA DCED Housing Programs

This section discusses how HUD funds housing programs for states and how federal funding is being used in Pennsylvania to impact health and housing issues.

McKinney-Vento Homeless Assistance Act

In 1987, Congress enacted the Stewart B. McKinney Homeless Assistance Act in response to the homeless crisis in the United States, and in 2000, the Act was renamed the McKinney-Vento Homeless Assistance Act. HUD administers several homeless assistance programs under the act. Through outreach, shelter, transitional housing, supportive services, short-and medium-term subsidies, and permanent housing, individuals and families experiencing homelessness or at risk of homelessness are supported through its program efforts.

In 2009, the HEARTH Act amended and reauthorized the McKinney-Vento Homeless Assistance Act and consolidated three homeless assistance programs into the HUD CoC Program.

Continuum of Care and Emergency Solutions Grant (ESG) Programs

The Continuum of Care program is a competitive grant for nonprofit providers, states, Indian tribes, or tribally designated housing entities "designed to promote a community-wide commitment to the goal of ending homelessness."[1] The ESG program is a formula grant for metropolitan cities, urban counties, territories, and states, otherwise called Direct Entitlement Communities.[2] It aims to assist those experiencing a housing crisis and at risk of becoming homeless in gaining access to permanent housing.

Under HUD, CoC and ESG recipients must use a centralized or coordinated entry (CE) process for all programs and projects. The CE process aims to increase local crisis response systems and improve fairness and ease of access to resources. CE helps communities prioritize the needs of individuals and families, identify service needs and gaps, allocate

[1] *See* https://www.hud.gov/program_offices/comm_planning/coc, accessed January 6, 2024.

[2] *Direct Entitlement communities* are principal cities of Metropolitan Statistical Areas (MSAs), other metropolitan cities with populations of at least 50,000, and qualified urban counties with populations of at least 200,000 (excluding the population of entitled cities). *Non-entitlement communities* are smaller units of general local government: cities with populations of less than 50,000 (except cities designated principal cities of Metropolitan Statistical Areas) and counties with populations of less than 200,000.

resources, and identify additional resource needs. Four key elements within the assessment and referral process work in tandem to connect participants to housing and resources:

- Assessment.
- Scoring.
- Prioritization.
- Determining Eligibility.

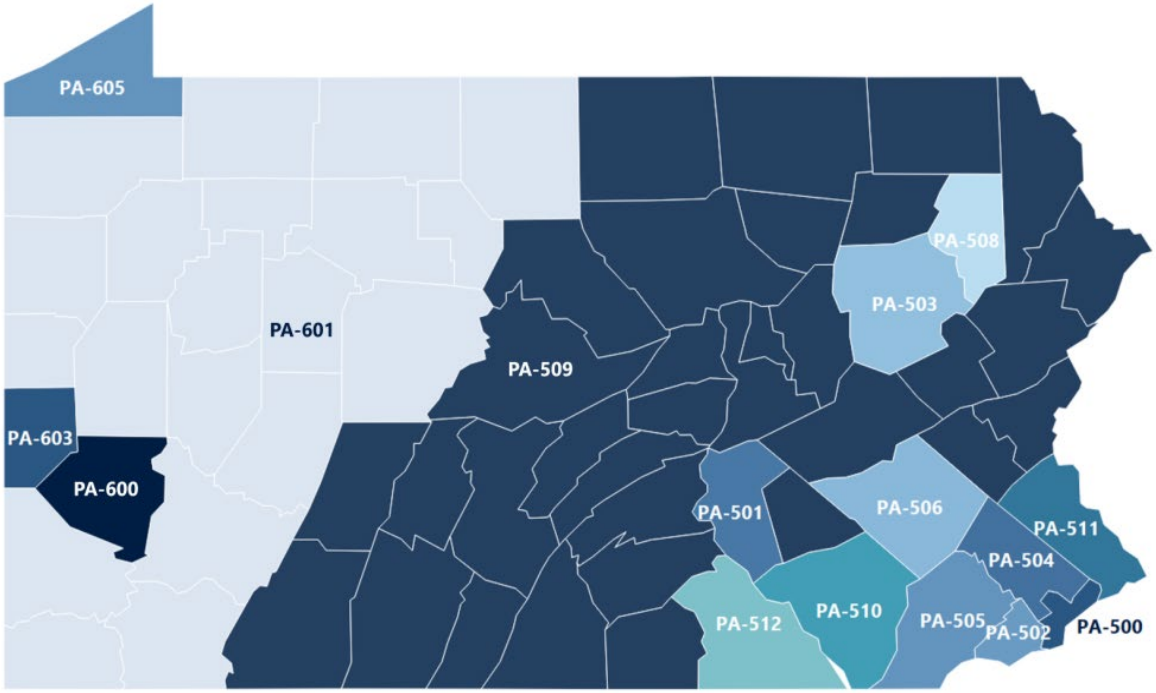
Continuums of Care. HUD defines a CoC as "a collaborative funding and planning approach that helps communities plan for and provide, as necessary, a full range of emergency, transitional, and permanent housing and other service resources to address the various needs of homeless persons."[3] Funds granted to a CoC can be used to support activities under five primary program components:

- Permanent housing (permanent supportive housing and rapid re-housing).
- Transitional housing.
- Supportive services only.
- Homeless management information system.
- Homelessness prevention in HUD-designated, high-performing communities.[4]

Pennsylvania has 16 CoCs, 14 of which are single-county entities.[5] The remaining 53 primarily rural counties are divided into two COCs, the PA-509 Eastern PA CoC and PA-601 Western PA CoC. The two COCs operate independently, but also advance joint efforts to end homelessness and are administered by the Department of Community and Economic Development (DCED).

[3] HUD refers to the group of service providers involved in decision-making as the "Continuum of Care."
[4] CoCs may also use funds for certain administrative costs.
[5] Pennsylvania CoCs are as follows: Philadelphia (PA-500), Harrisburg/Dauphin County (PA-501), Upper Darby, Chester, Haverford/Delaware County (PA-502); Wilkes-Barre, Hazelton/Luzerne County (PA-503); Lower Merion, Norristown, Abington/Montgomery County (PA-504); Chester County (PA-505); Reading/Berks County (PA-506); Scranton/Lackawanna County (PA-508); Eastern Pennsylvania (PA-509); Lancaster City and County (PA-510); Bristol, Bensalem/Bucks County (PA-511); York City and County (PA-512); Pittsburgh, McKeesport, Penn Hills/Alleghany County (PA-600); Western Pennsylvania CoC (PA-601); Beaver County (PA-603); and Erie City and County CoC (PA-605).

Pennsylvania Statewide Continuums of Care



Source: Developed by LBFC staff from the PA Department of Community and Economic Development.

Emergency Solutions Grant. ESG is a formula grant program for states, metropolitan cities, urban counties, and territories that aims to assist those experiencing a housing crisis or homelessness in gaining access to permanent housing. In Pennsylvania, 21 entitlement communities received funds directly from HUD during the most recent calendar year.[6] ESG is a competitive application grant program for metropolitan cities, urban counties, and territories that may subgrant ESG funds to private nonprofit organizations. ESG grant recipients require a 100 percent match requirement for awarded funds on eligible activities under the program.

ESG Funds may be used for individuals and families experiencing homelessness or at risk of becoming homeless. The ESG program provides funding to:

- Engage homeless individuals and families living on the street.

[6] Direct Entitlement communities are principal cities of Metropolitan Statistical Areas (MSAs), other metropolitan cities with populations of at least 50,000, and qualified urban counties with populations of at least 200,000 (excluding the population of entitled cities).

- Improve the number and quality of emergency shelters for homeless individuals and families.
- Help operate these shelters.
- Provide essential services to shelter residents.
- Rapidly re-house homeless individuals and families.
- Prevent individuals and families from becoming homeless.

Eligible ESG-funded projects include street outreach, emergency shelter, homelessness prevention, rapid re-housing, and data collection.

Community Planning and Development Housing-Related Grant Programs

Title 1 of the Housing and Community Development Act of 1974 authorizes several community development and planning programs. HUD regulates and DCED administers the following programs under the act for non-entitlement communities.[7] Through a comprehensive consolidated plan, formula grants are used to allocate funding for the following programs:

1. ***Community Development Block Grant (CDBG)****:* Grants for community development activities directed toward neighborhood revitalization, economic development, and improved community facilities and services.
2. ***HOME Investment Partnerships (HOME):*** Grants to states, units of general local government, consortia, and insular areas ("participating jurisdictions") to implement local housing strategies to increase affordable housing opportunities for low- and very low-income families.
3. ***Housing Opportunities for Persons with AIDS (HOPWA):*** Formula grants to states and units of general local government, and competitively awarded grants to states, units of general local government, and nonprofit organizations to provide housing assistance and related supportive services to meet the housing needs of low-income persons living with HIV/AIDS and their families.
4. ***Emergency Solutions Grants (ESG):*** Grants to provide emergency assistance to people who are homeless or at risk of homelessness and help them quickly regain stability in permanent housing.

[7] Grants for three of these components are awarded to entitlement communities through HUD and non-entitlement communities through DCED. Under the HOPWA Program, HUD makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.

Other DCED Administered Programs

Two additional housing-related programs are federally funded and administered by DCED.

Whole-Home Repairs Program (WHRP). The WHRP authorized DCED to issue guidelines and award grants. It provides funding to county-wide agencies (county government, nonprofit organizations, or governmental entities) to address habitability and safety concerns, provide measures to improve energy or water efficiency and make housing units accessible for individuals with disabilities. WHRP program grantees can make grants available to homeowners whose incomes do not exceed 80 percent of the area median income and loans to small landlords who rent affordable housing units. Lastly, grantees can use funds for program administration and investments in workforce development programs.

In July 2022, DCED received a one-time allocation from Pennsylvania's American Rescue Plan Act (ARPA)-State and Local Fiscal Recovery Funds (SLFRF) for $125 million to establish the WHRP. Each county had to apply for funding or designate one recipient on its behalf to obtain funding. DCED developed an allocation formula using HUD county data (Area Median Income), age of home, homes without complete kitchens or baths, etc.) to determine awards for all 67 counties. However, some counties did not apply for funding, so those dollars were redistributed to the 64 counties that applied.

In FY 2023-24, $50 million was included in the budget for WHRP; however, these additional funds were not included in the budget-enabling code bills passed on December 13, 2023. WHRP was a line item within the governor's proposed FY 2024-25 budget but was not included in the enacted budget.

Weatherization Assistance Program (WAP). The WAP, funded by the US Department of Energy, was established to help low-income families reduce energy costs by increasing energy efficiency in their homes while ensuring their health and safety.

WAP, implemented in Pennsylvania in 1977 and administered by DCED, is for low-income households at or below 200 percent of the federal poverty level. Priority is given to the elderly, disabled individuals, families with children, and high-energy users. Weatherization services focus on diagnostic assessment of air leakage, health and safety repairs, electric baseload measures, and client energy education.

WAP services are provided through a network of public and nonprofit agencies operating in single or multi-county regions. Currently, 34

nonprofit organizations (subgrantees) provide weatherization services across the commonwealth.

US HUD, Public Housing, and Housing Choice Voucher Programs

HUD provides housing subsidies for government-owned and privately-owned housing. HUD provides subsidies to public housing agencies (PHAs), which administer public housing programs and various housing choice voucher programs.

Public Housing. The US Housing Act of 1937 established public housing to assist states and political subdivisions of states to:

- Remedy unsafe housing conditions and the acute shortage of decent and safe dwellings for low-income families.
- Address the shortage of affordable housing for low-income families.
- Give public housing agencies the responsibility and flexibility in program administration, with appropriate accountability to public housing residents, localities, and the general public.
- To provide decent, safe, and sanitary rental housing for eligible low-income individuals, families, older adults, and persons with disabilities.

Approximately 1.2 million households live in public housing units managed by 3,300 PHAs across the US.

HUD provides federal aid to local PHAs from the Public Housing Operating Fund (PHOF), authorized under Section 9 of the US Housing Act of 1937, for public housing operations, administration, and program implementation. In addition, PHAs receive funding from the Public Housing Capital Fund (PHCF) for developing, financing, and modernizing public housing.[8] Through these federal subsidies, PHAs provide affordable rent for low-income families. PHAs are locally managed and administer several federally funded housing assistance programs. Each tenant is responsible for paying a portion of the rent (if applicable) based on a statutory formula and family income information, which is used to determine the Total Tenant Payment (TTP).

Housing Choice Voucher Program (HCV). The Housing Choice Voucher (HCV) Program, also known as Section 8, is "the federal government's major housing assistance program for low-income

[8] Funding limitations include luxury improvements, direct social services, costs funded by other HUD programs, and ineligible activities as determined by HUD.

families, the elderly, and the disabled." [9] PHAs also administer the HCV program: Section 8 Tenant-Based Vouchers (TBV), Project-Based Vouchers (PBV), and Special-Purpose Vouchers (SPV) programs. The HCV program eligibility requirements are the same as those for low-income public housing; however, SPV requirements vary and are program-specific.

HUD, Public Housing, and Section 8 Housing Choice Voucher Programs

Public Housing	Section 8	
	Tenant-based Housing Choice Vouchers	Project-based Housing Choice Vouchers
Government-owned	Privately owned	Privately owned
Subsidy attached to the housing unit	Vouchers assigned to tenants/families	Voucher attached to the housing unit
Must remain in a public housing unit to keep the subsidy	Voucher stays with the tenant when they move	Voucher is attached to a particular unit (is assigned to that unit)
Waiting List	Waiting List	Waiting List

Source: Developed by LBFC staff from information obtained from HUD.

The portability of HUD's low-income housing subsidies slightly differs. For instance, if an individual or family lives in public housing or a PBV housing unit and decides to move, the subsidy remains with the housing unit. However, under the Tenant-based HCV, if an individual or family moves, the voucher assigned to them will move with them, and they can retain the subsidy.

Seven special vouchers for special populations account for less than nine percent of total housing choice vouchers in Pennsylvania. They are Mainstream, Non-Elderly Disabled, Family Unification Program, Foster Youth to Independence, HUD-Veterans Affairs Supportive Housing, Emergency Housing Vouchers, and Stability Vouchers.

[9] *See* https://www.hud.gov/topics/housing_choice_voucher_program_section_8#hcv01, accessed April 24.

Hospitals/Health Systems and Housing

Hospitals and healthcare systems are becoming increasingly involved in providing services to homeless individuals and creating more affordable housing opportunities. This section discusses hospitals' and health systems' roles in providing healthcare and housing opportunities to homeless individuals with physical and behavioral health needs.

Role of Hospitals and Health Systems in Housing Opportunities

A lack of medical insurance, financial means, and general stability leaves homeless individuals with fewer options for viable healthcare. Homeless and housing-unstable individuals who are unable to receive and adhere to treatment plans are more likely to experience prolonged medical issues. Consequently, hospital emergency departments (EDs) serve as primary healthcare providers for many homeless individuals without reliable access to a primary care physician (PCP), as EDs are legally required to treat anyone with a medical emergency regardless of insurance status.

ED utilization by homeless patients has increased by 80 percent over the last ten years.[10] Homeless patients are also more likely to be "frequent users," more than four visits a year, or "super users," more than 20 visits a year to EDs, and thus use more hospital resources.

One study suggested several touchpoints of homeless interventions that can help hospital EDs better provide care for the homeless, which include the waiting room environment, identifying the homeless among patients, linking homeless patients to community services, and discharge planning.

In addition to being the most efficient way to improve the health of homeless individuals, supportive housing is more cost-effective for hospitals than continually housing homeless patients in the ED. Hospital systems investing in housing would benefit both hospital systems and homeless patients.

Studies show that housing and supportive services that help homeless individuals avoid using an ED produce average annual cost savings of

[10] Hwang SW, Weaver J, Aubry T, Hoch JS. *Hospital Costs and Length of Stay Among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services*, 2011.

between $4,800 and $6,875 per person for hospitals that invest in such initiatives.[11,12]

Housing Investment in Pennsylvania

Hospitals and health systems in Pennsylvania have invested in affordable housing opportunities and are supporting and building programs to address social determinants of health, focusing on housing needs.

The Hospital and Healthsystem Association of Pennsylvania (HAP) solicited input from its members on any initiatives they are implementing to address health and housing needs. One member hospital system reported a program that has supported the basic needs of more than 100 unique patients. HAP also indicated that hospitals are working with local school districts to identify families with significant needs, housing or otherwise, to better connect them with the appropriate resources and support. One member health system coordinated support for more than 300 students from one school district.

HAP also pointed to hospitals as partners for community initiatives that support housing opportunities, such as Habitat for Humanity. These programs provide essential home repairs, accommodations for medical needs, and lead abatement and prevention services.

HAP also cited some specific programs, such as Housing Smart in Philadelphia, Highmark Health and Allegheny Health Network in Westmoreland and Allegheny Counties, and the Transition Living Center in the Lehigh Valley. We also spoke directly to WellSpan and Penn Medicine Lancaster General Hospital about their initiatives.

Other Housing Initiatives

In addition to housing investment initiatives in Pennsylvania, other hospitals and health systems nationwide have begun investing in affordable housing to support their communities and take advantage of long-term cost savings. Our report cites several examples of this program.

[11] National Alliance to End Homelessness*, Ending Chronic Homelessness Saves Taxpayers Money*, 2017.
[12] Committee on an Evaluation of Permanent Supportive Housing Programs for Homeless Individuals, *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*, 2018.

Housing and Health Initiatives

Other initiatives and programs impact housing and health, some within state government agencies or counties. Nonprofit organizations also assist low-income and homeless individuals with housing, shelter, and health support.

Pennsylvania Housing Finance Agency (PHFA)

The PHFA is a state-affiliated agency created by the Housing Finance Agency Law in 1972. It primarily provides financial assistance to home-buyers and homeowners through various mortgage and loan programs, such as refinancing, home improvements, and foreclosure assistance. It administers the Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund (PHARE), which assists with creating, rehabilitating, and supporting affordable housing. It is funded by the Marcellus Shale Impact Fee, the Realty Transfer Tax, and the National Housing Trust Fund.

The PHARE Health for Housing investment is a funding initiative prioritizing housing as an SDOH. This initiative encourages housing and community developers, who may apply annually, to seek partnerships with hospitals or health systems to enhance health and housing conditions in Pennsylvania. The minimum capital contribution from the healthcare entity is at least $100,000.

The Health for Housing Investment is a supplemental capital investment for eligible applicants to PHFA's four and nine percent Low-Income Housing Tax Credits (LIHTC) programs. The PHFA's investment comprises $10 million of PHARE funds to match the healthcare entity's capital contribution. PHFA will match the capital contribution made by healthcare entities to a maximum of $2 million for nine percent LIHTC developments and $1.5 million for four percent developments. This is the Housing for Health Initiative's first year; awards from the PHARE Fund are typically made in June or July.

Home4Good is a joint initiative developed and operated by the Federal Home Loan (FHL) Bank of Pittsburgh and various state-affiliated housing agencies, including PHFA, to address unmet and critical needs in the existing CoCs across Pennsylvania.[13] This is done by providing additional funding to local service organizations that assist the homeless and those

[13] FHL Bank of Pittsburgh also operates the Home4Good program in collaboration with the Delaware State Housing Authority and the West Virginia Housing Development Fund.

at risk of homelessness. FHL Bank of Pittsburgh funds its housing agency partners, who distribute them.

Veterans' Housing Programs

Several veterans' programs are administered by the Department of Military and Veteran's Affairs.

Veterans' Temporary Assistance (VTA) Program (VTA). The VTA program provides eligible Pennsylvania veterans and their beneficiaries with financial assistance if they experience an unexpected financial hardship. The aid, up to $1,600 in 12 months, may be used for necessities such as food, shelter, fuel, and clothing. The VTA funding comes from the Veterans' Trust Fund (VTF), which has provided over $3.3 million in 2,250 grants over five years.

Veterans' Trust Fund (VTF). The VTF, through partnerships built by the DMVA with charitable organizations, veterans' service organizations, and county directors of veterans' affairs, assists and supports Pennsylvania veterans and their families. The VTF is a special, nonlapsing fund within the Pennsylvania State Treasury for which the DMVA is authorized to solicit and accept donations. Since its inception, the VTF has awarded over $82 million to over 100,000 servicemembers, veterans, and their families.

PA VETConnect. PA VETConnect is a network of organizations that connects homeless veterans and their families to services such as health care, homelessness, food insecurity, financial assistance, employment, mental health disorders, and substance abuse.

Military Family Relief Assistance Program (MFRAP). The MFRAP provides financial assistance through grants to eligible Pennsylvania service members, veterans, and their families. The maximum assistance that can be awarded is $5,000 in 12 months. The MFRAP grants can be used for housing, food, childcare, utilities, medical needs, insurance, and vehicle payments, among other things. The MFRAP is funded through voluntary, state tax-deductible donations or designation from Pennsylvania Personal Income Tax refunds. All money goes directly into a fund established at the DMVA and is used solely for relief grants and administrative costs. From FY 2018-19 through FY 2022-23, $147,738 was distributed through 50 grants.

Other Stakeholder Programs

Many nonprofit organizations throughout the state work to assist low-income and homeless people in navigating available programs that help them obtain a healthy living environment and achieve good health.

Throughout our work, we spoke to numerous nonprofit organizations that assist the homeless or those at risk of homelessness, several of which are highlighted in our report.

United Way/PA-211. PA-211 is a subsidiary of the United Way of Pennsylvania. The organization is a comprehensive resource for health, housing, and human services assistance and referrals. PA-211 tracks the nature of the calls it receives, with the housing and shelter category including shelters, low-cost housing, home repair/maintenance, rent assistance, mortgage assistance, landlord/tenant issues, contacts (for shelters and housing organizations), and other housing and shelter-related information. The average number of calls annually to PA-211 from CY 2019 to 2023 was 233,526, while the average number of total requests, whether from telephone, text, or website, was 289,685. Of those total requests, 176,688 (61.0 percent) were for housing and shelter.

Second Avenue Commons. This collaborative facility involves Pittsburgh Mercy Hospital, the University of Pittsburgh Medical Center (UPMC), Allegheny County Department of Human Services, and Community Kitchen Pittsburgh. It serves individuals without stable housing and offers comprehensive support services. Services include an emergency shelter, a drop-in day program, a medical and behavioral health clinic, housing units, a professional kitchen providing job training, and street outreach. The $22 million facility was partly funded through donations from private companies, and the clinic is now supported by funding from UPMC. However, 95 percent of the individuals who receive services at Second Avenue Commons are enrolled in the commonwealth's HealthChoices program.

Project HOME. Project HOME in Philadelphia provides extensive housing and support services. It also engages in street outreach through its Outreach Coordination Center, which is open 24/7. Other key services include over 1,000 housing units, employment opportunities, physical and behavioral health care, and education. A new initiative focuses on those affected by the opioid epidemic with integrated healthcare, permanent housing, and employment initiatives.

NewCourtland. In Philadelphia, NewCourtland's supportive housing program, which started in 2019, aims to prevent people from returning to homelessness through coordinated health, housing, and social services. It has an interdisciplinary team consisting of a property manager, nurse, and housing coordinator located on-site. The program helps residents structure individualized goals around stabilizing their health, finances, and roles in the community. Forty-one people have participated in the program since 2019. Most of NewCourtland's referrals come from community providers and, most commonly, from veterans' organizations, as about 90 percent of the program's participants

have a military background. The program caps rent at 30 percent of participants' income.

Pathways to Housing PA. Contracted by the City of Philadelphia since 2008, this program aims to end chronic homelessness with a housing-first approach, emphasizing stable housing as a prerequisite for addressing other health issues. Over 600 individuals are housed through Pathway's Housing First program, which provides comprehensive wraparound services to support participants. Pathways also has an Assertive Community Treatment program, which consists of high-level treatment teams that serve about 80 people on the street.

Other Programs with Housing Impacts

While not directly in the healthcare sector, other initiatives impact individuals' ability to obtain safe, affordable housing.

Optional County Affordable Housing. Act 1992-137 (Act 137), known as the Optional County Affordable Housing Funds Act, allowed 66 of the state's 67 counties to raise revenues and establish county-operated trust funds for affordable housing.[14] Act 137 stipulates that monies from the fund must be expended on projects and programs that improve the availability, accessibility, or quality of affordable housing.

Counties generate revenue for the housing trust fund by collecting a supplemental recording fee on deeds and mortgages and base recording fees charged by the county recording office. Act 137 indicates that any supplemental recording fee may not exceed 100 percent of the base recording fee charged by counties on February 12, 1993, for non-first-class cities. Supplemental recording fees levied by Philadelphia were not permitted to exceed 100 percent of the base recording fee charged by counties on January 31, 2005.

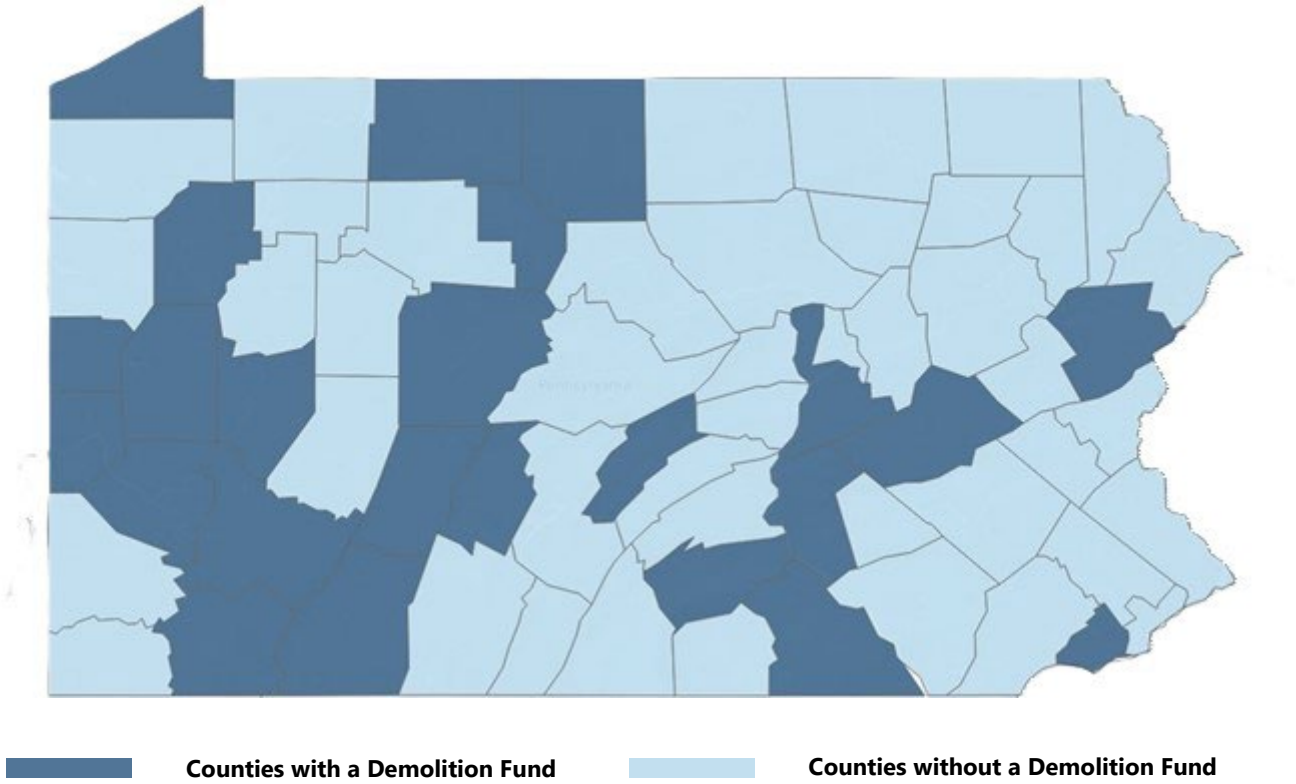
Neither Act 137 nor Act 49 included many formal procedural requirements for counties; as a result, counties distribute, manage, and collect revenue for affordable housing trust funds differently. The most common uses of funds were new affordable housing production (59 percent of surveyed counties), first-time homebuyer closing costs and down payment assistance (55 percent), and home rehabilitation and repair (55 percent).

County Demolition Funds. Act 2016-152 (Act 152) allowed counties to charge and collect an additional fee, not exceeding $15, for

[14] Act 2005-49 (Act 49) reenacted the former law and added a provision permitting Philadelphia to establish and contribute to an affordable housing trust fund.

deeds and mortgages recorded in the county to be deposited into a demolition fund. Monies collected from this fee may only be used to demolish blighted property.

Counties with Demolition Funds
CY 2024



Source: Developed by LBFC staff from information obtained from DCED.

Since Act 152 became effective in 2017, counties with demolition funds have collected $21.2 million from fee increases and have demolished 398 blighted properties.

Evictions in Pennsylvania. Evictions pose a barrier to Pennsylvanians accessing stable housing opportunities and are one of the most common causes of homelessness. According to the Housing Alliance of Pennsylvania, more than a third of people experiencing homelessness report eviction as a cause of housing instability. Pennsylvania had 113,183 eviction filings from July 2022 to June 2023. Statewide, the eviction filing rate, defined as the number of eviction filings per 100

rented homes, was 7.3. Individuals with eviction records have more difficulty finding housing, regardless of the outcome of their cases or the elapsed time since their last evictions. These challenges arise partly because there is no legal mechanism for sealing an eviction filing or expunging it from a tenancy record.

Recommendation

Since 25 counties in the PHFA housing trust fund report reported the additional fee is at the maximum statutorily allowed levels in 2020, and because the maximum allowable fee had not been raised since implementation for Philadelphia in 2005 and all other counties in 1992, we recommend that the General Assembly consider allowing all counties the flexibility to increase the amount of the maximum allowable fee commensurate with their current recording fees, and subsequently index the fee maximum for inflation.

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SECTION I
OBJECTIVES, SCOPE, AND METHODOLOGY

Why we conducted this study…

The Pennsylvania House of Representatives adopted House Resolution 2022-66 (HR 66) on the impacts of housing on health.

HR 66 directs the LBFC to conduct a study…

Objectives

On June 26, 2023, the Pennsylvania House of Representatives adopted House Resolution 2022-66 (HR 66), which sought information on the impact of housing on health.

Our objectives for this study are:

1. To develop background information and data relating to housing conditions, including access to utility service and health effects described in the resolution, which include, but are not limited to, adverse physical and mental health effects, inadequate nutrition and medical care, infectious disease, and respiratory and pulmonary conditions.
2. To review health-related housing initiatives across the nation and any other information or data deemed necessary or appropriate.
3. To perform an analysis of whether there are Medicaid health expenditures related to unmet housing needs.
4. To develop an analysis of the health care cost savings achievable through addressing unmet housing needs.
5. To perform an analysis of the efficacy of interventions to address unmet housing needs, improve health outcomes, and reduce healthcare expenditures.
6. To make any recommendations as to any appropriate action.

Scope

Our study primarily covered the period from July 1, 2017, through June 30, 2022. However, some data was available from 2023. This report includes information by calendar year, state fiscal year, and federal fiscal year.

Methodology

We conducted over 40 interviews, a primary source of information for this study, with county, state, and federal government agencies, housing

providers, hospitals and healthcare systems, health plans and managed care organizations (MCOs), nonprofit groups, policy and research institutes, and other stakeholders that have vested interests in this topic. Our staff also attended statewide conferences, public forums, town halls, and seminars over our project's seven-month engagement period. This first-hand knowledge and insight supplemented our independent research on housing and health-related issues across the state.

Our discussion of current housing supports offered within the commonwealth's Medical Assistance (MA) program was based on unique recipient count and expenditures data from Medicaid claims provided by the Department of Human Services (DHS) for calendar years 2018 to 2022. Due to federal data suppression guidelines, we mainly focused on expenditure data for our county-level analysis.[15] However, our assessment of the full scope of housing services currently provided under MA was limited due to the lack of available outcomes data, especially for newer initiatives related to social determinants of health (SDOH) and health-related social needs (HRSN). Additionally, we surveyed the Pennsylvania Medicaid MCOs – Physical HealthChoices, Community HealthChoices (long-term support services), and Behavioral HealthChoices - for additional input on the managed care program in Pennsylvania.

We also worked with the Department of Human Services for information regarding its newest initiative: the "Bridges to Success: Keystones of Health for Pennsylvania" Section 1115 demonstration waiver. We reviewed the waiver application and supplemental demonstration materials submitted to CMS in January. We engaged department officials on the next steps for the program if the pending demonstration is approved. We received outside feedback on the waiver's proposals from members of the housing and healthcare communities, which helped inform us of our analysis, given that large portions of the demonstration remain undefined.

To supplement our work on DHS's 1115 waiver application, we reviewed other states' waivers that the Center for Medicare and Medicaid Services (CMS) has already approved under the new HRSN framework.

We also collaborated with DHS to review programmatic information for various housing programs that do not receive funding through MA. Although not the primary focus of this study, we provide an overview of each program and review enrollment and funding data for our observation period.

[15] To protect beneficiary confidentiality, the Centers for Medicare and Medicaid Services (CMS) prohibits the reporting of any recipient data between one and 10 individuals. *See* https://www.hhs.gov/guidance/document/cms-cell-suppression-policy, accessed March 27, 2024.

To inform our review of potential cost savings and improved health outcomes that Pennsylvania could realize from MA spending on housing, we relied on the research of the University of Pittsburgh Medicaid Research Center and efforts conducted at Temple University Hospital. These institutions have explored this issue for multiple years and have documented their findings through work with DHS (University of Pittsburgh) or independent collaboration with Medicaid MCOs (Temple).

To understand housing-related programs, we researched programs for individuals and families who are homeless or at risk of homelessness. For housing programs under the US Department of Housing and Urban Development (HUD), we reviewed housing programs, policies, awards, and reports on the HUD-Exchange platform. We obtained data from HUD and the PA Department of Community and Economic Development (DCED) to quantify federally funded program allocations and outcomes.

To understand public housing in Pennsylvania, we reviewed Public Housing Agencies (PHA) policies, funding, and the Housing Choice Voucher (HCV) program. Next, we used data from HUD's public housing and housing choice voucher program to highlight public housing and HCVs.

To develop an understanding of healthcare costs associated with frequently treating homeless patients and cost savings in addressing unmet housing needs, we consulted peer-reviewed articles and studies. We also reviewed publications from various stakeholders to learn more about the issue of homeless patients, including the American Hospital Association, the National Alliance to End Homelessness, and the Democracy Collective.

We reviewed the various organizations' websites and official press releases to discuss specific hospital housing investment initiatives. Additionally, we gained a better understanding of these programs by soliciting specific information through interviews and information requests from the Hospital and Healthsystem Association of Pennsylvania, Penn Medicine's Lancaster General Hospital, and Wellspan Health.

To understand the Pennsylvania Housing Finance Agency (PHFA), its operations, and relevant initiatives, we reviewed resources on its website, including the Qualified Action Plan, the Request for Proposals for affordable housing financing, and the Annual Report across multiple years. We also used information from a 2020 survey published by PHFA, conducted by financial firms Reinvestment Fund and Real Estate Strategies, Inc.

We met with the Department of Military and Veterans Affairs (DMVA), which provided data and information on Pennsylvania's veterans programs.

We met with various nonprofit organizations to learn about their services to the homeless population. We also obtained data from PA-211, a public social services referral hotline, to determine caller-identified requests for housing assistance. We then requested the total number of households assisted by type of housing project from each of the 16 Continuums of Care (CoCs).

We also reviewed other initiatives that, while not directly related to the healthcare sector, can impact the ability to obtain safe, affordable housing.

Frequently Used Acronyms

This report uses numerous abbreviations for government-related agencies, terms, and functions. A list of these acronyms is in Appendix B.

Acknowledgments

The LBFC acknowledges the excellent assistance and cooperation provided by the Department of Human Services and its staff, especially Stephanie Meyer, Special Assistant to the Secretary. We would also like to thank the officials of the other government offices and agencies who assisted us with this report: the Department of Community and Economic Development, the Pennsylvania Housing Finance Agency, and the Department of Military and Veterans Affairs. We also appreciate the assistance from the many stakeholders involved with housing and health, including nonprofit agencies, hospitals and healthcare systems, academics, and other housing and healthcare experts.

Important Note

This report was developed by the Legislative Budget and Finance Committee staff, including project manager Anne Witkonis and staff analysts Matthew Thomas, Shanika Mitchell-Saint Jean, James Wynne, and Amy Hockenberry. The release of this report should not be construed as an indication that the Committee as a whole, or its individual members, necessarily concur with the report's findings, conclusions, or recommendations.

Any questions or comments regarding the contents of this report should be directed to the following:

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SECTION II
BACKGROUND INFORMATION

Fast Facts…

- *SDOH and HRSN, including housing, are becoming increasingly integrated into Medicaid coverage nationwide.*
- *Varied factors contribute to housing insecurity.*
- *Housing has an impact on physical and mental health.*
- *Pennsylvania had 9,334 homeless households in 2023, a 9.3 percent decrease from 2013.*

This study is in response to House Resolution 2023-66, adopted by the House of Representatives on June 26, 2023. HR 2023-66 requires the Legislative Budget and Finance Committee (LBFC) to conduct a study and issue a report about the impact of housing on health in Pennsylvania.

According to the Department of Human Services (DHS), "Access to safe, quality, affordable housing and the services necessary to maintain stable housing constitutes one of the most basic social determinants of health. Securing housing requires a package of supportive services that cover and facilitate the housing search, transition into stable housing, and maintenance of that situation, as each step in the process can constitute a significant barrier to housing stability."

In this section, we provide the necessary background and contextual information to guide readers through the remaining topic areas of this report.

Social Determinants of Health (SDOH) and Health-Related Social Needs (HRSN)

Although sometimes used interchangeably, there are distinctions between SDOH and HRSN within the healthcare industry. SDOH refers to broad environmental conditions, while HRSN are specific to the individual.

SDOH, as defined by the World Health Organization, are conditions in which a person is born, grows, works, lives, and ages, and the broader set of forces and systems shaping their conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems. The Centers for Disease Control and Prevention call SDOH non-medical factors that can impact health. Evidence shows that identifying and addressing SDOH can have an impact on reducing health disparities and promoting health equity.[16]

[16] Artiga, S. and Hilton, E., *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, 2018.

Housing instability is a basic SDOH included under the umbrella of economic insecurity. Other SDOH include:

- ***Economic Stability*:** employment, food insecurity, housing instability, and poverty.
- ***Education Access and Quality:*** early childhood development and education, enrollment in higher education, high school graduation, and language and literacy.
- ***Health Care Access and Quality*:** access to health services, primary care, and health literacy.
- ***Neighborhood and Built Environment*:** access to foods that support healthy diets, crime and violence, environmental conditions, and housing quality.
- ***Social and Community Context*:** civic participation, discrimination, incarceration, and social cohesion.

The Centers for Medicare & Medicaid Services (CMS) defines HRSN as "an individual's unmet, adverse social conditions that contribute to poor health (e.g., food insecurity, housing instability, unemployment, or lack of reliable transportation). HRSN can drive health disparities across demographic groups, resulting from their community's underlying Social Determinants of Health."[17] Research has shown that SDOH and associated HRSN can account for as much as 50 percent of health outcomes.[18] Examples of HRSN are:

- Housing instability.
- Safety needs.
- Food insecurity.
- Lack of education.
- Utility needs.
- Lack of access to transportation.
- Financial strain.
- Unemployment.
- Lack of access to affordable health care or medicine.
- Social isolation.
- Stress.

CMS considers HSRN significant enough to assist states in addressing them and has published a framework for services and supports to focus on HRSN. Pennsylvania's Department of Human Services (DHS) has applied for a Medicaid waiver targeting HRSN, including housing. We highlight CMS's recent guidance regarding HRSN services in Section III of this report, while the commonwealth's proposed waiver is discussed in Section IV.

[17] CMS, *CMCS Informational Bulletin*, November 16, 2023.
[18] US Department of Health and Human Services, *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*, 2022.

Housing Instability

This study focuses on housing instability, SDOH and HRSN, and its impact on health. Housing instability can be defined as:

1. ***Homelessness:*** individuals/families experiencing a total lack of shelter or residing in transitional or emergency shelters.
2. ***Lack of affordable housing:*** households experiencing severe rent burden, overcrowding, eviction or foreclosure, and frequent moves.
3. ***Poor housing conditions:*** includes many issues, such as structural issues (leaks, insulation, heating, and cooling issues) and exposure to allergens (mold, pests, chemicals, asbestos).

Cost Burden

Cost burden is a crucial factor in housing instability; a household is cost-burdened if more than 30 percent of household income is spent on housing, and a household that spends more than 50 percent on housing is said to be severely cost-burdened.

According to a study by the Joint Center for Housing Studies of Harvard University, 42 million households and 22.4 million renters were cost-burdened in 2022. The National Low-Income Housing Coalition cites that 72 percent of extremely low-income renter households are severely cost-burdened in Pennsylvania.

Being cost-burdened for housing means families have fewer dollars to spend on other essential expenses, including healthcare. Low-income families pressed to pay their mortgages and utilities are less likely to have primary medical care, and those severely cost-burdened are 23 percent more likely to have difficulty buying food.[19]

Lack of Affordable Housing

According to the National Low Income Housing Coalition, no state has an adequate supply of affordable rental housing for low-income renters. Additionally, the US has a shortage of 7.3 million affordable and available rental homes to those with extremely low incomes, defined as those with incomes at or below the federal poverty level guideline or 30 percent of their area median income, whichever is greater. The coalition provided the following statistics for Pennsylvania:

- 447,362 renter households are extremely low income.

[19] Health Affairs, *Health Policy Brief: Housing and Health: An Overview of the Literature*, 2018.

- Pennsylvania has a shortage of over 260,000 affordable and available rental homes for extremely low-income renters, with 41 available per 100 for the same group.
- $29,850 is the average income limit for a four-person, extremely low-income household.

Eviction

Evictions pose a barrier to Pennsylvanians accessing stable housing opportunities and are one of the most common causes of homelessness. According to the Housing Alliance of Pennsylvania, more than a third of people experiencing homelessness report eviction as a cause of housing instability.

Eviction can also compromise a person's physical and mental health by exposing them to periods of insecurity, including homelessness, and acute stress; in addition, eviction can increase exposure to infectious diseases, as seen during the COVID-19 pandemic.[20]

The Intersection of Health and Housing

Poor health can be a determinant of homelessness, and homelessness can contribute to poor health. A Health Affairs article stated that although there are no randomized controlled trials to prove a correlation, there is evidence to suggest that poor health is associated with an elevated risk of homelessness and that "compared to low-income populations with housing, people experiencing homelessness have a higher prevalence of acute and chronic physical and mental health conditions and higher mortality rates.[21]"

According to the American Hospital Association, individuals experiencing housing instability are more likely to have chronic health conditions and shorter life spans, with the average life expectancy being 27.3 years less than those with stable housing. Housing instability can not only cause health issues but can also exacerbate already existing health conditions. Exhibit 1 below shows types of housing instability and their related health conditions.

[20] Social Science and Medicine, *The Impacts of Rent Burden and Eviction on Mortality in the United States, 2000–2019,* 2024.

[21] Health Affairs, *Homelessness, and Health: Factors, Evidence, Innovations That Work, And Policy Recommendations*, Volume 43, No. 2.

Exhibit 1

Three Types of Housing Instability and Related Health Conditions

	Homelessness	Lack of Affordable Housing	Poor Housing Conditions
Examples and Housing Outcomes	Total ***lack*** of ***shelter*** Residence in ***transitional*** or ***emergency shelters***	Severe ***rent burden*** ***Overcrowding*** ***Eviction*** or ***foreclosure*** ***Frequent moves***	***Structural issues*** Allergens like ***mold***, ***asbestos***, or ***pests*** ***Chemical exposure*** Leaks or ***problems*** with ***insulation***, ***heating***, and ***cooling***
Related Health Conditions	Increased rates of chronic and infectious conditions such as ***diabetes***, ***asthma***, ***chronic obstructive pulmonary disease***, and ***tuberculosis*** Mental health issues, including ***depression*** and ***elevated stress*** ***Developmental delays*** in ***children***	***Stress***, ***depression***, and ***anxiety disorders*** ***Poor*** self-reported ***health*** Delayed or ***diminished access*** to ***medications*** and ***medical care***	***Asthma*** and other ***respiratory issues*** ***Allergic reactions*** ***Lead poisoning***, ***harm*** to ***brain development*** Other ***chemical*** or ***carcinogenic exposures*** ***Falls*** and other ***injuries*** due to structural issues

Source: Developed by LBFC staff from information from the American Hospital Association.

Types of Housing Services

Many organizations exist to assist those experiencing homelessness and those at risk of homelessness, including street outreach, different types of shelters, housing supports, home remediation or modifications, medical and behavioral health care, eviction assistance, tenancy support, and case management services.

Continuums of care (CoCs), generally considered the "gateway" to home and housing services, can provide access to many services, including many nonprofit organizations providing services and supports to the homeless or those at risk for homelessness. Shelter services vary depending on the individuals and families they accept. For example, some will accept children, and some will not. Shelters also differ in their requirements or expectations for a stay:

- ***Low-barrier shelter*:** A shelter with minimal requirements and expectations for entry.
- ***High-barrier shelter*:** A shelter that requires guests to meet certain criteria, such as sobriety, curfews, church attendance, program participation, identification, income requirements, chore requirements, or criminal background checks.

Within low and high-barrier shelters, facilities differ:

- ***Congregate shelter –*** Individuals and households are provided space in a common area with limited or no privacy, such as a gymnasium or auditorium.
- ***Semi-congregate shelter*:** Each individual or household has space that offers privacy, such as smaller rooms or partitions.
- ***Non-congregate shelter*:** Each individual or household has a private space with a door that separates them from other persons/households, such as a hotel room.
- ***Transitional shelter*:** Provides temporary residence, ranging from six-24 months.

Many nonprofit organizations, including hospitals and healthcare systems, provide housing supports in addition to a place to stay. These types of services include attention to physical and behavioral health in both clinic and street settings, help with substance abuse, case management services, tenancy support services, eviction assistance, and assistance in finding permanent housing, among others.

As discussed in Section V of this report, the US Department of Housing and Urban Development also funds public housing and housing voucher programs.

Cost Savings from Better Housing

Throughout our work on this report, we have sought health cost savings realized through Medical Assistance (MA) recipients receiving better housing and necessary supportive services. Robust outcomes data is limited on this topic; however, some qualified evidence of cost savings has emerged in recent years. We discuss several studies conducted in Pennsylvania in Section III of this report and further elaborate on how innovative programming for Pennsylvania's MA populations may reduce healthcare spending.

Nationally, one study, conducted by the Center for Outcomes Research and Education, found that affordable housing for Medicaid recipients reduced overall health expenditures by 12 percent. The authors of this study attributed these savings to more cost-efficient use of healthcare

services, including an 18 percent reduction in emergency department visits and a 20 percent increase in less costly primary care.

A RAND study of Los Angeles County, California, and its Housing for Health Program found similar results. For the program, the county began to identify frequent users of health services, move them into supportive housing, and then address their physical and mental health needs. RAND reports program participants made 70 percent fewer visits to emergency departments and spent 75 percent less time in hospitals. After accounting for program costs, Los Angeles saved $6.5 million in the second year of the program. The study cites that the county saved $1.20 for every dollar spent.

Homelessness in Pennsylvania

Because of the fluid nature of homelessness, it is difficult to accurately know how many individuals are living without housing at any given time. The McKinney-Vento Homelessness Assistance Act authorized the United States Department of Housing and Urban Development (HUD) to conduct a Point-in-Time Count (PIT), which counts sheltered and unsheltered people experiencing homelessness. The PIT count takes place annually on a single night in January. It is conducted by Pennsylvania's 16 CoCs, which, among other responsibilities, coordinate the implementation of housing and service systems within specific geographic areas to meet the needs of the individuals and families who experience homelessness.[22]

The PIT count captures people experiencing homelessness who are unsheltered and those who are sheltered in transitional housing, emergency shelters, and safe havens.[23] Exhibit 2 shows the average number of homeless individuals in each county. The average was calculated using the once-per-year PIT data from 2019-2023. Philadelphia, by far, has the highest number of homeless. Twenty-four Pennsylvania counties have fewer than 20 homeless people, on average.

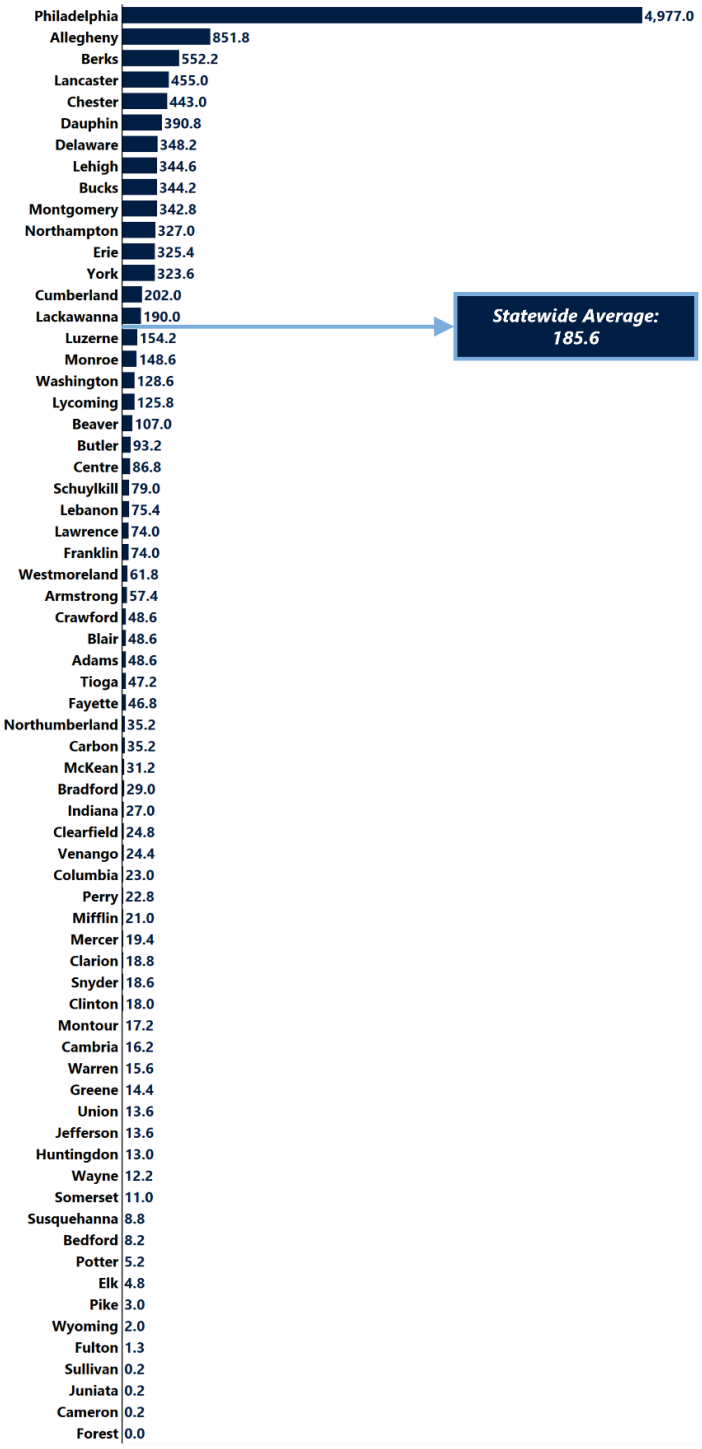
[22] Section V of this report discusses the CoCs and their role in homelessness programs.

[23] A safe haven is a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness (SMI) who come primarily from the streets and have been unable or unwilling to participate in housing or supportive services. *See* HUD, *Safe Havens Fact Sheet*, 2012.

Exhibit 2

Average Number of Homeless Individuals by County

2019 – 2023



Source: Developed by LBFC staff from information obtained from the US Department of Housing and Urban Development.

Pennsylvania had 9,334 homeless households and 12,556 total homeless individuals in 2023.

Nationally, in 2023, about 46 percent of the homeless population was unsheltered; in Pennsylvania, the ratio was 14 percent, up from nine percent in 2013. Unsheltered homelessness can be associated with a higher prevalence of mental health and substance abuse issues, exposure to weather conditions, lack of health care, and other risk factors.

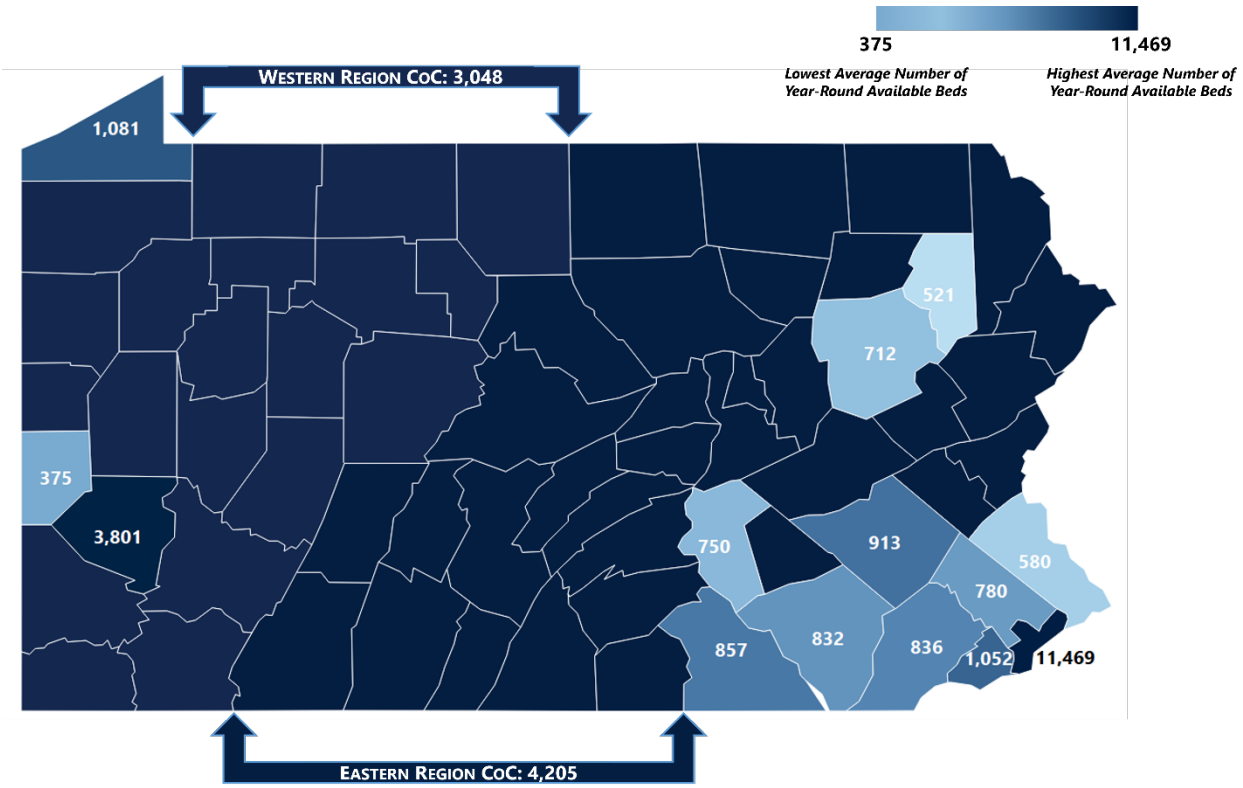
In addition to many homeless persons having health issues, of the 12,556 homeless individuals in the state, many have other extenuating circumstances, including:

- Severe Mental Illness: 19.8 percent.
- Chronic Substance Abuse: 18.2 percent.
- Veterans: 6.6 percent.
- HIV/AIDS: 1.6 percent.
- Victims of Domestic Violence: 8.3 percent.

CoCs also perform an annual Housing Inventory Count, a point-in-time inventory of provider programs within a CoC that offer beds to serve people experiencing homelessness. These are categorized into five program types: emergency shelter, transitional housing, rapid re-housing, safe haven, and permanent supportive housing. Exhibit 3 shows the average number of year-round available beds in the 16 CoCs in Pennsylvania.

Exhibit 3

Average Number of Year-Round Available Beds Reported by Continuums of Care
2019 – 2023



Source: Developed by LBFC staff from information obtained from HUD.

SECTION III
MEDICAL ASSISTANCE AND HOUSING

Fast Facts…

- *As of March 2024, 3.1 million Pennsylvanians received medical coverage via the Medical Assistance program.*
- *Select housing services are currently MA-funded for those requiring long-term health, intellectual, or behavioral support.*
- *Through its HealthChoices agreements, DHS has started to prioritize value in treatment and in addressing Social Determinants of Health (SDOH) needs.*

Guided by HR 66, we were tasked with determining how Medicaid expenditures are currently directed to unmet housing needs and examining whether those housing interventions have effectively improved health outcomes and reduced healthcare costs in the commonwealth.

Key Findings:

1. Within Medicaid, the Centers for Medicare and Medicaid Services (CMS) has historically not allowed federal financial participation for room and board outside specific institutional settings, but new guidance from the agency has allowed states to test strategies that would have previously been unallowable.

2. Within the Department of Human Services (DHS) Office of Long-Term Living (OLTL), targeted housing supports claims $504 million during the Community HealthChoices (CHC) rollout (calendar years 2018 to 2020) and declined to $155.8 million after its implementation (2021 and 2022), primarily due to changes in administrative billing processes for CHC managed care organizations (MCOs). Within DHS's Office of Developmental Programs (ODP), which oversees intellectual and developmental disability services, spending on housing-related services was more straightforward, totaling over $12.2 billion for the five years.

3. In recent years, DHS has introduced several initiatives that incentivize or require MCO spending on social determinants of health (SDOH) and health-related social needs (HRSN) interventions such as housing. However, a reoccurring issue with many of the current housing-related supports in the MA program was a lack of measurable outcomes data, which prevented us from fully assessing the initiatives' impacts on health and costs.

4. Several researchers and public health professionals have been studying the impacts of housing on healthcare outcomes and costs for most of the last decade. Most recently, the University of Pittsburgh Medicaid Research Center documented MA cost savings of $162 per member per month for permanent supportive housing (PSH) participants the year after leaving the program. However, "cost savings" is more appropriately defined in the healthcare industry as "cost containment," which prevents

costs from increasing further by reducing the use of more expensive services.

In this section, we recommend:

1. **DHS should develop health-centered outcome measures and key performance targets for housing-related services within the MA program to ensure that state and federal Medicaid spending is being efficiently used to improve the independence and health of MA participants.**

2. **Healthcare and housing stakeholders from across the commonwealth should collaborate and engage in new data-sharing partnerships that will provide the insights needed to benefit the shared goal of improving the health and well-being of Pennsylvanians.**

A. Available Mechanisms for States to Use Medicaid Funding on Housing Supports

Medicaid provides healthcare coverage for approximately one out of every four people in the United States. Before the Affordable Care Act (ACA), coverage was primarily provided to low-income children, pregnant women, elderly adults, and individuals with disabilities.[24] With Medicaid expansion in Pennsylvania in 2015, coverage was extended to low-income adults.[25] As of June 2023, 24.5 million low-income adults in the United States received Medicaid coverage in states that chose to expand under the ACA.

States provide Medicaid coverage through contracts with the Centers for Medicare and Medicaid Services (CMS), known as Medicaid State Plans. While Medicaid State Plans enumerate services included in a state's plan and eligible for federal reimbursement, states may also seek waivers to allow them to provide additional benefits for all eligible beneficiaries or for certain population groups.[26]

[24] The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) together make up the package of federal legislation commonly referred to as the Affordable Care Act. *See* DHS, *Medicaid Expansion Report Update*, 2019.

[25] Individuals (aged 19 to 64) or families that make less than 138 percent of the Federal Poverty Level qualify for Medicaid based solely on income. *See* https://www.healthcare.gov/glossary/federal-poverty-level-fpl/, accessed February 27, 2024.

[26] States may, at their option, pay for additional specified services.

Over the last decade, CMS has guided states regarding waivers and state plan amendments to address various social determinants of health (SDOH) and health-related social needs (HRSN), including housing.

State Medicaid programs have generally received federal funding for programs using housing-related supports and services to promote health and community integration (e.g., home accessibility modifications, one-time community transition costs, tenancy sustaining services, etc.). Federal financial participation has historically been unavailable for room and board outside specific institutional settings (e.g., nursing facilities).[27] However, CMS has issued new policies allowing states to test strategies that previously would have conflicted with this room and board prohibition.

Recent guidance from November 2023 outlines the HRSN services and supports considered allowable under specific Medicaid and CHIP authorities.[28] While each waiver authority carries its unique considerations, CMS outlines specific stipulations that must be followed:[29]

- States can propose clinically focused, needs-based criteria when defining a medically appropriate population for a waiver. However, all interventions must be evidence-based and medically appropriate for the defined population according to clinical and social risk factors.
- Services are optional for enrollees who may opt out of additional benefits at any time. In all circumstances, states or managed care plans must cover other medically necessary services.
- Services must be integrated with existing social services and housing assistance programs and may not supplant the work or funding of another federal or non-Medicaid state agency.
- CMS will not approve federal financial participation payments for services that include room and board outside of specifically enumerated care or housing transitions or for approved services that last beyond allowable periods. All other services have no time limitations unless otherwise specified by CMS.
- Medicaid, CHIP coverage, or any other benefit or service cannot be made conditional upon receiving HRSN services.

[27] According to CMS, the prohibition of federal Medicaid spending on room and board is codified in multiple regulatory provisions, such as 42 CFR § 441.310(a)(2) and 42 CFR § 441.360(b). *See* CMS, *Opportunities for Medicaid and CHIP to Address Social Determinants of Health (SHO# 21-001)*, 2021.

[28] CHIP provides health insurance to children under the age of 19. All children are eligible for CHIP; while most families receive free coverage, some households may be required to pay premiums and copays based on income level. However, children will be enrolled in MA if they meet the eligibility requirements for Medicaid. *See* https://www.dhs.pa.gov/CHIP/Eligibility-and-Benefits/Pages/Eligibility-and-Benefits.aspx, accessed February 27, 2024.

[29] CMS, *Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)*, November 2023.

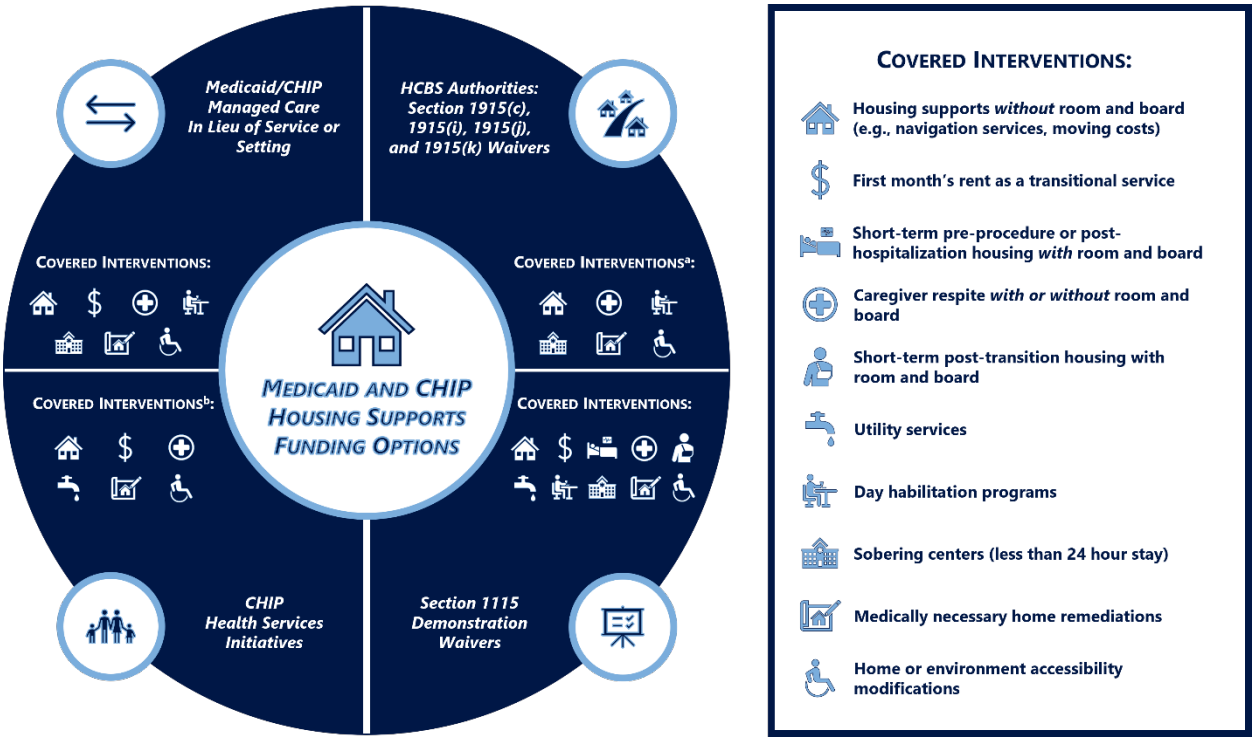
Specifically, regarding housing, CMS has approved 10 distinct interventions covered under Medicaid and CHIP:

1. ***Housing supports without room and board***, including transition and navigation services (finding and securing housing), pre-tenancy navigation services, one-time transition and moving costs (security deposits, application, inspection, and utility application fees, etc.), and tenancy sustaining services and individualized case management (eviction prevention services, tenant rights education, assistance attaining state and federal benefit programs, etc.).
2. ***First month's rent***, used as a transitional service.
3. ***Short-term pre-procedure or post-hospitalization housing with room and board***. This housing can occur only in settings where integrated, clinically oriented recuperative or rehabilitative services are provided. These supports are limited to a clinically appropriate period.
4. ***Caregiver respite, with or without room and board***, can be offered in a home or institutional setting.
5. ***Short-term post-transition housing with room and board***, where clinically oriented rehabilitative services may or may not be integrated. These supports are limited to a clinically appropriate period.
6. ***Utility assistance***.
7. ***Day habilitation programs without room and board***.
8. ***Sobering centers without room and board***, limited to a stay of less than 24 hours.
9. ***Medically necessary home remediations***, such as air filtration/air conditioning improvements, medication refrigeration, carpet replacement, mold and pest removal, and housing safety inspections.
10. ***Home or environmental accessibility modifications***, including wheelchair accessibility ramps, handrails, and grab bars.

Exhibit 4 illustrates the recent guidance from CMS regarding coverage of HRSNs in Medicaid and CHIP, including the allowable housing interventions covered by each waiver authority.

Exhibit 4

Medicaid and CHIP Housing Support Funding Options
November 2023



[a] First month's rent is only a covered intervention under section 1915(k) waivers. Short-term post-transition housing and utility assistance interventions are not allowable under the four 1915 waivers shown above but are covered by Money Follows the Person (MFP) home and community-based services (HCBS) demonstrations. Additional restrictions exist on allowances for housing support and caregiver respite for 1915(c) and 1915(i) waivers.

Source: Developed by LBFC staff from information obtained from the Centers for Medicare and Medicaid Services.

As of November 2023, the housing interventions outlined by CMS can be covered under four Medicaid and CHIP authorities. However, due to the specific requirements of each authority, not all interventions are considered allowable under each waiver authority.

Section 1915 Waivers: Waivers available under section 1915 of the Social Security Act offer states an array of options to provide home and community-based services (HCBS) to facilitate beneficiary independence and promote community integration. These additional benefits are designed for individuals who need long-term services and supports (LTSS) due to disabling conditions or chronic illnesses. Within the HCBS authorities, four waivers – 1915(c), 1915(i), 1915(j), and 1915(k) – may cover housing-related interventions. With few exceptions, six interventions are considered allowable under 1915 waivers, including housing supports

without room and board, caregiver respite, day habilitation programs, sobering centers, home remediations, and home modifications.[30] The DHS currently provides several housings supports under its 1915 authorities, which will be discussed in greater detail in this section.

CHIP: Health services initiatives (HSIs) offered under CHIP are programs designed to improve the health of low-income children. According to CMS, HSIs must include activities that protect public health, protect beneficiaries' health, promote or enhance a state's capacity to deliver public health services, or strengthen the human and material resources needed to accomplish public health goals for improving children's health. Six housing interventions have been approved under HSIs, including housing support without room and board, first month's rent, caregiver respite, utility services, home remediations, and home modifications.[31]

First codified by CMS in the 2016 Medicaid and CHIP managed care final rule, states are permitted to offer alternative services, known as in lieu of services or settings (ILOS), to the care described in the Medicaid State Plan. ILOSs are designed to serve as immediate or long-term substitutes for state plan-covered services, or to reduce or eliminate the future need to utilize state plan-covered services (e.g., providing a beneficiary with asthma a dehumidifier for use in their home). These services must advance the objectives of the Medicaid program, be medically appropriate and optional to the recipients, and be cost-effective. CMS has deemed that seven housing interventions can be covered under ILOS: housing supports without room and board, first month's rent, caregiver respite, day habilitation programs, sobering centers, home remediations, and home modifications.[32]

Section 1115 Demonstration Waivers: Section 1115 of the Social Security Act allows CMS to waive certain Medicaid provisions and provide matching funds for programs that otherwise would not be allowable if they meet Medicaid's objectives and test a novel hypothesis. States have long used Section 1115 waivers to test new Medicaid delivery strategies and improve care and coverage for beneficiaries. Of the authorities outlined in CMS's guidance, Section 1115 waivers have the greatest range of housing services covered, with 10 interventions deemed allowable. Section 1115 waivers are discussed in greater detail regarding DHS's proposed Keystones of Health application in Section IV.

[30] First month's rent is only a covered intervention under 1915 (k) waivers.
[31] CMS notes that the remaining four housing interventions outlined have not previously been approved under the CHIP HSI authority, but may ultimately be allowable.
[32] CMS, *SMD 23-001: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care*, 2023.

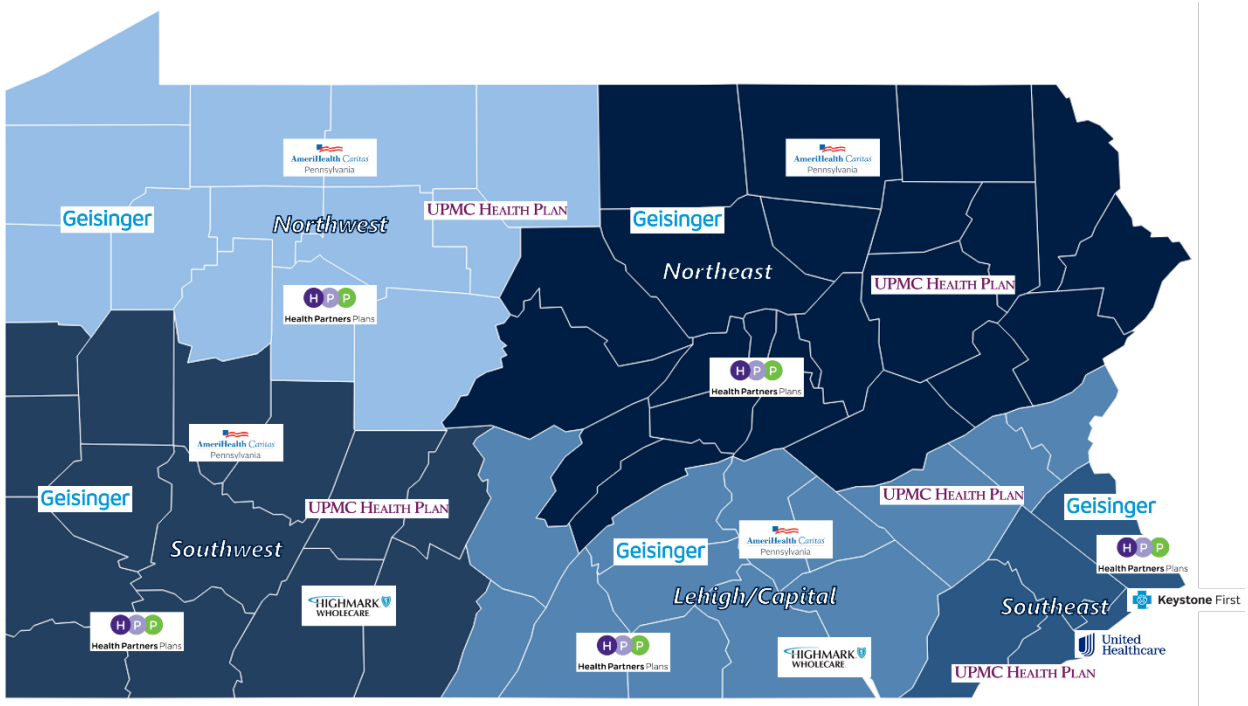
B. Medical Assistance Programs with Impacts on Housing

The state's mandatory managed care program, HealthChoices, was launched in the southeastern portion of Pennsylvania in 1997. Now the primary service delivery model for the MA program, DHS offers physical health, behavioral health, and LTSS, among other services, via managed care. These programs operate under the authority of concurrent 1915(b) and, for some services, 1915(c) waivers.

Administered by the department's Office of Medical Assistance Programs (OMAP), over 2.5 million of the state's 3.1 million MA recipients received medical coverage through Physical HealthChoices as of March 2024. DHS currently contracts with seven physical health MCOs to provide services in at least one of the five Physical HealthChoices administrative zones in the state, which are illustrated in Exhibit 5.

Exhibit 5

Physical HealthChoices Zones and MCOs[a]



[a] In 2024, Health Partners Plans began a phased rebranding as Jefferson Health Plans.

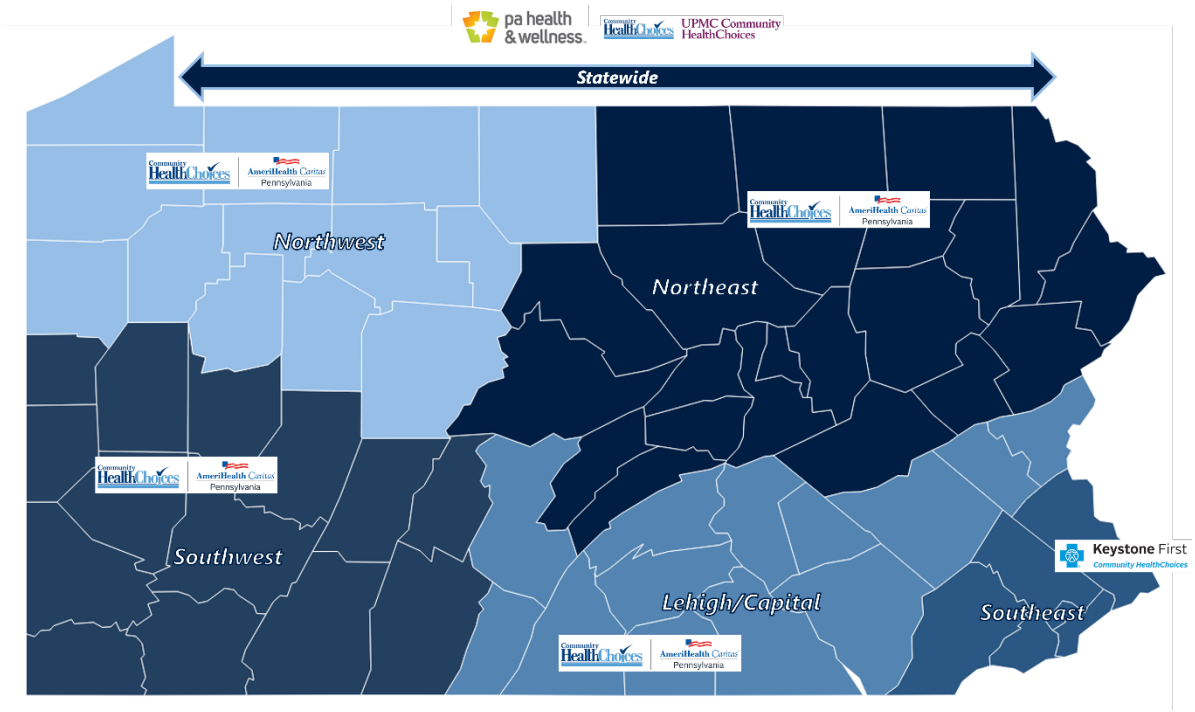
Source: Developed by LBFC staff from information obtained from DHS.

Implemented statewide between 2018 and 2020, CHC provides LTSS to the elderly and individuals with disabilities to help recipients stay in their

homes.[33] As of March 2024, over 397,000 Pennsylvanians were enrolled in CHC. DHS's Office of Long-Term Living (OLTL) manages CHC across the same administrative zones as Physical HealthChoices. However, unlike Physical HealthChoices, DHS contracts with two statewide MCOs to operate CHC, while two MCOs operate in one or more zones.[34] Exhibit 6 shows the CHC zones and MCOs in Pennsylvania.

Exhibit 6

Community HealthChoices Zones and MCOs



Source: Developed by LBFC staff from information obtained from DHS.

Mental health and substance abuse services are offered through DHS's Behavioral HealthChoices program. The DHS's Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the administration of

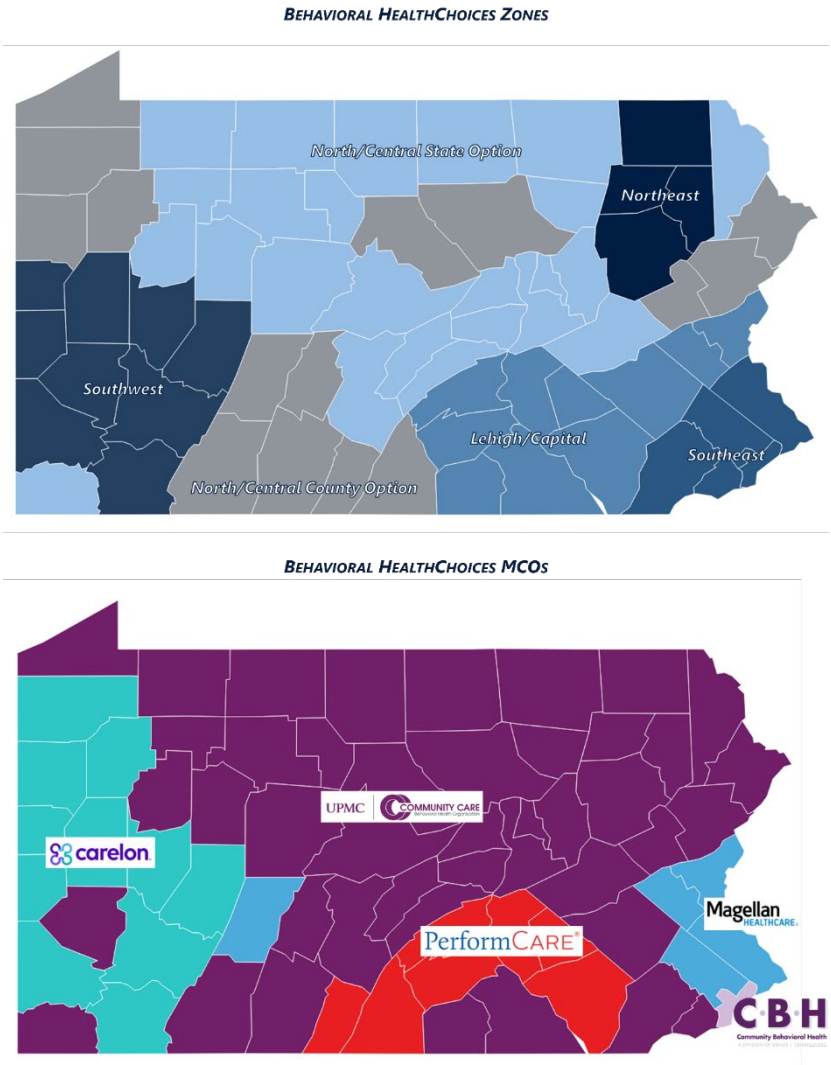
[33] DHS describes the CHC population as adults aged 21 and over who require MA LTSS (in the community or in private or county nursing facilities) and individuals aged 21 and older who are dually eligible for Medicare and Medicaid. *See* https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-Historical-Data.aspx, accessed March 21, 2024.

[34] AmeriHealth Caritas Pennsylvania Community HealthChoices and Keystone First Community HealthChoices are both part of the AmeriHealth Caritas organization. *See* https://www.amerihealthcaritas.com/our-story/our-national-footprint.aspx, accessed March 21, 2024.

the Behavioral HealthChoices program.[35] Unlike Physical HealthChoices and CHC, where MCO contracts are negotiated at the state level, counties have the "right of first opportunity" to contract with behavioral health MCOs (BH MCOs). Exhibit 7 shows the Behavioral HealthChoices administrative zones, including counties exercising a county option, and the BH MCOs servicing each county.

Exhibit 7

Behavioral HealthChoices Zones and MCOs



Source: Developed by LBFC staff from information obtained from DHS.

[35] According to DHS, enrollment numbers for Behavioral HealthChoices are counted with the total number of MA recipients in the commonwealth, which was over 3.1 million in March 2024.

Also relevant to this report is the department's Office of Developmental Programs (ODP), which administers various HCBS programs to support individuals with disabilities in gaining greater independence and choice in their daily lives. In FY 2022-23, 62,756 individuals received services under ODP's purview.[36]

DHS offers several types of targeted housing-related supports and services to specific subsets of the commonwealth's MA population. The following discussion highlights some housing services that DHS provides through the MA program. In addition to these MA-funded supports, DHS offers a range of state-funded housing initiatives discussed in Section F.

The services highlighted in this section function as part of much larger initiatives within the MA program, with nuances, rules, and requirements outside this report's scope. As a result, please note that many of the descriptions and illustrations provided in the discussion below have been simplified for summary purposes.

Office of Long-Term Living (OLTL)

DHS's OLTL manages the commonwealth's CHC program using concurrent 1915(b) and (c) waiver authorities. OLTL also oversees the state's Omnibus Budget Reconciliation Act waiver to operate the HCBS program under 1915(c) authority. According to DHS, OLTL provides many services designed to help keep beneficiaries in, or return them to, a community setting.[37] Our review focused on a featured subset from OLTL's array of supports:

- ***Community Transition Services:*** One-time expense for a participant transitioning from an institution (e.g., nursing facility) or other provider-operated living arrangement to a private residence where the individual is responsible for living expenses. Expenses are limited to $4,000 per participant's lifetime and can be used for goods or services when moving into and setting up a living arrangement.
- ***Home Adaptations:*** Physical changes to a participant's private residence to ensure health, welfare, and safety and enable the participant to have more independence in the home, including activities such as entering and exiting the home, accessing shared areas of the residence, and facilitating personal hygiene.

[36] According to DHS, enrollment numbers for ODP programs are not based on the MA population but rather on the county mental health dollars that are allocated on an annual basis.
[37] Examples include home health aide, clinic services, and live-in caregiver. *See* DHS, *CHC 1915(c) Appendix C-1/C-3: Summary of Services Covered and Services Specifications*, 2024.

- ***Residential Habilitation Services:*** Services designed to assist a participant in acquiring the basic skills needed to maximize independence in daily living and fully participate in the activities of community life. These services are tailored to the unique needs of the individual and must be delivered in a provider-owned, rented, leased, or operated setting, whether licensed (e.g., personal care home) or unlicensed.[38]
- ***Service Coordination:*** Functions necessary to facilitate a participant's transition from an MA-funded institution (e.g., nursing facility) to supportive housing in a community-integrated setting. The participant must have resided in the MA-funded institution for at least 90 consecutive days prior to the transition.

Exhibit 8 provides an overview of the housing-related services provided by OLTL.

Exhibit 8

Housing-Related Services Offered by OLTL[a]

Community Transition Services	*Home Adaptations*	*Residential Habilitation Services*	*Service Coordination*
One-time expenses aiding transition from institution to private residence.	Physical adaptations to a primary residence to ensure the health, welfare, and safety of the participant, and to allow the individual to function with greater access in the home.	Services designed to assist participant in acquiring the basic skills needed to maximize independence in daily living and to fully participate in the activities of community life.	Functions necessary to facilitate a transition of participant from a MA-funded institution to supportive housing in the community.
Eligible expenses:	***Eligible expenses:***	***Requirements:***	***Eligible expenses:***
Security deposits	Installation of necessary medical equipment	Services are individually tailored to the participant	Conducting a housing assessment to determine housing needs and potential barriers to transition
Moving expenses	Building repairs	Services must be delivered in provider owned, rented, leased, or operated settings	Develop housing support plan to inform choice of living options and needed supports
Essential furnishing, eating utensils, and food	Maintenance		Assistance with finding and securing housing
Set up fees/deposits for utilities or service access	Permit acquisition		
Services necessary for health and safety (e.g., one-time cleaning, allergen control, etc.)	Inspections		
	Warranty extensions		

[a] Please note that this summary has been simplified for illustrative purposes.

Source: Developed by LBFC staff from information obtained from DHS.

[38] Licensed provider settings are those authorized under 55 Pa Code Chapter 2600 as personal care homes with four or more residents. Unlicensed settings are provider-owned, rented/leased, or operated facilities with no more than three residents. *See* OLTL, *Office of Long-Term Living Waiver Programs – Service Descriptions*, 2023.

DHS provided the unique recipient count and expenditures for OLTL MA claims with billing codes for the four housing-related services described above. Data was provided for the five most recent calendar years, 2018 through 2022, which were available at the time of our study.[39]

We observed a significant decline in statewide encounters over the five-year period, from over 92,500 in 2018 to just over 6,400 in 2022.[40] This is due to the phased statewide CHC rollout between CYs 2018 and 2020. According to DHS, supports such as service coordination became part of the managed care administrative costs within CHC, meaning this service was less likely to be billed separately following the rollout. As a result, we looked at the period during the CHC rollout – 2018 to 2020 – independently from the two years following the statewide implementation.

For our granular analysis, we reviewed the MA expenditure data by county as provided by DHS. We did not include recipient counts in our analysis due to federal data suppression guidelines, which state that in order to protect the confidentiality of Medicaid and Medicare beneficiaries, CMS prohibits reporting any data between one and 10 recipients.[41] Although DHS reported all county-level data, many rural areas of the commonwealth did not have enough available information for us to provide an accurate level of beneficiary participation for each program.

Exhibit 9 shows the total MA expenditures by county and each service's share of total spending for the CYs 2018 to 2020.

[39] Due to a lag in Medicaid claims billing, data for calendar year 2023 was not available in early 2024 at the time of this analysis.

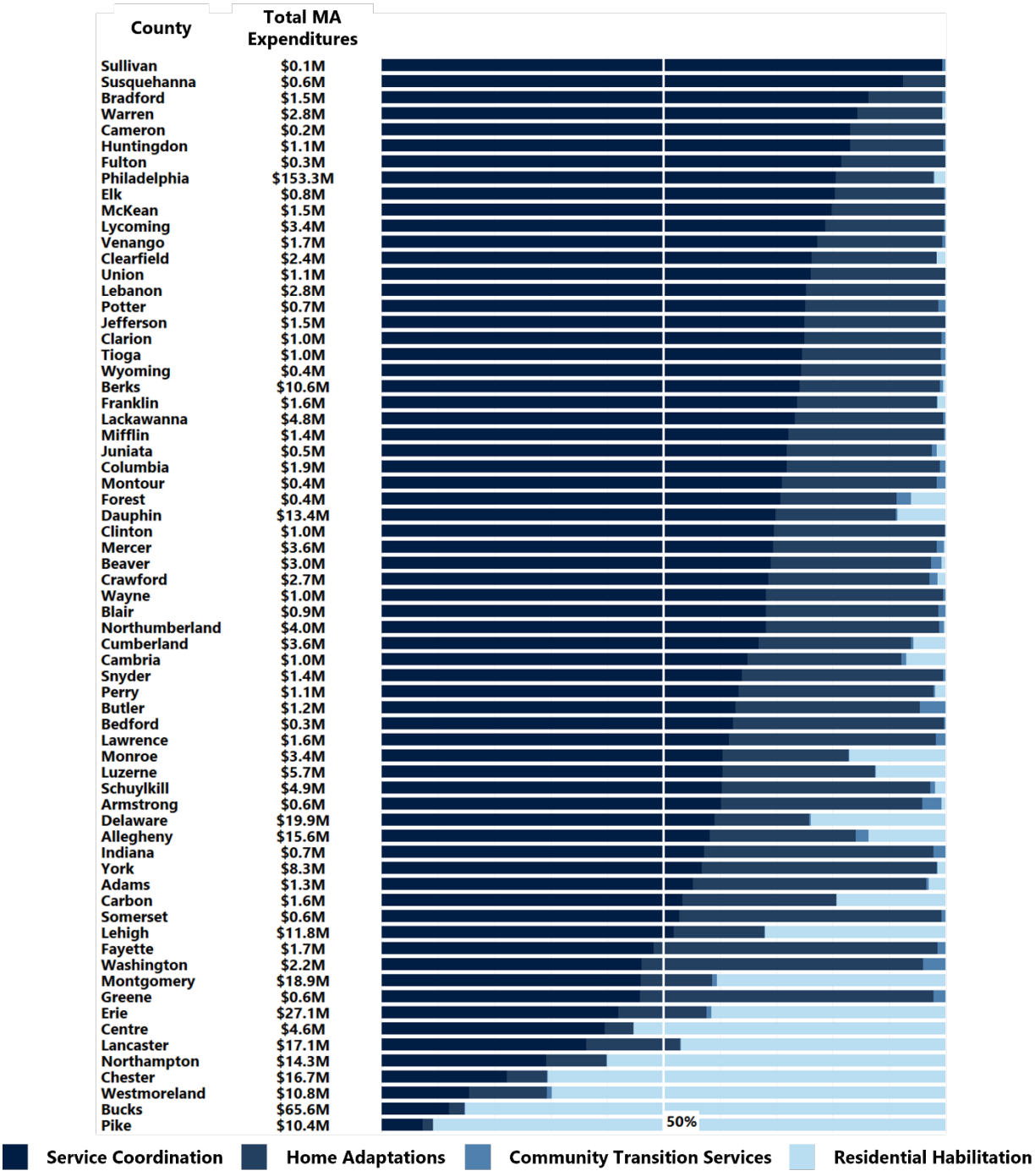
[40] We refer to the statewide recipient count across all four programs as "encounters," as participants can receive services from more than one program.

[41] This requirement applies to all data reported to CMS. *See* https://www.hhs.gov/guidance/document/cms-cell-suppression-policy, accessed March 27, 2024.

Exhibit 9

Service Coordination was the Primary MA Expense Related to Housing for OLTL during CHC Implementation

CYs 2018-2020



Source: Developed by LBFC staff from information obtained from DHS.

Between CYs 2018 and 2020, OLTL spent over $504 million on housing-related supports throughout the commonwealth. Total MA expenditures exceeded $1 million in each of the 50 counties. At $153.3 million, more MA dollars were spent on housing services in Philadelphia than the next five highest-utilizing counties combined.[42] This significantly skews the average expenditures for the period upwards to $7.5 million per county. Only 15 counties exceeded this average.

Other findings for the period are as follows:

- Service coordination was the most utilized housing support over the three years, consisting of at least half the total expenditures in 55 counties.
- Total MA expenditures for service coordination were $277.3 million between CYs 2018 and 2020, more than the other three housing supports combined.
- Residential habilitation was the second-most expensed service at just under $140 million for the period.
- Home adaptation expenditures totaled $84.7 million, while community transition services were slightly over $2 million.

The trends highlighted above most likely contributed to the historical allocation of services within the MA program. For example, DHS notes the southeastern portion of the state traditionally has experienced a higher percentage of its population served by MA, explaining why the five counties of what is now the CHC Southeast Zone were among the highest utilizers in the state between CYs 2018 and 2020.[43] In addition, while MCOs have some discretion in how funding is allocated, MA spending on these housing supports is largely driven by the services historically available at the county level and the participants' needs.

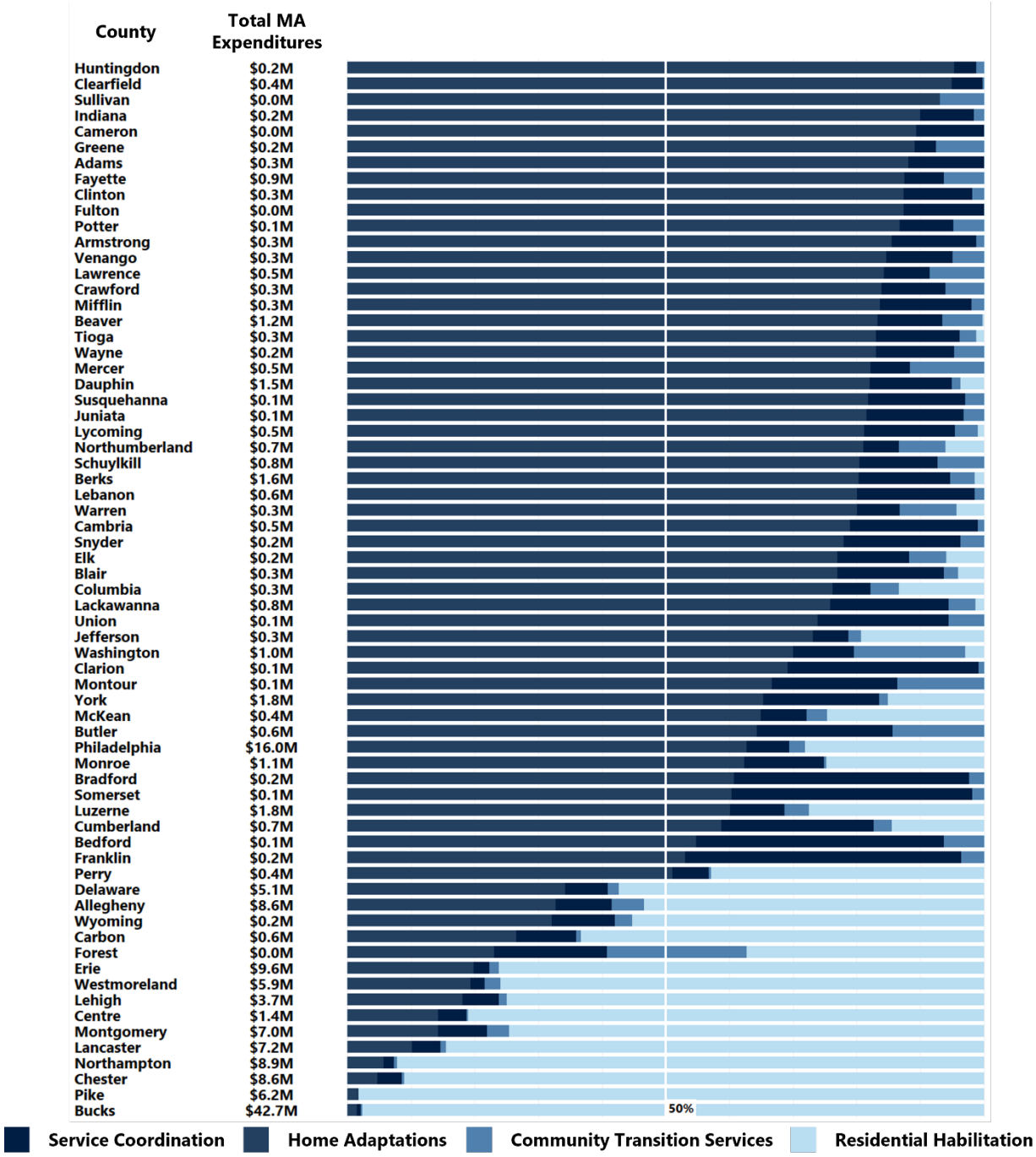
The statewide implementation of CHC saw a drastic shift in the total amount of MA dollars directed to these four housing supports and in the distribution of spending within the services. Exhibit 10 shows total MA expenditures by county and each service's share of that total spending for CYs 2021 and 2022.

[42] The 10 counties with the highest MA expenditures during the period in order were: Philadelphia, Bucks, Erie, Delaware, Montgomery, Lancaster, Chester, Allegheny, Northampton, and Dauphin. The 10 lowest (from lowest to highest) were: Sullivan, Cameron, Fulton, Bedford, Wyoming, Forest, Montour, Juniata, Somerset, and Susquehanna.
[43] The CHC Southeast Zone is comprised of Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.

Exhibit 10

Residential Habilitation was the Most Commonly Used MA Expense Related to Housing for OLTL following Full CHC Implementation

CYs 2021 and 2022



Source: Developed by LBFC staff from information obtained from DHS.

Even with one less year of observable data, MA expenditures of other housing supports dropped significantly with the statewide implementation of CHC. MA spending for the four OLTL services totaled $155.8 million in 2021 and 2022, a decrease of 69 percent from the three years prior. Nineteen counties spent more than $1 million during the two years, with only two counties – Bucks ($42.7 million) and Philadelphia ($16 million) – surpassing the $10 million threshold.[44] Average OLTL MA expenditures were still skewed towards higher utilizing counties at $2.3 million. Twelve counties exceeded this average.

Unlike the period before statewide CHC, the distribution of services following the LTSS managed care rollout tells a mixed story. Regarding the proportion of county spending, home adaptations were the most frequently used service, with at least half of OLTL MA expenditures going toward the support in 52 counties. However, over half of all MA expenditures for the period were directed to residential habilitation services, totaling $105 million in 2021 and 2022. A leading contributor to this trend is Bucks County, which spent almost 98 percent of its total expenses, $41.8 million, on the service over the two years. Home adaptations made up the other considerable allotment of spending with $40.1 million. Service coordination saw a decline in spending of approximately $270 million, totaling $7.6 million for the period, while community transition services increased to $2.9 million.

As referenced previously, the decline in total expenditures and the shift in spending distribution are largely due to the implementation of CHC. This trend is most notably observed with the decline in service coordination spending, which is now a managed care administrative expense rather than an FFS expenditure.

Office of Developmental Programs (ODP)

ODP within DHS oversees intellectual and developmental disability services for the commonwealth. Much like OLTL, ODP provides many services designed to maximize participant independence in a home or community setting.[45,46] Our review focused on a subset of these services and payments, which are paid for using fee-for-service (FFS) rates:

- ***Housing Transition and Tenancy Sustaining Services:*** Direct or indirect services designed to assist participants in being

[44] The 10 counties with the highest MA expenditures during the period in order were: Bucks, Philadelphia, Erie, Northampton, Chester, Allegheny, Lancaster, Montgomery, Pike, and Westmoreland. The 10 lowest (from lowest to highest) were: Sullivan, Fulton, Cameron, Forest, Bedford, Juniata, Montour, Potter, Susquehanna, and Clarion.
[45] Examples include homemaker/chore services and home accessibility adaptations.
[46] DHS also notes that there is the federal Money Follows the Person program, which provides one-time services to support a participant's transition to the community. See DHS, *Money Follows the Person and Nursing Home Transition*, 2022.

successful tenants in homes they own, rent, or lease. This service can include a wide array of pre-tenancy and housing-sustaining supports, including developing housing support plans, assisting with the housing application/voucher process, identifying resources to cover expenses and moving costs, and tenant rights and education.

- ***Life Sharing:*** Direct or indirect services designed to provide participants with support and guidance in daily activities. Life sharing services can be provided in a private home by relatives or legal guardians of participants or by individuals who are not related to participants but who share the same primary residence. Services include assistance, support, and guidance in the areas of self-care, health maintenance, decision-making, resource management, transportation, and socialization.
- ***Residential Habilitation:*** Direct or indirect services offered in provider-owned, rented, or leased residential settings to assist participants in living more independent lives.[47] Services include assistance, support, and guidance in the general areas of self-care, health maintenance, decision-making, resource management, transportation, and socialization, among others. Claims billed under this category can receive federal financial funding participation (e.g., funding for facility staffing).
- ***Residential Habilitation – Life Sharing:*** Direct or indirect services offered in provider-owned, rented, or leased residential settings to assist participants in living more independently. Services involve the general areas of self-care, health maintenance, decision-making, resource management, transportation, and socialization, among others. These services can be provided by relatives, legal guardians, etc., in a manner like those of Life Sharing services.
- ***Supported Living Services:*** Direct or indirect services are provided to protect the health and welfare of participants and help them acquire skills for independent and community life. These services are offered to participants who live in a private home that is owned, leased, or rented by the participant or provided for the participant's use by a Special or Supplemental Needs Trust in Pennsylvania.[48] Services include assistance with the general areas of self-care, health maintenance, decision-making,

[47] Residential habilitation can be offered in licensed provider facilities authorized under 55 Pa. Code Chapter 6400. Unlicensed residential habilitation may be provided to participants in provider-owned, rented, or leased facilities that are exempt from licensure under 55 Pa. Code §6400.3(f)(7), which excludes community homes that serve three or fewer individuals with an intellectual disability or autism 18 years of age or older who need a yearly average of 30 hours or less of direct staff contact per week per home.

[48] A Special Needs Trust is a fund established with the resources of a disabled individual for the purpose of allowing the individual to qualify for MA. A Supplemental Needs Trust is a fund established with the resources of a third party. *See* DHS, *Special Needs Trust Fact and Information Sheet*, 2018.

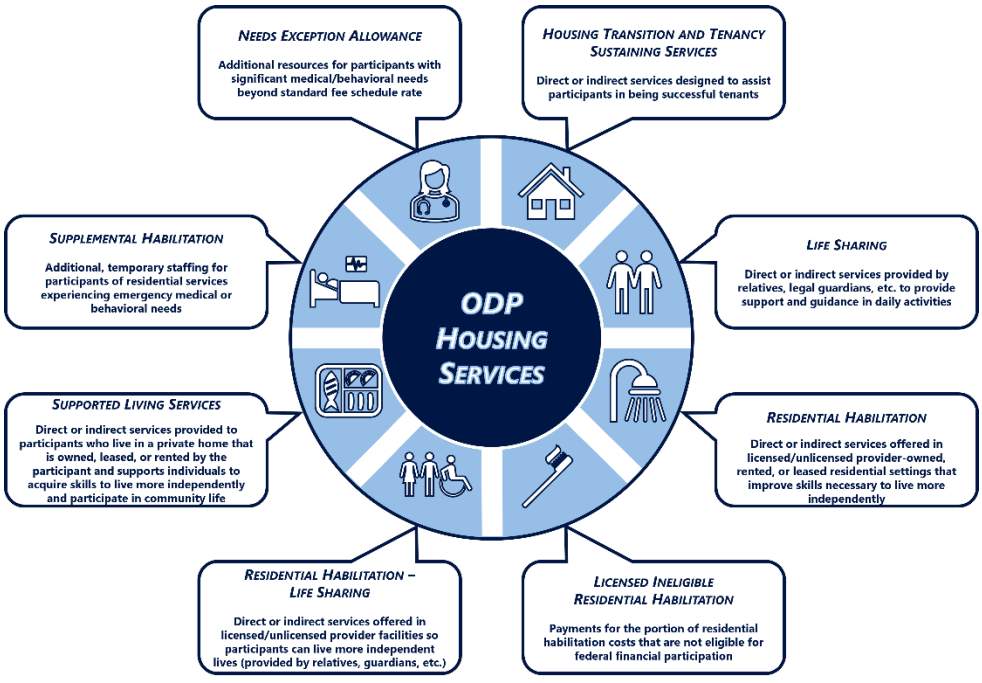
resource management, transportation, and socialization, among others.

- ***Supplemental Habilitation:*** Additional, temporary staffing for participants receiving residential services (residential habilitation, life sharing, and supported living) experiencing medical or behavioral emergencies.
- ***Licensed Ineligible Residential Habilitation:*** Payments for the portion of residential habilitation costs that are not eligible for federal financial participation (e.g., room and board).
- ***Needs Exception Allowance:*** Additional resources, particularly staffing (additional staffing patterns, staff expertise, etc.), for a participant who experiences a significant medical or behavioral need that exceeds the assumptions factored into the standard fee schedule rate.

Exhibit 11 below provides an overview of the housing-related services and payments provided by ODP:

Exhibit 11

ODP Housing-Related Services and Payments[a]



[a] Note: This summary has been simplified for illustrative purposes.

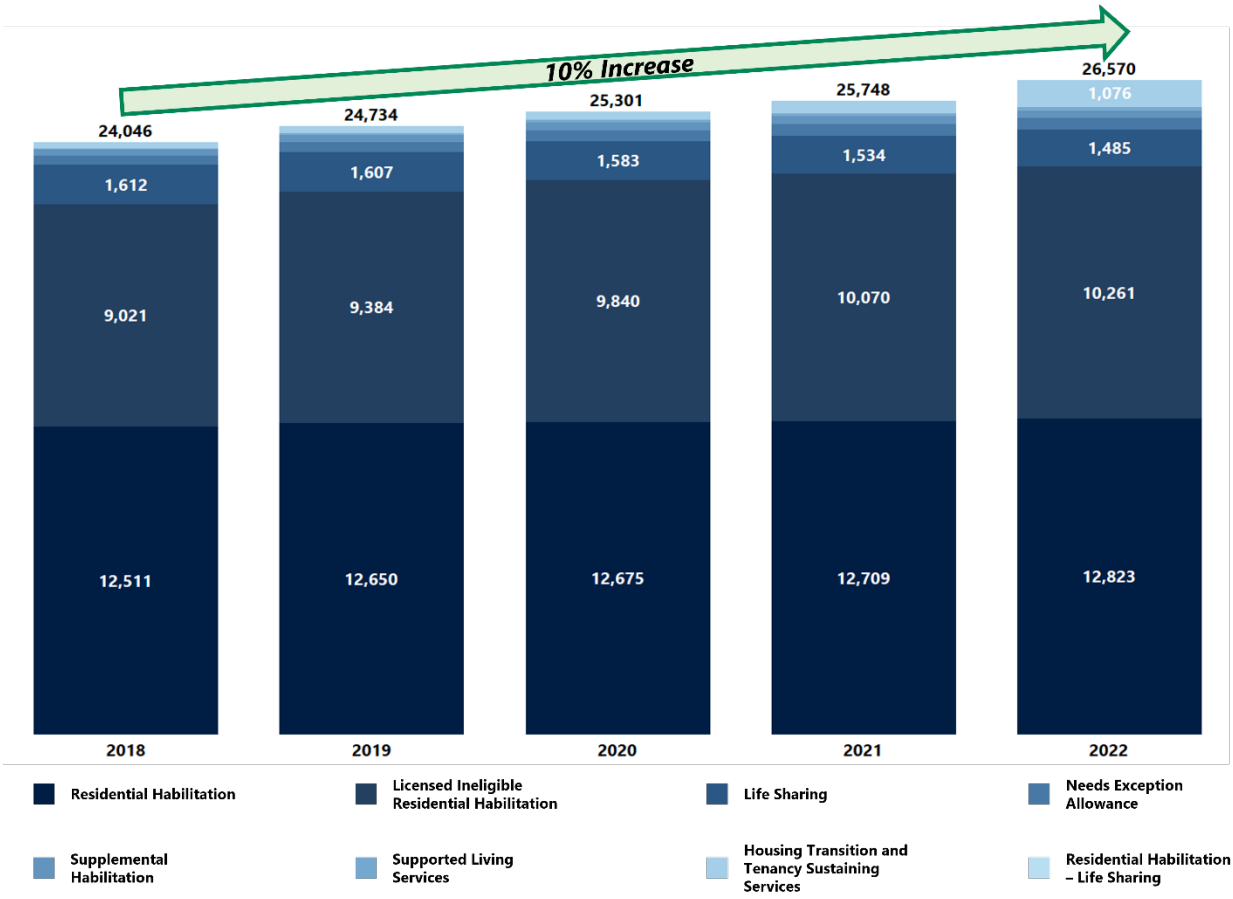
Source: Developed by LBFC staff from information obtained from DHS.

Unlike the services provided by OLTL following the transition to CHC, ODP housing supports did not experience any dramatic programmatic

shifts during our observation period. We found that total encounters for ODP services and payments increased by 10 percent, from slightly over 24,000 in CY 2018 to over 26,500 in CY 2022.[49] Exhibit 12 shows the total number of encounters statewide by year and service type between CYs 2018 and 2022. Like the OLTL data, we do not review encounters at a granular level due to CMS suppression guidelines.

Exhibit 12

Residential Services were at least 93 Percent of all ODP Housing-Related Encounters Each Year
CYs 2018 and 2022



Source: Developed by LBFC staff from information obtained from DHS.

Residential services comprised most housing-related encounters each year, including residential habilitation, life sharing, and supported living services. Between CYs 2018 and 2022, these services accounted for between 93 and 96 percent of all encounters annually.

[49] Encounters do not equate to individuals served, as participants can potentially receive multiple services.

Residential habilitation was the most utilized support within this group of services and payments, with over 63,000 encounters – half of all statewide claims – for the period. Licensed ineligible residential habilitation comprised 38 percent of statewide encounters, with 48,500 between CYs 2018 and 2022. At 7,800 encounters, life sharing was the next most utilized service, with six percent of claims.

Despite the widespread use of residential services, supported living and residential habilitation-life sharing were sparsely used, with less than half a percent of all encounters over the five years.

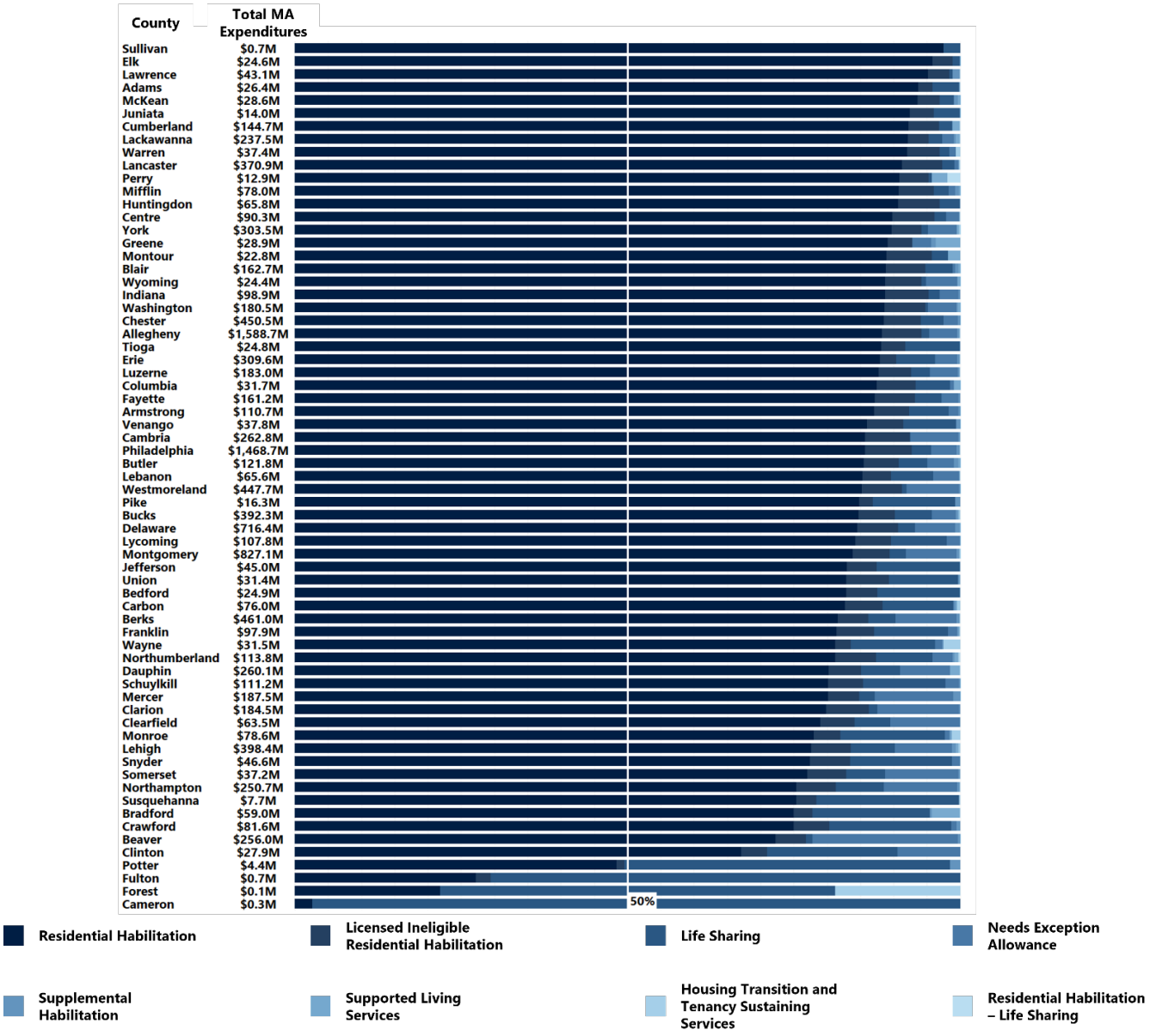
Other support use was limited outside of residential services, with slightly over 6,100 encounters claimed between CYs 2018 and 2022. Housing transition, tenancy-sustaining services, and exception allowances comprised approximately two percent of all encounters. Supplemental habilitation accounted for one percent of encounters statewide for the period.

As with OLTL, we reviewed the MA expenditure data by county for housing-related ODP services and payments between CYs 2018 and 2022. Exhibit 13 shows each service's share of total spending and MA expenditures by county for the period.

Exhibit 13

Residential Habilitation was the Most Commonly Used MA Expense Related to Housing across ODP

CYs 2018 and 2022



Source: Developed by LBFC staff from information obtained from DHS.

Between CYs 2018 and 2022, MA expenditures on housing-related supports within ODP exceeded $12.2 billion. Spending was primarily centered around the state's major population centers, with Allegheny ($1.6 billion) and Philadelphia ($1.5 billion) having the highest expenditures out of the 67 counties. Twenty-nine counties each had total MA

expenditures for the period of over $100 million.[50] Only four counties – Fulton, Sullivan, Cameron, and Forest – did not have expenditures above $1 million for the five years.

Much like OLTL after the statewide rollout of CHC, residential habilitation was the main driver of MA expenditures for ODP during our observation period. The service made up at least half of all expenditures for 63 counties and totaled over $10.4 billion during that time. Residential habilitation expenditures were 90 percent or more of the total spending for 13 counties, and all but one of those 13 had MA expenses of at least $10 million for the period.[51]

Licensed ineligible residential habilitation had the second highest expenditure for the period, with just under $684 million for the five years. Within residential services, spending on life sharing totaled nearly $447 million, while statewide supported living services and residential habilitation – life sharing were $22.1 million and $1.3 million, respectively. Almost $11.6 billion, or 95 percent, of statewide MA housing-related expenditures under ODP's management were for residential services.

Outside those supports, needs exception allowances ranked third highest among all statewide expenditures for the period at $624 million. Spending on supplemental habilitation totaled $40.5 million, and payments for housing transitions and tenancy sustaining services were nearly $7.9 million.

Overall, the spending trends observed in the ODP data align with the patterns seen in the office's encounters data. In both instances, residential services – especially residential habilitation – were the most heavily utilized services. As we observed with OLTL, expenditures at the county level are most likely impacted by the historical allocation of services within the MA program.

Office of Mental Health and Substance Abuse Services (OMHSAS)

Within DHS, OMHSAS oversees the provision of behavioral health and substance abuse services for the MA program. The office informed us

[50] These counties are: Allegheny, Philadelphia, Montgomery, Delaware, Berks, Chester, Westmoreland, Lehigh, Bucks, Lancaster, Erie, York, Cambria, Dauphin, Beaver, Northampton, Lackawanna, Mercer, Clarion, Luzerne, Washington, Blair, Fayette, Cumberland, Butler, Northumberland, Schuylkill, Armstrong, and Lycoming.

[51] These counties are Sullivan, Elk, Lawrence, Adams, McKean, Juniata, Cumberland, Lackawanna, Warren, Lancaster, Perry, Mifflin, and Huntingdon. Sullivan was the only county without total MA expenditures above $10 million for the period, spending approximately $700,000.

that there are four services with housing-related activities within its current MA-funded service array:

- ***Targeted Case Management:*** Primary, direct services for individuals with serious mental illness (SMI) or emotional disorders, which are designed to assess, link, and monitor the supports needed for a healthy community life.[52] As a service that participants must enter voluntarily, targeted case management supports include a wide array of assessment, planning, referral, and monitoring activities, such as tenancy screening assessments, development of housing support plans, and connections to resources to cover start-up expenses. However, activities should not constitute the direct delivery of services to address the participant's underlying medical, behavioral, or social needs.
- ***Assertive Community Treatment:*** Evidence and community-based, multidisciplinary treatments to lessen the effects of severe and persistent mental illness, allowing participants to live more independent lives.[53] Assertive Community Treatment services are offered by teams of multidisciplinary clinical staff ranging from six to 12 members, plus a psychiatrist and program assistant. These teams can provide an expansive array of supports, including developing housing support plans, assisting with rental subsidy applications, advocating on behalf of the tenant to prevent eviction, and providing ongoing tenant rights education.
- ***Mobile Psychiatric Rehabilitation:*** Community-based, services for individuals with mental illness and co-occurring challenges to relearn and develop the skills needed to live productive lives. These services are centered on assessment, planning, and rehabilitation, including activities such as creating interventions for actions that may jeopardize housing, developing skillsets to resolve disputes with landlords or neighbors, or other tasks leading to a successful tenancy.
- ***Peer Support Services:*** Therapeutic interactions directed by trained and certified current or former behavioral health services consumers designed to aid in participants' recovery and community integration process. Peer Support Specialists aim to help prevent and combat social isolation through mentoring, crisis support, individual advocacy, self-help, self-improvement,

[52] Serious mental illness is defined as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities." *See* https://www.nimh.nih.gov/health/statistics/mental-illness, accessed April 26, 2024.

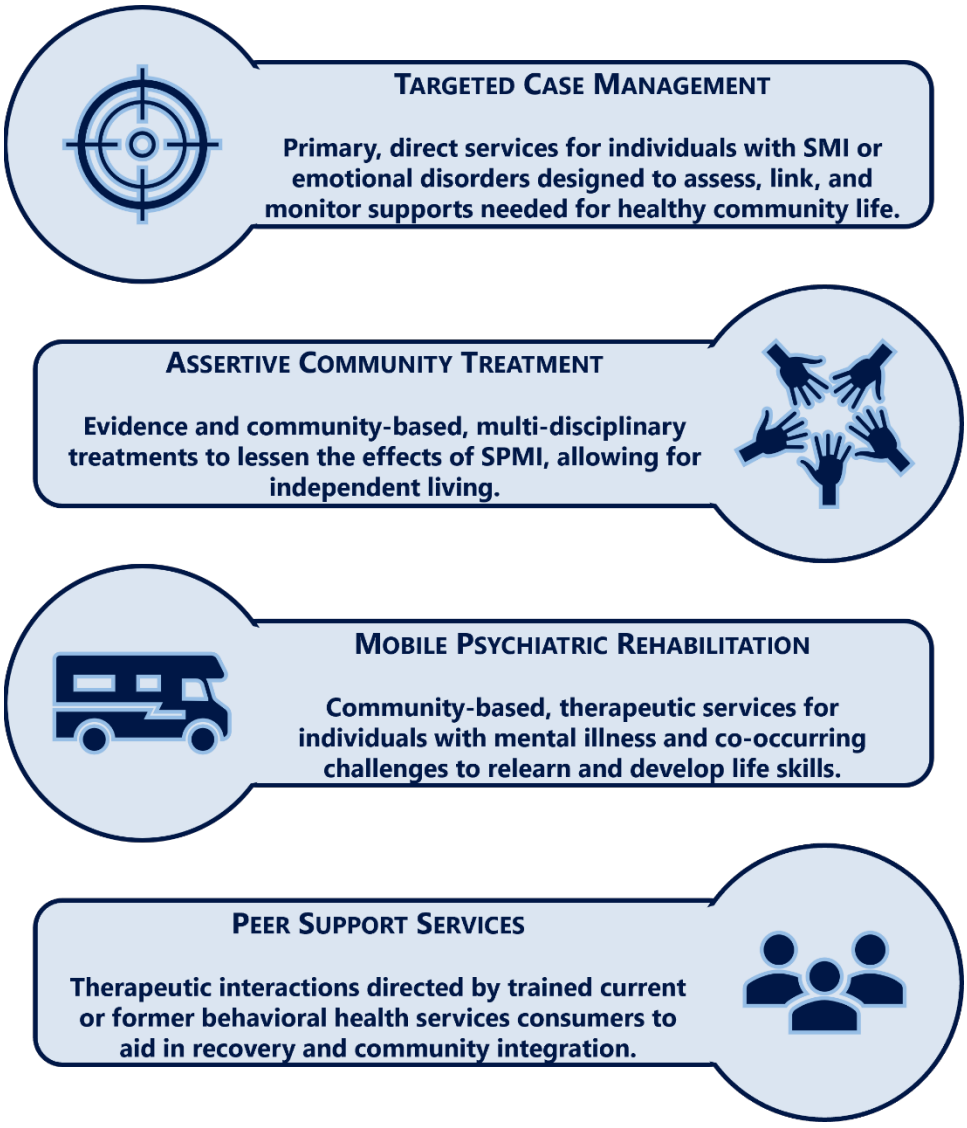
[53] While the two can be used interchangeably, generally, the distinction between serious mental illness and severe and persistent mental illness is that the latter is chronic and always disabling, whereas that may not be the case for the former. *See* SAMHSA National Registry of Evidenced-Based Programs and Practices, *Behind the Term: Serious Mental Illness*, 2016.

developing community roles and supports, and integration into social networks.

Exhibit 14 provides an overview of the housing-related services offered by OMHSAS:

Exhibit 14

Housing-Related Services Offered by OMHSAS[a]



[a] This summary has been simplified for illustrative purposes.

Source: Developed by LBFC staff from information obtained from DHS.

According to DHS, targeted case management and peer support services are offered as required services under the Medicaid State Plan, and all four services are funded through HealthChoices. However, DHS informed us there are no additional procedure billing codes beyond those provided for our discussion. As a result, OMHSAS is unable to track more detailed data for a single service activity (e.g., housing) since the information is embedded as a component of the four services highlighted above.

While Medicaid billing codes are set at the federal level by CMS, this roadblock does highlight a reoccurring issue we encountered throughout this study regarding the availability of housing-related health data. As discussed in later sections of this report, our analysis was repeatedly hampered by the lack of available outcomes data for this emerging field of study in both the public and private sectors.

Initiatives to Address Social Determinants of Health (SDOH) and Health-Related Social Needs (HRSN)

In addition to the housing supports offered in the service arrays of its program offices, DHS has also started to implement initiatives to address SDOH and HRSN, including housing. These initiatives, Community Based Care Management (CBCM), Value Based Purchasing (VBP), and MCO Revenue Sharing Plans (RSPs), are designed to be flexible enough to meet specific population needs. Exhibit 15 provides a brief introduction to these initiatives and indicates the status of each in the Physical HealthChoices, Behavioral HealthChoices, and CHC programs.[54]

[54] DHS notes that the Physical HealthChoices MCOs can also include value-added services and cover home accessibility durable medical equipment (e.g., stair glides, ramps, lifts, etc.) to help a recipient maintain their housing.

Exhibit 15

CBCM, VBP, and RSP are at Various Stages within the MA Managed Care Program



	Community-Based Care Management	*Value Based Purchasing*	*MCO Revenue Sharing Plans/Reinvestment*[a]
	Partnerships between MCOs and Community-Based Organizations (CBOs), hospital/health systems, or providers that use preventative services to mitigate SDOH barriers, reduce health disparities, and improve maternal and child health.	Agreements between MCOs and providers that link provider payments to the value of services provided while improving care quality, efficiency of services, reducing costs and can address SDOH barriers.	Agreements between DHS and MCOs or primary contractors allowing entities to keep half of excess revenue beyond allowable 3% profit threshold, if remaining revenue is invested in projects to support provider networks, address HRSN, advance health equity, or engage in community development.
Physical HealthChoices	✓	✓	***New in 2023***
Behavioral HealthChoices	✓	✓	✓
Community HealthChoices		✓	***New in 2024***

[a] The program utilizing excess revenues for Behavioral HealthChoices is called reinvestment, described by DHS as "capitation revenues from DHS and investment income which are not expended during an agreement period by the primary contractor may be used in a subsequent Agreement period to purchase start-up costs for State Plan services, development or purchase of in lieu of and in addition to services or non-medical services, contingent upon DHS prior approval of the primary contractor's reinvestment plan."

Source: Developed by LBFC staff from information obtained from DHS.

These initiatives are at various stages of implementation within each DHS program office, creating a segmented picture of progress across the state. To provide a more comprehensive view, we spoke with staff from multiple DHS program offices who are involved with the development, administration, and oversight of these three initiatives.

In addition, we worked with DHS and the Pennsylvania Medicaid Managed Care Organizations to conduct a survey of the seven Physical HealthChoices MCOs, the four CHC MCOs, and Behavioral HealthChoices MCOs, or primary contractor representatives, from the 67 counties. This discussion integrates data, perspectives, and insights from this spectrum of resources.

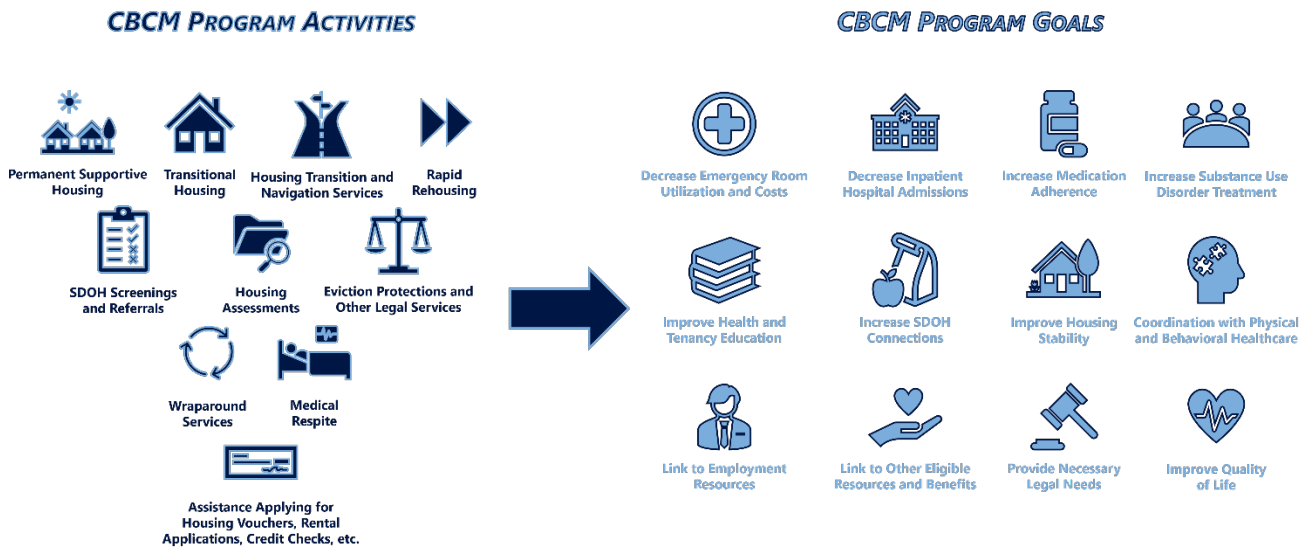
Community-Based Care Management. DHS launched CBCM in 2015 to encourage MCOs to partner with Community-Based Organizations (CBOs), hospitals, health systems, or providers to mitigate

SDOH and reduce healthcare disparities. Active for both physical and behavioral health in managed care, DHS provides funding to MCOs that use preventative interventions and holistic approaches to patient care to improve the health and wellness of at-risk populations. MCOs have the flexibility to design activities to support vulnerable groups in various areas, including housing.[55]

This flexibility allows MCOs to create many types of housing-related programs based on the unique needs of their populations. According to DHS, 15 housing-related CBCM programs were approved by the department for four Physical HealthChoices MCOs between CYs 2018 and 2022. Exhibit 16 highlights many of the recurring program activities and outcome goals MCOs included in initiative narratives provided to us by DHS. Please note this list is not exhaustive nor exclusive to any MCO program; multiple programs include one or more of these activities or goals.

Exhibit 16

DHS Approved 15 MCO CBCM Programs for Physical HealthChoices between 2018 and 2022



Source: Developed by LBFC staff from information obtained from DHS.

[55] MCOs are allowed to design activities that: assess, refer, and mitigate SDOH; promote maternal, infant, and early childhood assessments; localize efforts to promote health education and wellness and encourage the use of preventative services; promote education on the appropriate management of chronic health conditions; enhance behavioral and physical health coordination of services; and reduce healthcare disparities. *See* DHS, *HealthChoices Physical Health Agreement*, 2023.

While DHS requires the Physical HealthChoices MCOs to submit regular reporting for CBCM programs, the initiative's flexibility makes uniform data collection challenging. For example, programs that provide eviction protections and other legal services would not be able to produce the same data as initiatives aimed at reducing emergency department utilization or those increasing permanent supportive housing availability. This challenge is even more evident when considering that CBCM initiatives expand beyond the scope of housing to include many other health-related needs.

However, DHS provided annual financial data for the entire CBCM program between CYs 2018 and 2022. Despite a negligible decline in 2019, DHS provided more funding to the MCOs each year, from $17.7 million in 2018 to $25.8 million in 2022.

MCO spending, on the other hand, varied. In CYs 2018 and 2019, the MCOs spent on aggregate approximately $2 million more than provided by the department, or just under $20 million per year. During CYs 2020 through 2022, the MCOs spent anywhere from $2.4 to $6.3 million less than the funding allocation provided by DHS, ranging between $17.9 and $20.4 million annually.

According to DHS, the department compares each MCO's annual financial reporting to the calculation used to allocate funding for the CBCM program, which is $0.75 per member per month of the health plan's base capitation rate.[56] When an MCO underspends, DHS has two options. First, it can sanction the health plan by recouping the unspent dollars to offset a future CBCM payment. The department informed us that it has not exercised this option to date. Rather, DHS typically allows an MCO to carry unspent funding for CBCM initiatives in future years. This excess funding can be used in years when the MCO overspends on its CBCM initiatives compared to the funding allocated from DHS. MCOs can also use other revenue sources to fund their CBCM programs, but these methods do not need to be reported to the department.

While MCOs are only required to report financial data for the entirety of their CBCM programs, some health plans provided budgets for their housing initiatives in project narratives submitted to DHS. From this information, we found that MCOs spent at least $4.7 million on CBCM housing initiatives between CYs 2018 and 2022. While one MCO operated a regional housing coordinator initiative with funding between $1.5 and $1.9 million over a two-year period, the budgets for other CBCM programs were much smaller. Typically, the annual budgets for these

[56] A capitation payment is a way of paying health care providers upfront, providing the organization with a set amount of funds to cover the predicted cost of all or some health care services for a specific patient over a certain time period. *See* https://www.cms.gov/priorities/innovation/key-concepts/capitation-and-pre-payment#:~:text=Capitation%3A%20A%20way%20of%20paying,a%20certain%20period%20of%20time., accessed May 8, 2024.

initiatives ranged between $30,000 and $300,000. Overall, MCO spending on housing-related CBCM initiatives was minor compared to the $97.2 million spent by the health plans on all programming over our five-year observation period.

Where uniform data collection issues presented challenges in documenting outcomes for CBCM on the physical health side of HealthChoices, we found reporting was less of an obstacle for behavioral health. One notable example with documented health outcomes came from our behavioral health survey via Montgomery County and its BH-MCO, Magellan Behavioral Health of Pennsylvania. Operational since 2021, Montgomery County has used a blended funding stream with CBCM and reinvestment dollars to address housing insecurity for hospitalized individuals with SMI or substance use disorder (SUD) who previously would have been excluded from programs funded by HUD. The program includes a variety of supports, including SDOH and housing screenings, rental subsidies, rapid rehousing, and care coordination, among others.

In addition to higher rates of screenings for housing insecurity, outreach for housing supports, and enrollment into rent-subsidized housing, Montgomery County also found that program participants were more likely to seek follow-up care after a hospitalization for a mental illness.[57] The 35 members in the program in 2023 were slightly more likely to obtain follow-up care seven days after a discharge for a mental illness-related hospitalization compared to other individuals served by the Montgomery County's Behavioral HealthChoices program. However, the gap widened significantly over a 30-day period, with program participants seeking follow-up care 75 percent of the time compared to 54 percent for non-program members.

Valued Based Purchasing. When an MCO sees a CBCM program succeed for a limited population, it will often expand the work into a VBP program. Launched for Physical HealthChoices in 2017, VBP strives to push the MA program away from a payment model that is dependent on the volume of services rendered and towards one based on value, defined by cost and quality. VBP agreements between MCOs and providers specify how providers are paid for services rendered and link payments to the value of services provided and to relevant quality measures that are indicative of health outcomes.

[57] One way to track follow-up after hospitalization for mental illness is through healthcare performance improvement measures established by the National Committee for Quality Assurance (NCQA) for the Healthcare Effectiveness Data and Information Set (HEDIS). According to NCQA, follow-up care for patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care. *See* https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/, accessed May 9, 2024.

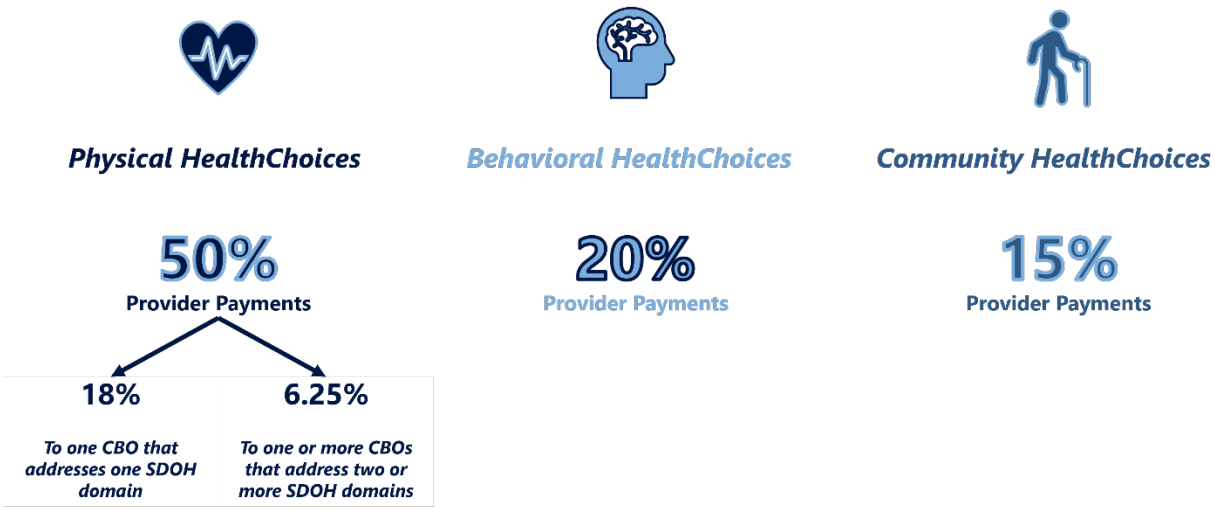
MCOs design VBP arrangements with guidelines established by DHS. These arrangements may use one of five provider payment strategies tiered by risk, followed by six different models to deliver care.

VBP is increasingly becoming an integral part of the managed care payment model in Pennsylvania. In 2023, DHS required MCOs to use VBP for 50 percent of provider payments in Physical HealthChoices, 20 percent in Behavioral HealthChoices, and 15 percent in CHC. In addition, HealthChoices MCOs are required to direct 18 percent of VBP payments to one CBO that addresses one SDOH and 6.25 percent of payments to one or more CBOs that address two or more SDOHs.

Exhibit 17 provides an overview of the VBP program's financial goals for MCOs.

Exhibit 17

VBP Program: MCO Financial Goals



Source: Developed by LBFC staff from information obtained from DHS.

Between 2018 and 2022, almost $58 billion was spent through VBP in the Physical HealthChoices program, for an average of nearly $11.6 billion per year. However, annual VBP spending fluctuated over the five-year period. This variation was caused by several factors, including an increase in VBP expenditure requirements in the Physical HealthChoices Agreement in 2019, the COVID-19 public health emergency throughout 2020 and 2021, and the re-procurement process for Physical HealthChoices MCOs starting in 2022.

Like CBCM, the variety of SDOH needs that can be addressed through VBP makes uniform outcomes data collection difficult. This challenge

was emphasized multiple times in our survey of Physical HealthChoices, Behavioral HealthChoices, CHC MCOs, and primary contractors. Since VBP is a required initiative, stakeholders expressed that MCOs must partner with a limited number of CBOs and providers for these agreements. The lack of standardized data points and reporting procedures creates additional workloads for all parties involved. Further, MCOs with varying expectations for their VBP programs can strain the operational capacity of CBOs and providers, especially smaller organizations with more limited resources.

Multiple MCOs also highlighted that CBOs and providers are at different stages of readiness for VBP, particularly regarding housing. MCOs report that some partners do not have the technology, staffing, or training needed to implement VBP programs successfully. Even among providers with the understanding and capacity to participate in the initiative, some MCOs expressed they have been met with an unwillingness to complete the extra quality assurance work required to be eligible for financial incentives.

Challenges aside, there are still examples of success within the VBP initiative. While not limited exclusively to the homeless population, the CHC MCO PA Health & Wellness (PHW) operates its Point of Care program to reduce the risk of emergency department utilization and hospitalization. PHW designed the program to provide support and on-site healthcare in participants' homes to mitigate unnecessary hospital stays. In 2023, PHW reported a 46 percent decrease in emergency department utilization and a 44 percent reduction in inpatient hospital utilization for enrolled participants.

Throughout our study, one of the most frequently cited examples from stakeholders across the housing industry was the Cultivating Health for Success (CHFS) program operated by the University of Pittsburgh Medical Center for You (UPMC for You). Launched in 2010, CHFS now uses VBP contracts to fund a permanent supportive housing model that utilizes housing subsidies, community resources, and healthcare supports tailored to an individual's needs. Initially, only in Allegheny County, UPMC for You expanded CHFS to Blair and Lawrence Counties in 2023. Since the program's creation, CHFS has housed 205 individuals, with 105 of those since 2019. The program has graduated 68 participants since 2019, meaning the individuals have reached a level of stability and can now live independently. Most recently, a 2023 analysis from UPMC for You found that CHFS participants saw an average cost savings of $914 per member per month in the 12 months after being placed in housing.

MCO Revenue Sharing Plans and Reinvestment.

While Medicaid capitation rates are determined using generally accepted actuarial methods that take into consideration baseline costs, healthcare utilization trends, non-benefit expenses, and risk

adjustments, among other factors, these payments to MCOs are still projections and, as a result, can be subject to vulnerability in the marketplace.[58]

DHS leadership expressed that with the push toward providing value-centric services in managed care, MCOs were experiencing excess revenue margins between 10 to 15 percent from unused capitation revenue each year. As a result, Physical HealthChoices and CHC introduced MCO RSPs into their programs with the goal of using most of these excess funds to benefit the MA population. RSPs are based on the reinvestment model used in the Behavioral HealthChoices program for over 25 years.

Since the behavioral health program funding is directed to counties, excess revenue cannot be retained by local government entities as "profits." Therefore, OMHSAS established an initiative in which up to three percent of unspent funds must be reinvested into the program. The HealthChoices agreement describes allowable uses of reinvestment funds. Although the counties have discretion on the use of reinvestment funds, the programs must benefit the MA population. These reinvestment plans must be approved by OHMSAS.

A similar structure has been established for the RSPs within Physical HealthChoices and CHC. DHS will determine the "maximum retained revenue," or excess revenue, that each MCO can keep each year by taking the health plan's annual capitation revenue and multiplying it by a "percent limit," or a cap on revenue, of three percent. The department next determines the MCO's "realized revenue" for the contract year by taking the plan's capitation revenue and subtracting expenses for allowable medically necessary services for plan members, spending on activities to improve healthcare quality (e.g., CBCM initiatives, external quality reviews, health information technology, etc.), and allowable administrative expenses.

Then, the MCO's realized revenue is compared to the maximum retained revenue value calculated from its capitation revenue. If realized revenue is less than the three percent maximum retained revenue threshold, then the plan is not eligible for an RSP, and it may retain excess revenue.

If realized revenue is greater than the maximum retained revenue, the value of the maximum retained revenue is returned to the MCO. The MCO can then elect to either remit the excess revenue to DHS or enter an RSP with the department. If the MCO submits and is approved for an RSP, then it may keep half of the excess revenue if the other 50 percent is used to fund initiatives that support DHS's goals of access and provider retention, SDOH mitigation, or community development.

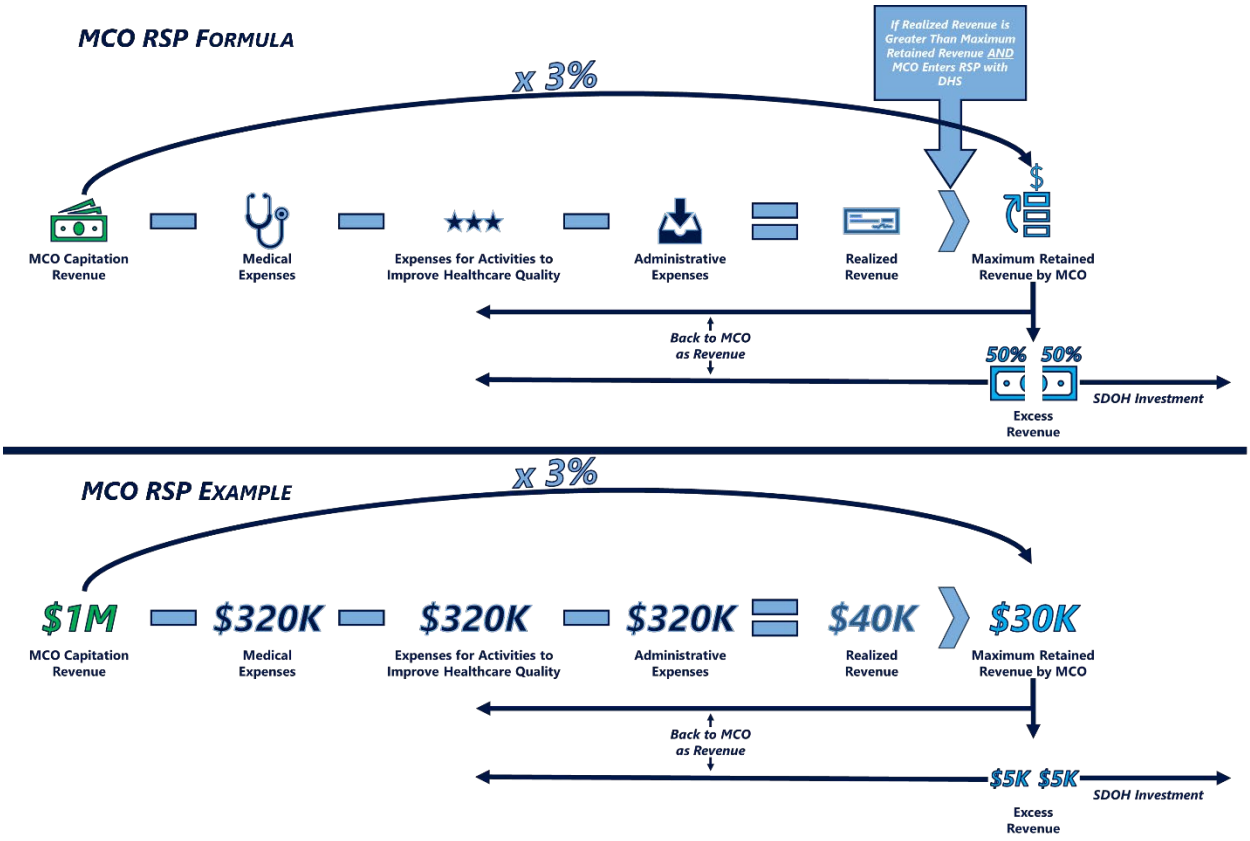
[58] Medicaid and CHIP Payment and Access Commission, *Medicaid Managed Care Capitation Rate Setting*, 2022.

While this process can initially be complex, it can be more easily understood through a simplified, hypothetical example. If an MCO's annual capitation revenue was $1 million, then the maximum retained revenue the health plan could keep would be $30,000. For simplicity, if the MCO's expenses totaled $960,000, the plan would be left with $40,000 in realized revenue. Since realized revenue is greater than the maximum retained revenue, then the MCO would automatically retain the three percent excess revenue threshold of $30,000. Under an RSP, the MCO could also retain an additional $5,000 of revenue if the remaining $5,000 were spent on initiatives that support the department's stated goals, such as housing initiatives.

Exhibit 18 below shows a graphical illustration of the MCO RSP formula and our hypothetical example.

Exhibit 18

MCO RSP Formula for Physical HealthChoices and CHC



Source: Developed by LBFC staff from information obtained from DHS.

DHS initiated RSPs in Physical HealthChoices and CHC for the 2023 and 2024 contract years, respectively. Due to the time lag in Medicaid claims

and other financial data needed to determine the MCOs' revenue, DHS does not anticipate the first RSP submissions for the Physical HealthChoices' contract year 2023 until early 2025.

However, even if the program were fully underway, there may be difficulty measuring health-related outcomes, as MCOs are not required to submit any documentation except a completed RSP form to DHS. While this form includes projected funding amounts and anticipated outcomes, it does not require performance data.

When we questioned the department on assessing outcomes as part of the RSP, we were informed that discussions about implementing a data collection process were ongoing.

While there have not yet been any examples of successful implementations of RSP in Physical HealthChoices or CHC, in Behavioral HealthChoices, where the program is well established, examples are much more plentiful. The Community Care Behavioral Health Organization, the BH-MCO for 43 counties in the commonwealth, provided us with 25 housing initiatives supported by reinvestment funds in its member counties. These projects are diverse, including supportive housing programs, flexible housing funds, master leasing agreements, residential habilitation services, and recovery houses, among other supports.

The Capital Area Behavioral Health Collaborative (CABHC) in southcentral Pennsylvania is another notable example of a successful implementation.[59] In 2021, CABHC began placing Community Health Workers in four Federally Qualified Health Centers to meet with individuals being treated at the center for behavioral and physical health, but who were also identified as needing social and coordination support. CABHC uses reinvestment dollars to pay for the SDOH needs identified by these individuals, the most common of which is housing.

While the program is being analyzed, CABHC reports that access to community health workers has reduced participants' emergency department utilization by almost 23 percent. The organization plans to assess the impact of housing-specific supports on participants' health.

Further, even though reinvestment has not been an official part of the Physical HealthChoices or CHC programs, MCOs across the state have already been using their funds to invest in their populations. In our survey of MA health plans, five of seven Physical HealthChoices MCOs and all four CHC MCOs reported they use their own funds to invest in housing-related SDOH initiatives. These services were tailored to the needs of each MCO's population (e.g., medical-legal partnerships, affordable housing investments, home repairs, service navigators, etc.). Even MCOs

[59] CABHC operates in Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties.

that hold contracts for both Physical HealthChoices and CHC make different investments based on the specific needs of the populations served by the programs.[60]

However, there are potential drawbacks to RSP initiatives. Some stakeholders expressed apprehension over the potential volatility that could come from the nature of reinvestment dollars only being "one-time funding." While investments are typically designed to span multiple years to aid program stability, indeed, reinvestment dollars may not be a consistent funding source that can be factored into long-term budgeting.

More broadly, the challenge we repeatedly encountered with many initiatives discussed in this section was the lack of measurable outcomes data. This problem is not exclusive to Pennsylvania or the MA program; it is a nationwide issue that crosses the private and public sectors. Still, the impact of housing on the healthcare system in the United States is gaining attention at all levels. With the increased focus it is expected to have on the future of the commonwealth's managed care program, it is vitally important for the department to have performance data for all housing-related programs within its purview.

As discussed in Section IV, the commonwealth's proposed Keystones of Health 1115 waiver cannot supplant existing services or supports offered by the MA program. We believe this requirement presents an opportunity for DHS to manage where housing-related services are offered throughout the MA program and evaluate how these initiatives impact Pennsylvanians' lives.

Therefore, we recommend that the department develop health-centered outcome measures and key performance targets for housing-related services within the MA program to help ensure that state and federal Medicaid spending is being efficiently used to improve the independence and health of MA participants.

C. Impacts of Housing Programs on Health Outcomes and Costs for Medical Assistance Participants

HR 66 directs us to analyze the healthcare outcomes and cost savings that may be achievable through unmet housing needs. As with our

[60] As noted by DHS, Physical HealthChoices MCOs with housing pilots can measure health related outcomes. Several MCOs reported positive outcomes, such as the PHW example cited on page 46 of this report.

discussion on housing-related MA expenditures, this type of analysis in an emerging field of study was challenging due to data limitations and the time lag required to realize cost savings.

However, we were able to engage several researchers and public health experts who have been working on this topic in Pennsylvania for the better part of the last decade. While not without limitations, their work is a significant first step in documenting cost savings and improved health outcomes realized in the MA program. The following discussion outlines several of their key findings while highlighting challenges for future consideration.

Cost Savings versus Cost Containment

First, it is essential to put the concept of "cost savings" into its proper context. Numerous stakeholders informed us that in the healthcare industry, this term is not necessarily viewed as cost "savings" in the traditional sense, meaning funds that go unspent or can be used elsewhere. Rather, the term is more accurately described as "cost containment" or "cost distribution."

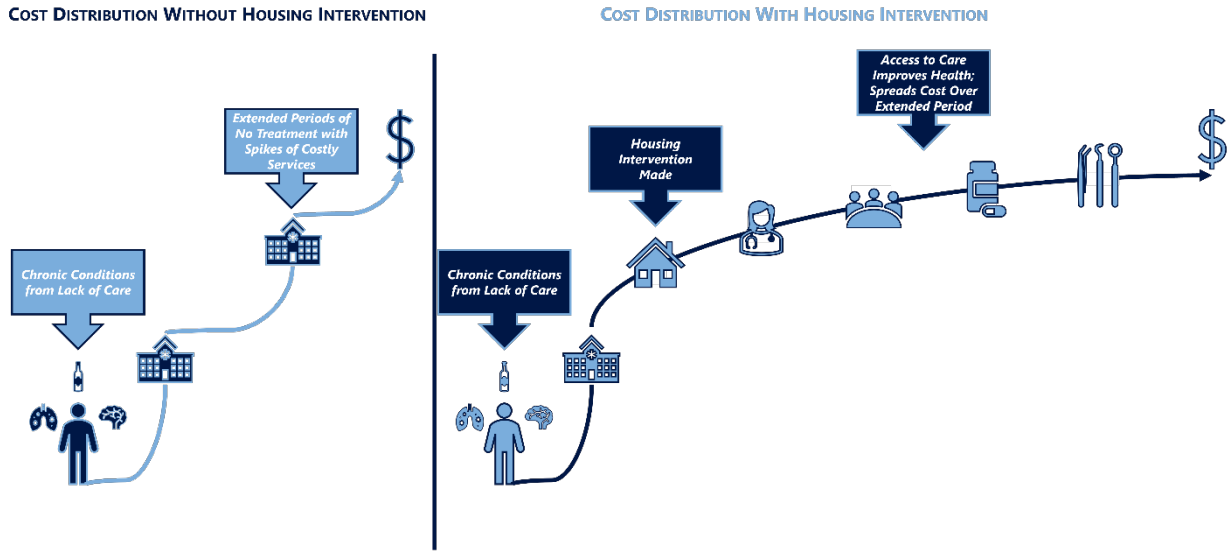
Homeless individuals are disproportionately high utilizers of costly services within the Medicaid system. Many of these individuals lack the resources to obtain routine primary or preventative care services, leading to increased levels of untreated chronic physical health conditions, SMI, and SUD. Without connections to primary care practices, costly emergency department visits are often the only option for homeless individuals when they decide to seek treatment. Deterioration of health from extended periods without care means that, when treatment is finally sought, these individuals likely have underlying conditions beyond the cause of the visit, thus extending the length of the stay in the hospital system.

Advocates for using Medicaid dollars to support housing initiatives argue that stabilizing an individual's living situation removes one more obstacle to focusing on their health. Further, these housing services often act as the starting point for other care the person may need, such as substance abuse treatment, counseling, medication management, or preventative care, with the goal of improving their long-term health. While costs may not be "saved," they are "contained" by reducing the use of more expensive services (e.g., emergency department care). These cost savings can then be "distributed" for the individual's care over a much longer period. Rather than obtaining cheaper care, this argument focuses on achieving more cost-effective care.

Exhibit 19 shows an example of a hypothetical cost distribution with and without housing interventions under this model.

Exhibit 19

Investment in Housing has the Potential to Distribute Costs Over an Extended Period of Time



Source: Developed by LBFC staff.

Emerging Examples of Positive Health and Cost Outcomes from MA Housing Interventions

While data sharing was a frequent issue highlighted by stakeholders throughout this study, we identified several organizations that used their unique position within the healthcare industry to overcome this obstacle.

In 2020, Temple University Hospital launched the Housing Smart program in collaboration with the MCOs Keystone First and Health Partners Plans (now Jefferson Health Plans), as well as the national human services nonprofit Resources for Human Development. Together, Housing Smart enrolled high healthcare utilizers – particularly those with opioid use disorder and persistent mental illness with co-occurring physical health conditions – into temporary housing with the goal of helping participants gain vouchers for permanent housing.

As of spring 2024, Temple University Hospital leadership informed us that 46 individuals have successfully completed the Housing Smart program. The program has realized impressive health-related outcomes, with an eight percent decline in inpatient hospitalizations and a 46 percent decline in emergency department visits for participants from pre-housed and post-housed periods. The program also saw a rise in

positive medical utilization, with doctor office and clinic visits increasing by 73 percent.

Beyond its impact on the lives of its participants and the healthcare system, the Housing Smart program successfully documented its outcomes. Temple's position as the hospital system and population health researchers allowed streamlined access to utilization data and other key metrics.

However, this was still not without its challenges. Temple leadership expressed that bringing the MCOs to the table to discuss data-sharing agreements was the most challenging part of the planning process, taking over a year. MCOs had significant reservations about the repercussions that data sharing could have in the healthcare marketplace in terms of cost, as they would be sharing their performance metrics with competitors. Ultimately, a series of agreements laid out a strategy to aggregate and present data to protect all the involved parties.

In western Pennsylvania, the University of Pittsburgh Medicaid Research Center (MRC) is engaged in a decade-long agreement with DHS to analyze aspects of the MA program, including the impacts of permanent supportive housing (PSH). To date, Pitt MRC has published three studies evaluating the impacts of PSH by linking MA enrollment and claims data to Homeless Management Information Systems (HMIS) records from 54 counties for various periods between 2011 and 2017.

In one of the first known studies to examine healthcare expenditures and utilization three years after starting PSH, Pitt MRC and associated researchers found that emergency department use for PSH participants declined by 4.7 visits per 100 person-months relative to the study's comparison group. Acute care hospitalizations declined by 1.6 visits per 100 person-months by year three in PSH, while days spent in residential SUD treatment went down by 27.3. In terms of spending, the researchers found monthly MA spending was $145 per person lower than expected had participants not been in PSH, which was a reduction of 12 percent from the baseline and equates to an average savings of $1,740 per recipient. These average annual savings included declines in behavioral health treatment and inpatient care expenditures while spending on outpatient pharmacy care increased.[61]

In a follow-up study, Pitt MRC explored how MA expenditures are impacted in the 12 months before and after exit from PSH. Findings suggest that PSH has continued benefits even after beneficiaries exited the

[61] Researchers report that spending on inpatient and residential behavioral health treatment declined by 11 percent, spending on non-behavioral health inpatient care fell by four percent, and spending on outpatient pharmacy care increased by 10 percent. *See* Hollander, Cole, Donohue, and Roberts, *Changes in Medicaid Utilization and Spending Associated with Homeless Adults' Entry into Permanent Supportive Housing*, 2020.

program. Researchers reported decreased spending by $162 per member, per month in the year after participants left PSH, which was 13 percent lower than expected if they had not been enrolled in the program. The Pitt MRC lead researchers informed us they are currently working on a follow-up study that will include data from five additional counties through 2022. This study is being accomplished in parallel to a similar study in New Jersey by Rutgers University.[62]

Most recently, researchers examined the impact that PSH has on children's dental health. After three years in the program, analysis showed that dental visits among PSH children increased by 12.7 visits per 1,000 person-months.[63] In addition, for children under the age of five, emergency room visits decreased by 13.16 visits per 1,000 person-months. However, the study did not find higher levels of preventative medical care among children receiving PSH, which contradicts prior research.[64]

However, all three studies were limited by the lack of HMIS data from 13 of Pennsylvania's 67 counties, including Philadelphia.[65] As noted in Section V, HUD requires each Continuum of Care (CoC) to have a data management system for HMIS records. To obtain data from the 13 additional counties, Pitt MRC would have needed to negotiate separate data-sharing agreements with each CoC. This would have required significant time and resources to ensure all agreements aligned with the study's criteria.

The examples in this section suggest that short-term cost savings and positive health outcomes can arise from housing interventions within the MA program. However, these examples also show that such results cannot be accomplished without collaboration from DHS, MCOs, hospitals and health systems, and housing stakeholders. Currently, the housing and healthcare industries are largely disparate and siloed from each other, creating fragmentation, and often frustration, when the two try to work together. For future initiatives, such as the Keystones of Health waiver, to have widespread, measurable success, this obstacle must be overcome.

We encourage healthcare and housing stakeholders from across the commonwealth to collaborate and engage in new data-sharing partnerships that will provide the insights needed to benefit the

[62] Cole, Hollander, Ennis, et al., *Do Medicaid Expenditures Increase After Adults Exit Permanent Supportive Housing?*, 2022.
[63] Person-months is a unit of measurement that, in this study, considers the length of time a child has been enrolled in Medicaid. For example, if one child has been enrolled in Medicaid for two years, that would equate to 24 person-months. The measurement accounts for continuous enrollment and dis-enrollment within Medicaid.
[64] Bohnhoff, Xue, Hollander Mara, et al., *Healthcare Utilization Among Children Receiving Permanent Supportive Housing*, 2023.
[65] Philadelphia is one of the five counties being added to Pitt MRC's follow-up study.

shared goal of improving the health and well-being of Pennsylvanians.

D. Other Non-Medical Assistance DHS Programs

DHS has several other programs that MA does not fund to assist the homeless. Like those funded with Medicaid dollars, many of these programs assist individuals with developing and maintaining the skills needed to live in the community. However, unlike their MA counterparts, these DHS programs often support individuals in finding and maintaining stable housing.

In addition, this section also discusses DHS's department-wide housing strategy for 2016 to 2020, which is currently being updated. Finally, we also highlight PA Navigate, a new resource launched in 2024 that connects citizens with CBOs, government agencies, and healthcare plans and providers for referrals to local resources for HRSN, such as food, shelter, and transportation.

Projects for Assistance in Transition from Homelessness (PATH)

The Projects for Assistance in Transition from Homelessness (PATH) grant aims to reduce or eliminate homelessness for individuals with SMI and SUDs who are experiencing homelessness or are at risk of becoming homeless. Operating in 37 counties, PATH is funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) and was created as part of the Stewart B. McKinney Homeless Assistance Amendments Act of 1990.

CMHS annually issues a Notice of Funding Opportunity (NOFO) for the PATH. State PATH Contacts (SPC) then complete and submit the application to CMHS with the signature of the governor (or other designee) of a state or territory. SPCs also help providers prepare PATH data reports, use the PATH Data Exchange, and assist providers in administering local PATH programs.

Each jurisdiction then solicits proposals and awards funds to local public or nonprofit organizations, known as PATH providers. Services eligible for PATH funding include:[66]

- Outreach services.
- Screening and diagnostic treatment.
- Habilitation and rehabilitation.
- Community mental health.
- Substance use disorders treatment.
- Referrals for primary health care, job training, educational services, and housing.

Exhibit 20 shows funding awards for the PATH program in Pennsylvania from FY 2018-19 to FY 2023-24

Exhibit 20

PATH Program Funding Awards and Enrollees for Pennsylvania
Federal FYs 2018-19 through 2023-24

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Federal Funds Awarded for PATH	$2,366,835	$2,367,227	$2,367,006	$2,386,444	$2,379,790	$2,430,781
Required 3:1 State Fund-ing Match	788,945	789,076	789,002	795,481	793,263	810,260
Optional County/Local Match	6,617	7,190	511,476	512,474	506,824	490,836
Total PATH Funding	**$3,162,397**	**$3,163,493**	**$3,667,484**	**$3,694,399**	**$3,679,877**	**$3,731,877**
Total Individ-uals Enrolled During FY	2,514	2,574	2,272	2,636	3,716	4,428

Source: Developed by LBFC staff from information obtained from OMHSAS.

[66] *See* https://www.samhsa.gov/homelessness-programs-resources/path, accessed May 14, 2024.

Homeless Assistance Program (HAP)

HAP is a state program administered by DHS that assists individuals and families who are experiencing or at risk of homelessness. HAP operates in all 67 counties and offers a variety of supportive services, including:

- Case management.
- Emergency shelter.
- Bridge housing.
- Supportive housing.
- Rental assistance.

Counties must meet the HAP objectives of providing homelessness prevention services that assist clients in maintaining affordable housing, helping people experiencing homelessness find refuge and care, and assisting people who are homeless or near homeless in attaining economic self-sufficiency.

As shown in Exhibit 21, HAP has two funding sources at the state level: allocations from the General Fund and the DHS Human Services Block Grant.

Exhibit 21

HAP State-Level Funding and Individuals Served
FYs 2018-19 through 2021-22

	2018-19	2019-20	2020-21	2021-22[a]
General Fund Allocation	$18,496,000	$18,496,000	$18,496,000	$18,496,000
DHS Human Services Block Grant Allocation	12,848,578	12,933,023	12,848,578	12,848,578
Total State-Level Funding	**$31,344,578**	**$31,429,023**	**$31,344,578**	**$31,344,578**
Individuals Served by HAP	69,659	60,709	44,895	46,993

[a] Most recent available DHS Human Services Block Grant funding data for HAP.

Source: Developed by LBFC staff from information obtained from DHS and The Governor's Executive Budget.

Permanent Supportive Housing

PSH is a housing intervention strategy that combines affordable housing with supportive services to address the needs of chronically homeless

individuals. PSH aims to assist individuals who face challenges such as very low incomes, persistent physical or mental health issues, or are consistently homeless or at risk of homelessness.

According to DHS, a supportive housing unit is:

- Readily available to a person or family whose head of household is eligible for supportive housing (experiencing chronic physical or mental health conditions or multiple barriers to employment and housing stability).
- Where the tenant pays no more than 50 percent of household income towards rent, and ideally no more than 30 percent.
- Associated with comprehensive services, including but not limited to:
    - Medical services.
    - Mental and behavioral health services.
    - Substance use management and recovery.
    - Vocational and employment assistance.
    - Money management.
    - Coordinated support (case management).
- Where services or programs are not a condition of ongoing tenancy.
- Where the tenant has a lease or similar form of occupancy agreement, and there are no limits on a person's length of tenancy if they abide by the conditions of the lease or agreement.
- Where there is a working partnership that includes ongoing communication between supportive services providers, property owners or managers, or housing subsidy programs.

In 2016, DHS developed a five-year supportive housing strategy titled "Supporting Pennsylvania Through Housing." The strategy presents the need for permanent supportive housing, the barriers to PSH, and strategies for expanding and accessing PSH for eligible individuals. The strategies were:

- Expand access and create new, affordable, integrated, and supportive housing opportunities.
- Strengthen and expand housing and housing-related services and supports.
- Assess new and existing programs to determine future needs and measure outcomes.
- Promote teamwork and communication in both state and local government to develop housing opportunities for all populations served by DHS.

Utility Assistance Programs

Because utilities are essential to maintain good health, several programs assist low-income households.

Low-Income Home Energy Assistance Program (LIHEAP). LIHEAP is a federal program that assists eligible low-income households with heating and cooling energy costs, bill payment assistance, energy crisis assistance, weatherization, and energy-related home repairs.

According to the US Department of Health and Human Services (HHS), in FY 2023-24, LIHEAP received roughly $6.1 billion in funding comprised of a block grant from the US Department of Health and Human Services, funds from the Infrastructure Investment and Jobs Act, and other supplemental appropriations from Congress. All 50 states, the District of Columbia, five US territories, and about 150 tribes apply for funds from HHS for LIHEAP by September 1 each year.

In Pennsylvania, LIHEAP, administered by the Department of Human Services (DHS), has three components:

- **Cash benefits** to help eligible households pay for their home heating fuel.
- **Crisis payments** to resolve weather-related, supply shortages, and other household energy-related emergencies.
- **Energy conservation and weatherization grants** to address long-range solutions to the home-heating problems of low-income households. [67]

Eligible households in Pennsylvania apply for LIHEAP benefits through the online tool COMPASS (Commonwealth of Pennsylvania Access to Social Services) or through a paper application submitted to local County Assistance Offices (CAOs). Applications are submitted for immediate disbursement to the applicant's utility account upon approval. The most recent grant application period was from November 1, 2023, to April 5, 2024, for all grant types.

The LIHEAP Cash Grant is a one-time payment credited to an eligible applicant's account with a utility company or fuel provider. LIHEAP grants in Pennsylvania range from $300 to $1,000 per household per year based on household size, income, and fuel type. The income limit

[67] Energy conservation and weatherization services and certain related energy crisis payments are provided by the Pennsylvania Department of Community and Economic Development (DCED) under its Weatherization Assistance Program (WAP). See Section V of this report.

begins at $21,870 for a single-person household and increases by $7,710 for each additional person.

Households experiencing an emergency regarding their heating may be eligible for additional benefits and funding through the LIHEAP Crisis program. Households may apply for regular crisis benefits regardless of whether they apply for or receive a LIHEAP Cash benefit. These grants range from $25 to $1,000 per household per year. DHS defines emergencies as:

- Broken heating equipment or leaking utility lines must be fixed or replaced.
- Lack of fuel.
- The primary or secondary heating source has been completely shut off.
- The danger of being without fuel, i.e., less than a 15-day supply.
- The danger of having utility service terminated, i.e., the household received a notice that service will be shut off within the next 60 days.

Exhibit 22 shows the number of households receiving either or both LIHEAP cash or crisis funds from FY 2018-19 to 2022-23, as well as the amount of payments for each type. Households may qualify for both types of LIHEAP funds, meaning a household may be counted twice for any given year. On average, for FY 2022-23, households received $402 in cash assistance and $1,002 in crisis assistance.

Exhibit 22

LIHEAP Disbursements
FYs 2018-19 to 2022-23

Fiscal Year	LIHEAP Cash		LIHEAP Crisis	
	Number of Households	Total Payment Amount	Number of Households	Total Payment Amount
2018-19	328,716	$90,890,673	105,038	$53,446,859
2019-20	312,591	88,703,938	124,264	59,952,081
2020-21	303,224	84,965,261	92,295	50,847,161
2021-22	329,873	187,685,348	91,013	73,091,664
2022-23	312,186	125,588,402	98,887	99,101,605

Source: Developed by LBFC staff from information obtained from DHS.

Most utilities in Pennsylvania have Customer Assistance Programs (CAPs) to support those experiencing hardship in paying utility bills. We also highlight two other utility assistance programs below.

Utility Emergency Services Fund (UESF). The Utility Emergency Services Fund (UESF) is a Philadelphia-based organization that provides grants to low-income households facing utility terminations. The USEF provides supplemental assistance to those who need assistance paying their utility bills and have unsuccessfully applied for LIHEAP benefits.

To be eligible for a UESF grant, an applicant must:

- Have a notice of termination from PECO, Philadelphia Gas Works, or Philadelphia Water Department.
- Be a Philadelphia resident.
- Have not received a UESF grant in the past 24 months.
- During LIHEAP season, applied for the LIHEAP Cash and Crisis programs first before applying to UESF.
- Owe an amount that is not more than the utility grant.
- Be at or below 200 percent of the current federal poverty level.

Dollar Energy Fund. Dollar Energy Fund's Pennsylvania Hardship Program provides one-time assistance grants to FirstEnergy utility customers that are applied directly to their utility bills.[68] Applicants can only receive one grant per utility per program year and must have previously attempted to apply for LIHEAP benefits. The maximum grant amount an applicant may receive is $500, but grant amounts are determined individually.

Housing Strategy 2024 Update

The DHS five-year (2016-2020) housing initiative — *Supporting Pennsylvanians Through Housing Plan* was developed to connect Pennsylvanians to affordable, integrated, and supportive housing. The housing plan was for:

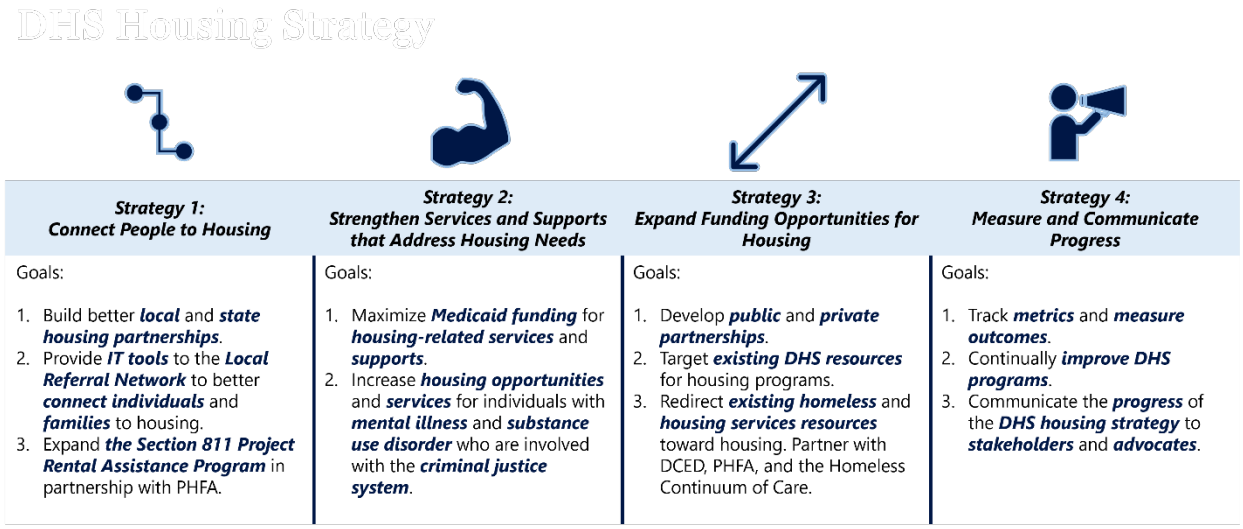
- Individuals who live in institutions could live in the community with housing services and support.
- Individuals and families who experience homelessness or are at risk of homelessness.
- Individuals who have extremely low incomes and are rent-burdened.

[68] FirstEnergy utility companies include Met-Ed, Penelec, Penn Power, and West Penn Power.

Exhibit 23 below shows the 2016-2020 housing plan strategies and corresponding goals.[69]

Exhibit 23

DHS Housing Strategy Strategies and Goals



Source: Developed by LBFC staff from the Pennsylvania Department of Human Services.

DHS is building upon the 2016-2020 housing plan through its 2024-2029 *Housing Strategy Project*. The new project priority areas include:

- Supportive Housing.
- Homelessness & Housing Stability.
- Housing and Supports.
- Housing Affordability.
- Housing Supply & Accessibility.

In this updated housing strategy, DHS is seeking expertise from individuals and families who have experienced housing instability and crisis, as well as agency partners' and providers' perspectives, to integrate into the plan. Further, DHS will perform a contextual analysis via environmental scans of Pennsylvania housing programs, policy and planning, and data obtained through housing needs surveys, interviews, listening, and engagement sessions. DHS will use the culmination of knowledge to develop its updated housing strategy.

DHS expressed that the 2024-2029 Housing Strategy Project is on track for a public comment period in mid-summer 2024. Following this

[69] The housing plan was updated during FY 2017-18 to further clarify goals and reorganize information.

comment period and the integration of feedback from stakeholder committees and department executives, DHS will publish the updated strategy, targeted for late summer 2024.

PA Navigate

Launched in January 2024, PA Navigate is an online resource that connects citizens with CBOs, county, and state government agencies, and healthcare providers for referrals to local HRSN resources, such as food, shelter, and transportation.

PA Navigate has its roots in the changes made to the Pennsylvania eHealth Partnership Program provisions found in Act 2016-76, which moved the program under the authority of DHS and tasked the department with creating a secure exchange of healthcare information in the commonwealth. DHS's first attempt at integrating a statewide resource and referral tool for HRSN into the health information exchange was called the Resources Information and Services Enterprise (RISE PA) initiative, which eventually became known as PA Navigate.

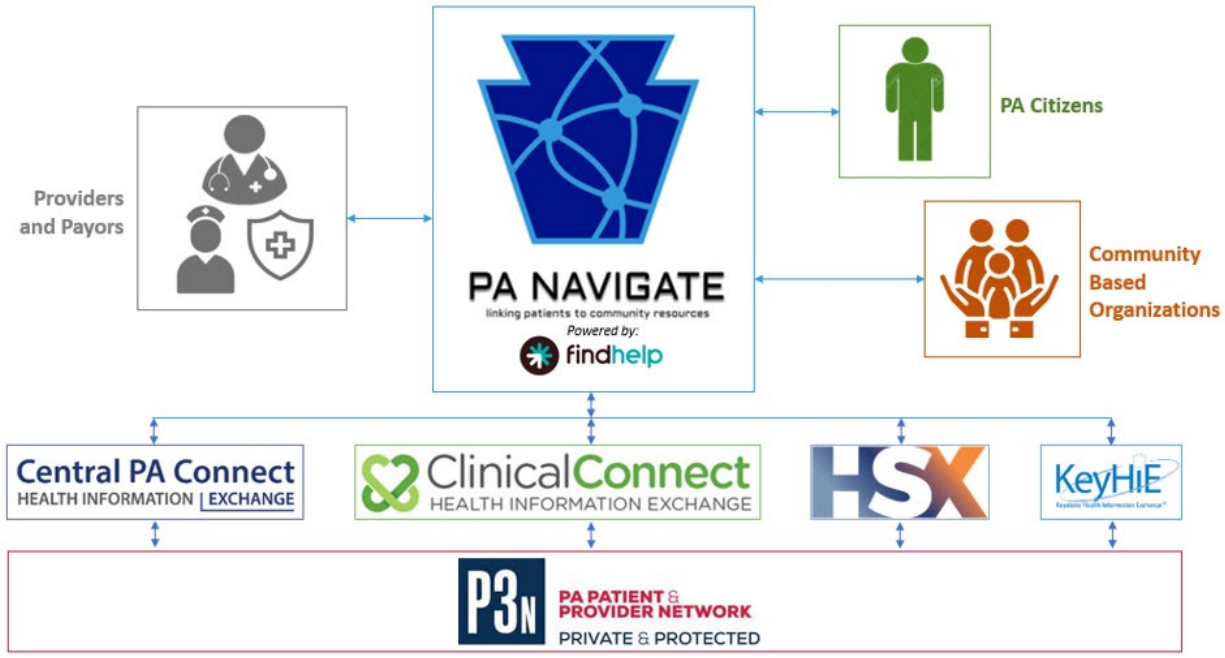
PA Navigate was designed as a "one-stop shop" for HRSN services. The tool connects patients, providers, health insurers, CBOs, government entities, and the commonwealth's health information organizations (HIOs) on a secure closed-loop system. These connections allow anyone in the state to search for services by HRSN area (housing, food, health, education, etc.) down to the zip code level.

PA Navigate can be a valuable tool to direct individuals to available community resources such as housing. For example, if a patient comes into an emergency department and is found to need housing, a healthcare professional can use PA Navigate to search for supports in the area.

Grouped into categories (e.g., temporary shelter, maintenance, housing advice, residential housing, etc.), supports can be filtered for age, income, veteran status, mental health status, disability needs, etc., to address the patient's specific needs. Referrals can be made to local CBOs, with the patient's needs and service status shared through PA Navigate to ensure appropriate care is received. Exhibit 24 illustrates key participants in the current iteration of PA Navigate.

Exhibit 24

PA Navigate Participants



Source: Developed by LBFC staff with information obtained from DHS.

DHS released the first grant applications for PA Navigate in 2021. Four HIOs were awarded grants in 2022, forming the consortium branded as PA Navigate. After finalizing system requirements, the HIO-controlled consortium procured findhelp as the software platform for PA Navigate in 2023.[70]

PA Navigate launched in January 2024 with the integration of the HIO networks into the findhelp platform. Integrations of CBOs, health insurers, and providers will take place throughout the rest of this year. DHS's initial grant funding for PA Navigate runs through January 31, 2025. DHS expects that the HIOs will carry the costs for the tool from that point forward.

Exhibit 25 shows the PA Navigate project timeline throughout the DHS grant period, calendar years 2021 to 2025.

[70] According to DHS, the HIOs used initial grant awards to fund a five-year, $9 million contract with findhelp. The contract will expire in 2028.

Exhibit 25

PA Navigate Timeline
CYs 2021 to 2025

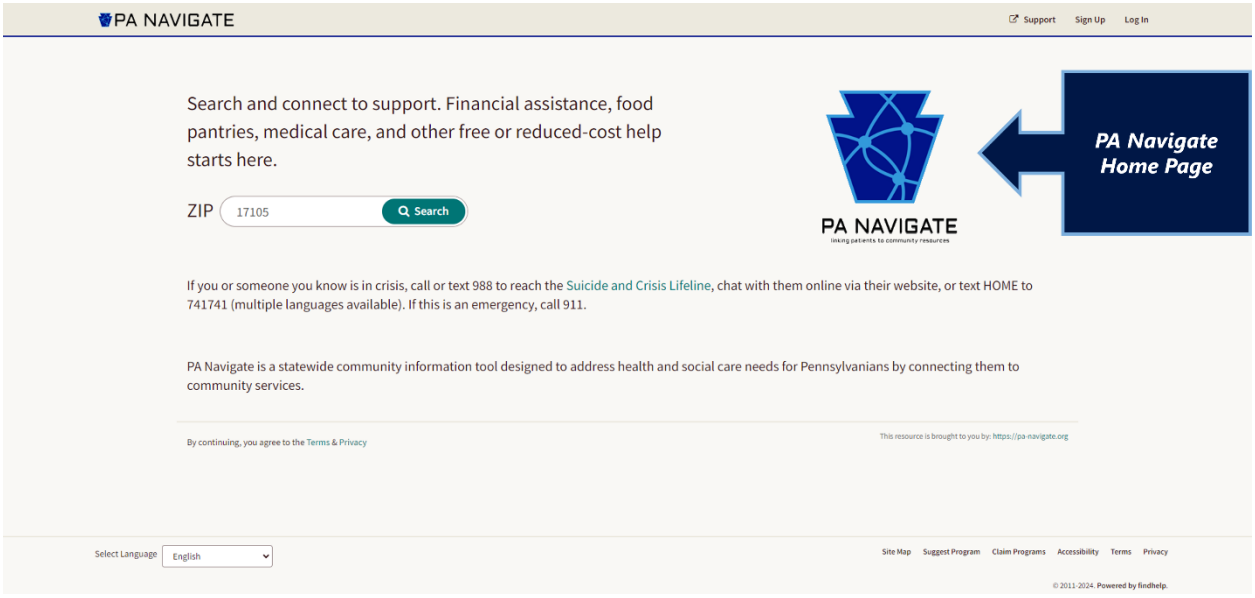
Source: DHS.

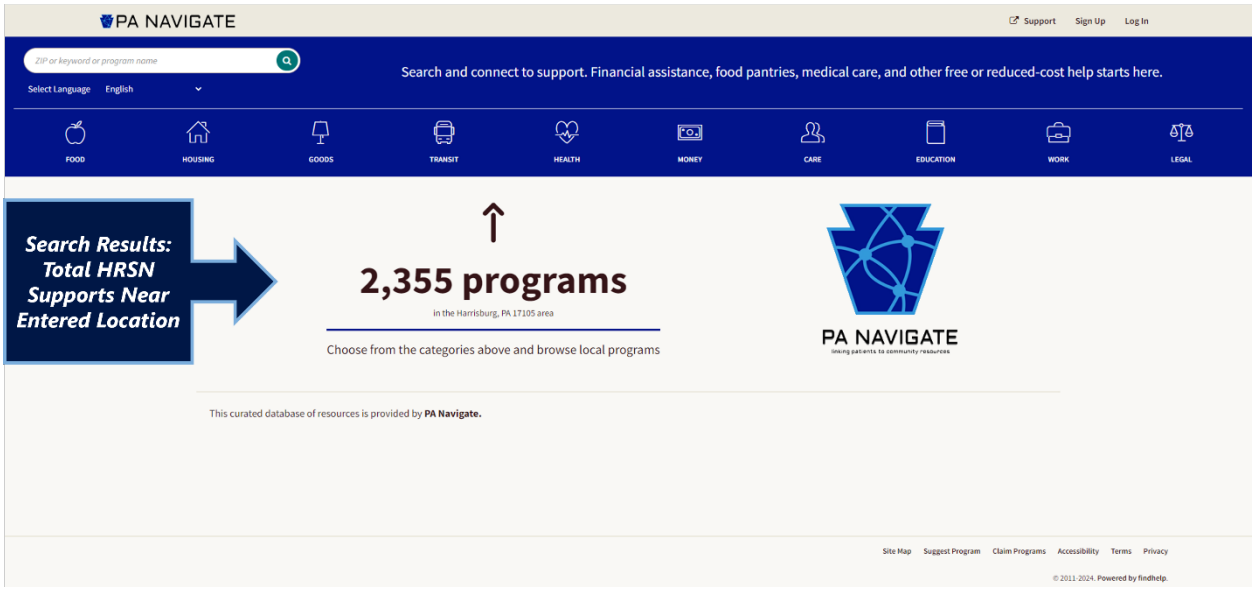
Although integration into PA Navigate will take place over the remainder of this year, expansion of the tool has already occurred. Many health systems previously had similar, separate tools in place, allowing for thousands of CBOs to swiftly be pulled into the statewide resource. There is no cost for new CBOs to join the tool, and healthcare partners can apply for grant funding to connect through a HIO.

Exhibit 26 shows the current state of PA Navigate, using a hypothetical example of an individual in need of a housing voucher in the Harrisburg area. Images are courtesy of the PA Navigate website, pa-navigate.org.

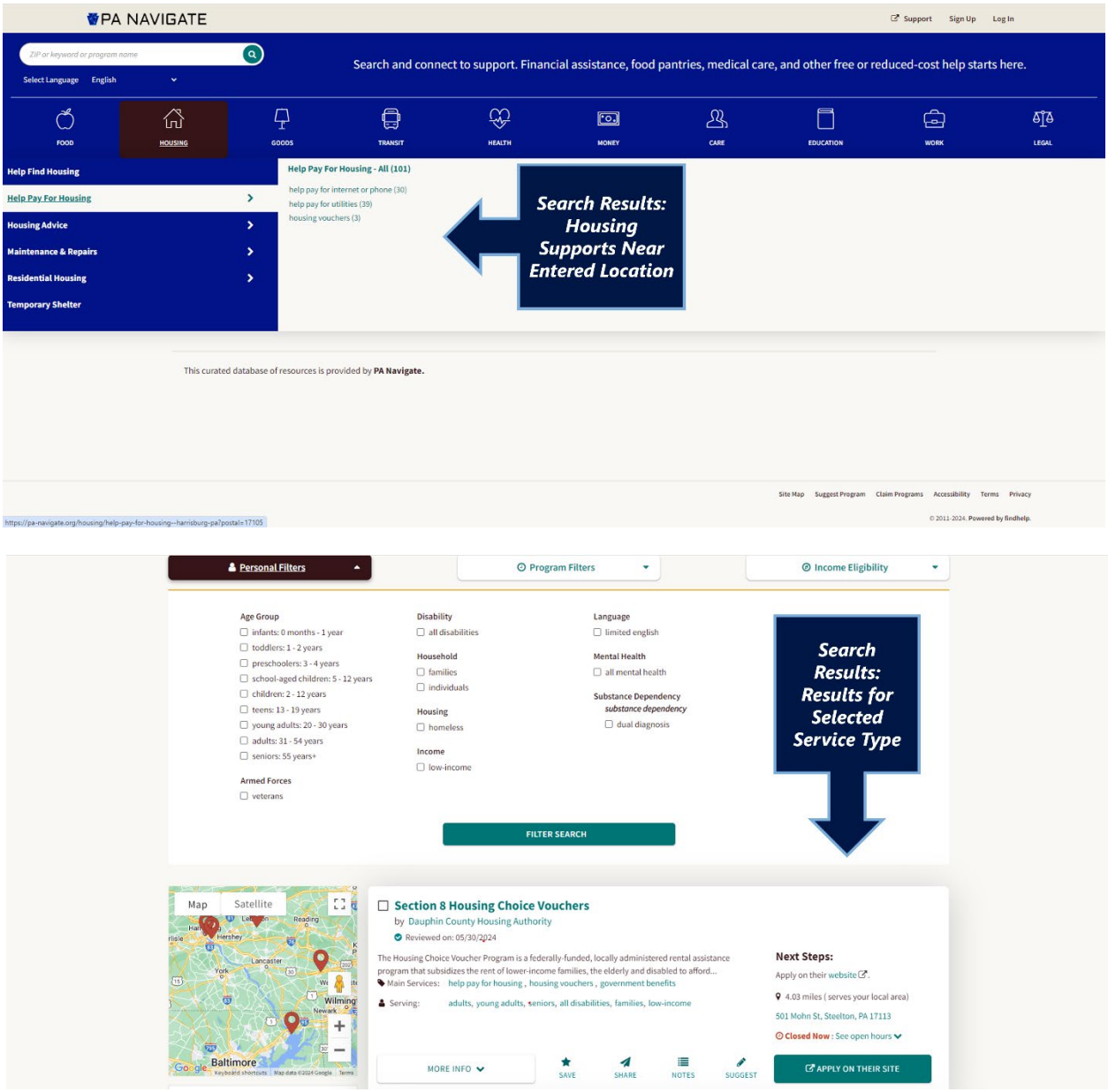
Exhibit 26

PA Navigate Current State
June 2024





(Exhibit 26 continued)



Source: pa-navigate.org.

As of spring 2024, PA Navigate's partners have contracted with the Community Action Association of Pennsylvania for community engagement and onboarding of CBOs to the platform.

Further, the planned state of PA Navigate aims to provide a seamless connection of individuals to HRSN supports. DHS has stated goals of using the tool to help stakeholders proactively identify individuals who are potentially eligible for supports, followed by automated outreach,

screening, and enrollment in services. With service status updated in one source, the tool could help CBOs claim reimbursement for HRSN services more easily. The department also sees PA Navigate as a tool to demonstrate the future impact of HRSN services on health. If seen to fruition, this future iteration of PA Navigate could be a resource to the department for the efficient and effective operation of the proposed Keystones of Health 1115 demonstration waiver discussed in Section IV of this report.

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SECTION IV
KEYSTONES OF HEALTH DEMONSTRATION WAIVER

Fast Facts…

- *"Bridges to Success: Keystones of Health for Pennsylvania" was submitted in January 2024 with a proposed demonstration period of 2025 to 2030.*
- *If Keystones of Health is launched in 2025, housing supports would not be phased into the MA program until 2026.*
- *DHS projects 6,700 MA members would be impacted by Keystones of Health housing supports during the five-year demonstration period.*

Recent CMS guidance regarding housing-related social needs (HRSN) interventions in Medicaid waivers has allowed states to test new strategies to improve coverage and care for beneficiaries. Pennsylvania became the latest state attempting to use this opportunity to improve access to housing with DHS's submission of the "Bridges to Success: Keystones of Health for Pennsylvania" Section 1115 demonstration waiver application to CMS in January 2024. This section reviews the key components of the pending waiver and examines its potential impacts on the commonwealth's MA program.

Key Findings:

1. In its Keystones of Health waiver application, DHS proposes four HRSN support areas: reentry support, housing support, food and nutrition support, and continuous coverage for children under age six.

2. DHS estimates the waiver's housing support would cost over $202 million for the five-year demonstration period, but budget neutrality calculations submitted to CMS should cap spending at $243 million.

3. Keystones of Health's pending status make many aspects of the waiver difficult to assess. We have questions regarding the extent to which rental assistance services can be combined within the waiver. Housing stakeholders, MCOs, healthcare experts, and DHS were unable to answer these questions. Upon inquiry to CMS, the agency responded that out request was "out of usual process".

4. As of February 2024, CMS has only approved housing-related 1115 waivers for eight states under the new HRSN guidance, while 18 states have waivers under the existing social determinant of health (SDOH) framework.

In this section, we recommend that:

1. **DHS continues to proactively engage stakeholders throughout the Keystones of Health waiver demonstration period, emphasizing statewide coordination.**

2. **DHS collaborates with managed care organizations (MCOs), community-based organizations (CBOs), and other Keystones of Health stakeholders to develop guidelines to mitigate the impact of transitioning off waiver rental assistance in situations where housing stability may not be achieved.**

3. **DHS collects data to assess potential healthcare cost savings and healthcare outcomes realized from housing supports during the Keystones of Health waiver demonstration period.**

4. **The General Assembly consider requiring DHS to report findings on healthcare cost savings experienced during the waiver period to the legislature.**

A. Keystones of Health Section 1115 Demonstration Waiver

In response to the growing emphasis placed on HRSN in healthcare, DHS submitted its "Bridges to Success: Keystones of Health for Pennsylvania" Section 1115 demonstration waiver application to CMS in January 2024. In this issue area, we highlight the core principles of the pending Keystones of Health proposal related to housing and discuss the waiver's potential impacts on the MA program in Pennsylvania.

Keystones of Health Overview

Using the authority granted under Section 1115(a)(1) of the Social Security Act, DHS submitted the Keystones of Health demonstration waiver to CMS on January 26, 2024, and subsequent revisions on February 9.[71] Using CMS guidelines and other states' best practices, the department employed an evidence-based HRSN framework to generate cost savings, enhance social supports, reduce unnecessary or avoidable healthcare utilization, and improve health-related outcomes for designated populations.[72]

As currently proposed, DHS will develop services and benefits that focus on four key HRSN areas:

[71] According to DHS, this update revised several research hypotheses.
[72] DHS, *Bridges to Success: Keystones of Health for Pennsylvania Medicaid Section 1115 Demonstration Application*, February 2024.

- ***Reentry Supports:*** Improve participants' transition from correctional facilities to the community. Planned to be available at state correctional institutions and a subset of interested county jails, these services will aid the transition from the care inmates receive to community-based healthcare and social services, particularly for individuals with significant health needs like serious mental illness (SMI) or substance use disorder (SUD).[73]
- ***Housing Supports:*** New services to assist participants without stable housing in finding and keeping a place to live. These supports will mainly focus on individuals with chronic health conditions or behavioral health issues where health outcomes are greatly improved by the consistent care and medication access that can come from a stable living environment.
- ***Food and Nutrition Supports:*** Provide food and nutrition services to participants facing food insecurity, including direct food support such as medically tailored meals or groceries. Targeted populations include pregnant mothers and individuals with diet-sensitive conditions. DHS's goal is to connect eligible beneficiaries to long-term food assistance like the Supplemental Nutrition Assistance Program.
- ***Multi-Year Continuous Coverage for Children Under Age Six:*** Provide continuous MA coverage for children from birth up to six years of age to reduce gaps in coverage that can interrupt access to essential healthcare services (e.g., preventative care). Coverage would be provided from birth or when the child receives Medicaid through the last day of the month, they turn six years old.[74,75]

While these support areas address HRSN that can impact an individual's health, services pertaining to reentry supports, food and nutrition, and continuous coverage for children under age six are outside the scope of this report. Therefore, unless otherwise noted, this discussion primarily focuses on proposed housing-related services in the Keystones of Health waiver.

All that will be provided under the Keystones of Health waiver cannot supplant existing supports provided within the MA program. Participants will be identified for housing needs via an HRSN assessment

[73] Currently, MA coverage is suspended for individuals who enter a state correctional facility for up to two years and can be reinstated upon release. As part of this proposal, DHS would require a legislative amendment to allow coverage to be suspended indefinitely and to allow limited benefits to be reinstated for eligible individuals 90 calendar days prior to release. The Department of Corrections expressed its support of the proposed amendment and emphasized its strong working relationship with DHS on relevant areas of the 1115 waiver application.

[74] Currently, CHIP provides continuous coverage until age 19. According to DHS, if approved, children under the age of six will be enrolled in the MA program if they meet the Medicaid eligibility requirements.

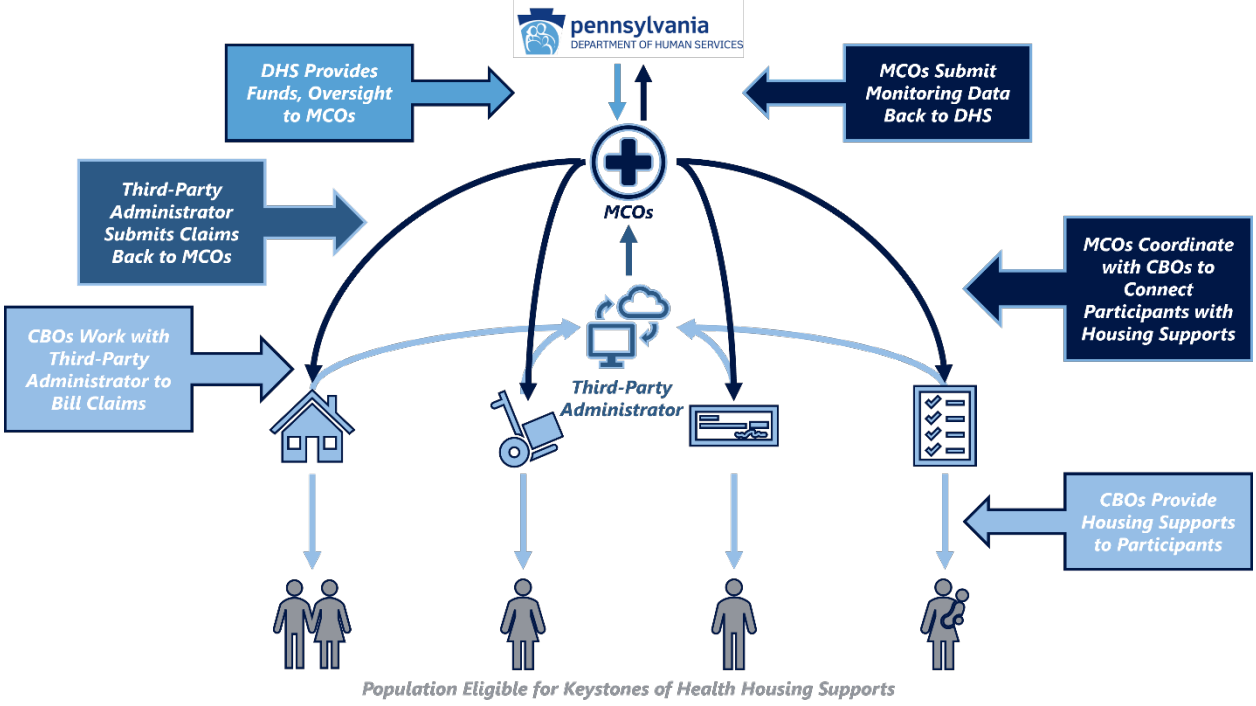
[75] DHS notes that the Keystones of Health waiver would provide new authorities to Pennsylvania's MA program, but would not create new obligations should the commonwealth elect not to implement certain provisions

conducted by MCOs, providers, and community partners. MCOs will be expected to utilize their existing relationships with community-based organizations (CBOs) providing SDOH services through programs like value-based purchasing or community-based care management to help build the HRSN infrastructure.

The health plans will also be expected to engage new partners as the waiver program develops. For CBOs that may not have previous experience working with Medicaid (e.g., housing providers), DHS anticipates contracting with a third-party administrator to offer technical assistance, help with billing Medicaid claims, and provide other support. Exhibit 27 illustrates an anticipated Keystones of Health workflow outlined by DHS.

Exhibit 27

Anticipated Keystones of Health Workflow: Housing Supports



Source: Developed by LBFC staff from information obtained from DHS.

The department requested a five-year demonstration period from January 1, 2025, to January 1, 2030. This includes a transitional authority in the first year for planning and implementation activities. As a result, many of the services proposed in the Keystones of Health waiver will not be phased into the commonwealth's managed care system until at least 2026.

Proposed Housing Supports in Keystones of Health Waiver

DHS plans to introduce a suite of HRSN services as a central part of the Keystones of Health waiver, with housing supports playing a leading role. DHS makes its case in the 1115 waiver application in the following way:

> *Access to safe, quality, affordable housing and the services necessary to maintain stable housing constitutes one of the most basic social determinants of health. Securing housing requires a package of supportive services that cover and facilitate the housing search, transition into stable housing, and maintenance of that situation, as each step in the process can constitute a significant barrier to housing stability.*

DHS proposes four housing supports using the HRSN framework discussed in Section III. These supports will consist of services designed to work alongside community, local, and state-run programs:

1. ***Pre-Tenancy, Transition Navigation, and Case Management Supports:*** Supports connecting participants to navigation and case management services, including local housing specialists for pre-tenancy and transition services. These specialists will assist participants with local, state, and federal program applications (covering application fees, form completion, etc.) and help beneficiaries find and maintain stable housing.
2. ***One-Time Transition Start-Up Services:*** Single-use services to cover moving costs and other transitional needs, including, but not limited to, application fees, inspection fees, fees to obtain necessary identification, security deposits, first month's rent, utility activation fees, movers, relocation expenses, pest control, and the purchase of household goods and furniture.
3. ***Rental Subsidies for Up to Six Months:*** Payment of rental subsidies, including rental and temporary housing assistance, for up to six months.
4. ***Tenancy Sustaining Services:*** Provide assistance and guidance to participants, including tenant rights education and eviction mitigation support.

The department proposes that all four housing supports be available to four eligible population groups within the Keystones of Health waiver:

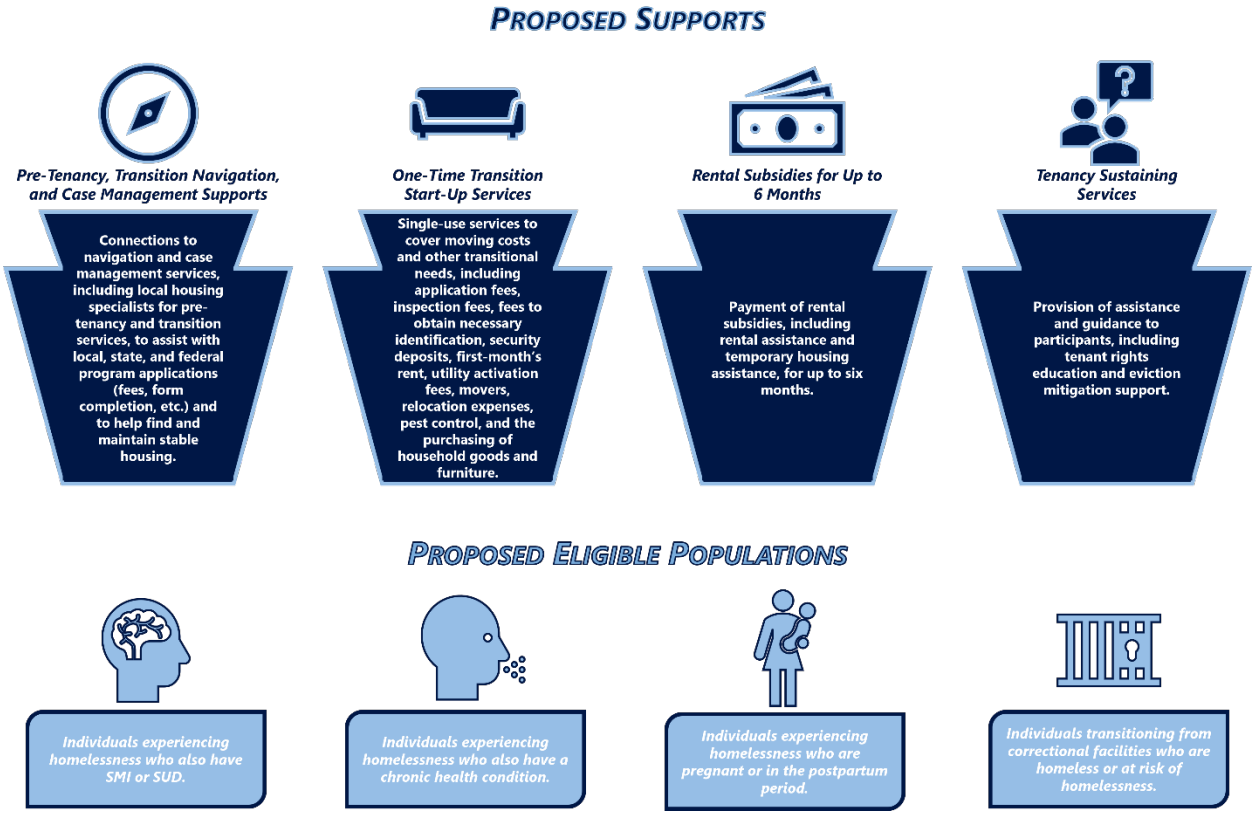
- Individuals experiencing homelessness who also have SMI or SUD.
- Individuals experiencing homelessness who also have a chronic health condition.

- Individuals experiencing homelessness who are pregnant or in the postpartum period.
- Individuals transitioning from correctional facilities who are homeless or at risk of homelessness.

Exhibit 28 summarizes DHS's proposed housing supports and populations for the Keystones of Health waiver.

Exhibit 28

Proposed Housing Supports and Eligible Populations in Keystones of Health



Source: Developed by LBFC staff from information obtained from DHS.

As the name of the waiver authority suggests, states can use 1115 waivers to fund otherwise unallowable Medicaid strategies and "demonstrate" to CMS that the approaches can improve coverage and care for beneficiaries. States perform these demonstrations by testing novel hypotheses throughout the waiver period.

For housing supports in Keystones of Health, DHS has listed two hypotheses it will attempt to prove over the five-year waiver period. First,

the department will test the theory that expanding housing supports will reduce homelessness, homeless recidivism, and housing instability of individuals. Secondly, DHS will examine the statement that improvements in housing stability will improve access to recommended or preventive care. These assumptions supplement three general waiver hypotheses:

1. Unmet HRSN in the Medicaid-eligible population will improve health outcomes and reduce the cost of care.
2. A focus on improving health equity for populations experiencing disproportionately poor health outcomes will improve health outcomes, increase care access, and reduce the gap with populations experiencing historically favorable health outcomes.
3. HRSN services designed to support individuals experiencing life transitions will reduce avoidable hospitalizations and medical utilization and increase recommended or preventive care use.

To assess these hypotheses, DHS has identified several data sources within the MA program and the housing industry. Notably, the department informs CMS that it plans to utilize housing data from Homeless Management Information System (HMIS)records and surveys of HRSN service recipients.

The department also identified three data sources to measure health-related outcomes. DHS indicates it will use information from the Healthcare Effectiveness Data and Information Set (HEDIS), which uses Medicaid claims data to create performance measures on important dimensions of care and service.[76] DHS also plans to use two primary survey data sources: the Consumer Assessment of Health Providers and Systems (CAHPS), which measures patients' experiences with healthcare providers and plans, and the National Health Interview Survey, which monitors illnesses, injuries, chronic conditions, health insurance coverage, and healthcare utilization, among other data, for the American population.[77,78]

However, given the Keystones of Health waiver application status, it is difficult for DHS to provide details on the specific data MCOs, CBOs, and

[76] HEDIS is used by over 90 percent of health plans in the United States, covering more than 190 million people in the US.

[77] Funded and administered by the Agency for Healthcare Research and Quality and CMS within the United States Department of Health and Human Services, there are multiple types of CAHPS surveys based on healthcare type, setting, and primary payer. *See* https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems#:~:text=Emergency%20Department%20CAHPS-,Consumer%20Assessment%20of%20Healthcare%20Providers%20%26%20Systems%20(CAHPS),several%20different%20patient%20experience%20surveys., accessed May 28, 2024.

[78] The National Health Interview Survey is supplied by the Centers for Disease Control and Prevention. *See* https://health.gov/healthypeople/objectives-and-data/data-sources-and-methods/data-sources/national-health-interview-survey-nhis, accessed May 28, 2024.

providers will be required to collect and submit to DHS. While DHS is preparing for waiver implementation on January 1, 2025, it is challenging for the department to move forward without official feedback from CMS.

The department expressed that it is currently planning data collection requirements and coordinating with other state agencies to share information. With the launch of housing services not anticipated until year two of the waiver period, much of the planning process will be conducted during the first year of Keystones of Health implementation.

Waiver Status, Projected Costs, and Potential Impacts

Our primary challenge in assessing the potential efficacy of Keystones of Health is that the waiver application is still pending with CMS as of October 2024. DHS notes it is in ongoing discussions with CMS regarding the waiver and expects that waivers for multiple states will be approved in early 2025. However, the department hopes the approval timeline will be expedited and that the proposed start date of January 1, 2025, can proceed as planned.

DHS expressed that implementation planning for housing supports within the Keystones of Health will begin immediately upon CMS's waiver approval. The department's top priority in the waiver's first year will be infrastructure investment, including integrations into closed-loop referral systems such as PA Navigate and strengthening the HMIS, which the commonwealth's 16 CoCs manage. In addition to identifying and procuring a third-party administrator to coordinate between MCOs and CBOs, DHS plans to build partnerships with public housing agencies and housing services providers.

Also, in year one, the department intends to develop an HRSN assessment tool to determine participant eligibility for housing supports, create and disseminate necessary policies, procedures, and resources, and provide training and technical assistance to Keystones of Health stakeholders. Housing services will be phased in during year two, tentatively set for 2026.

With the pending status of the waiver, projecting potential costs for Keystones of Health is challenging. DHS has mapped out supports to be included in Keystones of Health, but specific services may be subject to change pending CMS approval of the waiver.

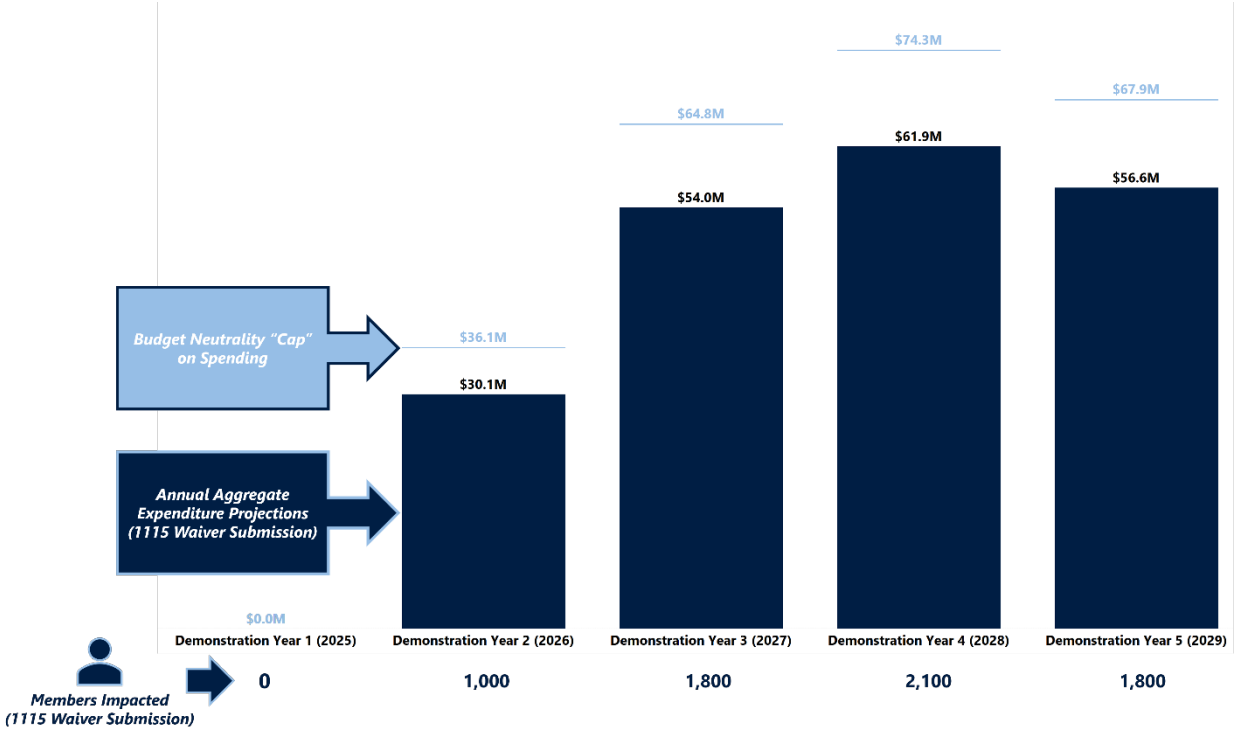
As part of the waiver application, DHS was required to submit cost projections to CMS. While helpful, these estimates must be viewed with a degree of caution. Section 1115 demonstrations must be "budget neutral" to the federal government, meaning that federal match spending

under the demonstration would not exceed projected costs for the state's Medicaid program in its absence. However, because demonstration waivers test hypothetical strategies, actual costs are unknown. Therefore, recent guidance from CMS allows states to, after establishing cost estimates, set higher budget neutrality projections to serve as a "cap" on spending.

Exhibit 29 shows cost estimates, budget neutrality caps, and potential enrollment figures submitted by DHS to CMS for the housing supports of the Keystones of Health waiver. The "annual aggregate expenditure projections" and "members impacted" fields were included in the 1115 waiver application, while the "budget neutrality caps" were submitted in supplemental materials required by CMS.

Exhibit 29

Proposed Housing Supports in Keystones of Health are Projected to Cost over $202 Million but are Capped at $243 Million for the Five-Year Period



Source: Developed by LBFC staff from information obtained from DHS.

For the five-year demonstration period, DHS anticipates the proposed housing supports in the Keystones of Health waiver will cost $202.6 million. As expected, spending does not begin until demonstration year two, which aligns with housing services implementation. Estimated costs peak in year four of the waiver period at nearly $62 million.

The department's budget neutrality calculations provide additional flexibility for the Keystones of Health housing supports, capping spending at $243.1 million for the five-year demonstration.[79] Budget neutrality caps follow the same pattern as DHS's cost estimates, peaking in year four. The difference between the annual aggregate expenditure projection and the budget neutrality cap is 18 percent yearly, equating to projection gaps between $6 million (demonstration year two) and $12.4 million (demonstration year four).

Regarding population, DHS projects housing services to impact 6,700 members over the five years. Peak enrollment aligns with the year of highest projected costs – demonstration year four – with 2,100 participants added to the program. Enrollment in all other years is below 2,000, with 1,000 members projected to be added in demonstration year two and 1,800 participants projected for demonstration years three and five. Again, we emphasize that all these projections should be viewed carefully, and DHS anticipates updating cost estimates, budget neutrality calculations, and enrollment projections throughout the waiver period.

As we have noted, with so many aspects of Keystones of Health still undefined, it is challenging to accurately assess the waiver's potential effectiveness in addressing homelessness in Pennsylvania. However, after our review of the waiver's proposals and discussions with DHS and stakeholders in the housing and healthcare industries, we feel that several considerations should be explored and, in some cases, addressed during the Keystones of Health demonstration period to help ensure the viability of the initiative within the MA program long term.

First, we note in Section III CMS's longstanding policy against using federally matched Medicaid funds for room and board, except in certain medical institutions. Recent CMS guidance resulting in the rent proposals seen in Keystones of Health and previously approved waivers in other states (see below) are a shift away from this policy at the federal level. This change appears to be part of a larger strategy from the federal government to address SDOH.[80]

However, the relationship between allowable rental assistance services is still unclear. In Keystones of Health, DHS proposes using one-time transition start-up services, including the recipient's first month's rent. The department also proposes a second support that would allow for the payment of rental subsidies for up to six months. Through discussions with housing stakeholders, MCOs, healthcare experts, and DHS, we could not determine if these services can be combined, allowing participants up to seven months of rental assistance. DHS forwarded our

[79] If a state exceeds its budget neutrality projections, excess funds must be returned to CMS. *See* CMS, *SMD 18-009: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects*, 2018.
[80] United States Domestic Policy Council, *The US Playbook to Address Social Determinants of Health*, 2023.

inquiry to CMS, requesting additional context on the policy change regarding room and board funding. CMS responded that our request was "out of usual process" for the agency and referred us to the same guidance used to inform this discussion.

We believe this is another example of the need for coordination, which has been highlighted throughout this report. A common theme in this study was uncertainty regarding the ability to implement and scale a housing service delivery infrastructure within the MA program.

An advantage we have identified is DHS's willingness to proactively engage with stakeholders statewide while preparing the Keystones of Health waiver application. We believe these efforts should not cease now that the waiver has been submitted. Further, we think that DHS would be uniquely positioned in the waiver's administration to foster collaboration between housing and healthcare stakeholders across Pennsylvania.

We recommend that DHS continue to proactively engage stakeholders throughout the Keystones of Health waiver demonstration period, emphasizing statewide coordination.

Second, we have concerns about tenant protection following the expiration of rental assistance measures. While other supports proposed in Keystones of Health, such as case management and tenancy-sustaining services, are intended to help participants maintain stable housing, industry experts told us about the typical timeframe for housing stabilization is six to 12 months.

With large portions of the program still undefined, we question what may happen to participants who have not reached housing stability after their rental assistance has expired. DHS must overcome this challenge, as it is limited in the amount of rental assistance it can provide per CMS guidelines.

We recommend that DHS collaborate with MCOs, CBOs, and other Keystones of Health stakeholders to develop guidelines to mitigate the impact of transitioning off waiver rental assistance in situations where housing stability may not be achieved.

Finally, the long-term financial viability of housing supports under the Keystones of Health waiver should also be considered. As noted, industry experts relayed that housing stabilization usually occurs within six to 12 months, often when cost savings will be realized. However, there is relatively little research regarding the enduring impacts of housing supports on healthcare costs and outcomes, particularly in Pennsylvania. For example, while the Pittsburgh Medicaid Research Center's follow-up study on permanent supportive housing found a decrease in MA

expenditures in the 12 months after participants exited the program, researchers also determined that it was unclear if this decline would continue beyond a year and that future research should explore the long-term effects that exiting supportive housing has on health outcomes and costs.[81]

While DHS's budget neutrality cap should limit spending on housing supports for the demonstration period, these considerations will be pertinent if the program extends beyond five years. Fortunately, the demonstration period presents a prime opportunity to collect, analyze, and report data regarding the efficacy of housing supports on healthcare spending.[82]

We recommend that DHS collect data to assess potential healthcare cost savings and healthcare outcomes realized from housing supports during the Keystones of Health waiver demonstration period.

We recommend the General Assembly consider requiring DHS to report findings on healthcare cost savings experienced during the waiver period to the legislature.

B. 1115 Demonstrations in Other States: HRSN Waiver Framework

CMS defines HRSN as "an individual's unmet, adverse social conditions that contribute to poor health (e.g., food insecurity, housing instability, unemployment, and/or lack of reliable transportation). HRSN can drive health disparities across demographic groups, resulting from their community's underlying Social Determinants of Health."[83] SDOH are broad environmental conditions, while HRSNs are specific to the individual. Research has shown that SDOH and associated HRSN can account for as much as 50 percent of health outcomes.[84]

Under several different Medicaid authorities, including state plans, 1915 waivers, ILOS, and Section 1115 demonstrations, states can address SDOH, including, e.g., housing transition and navigation services, eviction prediction, home accessibility modifications, etc. However, these waiver authorities cannot pay for room and board.

[81] Cole, Hollander, Ennis, et al., *Do Medicaid Expenditures Increase After Adults Exit Permanent Supportive Housing?*, 2022.
[82] As part of the 1115 waiver, the federal government requires an independent evaluation at the end of the approved demonstration period.
[83] CMS, *CMCS Informational Bulletin*, November 16, 2023.
[84] US Department of Health and Human Services, *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*, 2022.

In December 2022, CMS released guidance for addressing HRSN under Section 1115 demonstrations. The initial SDOH framework was for states to look within their current programs/waivers for ways to address SDOH. The released HRSN policy framework focused on approaches to identifying HRSNs through SDOH. Section 1115 demonstrations allow states to "help beneficiaries stay connected to coverage, access healthcare services, and supplement (not supplant) existing local, state, and federal support."[85] Under the New 1115 demonstration opportunity, CMS "supports states in addressing HRSN, with the goals of improving coverage, access, and health equity across Medicaid beneficiaries."[86]

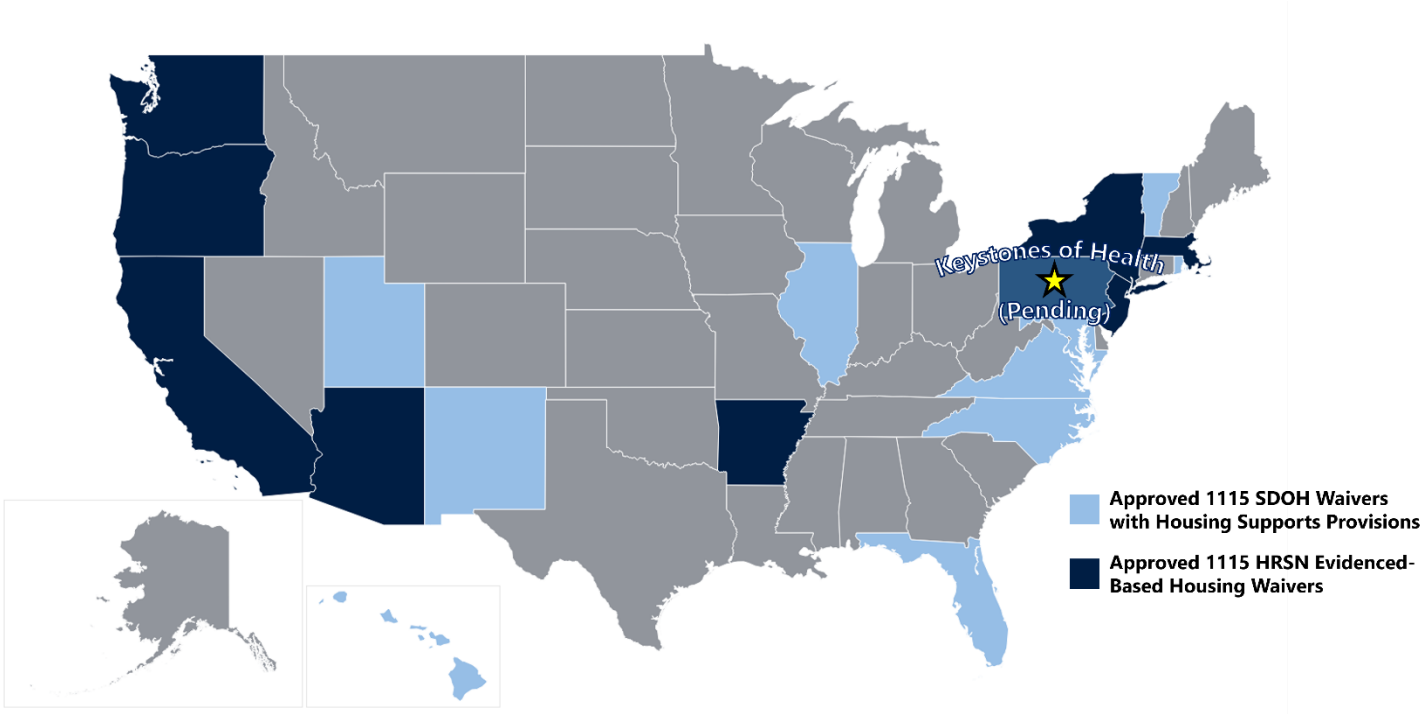
Through section 1115 waivers, CMS has allotted states the flexibility to design and improve their programs for Medicaid beneficiaries through HRSN services and supports, care delivery transformations, and performance measurements. As of February 2024, eight states have approved section 1115 waivers under the new HRSN framework, which covers evidenced-based housing and nutrition services for specific high-need populations. States must adhere to fiscal limitations, systematic monitoring, and evaluation requirements, which include quality performance reporting and health equity measures.

Exhibit 30 provides an overview of states with section 1115 waivers under the new HSRN framework.

[85] CMS, *CMCS Informational Bulletin*, November 16, 2023.
[86] *See* https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf., accessed November 16, 2023.

Exhibit 30

Approved Section 1115 Waivers with Housing-Related Supports



Source: Developed by LBFC staff from information obtained from the Centers for Medicare and Medicaid Services.

Eighteen states have approved section 1115 waivers under the SDOH framework.[87] These state approvals include infrastructure funding or delivery system changes, for example:

- Data integration and sharing.
- Incentive payments for MCOs.
- Housing supports.
- Nutrition supports.
- Employment supports.
- Medical respite.
- Other supports.

Eight of those 18 states (Arizona, Arkansas, California, Massachusetts, New Jersey, New York, Oregon, and Washington) have approved section 1115 waivers under the new HRSN policy framework, which allows states to provide services to a broader group of Medicaid participants with high needs. Because states are at various stages of implementation, programs may not yet be in operation, or start dates may have been

[87] Arizona, Arkansas, California, Florida, Hawaii, Illinois, Maryland, Massachusetts, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Utah, Vermont, Virginia, and Washington.

delayed. Therefore, we could not obtain any publicly available HRSN-related program outcomes data.

Exhibit 31 below provides a snapshot of states with approved evidenced-based housing 1115 demonstration waivers.

Exhibit 31

Snapshot of States with Approved Evidenced-Based Housing 1115 Waivers

	Arizona October 2022 – September 2027	Arkansas January 2022 – December 2026	California Existing waiver – December 2026	Massachusetts October 2022 – December 2027	New Jersey April 2023 – June 2028	New York April 2022 – March 2027	Oregon October 2022 – September 2027	Washington July 2023 – June 2028
Rent or temporary housing for up to 6 months	✓					✓	✓	✓
Utility costs	✓						✓	
Pre-tenancy and tenancy-sustaining services	✓	✓		✓	✓	✓	✓	
Housing transition and navigation services	✓	✓		✓	✓	✓	✓	✓
One-time transition and moving costs	✓	✓		✓			✓	
Medically necessary home remediations	✓			✓	✓	✓	✓	
Home or environmental accessibility modifications	✓			✓	✓	✓	✓	
Recuperative care and short-term post-hospitalization housing			✓			✓	✓	✓

Source: Developed by LBFC staff from information obtained from the Centers for Medicare and Medicaid Services.

States approved under the new section 1115 HRSN framework have an identified target population, which includes health needs criteria and social risk factors. Each state also has CMS-approved section 1115 SDOH demonstration provisions. The waiver approval periods for new HRSN demonstrations may overlap because the new waiver builds upon prior SDOH initiatives (e.g., California's "CALAIM" transformation). The following information provides a brief overview of states with approved 1115 waivers under the new HRSN framework.

Arizona's Housing and Health Opportunities (H2O) program includes expanded housing services for individuals who are homeless or at risk of homelessness and have at least one or more conditions or circumstances, for example, SMI, high-risk or high-cost chronic health

conditions or co-morbidities or enrolled in AZ's Long Term Care System. A third-party administrator determines member eligibility and provides ongoing technical assistance and training, provider onboarding, and data analysis. In addition, the third-party administrator will act as a clearinghouse for provider claims for H2O services. H2O is scheduled to be implemented in October of 2024.

Arkansas Health and Opportunity for Me (ARHOME) - LIFE 360 HOMEs programs "provide beneficiaries with intensive care coordination and connect them to necessary health services and community supports, address HRSNs, and actively engage beneficiaries in promoting their own health care."[88] Life 360 programs include Maternal Life360, Rural Life360, and Success Life360. The programs will target individuals with high-risk pregnancies, rural residents with mental illness or substance abuse disorders, and young adults at risk for long-term poverty, such as foster children or the formerly incarcerated. To date, there are no active Life 360 Home programs. However, the state accepts applications from hospitals wanting to become LIFE360 Home providers.

California's Advancing and Innovating Medi-Cal (CalAIM) is a "part of the state's larger CalAIM initiative, that includes the transition of the Medi-Cal managed care from the demonstration into 1915 (b) waiver authority."[89] The state currently has community supports under section 1915(b) waiver authority. However, under the new HRSN policy framework, the state will provide two additional community supports through its managed care plans: (1) recuperative care services for individuals exiting the hospital but need a safe place to recover from an injury or illness and (2) short-term post-hospitalization services, which is for individuals with high medical or behavioral needs to continue treatment after leaving an inpatient setting. Lastly, California also has a pending amendment to its section 1115 demonstration waiver for transitional rent services.

Massachusetts Flexible Services Program (FSP) is a pilot program that addresses certain HRSNs, such as housing instability and food insecurity among Mass Health's Accountable Care Organization (ACO) program enrollees.[90,91] ACOs are required to screen members for HRSN and connect them to needed services. Through the ACO, eligible enrollees are linked with community-based organizations for flexible services, such as individual pre-tenancy supports, transitional assistance, tenancy-

[88] Arkansas Department of Human Services, *Arkansas Health and Opportunity for Me (ARHOME) 1115 Demonstration amendment approval*, November 1, 2022.
[89] California Department of Health Care Services, *California Advancing and Innovating Medi-Cal (CalAIM*) *1115 Demonstration extension*, December 29, 2021.
[90] Blue Cross Massachusetts Foundation, *What to Know Now About MassHealth ACOs*, 2023.
[91] Accountable Care Organizations are provider-led entities that contract with MassHealth. ACOs are responsible for providing or coordinating access to all MassHealth services for eligible members.

sustaining supports, home modifications, and nutrition-sustaining supports.

New Jersey FamilyCare Comprehensive Demonstration was recently amended to include targeted Medicaid coverage of key housing-related services, including housing transition and tenancy support services, nutritional services, and education.[92] Eligible individuals include beneficiaries who are homeless or at risk of becoming homeless, transitioning from an institution to the community, being released from correctional facilities, at risk of institutionalization who require a new housing arrangement to remain in the community, or those who are transitioning out of high-risk or unstable housing situations.

Lastly, New Jersey's approval includes infrastructure investments to support related services (e.g., case management, outreach, and education). New Jersey formed various stakeholder housing workgroups and began meeting in the late summer of 2023.[93]

New York's Medicaid Redesign Team (MRT) is a long-standing state waiver "aiming to reduce health disparities and improve health equity, through the combination of a Medicaid Hospital Global Budget Initiative, HRSN services and activities, workforce initiatives, and the establishment of a Health Equity Regional Organization (HERO)."[94]

The New York waiver under the new HRSN policy framework includes expanding access to housing supports through regional Social Care Networks (SCN). SCNs will provide HRSN screening and referral services for beneficiaries. The two-tiered system includes Levels 1 and 2, in which all Medicaid beneficiaries are screened, and those determined to need Level 1 services are referred to existing state, federal, and local programs.

Individuals eligible for Level 2 HRSN services must have predetermined and documented clinical and social risk factors. Level 2 HRSN services are targeted to Medicaid managed care enrollees who meet certain criteria such as high utilization of Medicaid, individuals enrolled in a New York state-designated Health Home, individuals with SUD or serious mental illness, among others. Lastly, SCNs will work with managed care plans to coordinate HRSN services. New York's MRT was approved in January 2024.

Oregon Health Plan (OHP) waiver supports social needs to better

[92] New Jersey Department of Human Services, *New Jersey FamilyCare Comprehensive Demonstration 1115 Demonstration extension*, March 30, 2023.
[93] New Jersey Department of Human Services, *Improving Community-Based Social Supports to Achieve Maternal Infant Health Equity and Quality: Food and Housing Security*, 2024.
[94] New York Department of Health, *Medicaid Redesign Team 1115 Demonstration amendment*, January 9, 2024.

coordinate services for people needing stability and to align with the state's health policy initiatives to achieve health equity. HRSN services include short-term post-transition housing for up to six months, housing supports, nutrition education, medically tailored food assistance, and clinically indicated devices to maintain healthy temperatures and clean air during climate emergencies.[95]

The target population includes individuals who are experiencing at least one of the following life transitions:

- Released from incarceration in the past 12 months.
- Discharged from an Institution for Mental Disease (IMD) in the past 12 months.
- Current or past involvement in the Oregon child welfare system.
- Transitioning from Medicaid-only to dual eligibility (Medicaid and Medicare) status within the next three months or the past nine months.
- Being homeless or at risk of becoming homeless.

HRSN services will be coordinated through CBOs and other partners. OHP housing support services will begin November 1, 2024.

Washington State Medicaid Transformation Project 2.0 (MTP 2.0), in conjunction with its In Lieu of Services (ILOS) renewed waiver, includes coverage expansion and access to care to advance whole-person primary, preventive, home, and community-based care and care delivery and payment innovation focused on health-related social needs.[96] The types of HRSN services that will be covered include nutrition education; medically tailored food assistance; short-term grocery resources; recuperative care and short-term posthospitalization housing; short-term post-transition housing for up to six months; housing supports; and medically necessary home modifications and remediations to address high-risk clinical conditions.[97] HRSN services will be coordinated through fee-for-service and managed care delivery systems.

Lastly, some services will be administered through newly developed Community Hubs and Native Hubs run by the states' nine Accountable Communities of Health (ACHs). ACHs are "independent, regional organizations that work with their communities on specific health care and social needs-related projects and activities."[98] These regional hubs will provide case management, outreach, and education services and

[95] Oregon Health Authority, *Oregon Health Plan (OHP) 1115 Demonstration waiver*, September 28, 2022.
[96] Washington State Health Care Authority, *About the Medicaid Transformation Project*, 2023.
[97] Washing Health Care Authority, *Medicaid Transformation Project (MTP 2.0)*, June 30, 2023.
[98] *See* https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/accountable-communities-health-achs, Accessed May 7, 2024.

support HRSN administration. On March 27, 2024, CMS approved Washington's MTP 2.0 HRSN infrastructure protocol.

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SECTION V
US HUD AND PA DCED HOUSING PROGRAMS

Fast Facts…

- *HUD awards funding for housing assistance under several federal programs.*
- *Pennsylvania has 16 Continuums of Care (CoC), which consist of community-wide organizations working together to assist individuals or families who are homeless or at risk of homelessness in gaining access to permanent housing.*
- *Pennsylvania Department of Community and Economic Development (DCED) administers several federally funded housing-related programs.*

This section discusses how the US Department of Housing and Urban Development (HUD) funds housing programs for states and how federal funding is being used in Pennsylvania to impact health and housing issues.

Key Findings:

1. As of 2023, Pennsylvania has 51,527 Housing Choice Vouchers (HCVs) currently leased and 2,654 issued but not presently leased under a housing contract.

2. The total number of persons/households benefitting from the Pennsylvania Department of Community and Economic Development (DCED) Community Development Block Grant from program years 2018 to 2022 increased by 77.8 percent.[99]

3. The US Department of Energy awarded DCED Weatherization Assistance Program (WAP) funding totaling $13 million in 2022 and $14.3 million in 2023. To date, Pennsylvania has weatherized an average of 1,292 homes per year.

4. The total number of households Assisted by Housing Opportunities for Persons with AIDS (HOPWA) in Pennsylvania from calendar years 2018 to 2023 was 2,311.

A. McKinney-Vento Homelessness Assistance Act

The US Department of Housing and Urban Development (HUD) administers several homeless assistance programs under the McKinney-Vento

[99] A program year is the single consolidated twelve-month period established by a jurisdiction for administering formula grant programs. Each grantee's accomplishment report is based on its program year, as established by the jurisdiction, not federal fiscal year.

Homeless Assistance Act. Through outreach, shelter, transitional housing, supportive services, short-and medium-term subsidies, and permanent housing, individuals and families at risk of or experiencing homelessness are supported through its program efforts.

In 2009, the HEARTH Act amended and reauthorized the McKinney-Vento Homeless Assistance Act and consolidated three homeless assistance programs, the Supportive Housing, Shelter Plus Care, and Section 8 Moderate Rehabilitation Single Room Occupancy programs, into the Continuum of Care (CoC) Program. In addition, Congress changed the Emergency Shelter Grant Program name to the Emergency Solutions Grant Program (ESG). Other changes include:

- The creation of a Rural Housing Stability Assistance Program.
- A change in HUD's definition of homelessness and chronic homelessness.
- A simplified match requirement.
- An increase in prevention resources.
- An increase in the emphasis on performance.

HUD's requirements for defining "homeless" can be found in the HEARTH "Homeless" Definition Final Rule. To meet the HUD definition of homeless, an individual's or family's current residence status must fall within one of these four distinct areas:

- Literally homeless.
- Imminent risk of homelessness.
- Homelessness under other federal statutes.
- Fleeing/attempting to flee domestic violence.

Exhibit 32 below shows HUD's criteria for defining homelessness by category.

Exhibit 32

HEARTH Act
Criteria for Defining Homelessness

Category 1: Literally Homeless	***Category 2: Imminent Risk of Homelessness***	***Category 3: Homeless Under Other Federal Statutes***	***Category 4: Fleeing or Attempting to Flee Violence***
Individual/family ***lacking a fixed, regular,*** and ***adequate nighttime residence***, such as: 1. A ***primary nighttime residence*** that is a ***public*** or ***private place not meant for habitation*** 2. A ***public*** or ***private shelter*** designated to provide ***temporary living arrangements*** 3. Exiting an ***institution*** after residing there for ***less than 90 days*** and ***resided*** in an ***emergency shelter*** or ***place not suited*** for ***habitation immediately before entering***	Individual/family will ***imminently lose primary nighttime residence***, provided that: 1. Residence will ***be lost within 14 days of applying for homelessness assistance*** 2. Subsequent ***residence has not been identified*** 3. Individual/family ***lacks resources or support*** needed to ***obtain other permanent housing***	Unaccompanied youth under age 25, or families with children and youth who ***do not otherwise qualify as homeless***, but: 1. Are ***defined*** as ***homeless under other federal statutes*** 2. Have ***not had*** a ***lease***, ***ownership interest***, or ***occupancy agreement*** in permanent housing ***within 60 days of applying for homelessness assistance*** 3. Have ***experienced persistent instability*** (2+ moves in previous 60 days) and can be ***expected to continue such status*** for an extended period due to ***special needs*** or ***barriers***	Individual/family who: 1. Is ***fleeing*** or ***attempting to flee violence***[a] 2. Has ***no other residence*** and ***lacks resources*** or ***support networks*** to ***obtain other permanent housing***

[a] Also includes domestic and dating violence, sexual assault, stalking, or other dangerous conditions in the individual's or family's housing situation.

Source: Developed by LBFC staff from information provided by the US Department of Housing and Urban Development.

Currently, under HUD, there are six active programs to assist individuals and families that are experiencing homelessness:

- Continuum of Care (CoC).
- Emergency Solutions Grant (ESG).
- Youth Homeless Demonstration Program (YHDP).[100]
- Housing Opportunities for Persons With AIDS (HOPWA).
- HUD-Veterans Affairs Supportive Housing Program (HUD-VASH).
- Title V.[101]

[100] The YHDP is to support selected communities, including rural, suburban, and urban areas across the United States, in developing and implementing a coordinated community approach to preventing and ending youth homelessness.

[101] Title V allows eligible organizations to use unutilized, underutilized, excess, or surplus federal properties to assist persons experiencing homelessness. No funding is available under Title V. Leases are free of charge, and Title V properties can provide shelter, services, storage, and other benefits to persons experiencing homelessness.

Lastly, homeless assistance programs under HUD include active and legacy programs, some of which have been consolidated under a single grant.

B. US HUD Continuum of Care and Emergency Solutions Grant Programs

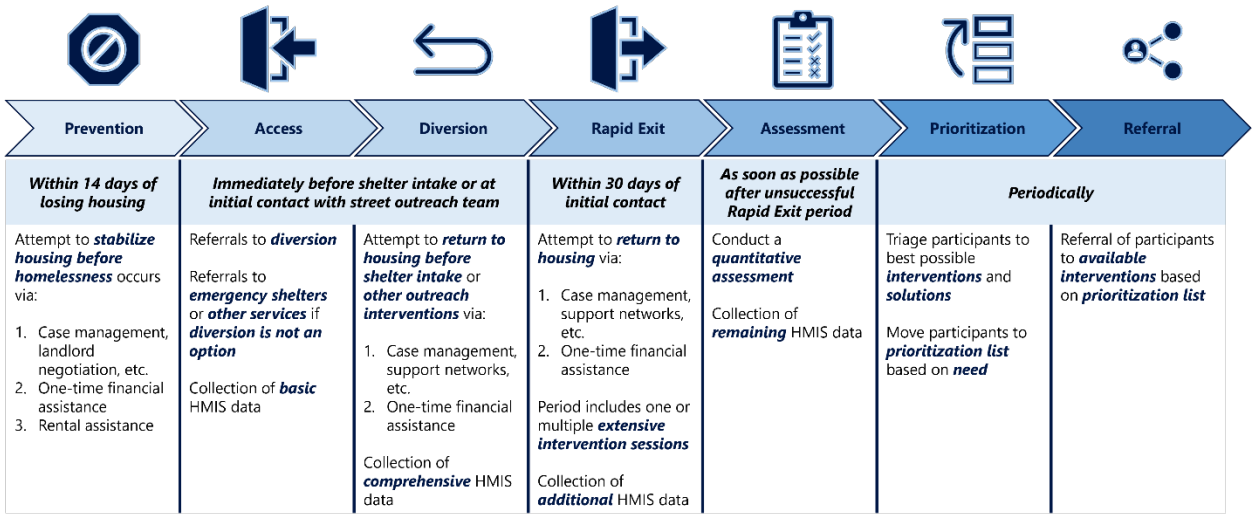
Under the authority of Title 24 CFR 578.7(a)(8), HUD established requirements for CoCs and recipients of ESG program funding. The CoC Program is a competitive grant for nonprofit providers, states, Indian tribes, or tribally designated housing entities "designed to promote a community-wide commitment to the goal of ending homelessness."[102] CoCs award funding to "quickly rehouse homeless individuals, families, persons fleeing domestic violence, dating violence, sexual assault, and stalking, and youth."[103] The ESG is a grant program for metropolitan cities, urban counties, territories, and states. It aims to assist those experiencing a housing crisis and at risk of becoming homeless in gaining access to permanent housing.

Under HUD, CoC and ESG recipients must use a centralized or coordinated entry (CE) process for all programs and projects. The CE process aims to increase local crisis response systems and improve fairness and ease of access to resources. CE helps communities prioritize the needs of individuals and families, identify service needs and gaps, allocate resources, and identify additional resource needs. Exhibit 33 provides an example overview of the coordinated entry process.

[102] *See* https://www.hud.gov/program_offices/comm_planning/coc, accessed January 6, 2024.
[103] Ibid.

Exhibit 33

Continuum of Care
Coordinated Entry Process



Source: Developed by LBFC staff from the Western Region CoC, Coordinate Entry Training Series.

CoCs must develop specific policies and procedures for the CE process established by HUD. The CE system must cover the geographic area claimed by the CoC, be easily accessible to individuals and families seeking housing services, be well-advertised, include a comprehensive and standardized assessment tool, and provide an initial comprehensive assessment of individuals and families for housing services. They must also include a specific guided policy within the CE system for individuals and families who are fleeing or attempting to flee violence (i.e., domestic or dating), sexual assault, or stalking.

The assessment tool for prioritizing individuals and families based on need must meet all HUD requirements. HUD states that "assessment and prioritization must be based on an individual's vulnerability or need level according to the specific and definable set of nondiscriminatory prioritization criteria."[104,105] Ultimately, the CE assessment should prioritize individuals and families based on the length of time they have been experiencing homelessness and the severity of their needs.

HUD does not recommend a specific assessment tool for CoCs; overall, standard written policies and procedures must be in place to prioritize

[104] *See* https://www.hud.gov/program_offices/comm_planning/coc/faqs, accessed January 6, 2024.
[105] HUD, *Notice CPD-17-01: Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System, Sections II.B.11 and III.A*, 2017.

individuals and families based on the severity of need. The prioritization process may use any combination of factors, which include:

- Significant challenges or functional impairments, including any physical, mental, developmental, or behavioral health disabilities, regardless of the type of disability, require a substantial level of support to maintain permanent housing. This factor focuses on the needed support level and is not based on disability type.
- High utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities.
- The extent to which people, especially youth and children, are unsheltered.
- Vulnerability to illness or death.
- Risk of continued homelessness.
- Vulnerability to victimization, including physical assault, trafficking, or sex work.
- Other factors determined by the community, based on the severity of needs.

Each CoC must follow the HUD guidelines to establish a single prioritized list. An assessment tool may provide a vulnerability "score," but it cannot be used to determine the priority level.

One such assessment tool is the Vulnerability Index-Service Prioritization Decisions Assistance Tool (VI-SPDAT), a self-reported pre-screening "survey." The survey includes questions about housing history, health, and street safety. The CE entity scores the responses - high, moderate, low - and determines the level of need. The outcome of this assessment does not equate to prioritization, and VI-SPDAT recommends further assessment once the CoC determines the score.

The Allegheny Housing Assessment (AHA) is another tool developed by the Allegheny County Department of Human Services in partnership with the Centre for Social Data Analytics at the Auckland University of Technology (New Zealand). The Allegheny County Department of Human Services launched AHA in 2020 to replace the county's VI-SPDAT. AHA is a Predictive Risk Model that "uses historical correlations and patterns from routinely collected administrative data to rapidly assign a risk score."[106] The model uses existing data within the county's data warehouse to generate a risk score.

Allegheny County uses the AHA to predict the likelihood of future interaction with the homelessness system. Due to its increase in housing needs and limited housing inventory, the county sought to develop a

[106] Allegheny County Department of Human Services, *Allegheny Housing Assessment, Frequently Asked Questions*, 2020.

prioritization tool that could "appropriately identify the most vulnerable, in combination with other business rules, to determine client eligibility and priority for the limited Permanent Supportive Housing (PSH), Rapid Re-housing (RRH), and bridge/transitional housing services."[107]

The AHA considers three types of events that may have occurred in the 12 months after the initial CE assessment:

- At least one inpatient mental health service funded by Medicaid.
- More than four emergency department visits.
- At least one Allegheny County Jail booking.

The AHA generates a risk score, and individuals and families are prioritized onto a waiting list and moved off the waiting list as housing resources become available.

The CE process must align with HUD's homeless program prioritization guidelines. Assessment tools used to determine housing priority vary and continue to evolve to ensure the process is standardized and prioritization is equitable for those experiencing homelessness.

Continuums of Care (CoC)

HUD defines a CoC as "a collaborative funding and planning approach that helps communities plan for and provide, as necessary, a full range of emergency, transitional, and permanent housing and other service resources to address the various needs of homeless persons." The CoC Program is a competitive grant administered by HUD. CoC grant funds can be used for planning costs, Unified Funding Agency (UFA) costs, acquisition, rehabilitation, new construction, leasing, rental assistance, supportive services, operating costs, Homeless Management Information Systems (HMIS), and project administration costs.[108,109] Furthermore, according to HUD, the program promotes community-wide planning and strategic use of resources to address homelessness.

HUD states the goal of the CoC is to provide funding used "to quickly re-house homeless individuals, families, persons fleeing domestic violence, and youth while minimizing the trauma and dislocation caused by homelessness; to promote access to and effective utilization of

[107] Centre for Social Data Analytics at the Auckland University of Technology, *Using Predictive Risk Modeling to Prioritize Services for People Experiencing Homelessness in Allegheny County*: *Methodology Paper for the Allegheny Housing Assessment*, September 2020.

[108] A UFA is a collaborative applicant selected by the CoC (and approved by HUD) to apply for, receive, and distribute funding for all projects in the CoC under a single entity and is the sole recipient of CoC funds.

[109] HMIS is a database used to aggregate confidential data on homeless populations.

mainstream programs by homeless, and to optimize self-sufficiency among those experiencing homelessness."[110]

CoC grants are awarded to eligible nonprofit providers, states, Indian Tribes or tribally designated housing entities, and local governments through a competitive grant application process. Annually, a CoC submits a consolidated plan for funding through its designated collaborative applicant. A collaborative applicant is an entity designated by the CoC to collect and submit the CoC registration, consolidated application, and apply for planning funds on behalf of the CoC during the program competition. In addition, the CoC designates an HMIS Lead and Homeless Services Coordinator from its member network.

The CoC Interim rule provides formal regulation for establishing and operating a CoC, each of which must establish a board to provide oversight and governance. The board must include representatives from relevant organizations, such as nonprofit organizations, victim services providers, local governments, and at least one homeless or formerly homeless individual. However, the board may appoint additional committees and workgroups to fulfill the CoC's responsibilities.

A CoC may use grant funds to support activities under five primary program components:

- Permanent housing (permanent supportive housing and rapid re-housing).
- Transitional housing.
- Supportive services only.
- Homeless Management Information System.
- Homelessness prevention in HUD-designated, high-performing communities.

Exhibit 34 provides an overview of each program component.

Exhibit 34

Continuum of Care Program Components

Program Component	Eligibility	Description
Permanent Supportive Housing	Individuals with disabilities and families in which one adult or child has a disability	Community-based housing (no designated length of stay).
Rapid Re-Housing	Homeless individual or family with or without a disability	Supportive services/Rental Assistance is short-term (up to three months) or medium-term (three to 24 months).

[110] US Department of Housing and Urban Development, *Programs of HUD Major Mortgage, Grant, Assistance, and Regulatory Programs*, 2023.

Transitional Housing	Homeless Individual or family	TH facilitates movement into permanent housing within 24 months of entering TH.
Supportive Services Only	Unsheltered and sheltered homeless persons	Funds can be used to conduct outreach, link clients to housing or other necessary services, and provide ongoing support.
Homeless Management Information System	HMIS Leads	Funds are used to pay costs associated with contributing data to the HMIS.
Homeless Prevention	CoC designated high-performing communities	Funding can be used for housing relocation services, stabilization services, and short/or medium-rental assistance to prevent an individual.

Source: Developed by LBFC staff from the HUD, CoC Program Introductory Guide.

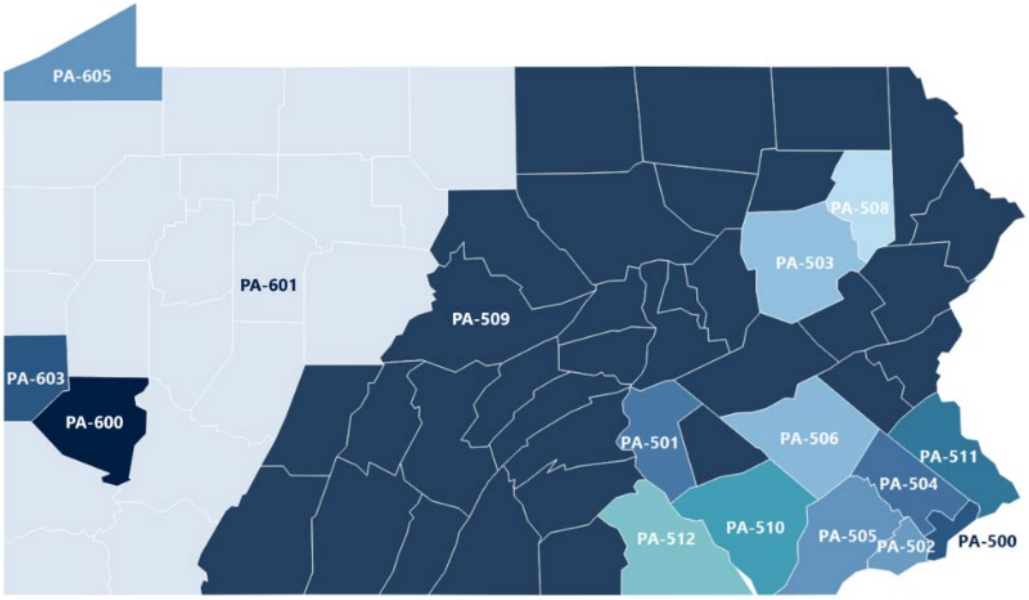
Eligible cost areas under each program component include acquisition, rehabilitation, new construction, leasing, rental assistance, supportive services, operating costs, HMIS project administration, CoC planning, and UFA costs.

As illustrated in Exhibit 35, Pennsylvania has 16 CoCs, 14 of which are single-county entities.[111] The remaining 53 primarily rural counties are divided into two COCs, the PA-509 Eastern PA CoC and PA-601 Western PA CoC. These two balance of state CoCs are unique in that they operate individually, but there are also joint efforts among the two CoCs to end homelessness.

[111] Pennsylvania CoCs are as follows: Philadelphia (PA-500), Harrisburg/Dauphin County (PA-501), Upper Darby, Chester, Haverford/Delaware County (PA-502); Wilkes-Barre, Hazelton/Luzerne County (PA-503); Lower Merion, Norristown, Abington/Montgomery County (PA-504); Chester County (PA-505); Reading/Berks County (PA-506); Scranton/Lackawanna County (PA-508); Eastern Pennsylvania (PA-509); Lancaster City and County (PA-510); Bristol, Bensalem/Bucks County (PA-511); York City and County (PA-512); Pittsburgh, McKeesport, Penn Hills/Alleghany County (PA-600); Western Pennsylvania CoC (PA-601); Beaver County (PA-603); and Erie City and County CoC (PA-605).

Exhibit 35

Pennsylvania Statewide Continuums of Care

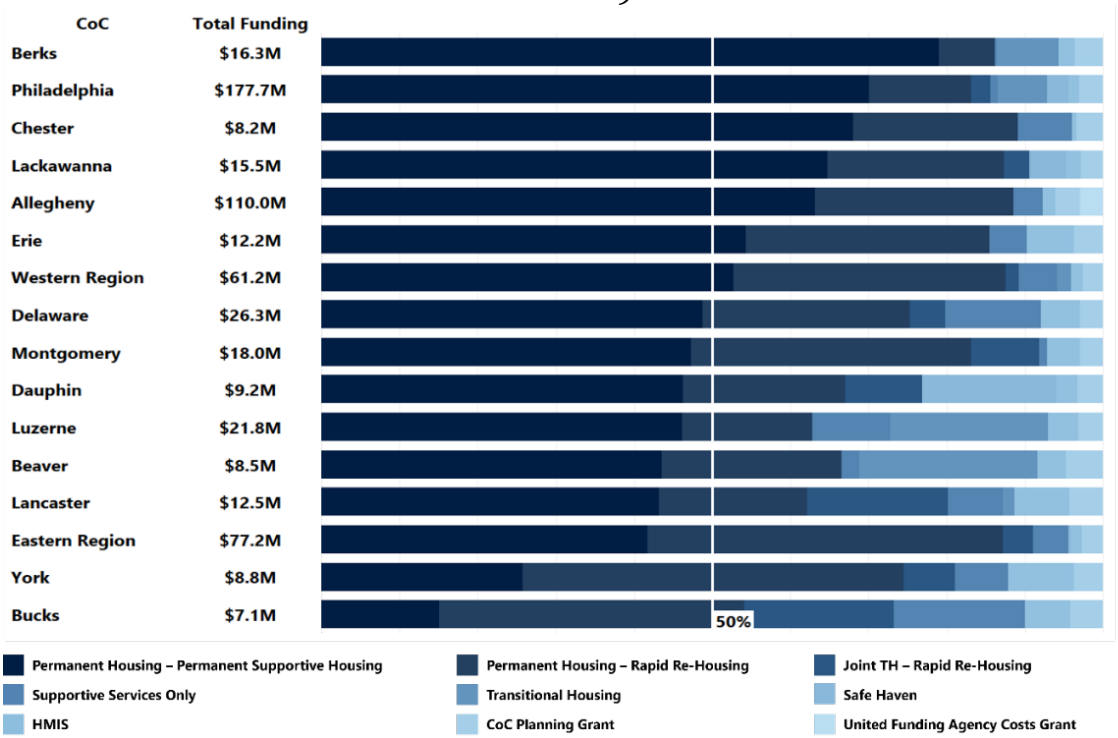


Source: Developed by LBFC staff from the PA Department of Community and Economic Development.

Exhibit 36 below shows total funding by CoC and five-year average funding awards by program component.

Exhibit 36

Pennsylvania Continuum of Care Program Funding Awards
5-Year Average
CYs 2018-19 to 2021



Source: Developed by LBFC staff from the Department of Housing and Urban Development.

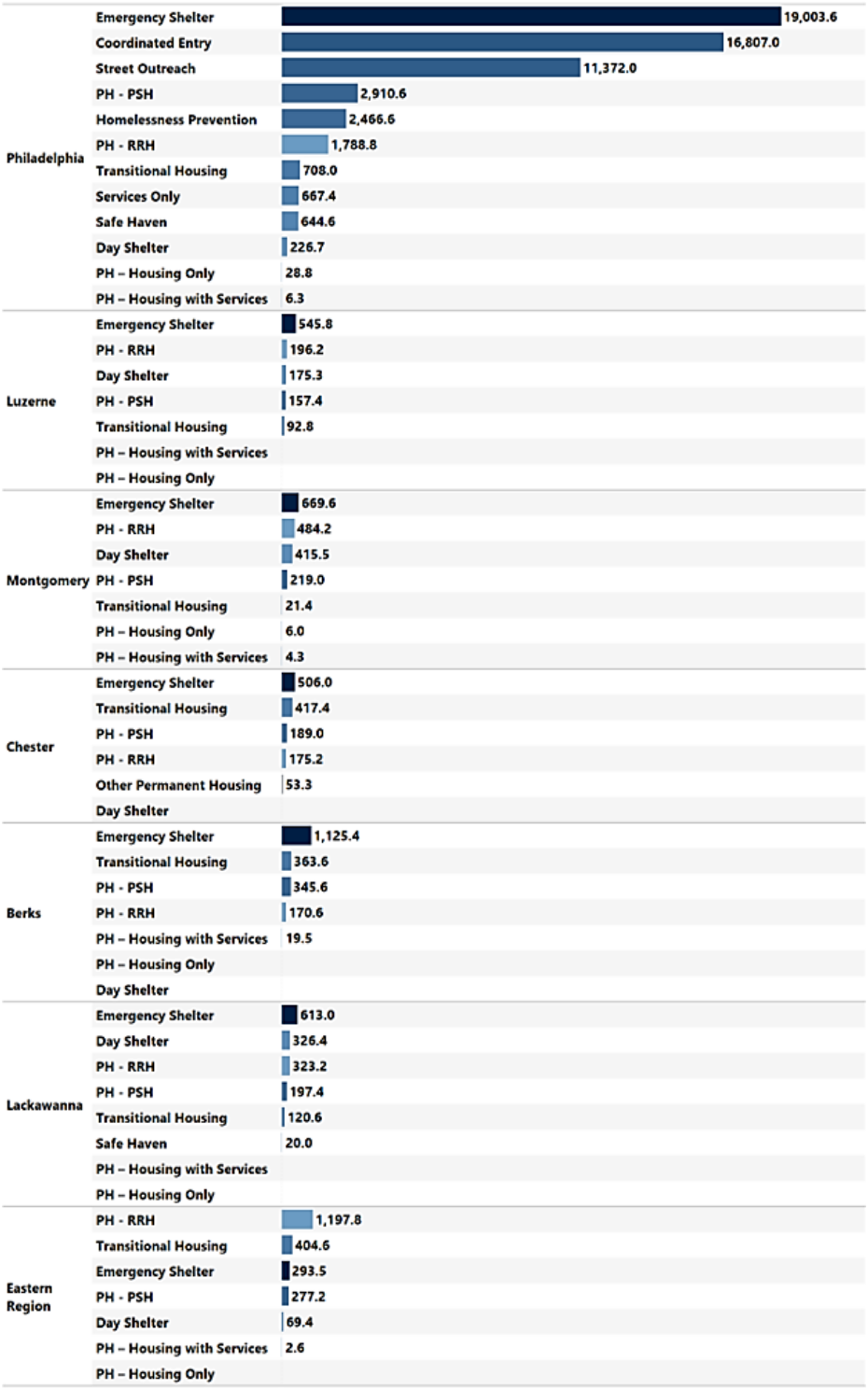
Over 50 percent of funding by program component fell within Permanent Supportive Housing, Rapid Rehousing, and Joint TH-Rapid Rehousing.

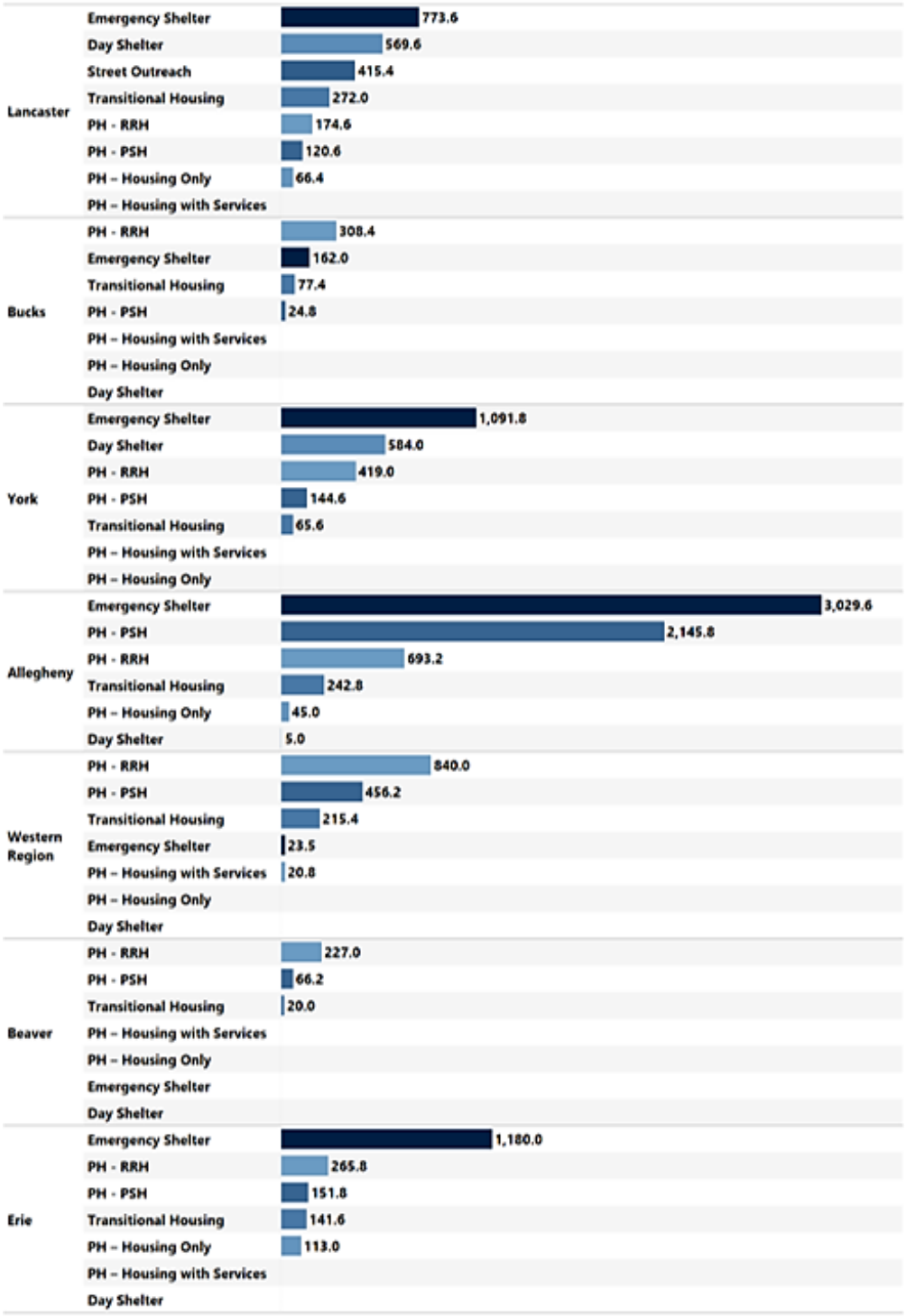
To understand the number of individuals being served each year within the CoCs, we requested HMIS data on the number of households served by calendar year under each of their homeless housing programs. We received HMIS data for 14 of the 16 CoCs for calendar years 2019 through 2023.[112, 113] Exhibit 37 below shows the total households served by housing program type.

[112] Duplicates may be present in the data. The data has not been audited. Household enrollments are counted across multiple program years. All data has been accepted as-is from each CoC.
[113] PA-501 Harrisburg/Dauphin County and PA-502 Upper Darby, Chester, Haverford/Delaware County CoC did not respond to our data request.

Exhibit 37

Pennsylvania Continuums of Care
5-Year Average Households Served by Calendar Year 2019-2023





Source: Developed by LBFC staff from CoC HMIS data.

Each CoC sets its housing priorities based on area needs; therefore, the types of housing programs available may vary. For CYs 2019 to 2023,

we calculated a five-year average number of households served by housing program type.

Emergency Solutions Grant (ESG)

ESG is a grant program for states, metropolitan cities, urban counties, and territories that aims to assist those experiencing a housing crisis or homelessness in gaining access to permanent housing. In Pennsylvania, 21 entitlement communities received funds directly from HUD during the most recent calendar year. [114] ESG funding for non-entitlement communities is allocated to DCED from HUD.[115]

ESG is a competitive application grant program for metropolitan cities, urban counties, and territories that may subgrant ESG funds to private nonprofit organizations. ESG grant recipients require a 100 percent match requirement for awarded funds on eligible activities under the program. The ESG Interim Rule provides formal regulation and guidance regarding program implementation.

HUD requires that states subgrant all program funds (except for funds for administrative costs and certain HMIS costs) to units of local government or private nonprofit organizations. In addition, all ESG funding recipients must consult their jurisdictions' CoCs to determine funding allocations. As established by the CoC, the CE process must be used by all ESG-funded recipients to identify, assess, and prioritize individuals and families based on need.

ESG Funds may be used for individuals and families experiencing homelessness or at risk of becoming homeless as defined in the ESG Program Interim Rule. The ESG program provides funding to:

- Engage homeless individuals and families living on the street.
- Improve the number and quality of emergency shelters for homeless individuals and families.
- Help operate these shelters.
- Provide essential services to shelter residents.
- Rapidly re-house homeless individuals and families.
- Prevent individuals and families from becoming homeless.

[114] Direct Entitlement communities are principal cities of Metropolitan Statistical Areas (MSAs), other metropolitan cities with populations of at least 50,000, and qualified urban counties with populations of at least 200,000 (excluding the population of entitled cities).

[115] Non-entitlement communities are smaller units of general local government: cities with populations of less than 50,000 (except cities designated principal cities of Metropolitan Statistical Areas) and counties with populations of less than 200,000.

ESG recipients must also have an HMIS system in place to identify and assess the needs of their homeless populations.

Eligible ESG-funded projects include street outreach, emergency shelter, homelessness prevention, rapid re-housing, and data collection. In addition, up to seven and a half percent of ESG funds can be used to administer the program. Exhibit 38 provides a summary of each project type:

Exhibit 38

Eligible Projects under HUD's Emergency Solutions Grant Program

Project	Description
Street Outreach	Connecting unsheltered homeless people with emergency shelter, housing, or critical services. Urgent, non-facility-based care to those unwilling or unable to access emergency shelter, housing, or an appropriate health facility.
Emergency Shelter[a]	Expansion or improvement of facilities with the primary purpose of temporary shelter for the homeless in general or specific populations.
Homeless Prevention	Financial assistance, rental assistance, and services to individuals and families at imminent risk of homelessness OR those who qualify as at-risk per HUD regulations. Individuals' or families' annual income must be below 30 percent of the Area Median Income (AMI).
Rapid Re-Housing	Financial assistance, rental assistance, and services are provided to individuals and families who are homeless.
Data Collection - Homeless Management Information System	Purchasing software or hardware or providing funding for staff to maintain the database.

[a] Shelters serving only women and children are not eligible per HUD guidelines.

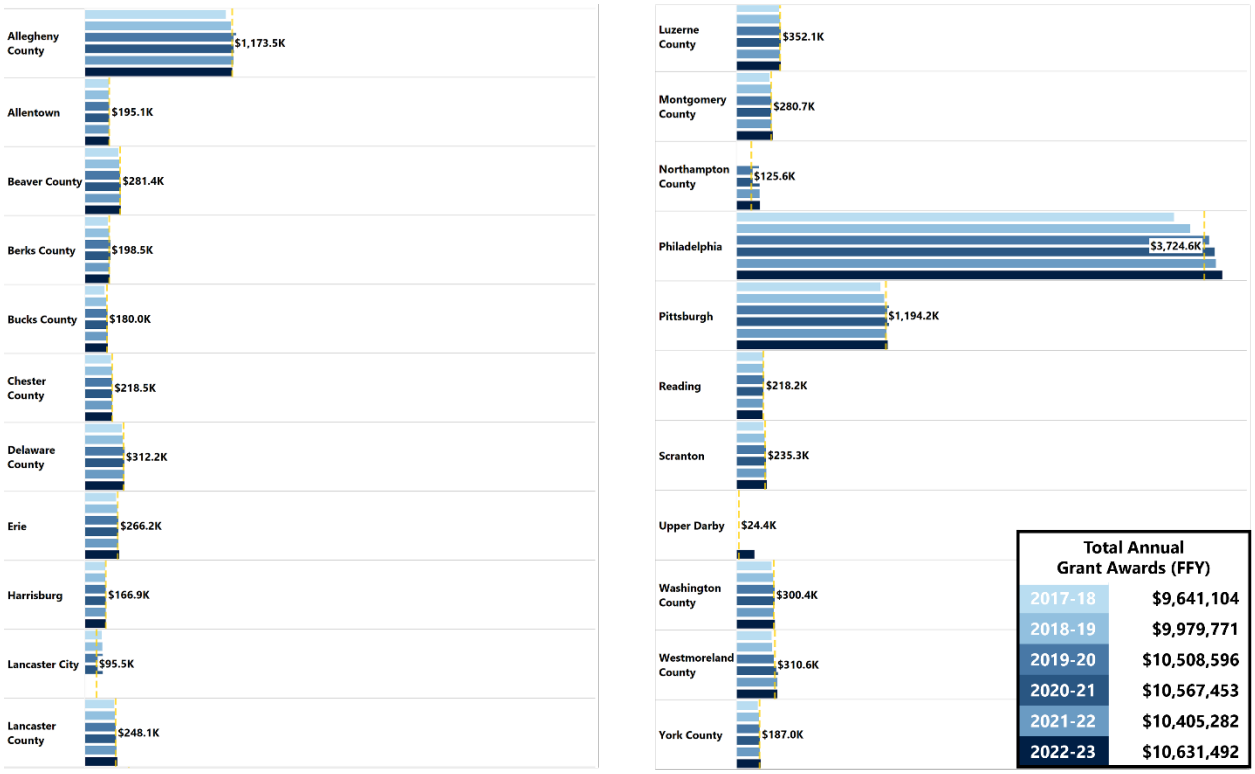
Source: Developed by LBFC staff from information obtained from DCED.

Lastly, to ensure that individuals and families experiencing a housing crisis are quickly connected to permanent housing, ESG recipients and subrecipients are expected to use the evidence-based "Housing First" approach to addressing homelessness.[116] Exhibit 39 shows the ESG direct entitlement awards by federal fiscal year.

[116] Housing First is an approach to quickly connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals before permanent housing entry.

Exhibit 39

Pennsylvania
Emergency Solutions Grant
Awards for Direct Entitlement Communities
Federal FYs 2018-2023[a]



[a] A supplemental appropriation for homeless assistance grants under ESG from the Coronavirus Aid, Relief, and Economic Security Act of 2020 was awarded to direct entitlement communities totaling $83.5 million.

Source: Developed by LBFC staff from information obtained from HUD.

ESG direct entitlement program funding increased by 10.3 percent from federal FYs 2018 to 2023.

The following section also discusses the ESG program because program funding is awarded by HUD for non-entitlement communities and administered by DCED.

C. Community Planning and Development Housing Related Grant Programs

Title 1 of the Housing and Community Development Act of 1974 authorizes several community development and planning programs. HUD regulates and DCED administers the following programs under the act for non-entitlement communities.[117] Through a comprehensive consolidated plan, formula grants are used to allocate funding for the following programs:

1. **Community Development Block Grant (CDBG)** - Grants for community development activities directed toward neighborhood revitalization, economic development, and improved community facilities and services.
2. **HOME Investment Partnerships (HOME) -** Grants to states, units of general local government, consortia, and insular areas ("participating jurisdictions") to implement local housing strategies to increase affordable housing opportunities for low- and very low-income families.
3. **Housing Opportunities for Persons with AIDS (HOPWA) -** Formula grants to states and units of general local government and competitively awarded grants to states, units of general local government, and nonprofit organizations to provide housing assistance and related supportive services to meet the housing needs of low-income persons living with HIV/AIDS and their families.
4. **Emergency Solutions Grants (ESG) -** Grants to provide emergency assistance to people who are homeless or at risk of homelessness and help them quickly regain stability in permanent housing.

Community Planning and Development formula grants are allocated to jurisdictions annually. To receive funding, a jurisdiction must develop and submit a comprehensive consolidated plan. The plan outlines a jurisdiction's goals for programs and affordable housing and how program funds will be used. Seventy percent of all grant funds expended during the CDBG period (not to exceed three years) must be used for activities that "benefit low-and moderate-income persons and affirmatively further fair housing."[118] Grantees are also responsible for submitting plans outlining specific actions, activities, and non-federal resources to address priorities and goals. Lastly, grantees submit a Consolidated

[117] Grants for three of these components are awarded to entitlement communities through HUD and non-entitlement communities through DCED. Under the HOPWA Program, HUD makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.
[118] HUD, *Programs of HUD*, 2023.

Annual Performance and Evaluation Report (CAPER) on program year accomplishments and progress toward plan goals.
Pennsylvania's DCED administers several funding resources for housing, planning, and community development. The following section provides a brief overview of some housing-related funding resources.

Community Development Block Grant (CDBG) – Direct Entitlement and Non-Entitlement. CDBG funding is awarded annually to entitlement communities (Metropolitan cities and urban counties) based on population data from the US Census Bureau and metropolitan area delineations published by the Office of Management and Budget. Each entitlement recipient of block funding determines its own program and funding priorities. All CDBG-funded activities must meet one of the following national objectives:

- Benefit low- and moderate-income persons.
- Prevent or eliminate slums or blight.
- Meet urgent community development needs.

At least 70 percent of grant funds must be used for activities that benefit low- and moderate-income persons. CDBG funds may be used for activities that include, but are not limited to:

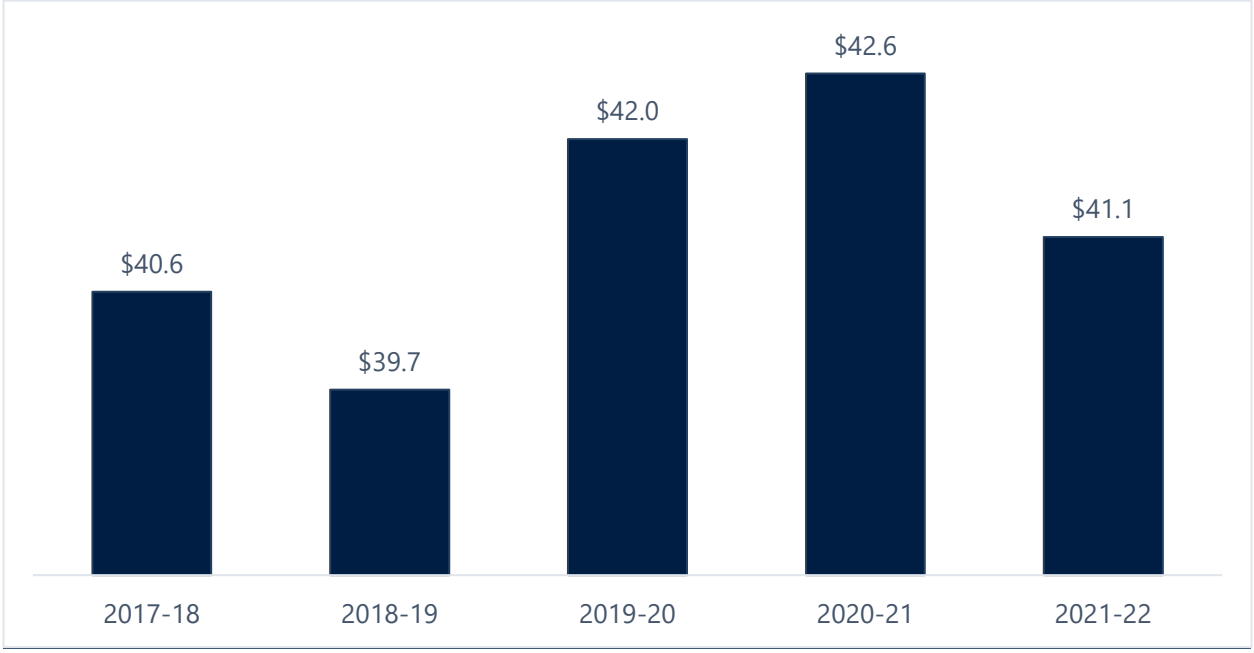
- Acquisition of real property.
- Relocation and demolition.
- Rehabilitation of residential and non-residential structures.
- Construction of public facilities and improvements, such as water and sewer facilities, streets, neighborhood centers, and the conversion of school buildings for eligible purposes.
- Public services, within certain limits.
- Activities relating to energy conservation and renewable energy resources.
- Provision of assistance to nonprofit and profit-motivated businesses to carry out economic development and job creation or retention activities.

Since 1981, states have been authorized to administer block grants for their non-entitlement programs and determine how block funds are awarded. In Pennsylvania, the DCED administers the CDBG program for non-entitlement local government units under Act 179 - Community Development Block Grant Entitlement Program for Non-urban Counties and Certain Other Municipalities.

Exhibit 40 shows the amount of funding Pennsylvania received from HUD for CDBG non-entitlement communities.

Exhibit 40

DCED Community Development Block Grant (CDBG) for Non-Entitlement Communities Program Awards
Federal FYs 2017-18 to 2021-22[a]
(in Millions)



[a] A supplemental appropriation under the Coronavirus Aid, Relief, and Economic Security Act of 2020 was awarded by HUD to DCED totaling $85.9 million.

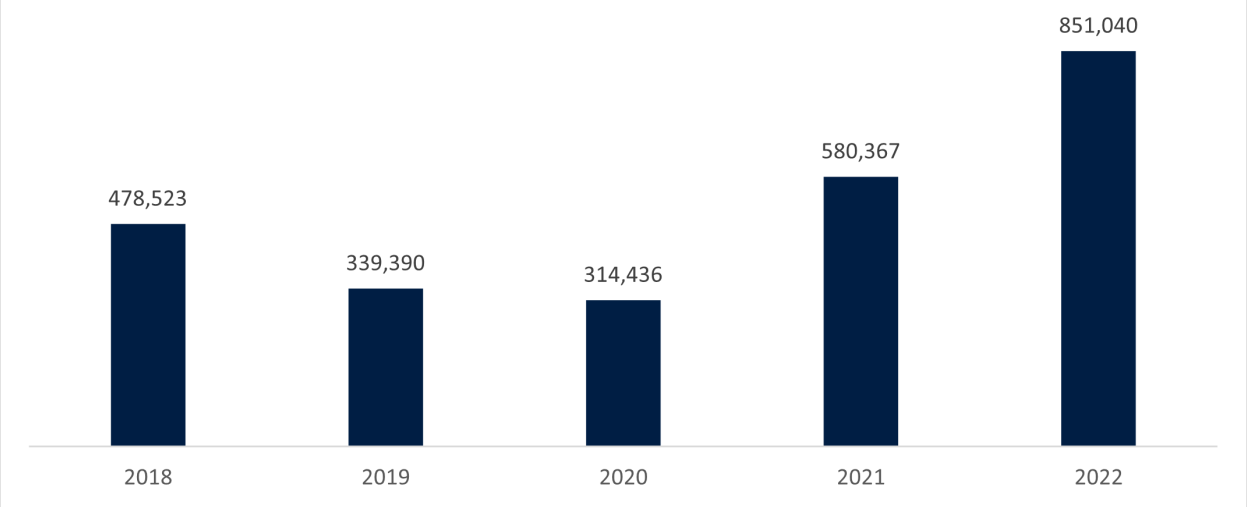
Source: Developed by LBFC staff from information obtained from HUD.

CDBG program funding for Federal FYs 2018 to 2022 increased by 1.2 percent. According to DCED, most CDBG funding goes to public facilities and infrastructure projects, which benefit low- and moderate-income persons on an area basis. During the review period, from federal FYs 2018 through 2022, 64 to 71 percent of program expenditures were for public facilities and improvements.

Exhibit 41 shows the total number of persons/households benefiting from CDBG program activities by program year.

Exhibit 41

DCED Community Development Block Grant (CDBG) for Non-Entitlement Communities - Total Number of Persons Benefiting
Program Years 2018-2022[a]



[a] Total number benefiting includes persons and households combined as per HUD guidelines.

Source: Developed by LBFC staff from information obtained from HUD.

The total number of persons/households benefiting from CDBG program activities is calculated on an area basis, representing program activities available to all residents of a given area. From program years 2018 to 2022, the number of persons/households benefitting from CDBG activities increased by 77.8 percent.

We reviewed housing activities under the CDBG program, including rehabilitation and acquisition for rehabilitation. Exhibit 42 shows housing activity accomplishments under the CDBG program by program year, according to the HUD Selected CDBG Accomplishment Reports.

Exhibit 42

DCED Community Development Block Grant
Households Assisted
Program Years 2018-2022

Activity	2018	2019	2020	2021	2022
Rehab; Single -Unit Residential	128	173	78	107	97
Acquisition for Rehabilitation	0	0	0	0	1
Rehab; multi-unit Residential	339	75	0	0	0
Total	**467**	**248**	**78**	**107**	**98**

Source: Developed by LBFC staff from information obtained from HUD.

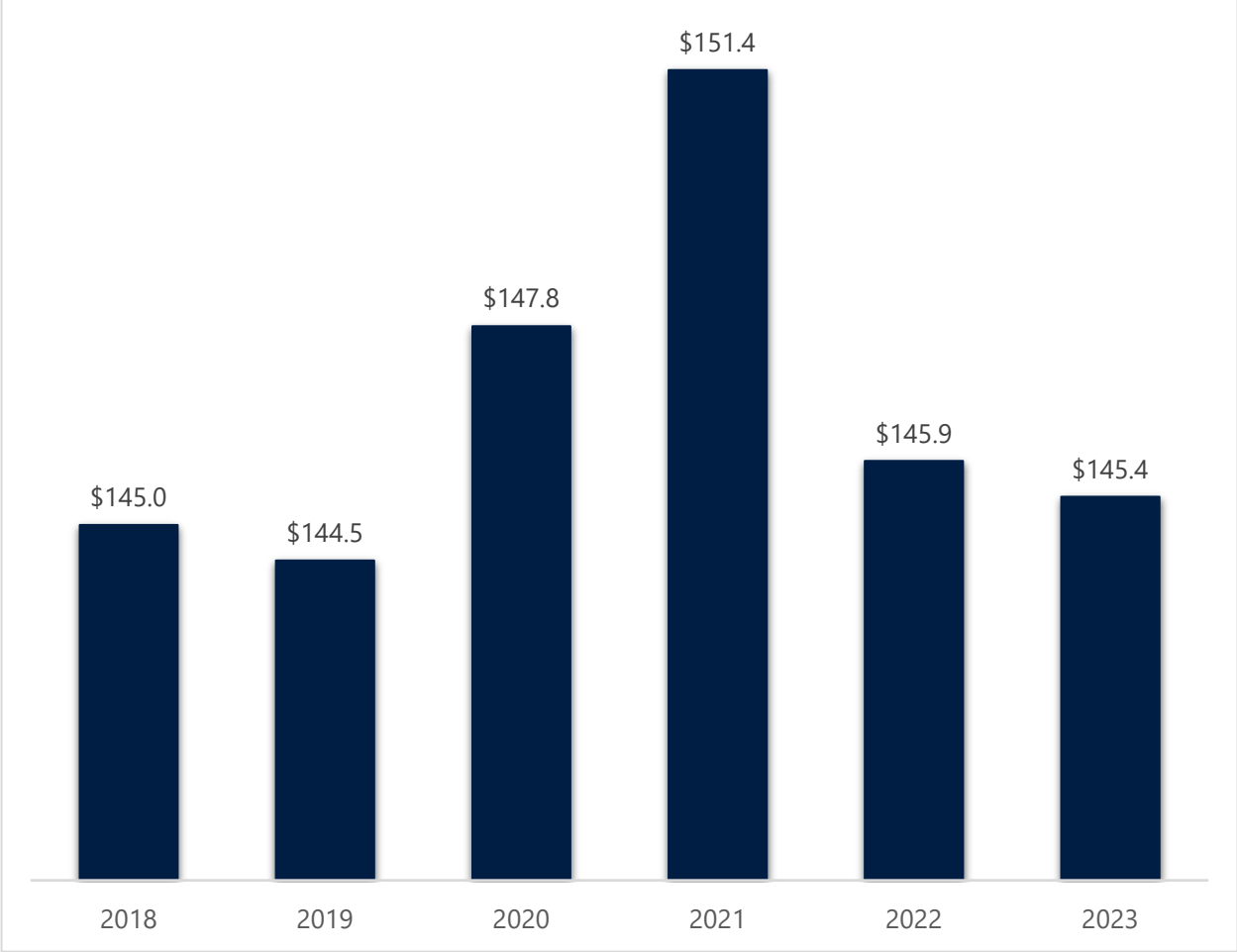
DCED's housing activities during our review period included single-unit rehab, multi-unit rehab, and acquisition for rehabilitation. From program years 2018 through 2022, housing activities ranged from 10 to 12 percent of program expenditures.

Exhibit 43 below shows CDBG program funding awarded from HUD to direct entitlement communities.[119]

[119] Direct entitlement communities awarded CDBG funding include: Abington, Allegheny County, Allentown, Altoona, Beaver County, Bensalem Township, Berks County, Berwick, Bethlehem, Bloomsburg, Bristol Township, Bucks County, Carlisle, Chambersburg, Chester County, Chester, Cumberland County, Dauphin County, Delaware County, Easton, Erie, Harrisburg, Haverford, Hazleton, Johnstown, Lancaster County, Lancaster, Lebanon, Lehigh County, Lower Merion, Lower Paxton Township, Luzerne County, McKeesport, Millcreek Township, Montgomery County, Norristown, Northampton County, Penn Hills, Philadelphia, Pittsburgh, Reading, Scranton, Sharon, State College, Upper Darby, Washington County, Westmoreland County, Wilkes-Barre, Williamsport, York County, York.

Exhibit 43

Community Development Block Grant (CDBG) for Direct Entitlement Communities Program Awards
Federal FYs 2017-18 to 2022-23[a]
(in Millions)



[a] A supplemental appropriation under the Coronavirus Aid, Relief, and Economic Security Act of 2020 was awarded to direct entitlement communities totaling $150.5 million.

Source: Developed by LBFC staff from information obtained from HUD.

CDBG program funding for direct entitlement communities from federal FYs 2018 to 2022 increased by less than one percent. CDBG program grantees have the flexibility to determine how their program funding will be used in their housing, economic, and community development activities.

Home Investment Partnership Program (HOME) Direct Entitlement and Non-Entitlement.

The HOME program was established by Title II of the Cranston Gonzalez National Affordable Housing Act of 1990, as amended, "to expand the supply of decent, safe, sanitary, and affordable housing; make new construction, rehabilitation, substantial rehabilitation, and acquisition of affordable housing feasible; and to promote the development of partnerships, public, private, for-profit, and nonprofit, to utilize resources to provide for more affordable housing."

The HOME program is funded through an annual entitlement appropriation from HUD and is allocated to state and local government jurisdictions. Funds can provide affordable housing (for rent or homeownership) or rental assistance to low-income individuals and families.

In Pennsylvania, HOME program funding is allocated to DCED and awarded to sub-grantees (local government units, including cities, towns, counties, boroughs, and townships) through a competitive application process.[120] In addition, a portion of HOME funds is allocated to the Pennsylvania Housing Finance Agency (PHFA), per the state Consolidated Plan, to administer rental and homebuyer projects.

The program's established priorities include:

- Rental housing.
- First-time homebuyers.
- Existing owner-occupied housing rehabilitation and new single-family affordable housing.

Uses for program funds include:

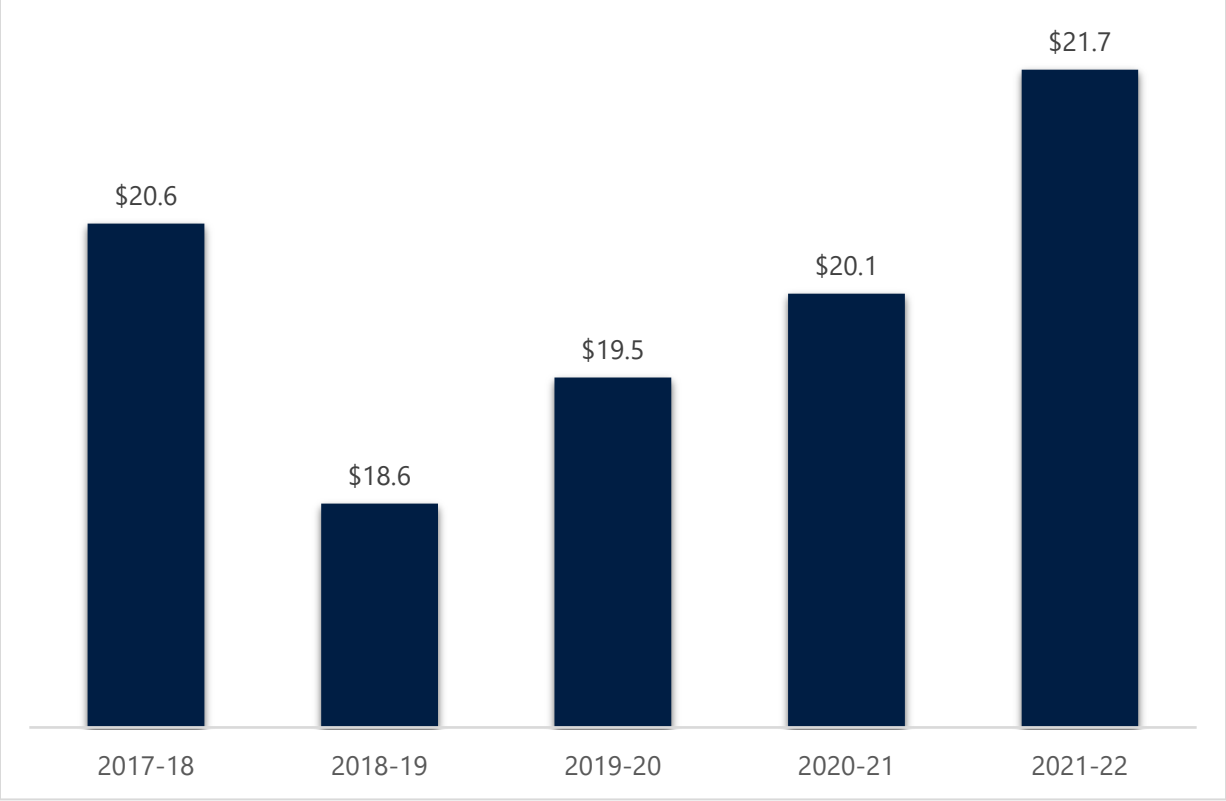
- Rehabilitation of substandard owner-occupied housing.
- Homebuyer assistance.
- Development of affordable homebuyer or rental housing units.
- Operational support for nonprofit groups that qualify as Community Housing Development Organizations.

[120] Nonprofit organizations, community development, or community housing development corporations cannot directly apply for HOME funding. An eligible applicant can apply for funding on behalf of the nonprofit organization or developer. In addition, HOME-participating jurisdictions may apply under specific criteria established by DCED.

All funding must benefit low or moderate-income households. Exhibit 44 shows program awards by federal fiscal year.

Exhibit 44

DCED Home Investment Partnership Program (HOME) Program Awards
Federal FYs 2017-18-2021-22[a]
(in Millions)



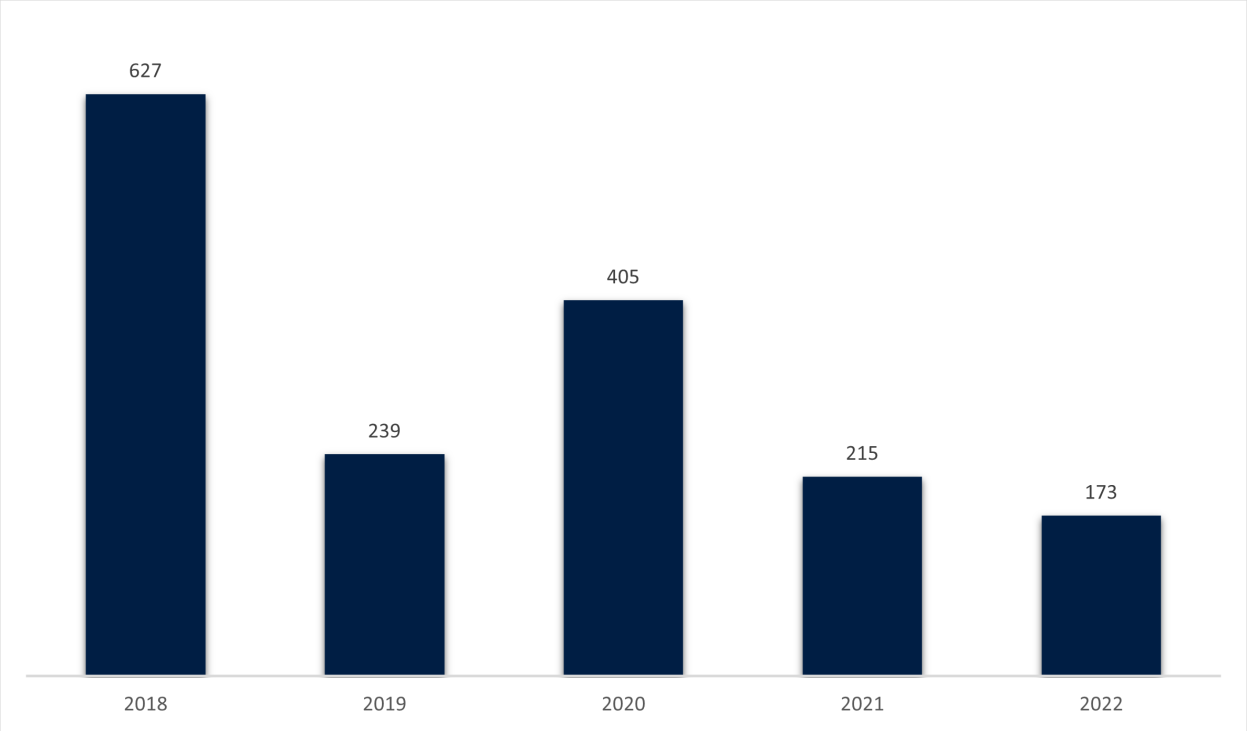
[a] During the 2020-21 federal fiscal year, the American Rescue Plan Act (ARPA) awarded DCED an additional $73.0 million in pandemic-related funding.

Source: Developed by LBFC staff from information obtained from HUD.

During the review period from federal FYs 2017-18 through 2021-22, HOME program awards increased by 5.3 percent. Exhibit 45 shows the number of households assisted by the program year.

Exhibit 45

DCED Home Investment Partnership Program (HOME)
Total Number of Households Assisted
Program Years 2018-2022



Source: Developed by LBFC staff from information obtained from HUD.

The data above consists of two five-calendar-year consolidated planning periods: 2018 (2014-2018) and 2019-2022 (2019-2023). Each year represents the total number of households directly benefiting from the HOME program. During the 2022 program year, DCED prioritized awards for the creation or preservation of affordable rental housing, first-time homebuyer programs, existing owner-occupied housing rehabilitated, and new single-family construction for homeownership.

Exhibit 46 shows HOME program awards for direct entitlement communities by calendar year.[121]

Exhibit 46

Home Investment Partnership Program (HOME)
Program Awards for Direct Entitlement Communities
Federal FYs 2017-18 to 2022-23[a]
(in Millions)

[a] During the 2020-21 federal fiscal year, the American Rescue Plan Act (ARPA) awarded direct entitlement communities an additional $133.3 million in pandemic-related funding.

Source: Developed by LBFC staff from information obtained from HUD.

[121] Direct entitlement communities awarded CDBG funding include: Allegheny County, Allentown, Altoona, Beaver County, Berks County, Bethlehem, Bucks County, Chester County, Chester, Cumberland County, Dauphin County, Delaware County, Erie, Harrisburg, Johnstown, Lancaster County, Lehigh County, Luzerne County, Montgomery County, Northampton County, Philadelphia, Pittsburgh, Reading, Scranton, State College, Upper Darby, Washington County, Westmoreland County, Wilkes-Barre, Williamsport, York County, and York.

During the review period from federal FYs 2017-18 through 2022-23, HOME program awards increased by 15.3 percent.

Housing Opportunities for Persons with Aids (HOPWA). The Housing Opportunities for Persons with AIDS (HOPWA) program, administered by HUD, was authorized by the AIDS Housing Opportunity Act, 42 USC 12901-12912. It awards funding to eligible grantees to provide housing assistance for individuals diagnosed with HIV/AIDS whose income is below 80 percent of a region's median income, as determined by HUD.

The PA Department of Health's Bureau of Communicable Diseases, Division of HIV Disease serves as the recipient of the designated formula allocation on behalf of the state. HUD uses the HOPWA formula to allocate funds based on the number of confirmed cases of HIV/AIDS and is adjusted for an area's fair market rent (FMR) and poverty rates.
The Division of HIV Disease allocates HOPWA funds to the state's six regional grantees, which serve as fiscal agents for HOPWA funds:

- Clarion University of Pennsylvania.
- North Central District AIDS Coalition.
- United Way of Wyoming Valley.
- Jewish Healthcare Foundation.
- Family Health Council of Central PA.
- AIDSNET.

Regional grantees' allocations are determined by the percentage of HIV/AIDS cases in the respective regions, historical funding, and housing activity plans by the regional grantees. These regional grantees, in turn, disburse funds through grants to eligible individuals and organizations. They are awarded based on the need for expenditures such as tenant-based rental assistance, short-term rent, mortgage, utility payments, permanent housing placement, and supportive services. Exhibit 47 shows allocations to regional grantees from federal FYs 2018-2022.

Exhibit 47

Distribution of HOPWA Funds for Regional Grantees
Federal FY 2018-19 to 2023-24

Regional Grantee	2018-19	2019-20	2020-21	2021-22	2022-23[a]	2023-24[a]
AIDSNET - AIDSNET Region	$48,172	$23,456	$22,701	$14,700	-	-
Family Health Council of Central PA - South Central Region	780,855	777,612	966,070	846,046	-	-
North Central District AIDS Coalition - North Central Region	211,200	211,200	238,444	211,200	-	-
Clarion University - North West Region	298,975	340,887	392,947	340,887	-	-
United Way of Wyoming Valley - North East Region	191,515	286,091	346,091	286,091	-	-
Jewish Healthcare Foundation - South West Region	96,618	96,618	111,661	96,618	-	-
Grantee Administration	10,568	10,000	11,525	10,000	-	-
Total	**$1,637,903**	**$1,745,864**	**$2,088,839**	**$1,805,542**	**$2,259,951**	**$2,482,567**

[a] DCED stopped tracking HOPWA funding at the grantee level after 2021. Instead, they reported the total allocation to DOH from HUD for 2022 and 2023.

Source: Developed by LBFC staff from information obtained from the DCED CAPERS report.

The allocation directed towards regional grantees is separate from the Philadelphia, Pittsburgh, Allentown, Harrisburg, and Bensalem Township Eligible Metropolitan Statistical Areas (EMSAs) that receive a direct allocation from HUD. These areas are defined as areas with an additional need for funding based on the number of identified cases of AIDS in the

area. To qualify as an EMSA, an area must have a population of more than 500,000 and have more than 1,500 cumulative cases of AIDS. Additionally, some external grantees are awarded HOPWA funding through a competitive application process conducted by HUD. Exhibit 48 shows the allocations of HOPWA funds to both EMSAs and competitive grantees.

Exhibit 48

Distribution of HOPWA Funds for EMSAs and Competitive Application Grantees

Federal FY 2018-19 to 2023-24

Entity	2018-19	2019-20	2020-21[b]	2021-22	2022-23	2023-24
Allentown, PA	-	$432,321	$557,828	-	$564,882	$629,087
Asociacion Puertorriquenos en Marcha[a]	-	-	1,442,075	-	-	-
Bensalem Township, PA	-	763,072	922,945	-	903,942	988,907
Calcutta House[a]	-	-	93,368	-	-	-
Harrisburg, PA	-	432,055	536,775	-	522,363	576,568
Philadelphia, PA	7,375,786	7,343,333	8,337,081	8,327,150	7,827,151	8,577,000
Pittsburgh, PA	948,891	1,071,974	1,306,237	1,202,295	1,275,737	1,410,014
Public Health Management Corporation (PHMC)[a]	837,358	-	-	-	-	-
Total	**$9,162,035**	**$10,042,755**	**$13,196,309**	**$9,529,445**	**$11,094,075**	**$12,181,576**

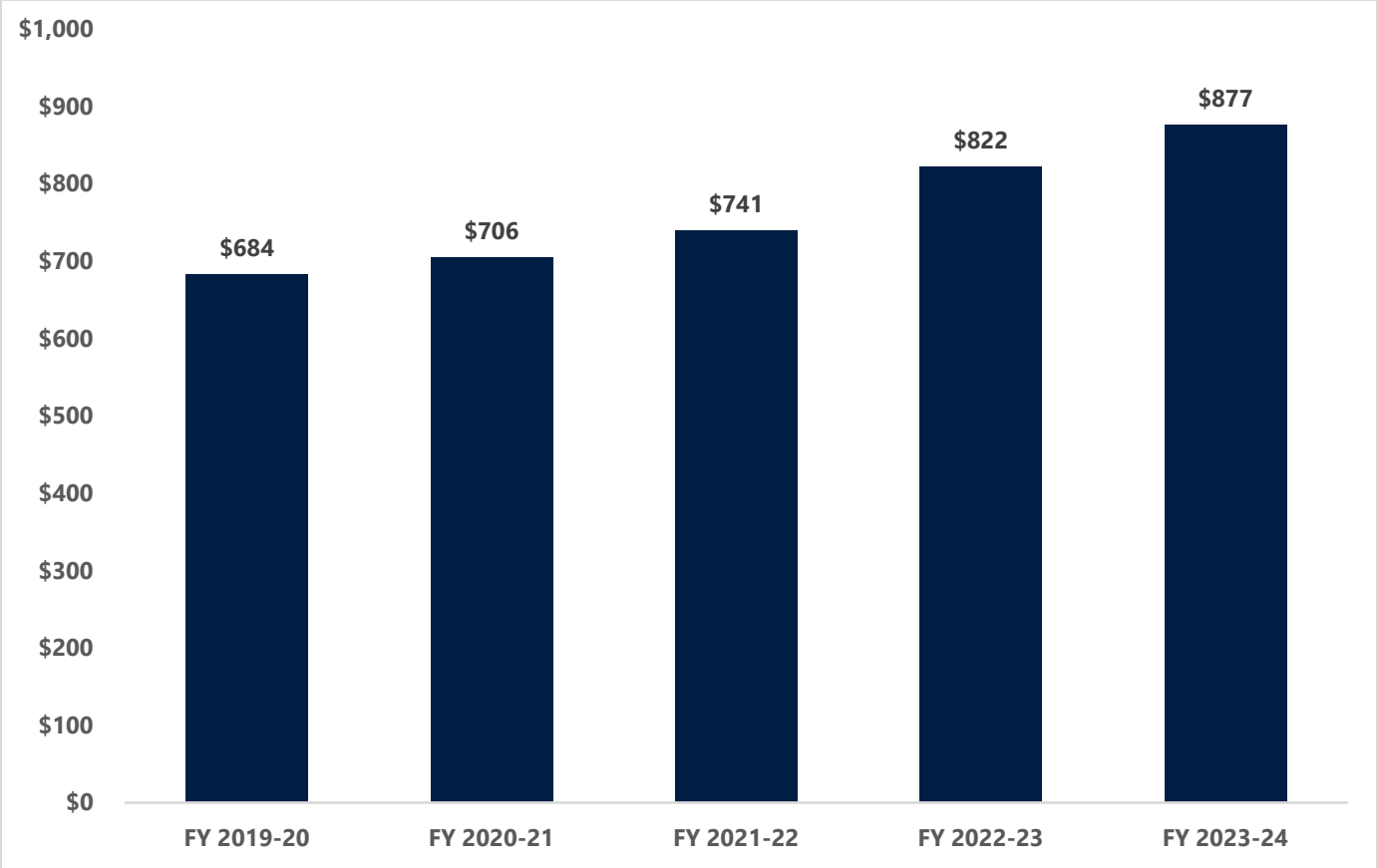
[a] Competitive Application Grantee
[b] Includes Housing Opportunities for Persons with AIDS CARES Act (HOPWA-CV) funding

Source: Developed by LBFC staff from information obtained from the HUD Exchange.

The 2022 Consolidated Annual Performance and Evaluation Report (CAPER) cites affordable housing as a significant barrier within the HOPWA program in Pennsylvania. According to the CAPER, affordable units that meet all HOPWA housing quality standards, and fair market rent requirements set by HUD, are currently limited throughout the state.

Exhibit 49

Average Statewide Fair Market Rates for Rental Housing in Pennsylvania
FYs 2019-20 to 2023-24



Source: Developed by LBFC staff from information obtained from HUD.

A low inventory of affordable housing also affects the ability to transition clients to permanent housing. With the increasing cost of rental housing, as illustrated in Exhibit 49, finding units that meet these requirements impacted services during 2022, as it limited the ability to offer tenant-based rental assistance and permanent supportive housing services to clients. Low housing inventory and high cost of rental housing likely contributed to the program's inability to meet its goal of assisting 600 households with HOPWA funds for 2022. The total number of households assisted with HOPWA funds from program years 2018-2023 is in Exhibit 50.

Exhibit 50

Number of Households Assisted by HOPWA Funds in Pennsylvania
Program Years 2018-2023

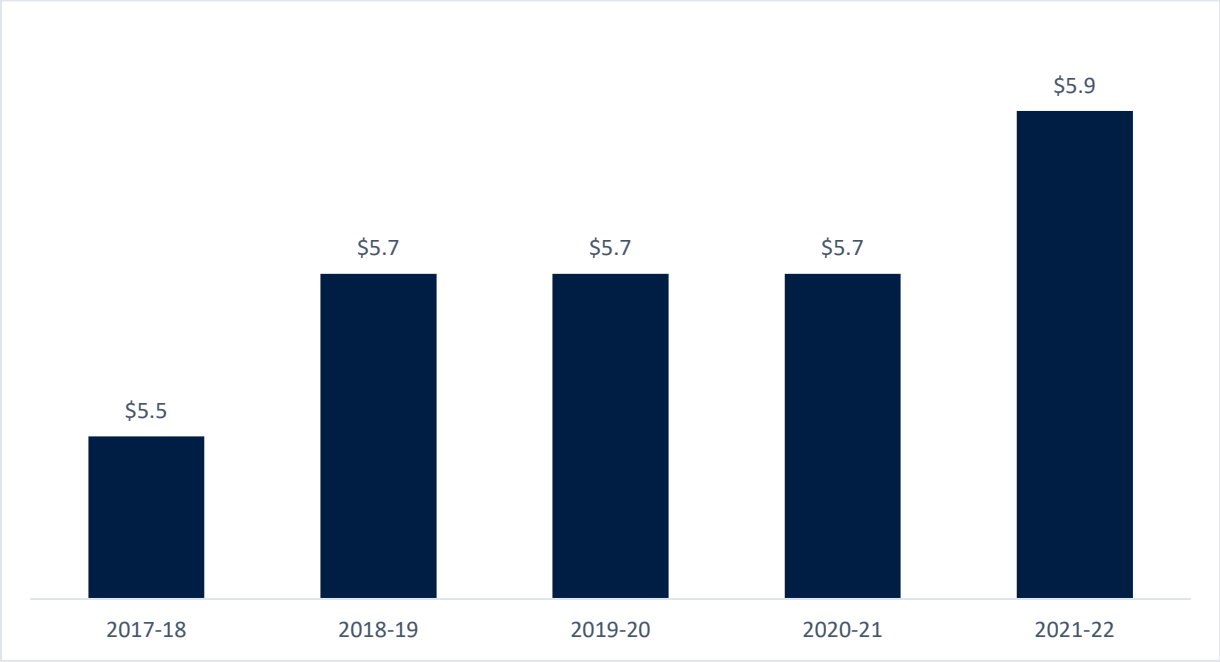
2018	2019	2020	2021	2022	2023
492	602	602	511	557	641

Source: Developed by LBFC staff from the DCED CAPERS report.

Emergency Solutions Grant. ESG funding is provided to states for non-entitlement communities to provide emergency assistance to people who are homeless or at risk of homelessness and help them quickly regain stability in permanent housing. We reviewed ESG program funding for non-entitlement communities administered by the DCED. Exhibit 51 below shows the ESG awards by federal fiscal year.

Exhibit 51

DCED
Emergency Solutions Grant Awards
Federal FYs 2017-18 to 2021-22[a]
(in Millions)



[a] A supplemental appropriation of $39.8 million from the Coronavirus Aid, Relief, and Economic Security Act of 2020 for homeless assistance grants under ESG was awarded to DCED.

Source: Developed by LBFC staff from information obtained from the DCED CAPERS report.

ESG program funding increased 6.3 percent for non-entitlement communities from federal FYs 2018 to 2022. Exhibit 52 shows the ESG households served by calendar year.

Exhibit 52

DCED
Emergency Solutions Grant, Households Served
Program Years 2018-2022

CY	Households Served	Without Children	With Children and Adults	With Only Children	Unknown Housing Type
2018	2,519	1,796	708	2	13
2019	2,237	1,492	730	2	13
2020	3,526	2,370	1,112	3	41
2021	3,235	2,304	899	1	31
2022	4,009	2,964	1,018	5	22

Source: Developed by LBFC staff from information obtained from the DCED CAPERS report.

The total number of households served under the ESG program increased 59 percent from program years 2018 to 2022. Families without children showed the largest increase, 65 percent, while families with children increased by 44 percent.

D. Other DCED Administered Programs

Two additional housing-related programs are federally funded and administered by DCED.

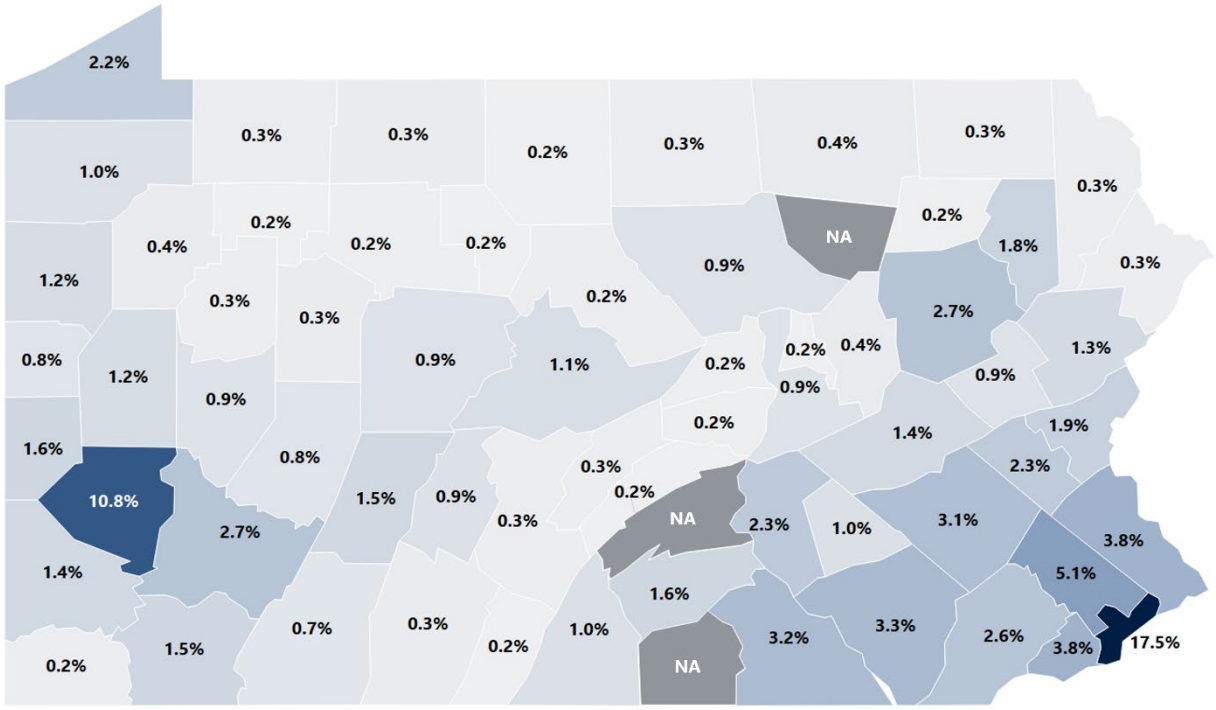
Whole-Home Repairs Program (WHRP)

Established by Act 54 of 2022, the WHRP program provides funding to county-wide agencies (county government, nonprofit organizations, or governmental entities) to address habitability and safety concerns, provide measures to improve energy or water efficiency, and make housing units accessible for individuals with disabilities. WHRP program grantees can make grants available to homeowners whose incomes do not exceed 80 percent of the area median income and loans to small landlords who rent affordable housing units. Lastly, grantees can use funds for program administration and investments in workforce development programs.

In July 2022, DCED received a one-time allocation from Pennsylvania's ARPA-State and Local Fiscal Recovery Funds (SLFRF) for $125 million to establish the WHRP. Each county had to apply for funding or designate one recipient on its behalf. DCED developed an allocation formula using HUD county data (Area Median Income), age of home, homes without complete kitchens or baths, etc.) to determine awards for all 67 counties. However, some counties did not apply for funding, causing DCED to re-distribute those dollars to the 64 counties that applied. According to DCED, $120.3 in WHRP funds were awarded to 64 counties in CY 2023.[122] Exhibit 53 shows the percentage of WHRP funds awarded to participating counties.

Exhibit 53

DCED Whole-Home Repairs Program (WHRP)
Percent of Funding by County
CY 2023



Source: Developed by LBFC staff from information obtained from DCED.

[122] Adams, Perry, and Sullivan counties did not apply for WHRP funds.

As of June 2023, all program funds were distributed to 64 counties. Each county established individual priorities and oversaw the administration of its WHRP. However, grant funds can only be used to address home repair needs (habitability, accessibility, and energy efficiency) and workforce development programs specializing in home repair fields. According to DCED, as of March 31, 2024, WHRP grantees and subgrantees have expended $29 million. Of these funds:

- Approximately $3 million was spent on administrative expenses.
- $26.7 million was awarded/obligated to 1,743 homeowners.

Quarterly, WHRP agencies administering the program must report to DCED WHRP funding (per project), expenditures, administrative costs, and workforce costs. DCED stated the $29 million may be understated and does not fully capture WHRP funds awarded or obligated by counties, and it is likely much higher than reported. DCED estimates total WHRP funds committed as of March 2024 to be approximately $40 million. To date, the average homeowner grant was approximately $17,000. In a recent survey conducted by DCED (April 2024), 58 counties reported 2,323 homes as "identified" to receive a WHRP grant. If DCED's estimated $40 million of WHRP funding has been awarded or obligated statewide, approximately $52 million, or 43.4 percent of WHRP funding, remains for homeowner grants and landlord loans. In addition, counties reported roughly $11 million set aside for workforce development programs.

DCED stated that to ensure consistency and accurate reporting, the agency is "setting up summer desktop monitoring visits with all grantees to monitor specific project files and ensure the counties are administering the program in compliance with SLFRF and WHRP guidance/legislation. In addition, DCED's budget office will conduct annual monitoring visits of all WHRP agencies to monitor all DCED programs and ensure that admin dollars are being spent according to each program's rules."

All 2023 WHRP funding must be expended by December 31, 2026.

Lastly, for FY 2023-24, $50 million was included in the budget for WHRP; however, these additional funds were not included in the budget-enabling code bills passed on December 13, 2023. WHRP was a line item within the governor's proposed FY 2024-25 budget but also was not enacted.

Weatherization Assistance Program (WAP)

The WAP, authorized by the Energy Conservation in Existing Buildings Act of 1976, Title IV of the Energy Conservation and Production Act, was established to help low-income families reduce energy costs by

increasing energy efficiency in their homes while ensuring their health and safety. The US Department of Energy funds the WAP.

The WAP program, implemented in Pennsylvania in 1977 and administered by DCED, is for low-income households at or below 200 percent of the federal poverty level. Priority is given to older adults, disabled individuals, families with children, and high-energy users. Weatherization services focus on diagnostic assessment of air leakage, health and safety repairs, electric baseload measures, and client energy education. WAP services are provided through a network of public and nonprofit agencies operating in single or multi-county regions. Currently, 34 nonprofit organizations (subgrantees) provide weatherization services across the commonwealth. During the current three-year contract cycle (CYs 2022-2025), DCED was awarded WAP funding totaling $13 million in CY 2022 and $14.3 million in CY 2023. To date, Pennsylvania has weatherized an average of 1,292 homes per year. The DCED current three-year grant contract expires in June of 2025.

Lastly, the DOE has allocated an additional $186 million to Pennsylvania, outside the state's standard allocation, from the Infrastructure Investment and Jobs Act (IIJA), also known as the Bipartisan Infrastructure Law (BIL), for weatherization investments. DCED has spent over $10.3 million of BIL funds and awarded over $47 million to statewide weatherization agencies. Currently, there is no formal expiration date on the BIL funds.

E. US HUD, Public Housing, and Housing Choice Voucher Programs

The US Department of Housing and Urban Development (HUD) provides housing subsidies for government-owned and privately owned housing. HUD provides subsidies to public housing agencies (PHAs), which administer public housing programs and various housing choice voucher programs. The following sections provide an overview of public housing and housing assistance programs funded by HUD and administered by state PHAs.

Public Housing

The US Housing Act of 1937 established public housing to assist states and political subdivisions of states to:

- Remedy unsafe housing conditions and the acute shortage of decent and safe dwellings for low-income families.
- Address the shortage of affordable housing for low-income families.
- Responsibilities and flexibility in program administration should be given to public housing agencies, with appropriate accountability to residents, localities, and the general public.
- To provide decent, safe, and sanitary rental housing for eligible low-income individuals, families, older adults, and persons with disabilities.

Approximately 1.2 million households live in public housing units managed by 3,300 PHAs across the US. In Pennsylvania, as of June 2024, a total of 99,784 people (which includes 33,522 children ages 18 or younger) live in public housing units managed by 75 PHAs.

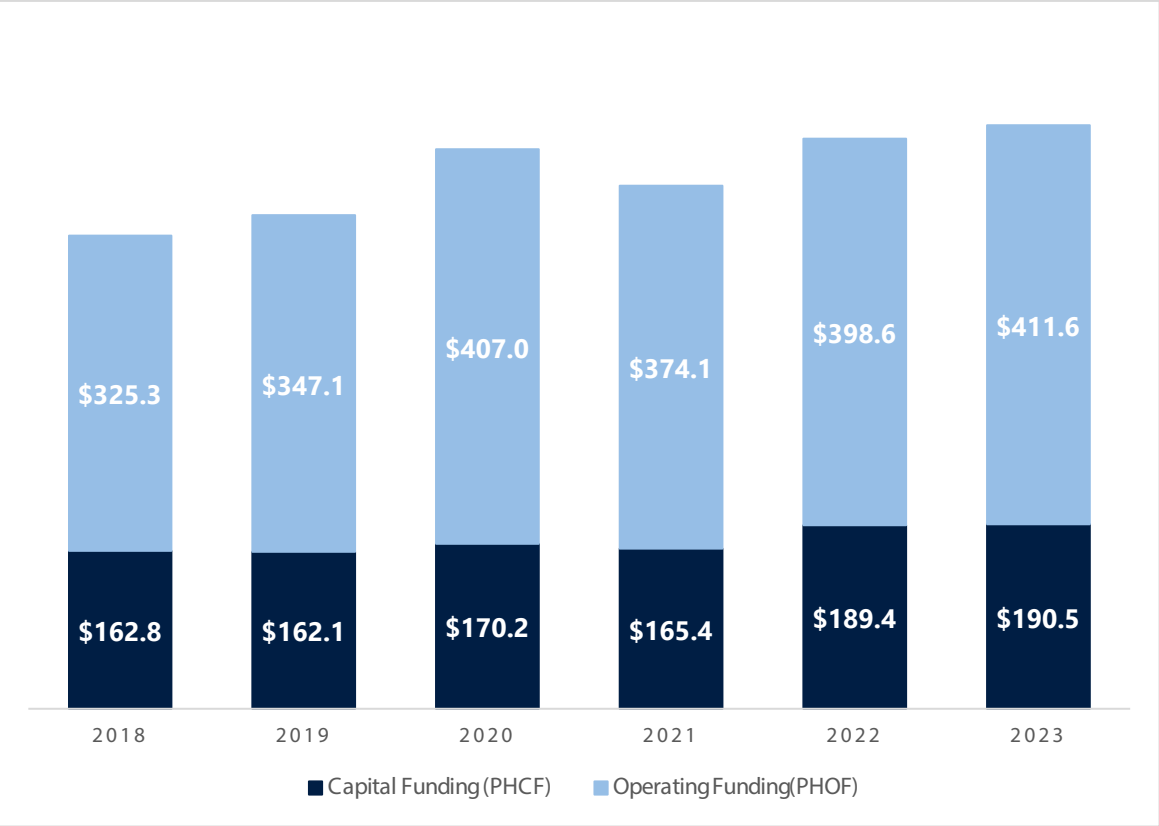
HUD provides federal aid to local PHAs from the Public Housing Operating Fund (PHOF), authorized under Section 9 of the US Housing Act of 1937, for public housing operations, administration, and program implementation. In addition, PHAs receive funding from the Public Housing Capital Fund (PHCF) for developing, financing, and modernizing public housing.[123] Through these federal subsidies, PHAs provide affordable rent for low-income families. PHAs are locally managed and administer several federally funded housing assistance programs.

Exhibit 54 shows Pennsylvania PHA's total operating and capital funding by calendar year.

[123] Funding limitations include luxury improvements, direct social services, costs funded by other HUD programs, and ineligible activities as determined by HUD.

Exhibit 54

Pennsylvania
HUD Capital and Operating Funding for Public Housing
CYs 2018-2023[a, b,c,d]
(in Millions)



[a] 2020 PHCF includes Emergency Safety and Security and Lead-based funding; PHOF includes Cares Act funding.
[b] 2021 PHCF includes Emergency Safety and Security funding; PHOF includes Shortfall funding.
[c] 2022 PHCF includes Emergency Safety and Security and Lead-based funding; PHOF includes Shortfall and Healthy Homes funding.
[d] 2023 PHCF includes Emergency Safety and Security; PHOF includes Shortfall funding.

Source: Developed by LBFC staff from information obtained from HUD.

Low-income public housing varies by type and size, from single-family houses to high-rise apartments. Eligibility for low-income housing is limited to individuals and families based on their gross income, occupancy type (e.g., older adults, a person with a disability, or family), and US citizenship or eligible immigration status. Annually, HUD sets low-income limits at 80 percent and very low-income limits at 50 percent of the median income for each county and metropolitan area.

Each tenant is responsible for paying a portion of the rent (if applicable) based on a statutory formula and family income information, which is used to determine the Total Tenant Payment (TTP).[124] The TTP is the greater of:

- Thirty percent of monthly adjusted income.
- Ten percent of monthly income.
- Welfare rent from a public agency (i.e., the part of welfare specifically designated to meet the tenant's housing costs) is used in as-paid states only.[125]
- PHA-determined minimum rent.

Of these calculations, the TTP made by the tenant family will be the highest of those calculations. The tenant will never pay less than TTP for the approved rental, but the rent amount could exceed the TTP if the rent is initially prorated, or the leased unit has a gross rent amount higher than the PHA payment standard.

Housing Choice Voucher Program (HCV)

In addition to low-income public housing, PHAs administer the HCV program: Section 8 Tenant-Based Vouchers (TBV), Project-Based Vouchers (PBV), and Special-Purpose Voucher (SPV) programs. The HCV program eligibility requirements are the same as those for low-income public housing; however, SPV requirements vary and are program specific. Exhibit 55 provides an overview of public housing and housing choice vouchers.

[124] If a calculated amount is not fully covered by the voucher or based on income, rent could be $0.

[125] An as-paid state, county, or local public assistance program is a welfare agency that designates a specific amount for shelter and utilities and adjusts that amount based on the amount the family pays for shelter and utilities.

Exhibit 55

HUD, Public Housing, and Section 8 Housing Choice Voucher Programs

Public Housing	Section 8	
	Tenant-based Housing Choice Vouchers	Project-based Housing Choice Vouchers
Government-owned	Privately owned	Privately owned
Subsidy attached to the housing unit	Vouchers assigned to tenants/families	Voucher attached to the housing unit
Must remain in a public housing unit to keep the subsidy	Voucher stays with the tenant when they move	Voucher is attached to a particular unit (is assigned to that unit)
Waiting List	Waiting List	Waiting List

Source: Developed by LBFC staff from information obtained from HUD.

TBV and PBV housing units are privately owned, while public housing is government-owned. A housing subsidy can be attached to an individual unit or tenant/family. The portability of HUD's low-income housing subsidies slightly differs. For instance, if an individual or family lives in public housing or a PBV housing unit and decides to move, the subsidy remains with the housing unit. However, under the Tenant-based HCV, if an individual or family moves, the voucher assigned to them will move with them, and they can retain the subsidy.

The Housing Choice Voucher (HCV) Program, also known as Section 8, is "the federal government's major housing assistance program for low-income families, the elderly, and the disabled." [126] The HCV can be "tenant-based" or "project-based." The program allows participants to find affordable, decent, safe, and sanitary housing in the private market. PHAs administer the HCV program through federal funding from HUD. Program eligibility is based on annual gross income (which cannot exceed 50 percent of the median income for the county or metropolitan area), family size, and US citizenship.[127]

Eligible applicants are placed on a waiting list until a voucher becomes available. At the local level, each PHA establishes its local preferences for waitlisted individuals or families. For instance, preference may be given to those on the waiting list who are homeless, living in substandard housing, someone who is paying more than 50 percent of their income for rent, or have been involuntarily displaced. Of the vouchers

[126] *See* https://www.hud.gov/topics/housing_choice_voucher_program_section_8#hcv01, accessed April 24.
[127] This also applies to specific categories of non-citizens with eligible immigration status.

issued by PHAs, 75 percent must go to applicants whose incomes do not exceed 30 percent of the area median income, as published by HUD.

Those eligible for TBV may choose any housing type, including single-family homes, townhouses, and apartments. Each individual or family who receives a voucher is responsible for finding suitable housing, and the owner must agree to rent under the HUD program requirements. The PHA approves a voucher holder's housing choice per HUD's requirements. Once approved, a Housing Assistance Payment (HAP) subsidy goes directly to the property owner on behalf of the voucher holder.[128] The difference between the actual rent amount and the subsidy is the responsibility of the program participant.[129]

PBVs are attached to a particular rental unit, and the PHA refers to eligible families to occupy available units. PBVs are optional for PHAs, and up to 20 percent of its authorized vouchers can be dedicated to these units. HCV program funds can be used for PBV units, but there is no additional funding for this voucher type. According to HUD, PHAs can deconcentrate poverty, expand housing choices, and encourage supportive housing development by leveraging PBVs. The PBV process includes:

- PHA sets policies and procedures.
- PHA competitively selects property and establishes a contract with the owner.
- Contracts are executed for specific units.
- Contracts are for a fixed amount of time, one to 20 years, with possible extension.
- Property owners provide PBV-dedicated units that meet Housing Quality Standards.

In addition, there are several benefits to PBVs, such as:

- Expanded availability of affordable rental housing.
- Improved renter access to neighborhoods of opportunity.
- Families' retention of housing choice.
- Incentivized housing development to meet specific needs (accessible units, supportive services).
- Preservation of affordable housing (after repositioning public housing).
- Financial security for property owners and developers.

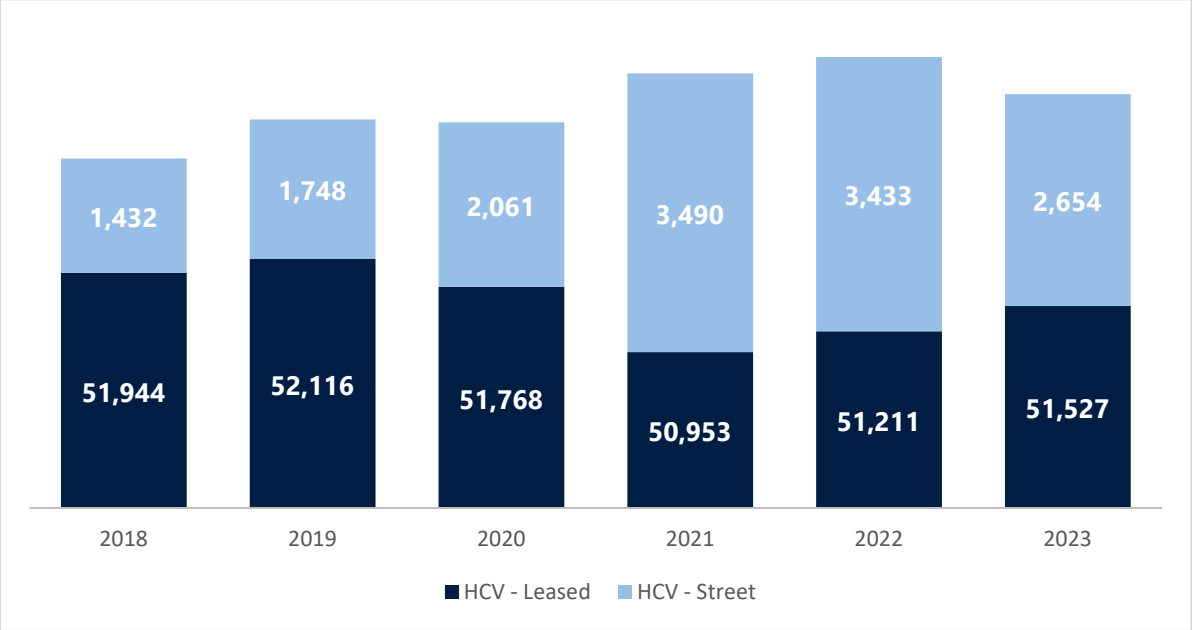
[128] A Housing Assistance Payment (subsidy) is a contractual agreement between the PHA, and the unit owner occupied by a Housing Choice Voucher program participant.
[129] Under certain circumstances, if authorized by the PHA, a family may use its voucher to purchase a modest home.

PBV units represent just over eight percent of the total HCV program. In Pennsylvania, as of December 2023, there were 4,297 PBV leased units and 268 unleased units.[130]

We also reviewed currently leased and on-the-street HCVs. HUD defines on-the-street vouchers are those that have been issued to a family by a PHA, but the family has yet to find a unit and execute a housing assistance contract. Exhibit 56 shows the total number of HCVs in Pennsylvania leased and on the street by calendar year.[131]

Exhibit 56

Pennsylvania
Housing Choice Vouchers
CYs 2018-2023[a,b]



[a] The total includes Mainstream (MS), Family Unification Program (FUP), Non-Elderly Disabled (NED), and HUD-VASH Voucher awards as of December 31st of each calendar year.
[b] HCV-Street as of November 30, 2023.

Source: Developed by LBFC staff from information obtained from HUD.

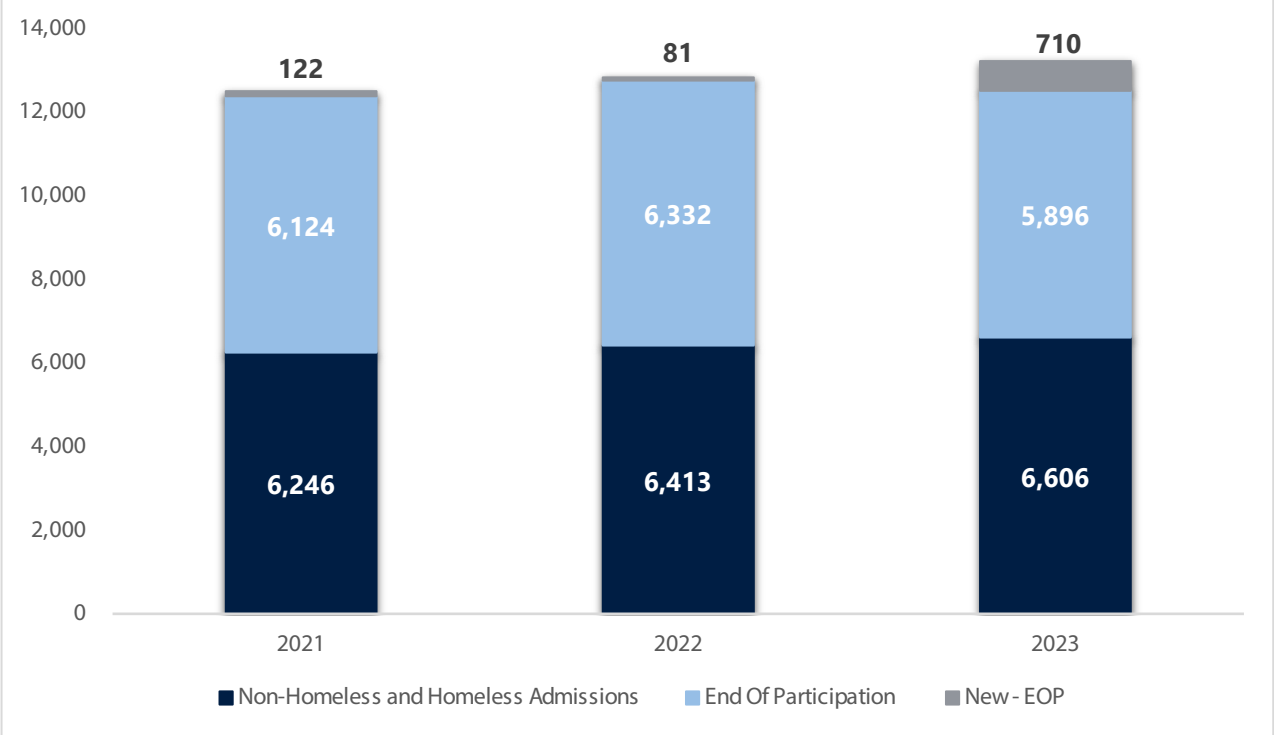
[130] PBV under HAP and Leased is the number of project-based Voucher (PBV) units under a Housing Assistance Payment (HAP) contract and leased as of the beginning of the month, as reported in HUD's Voucher Management System.
[131] HCV program data throughout this section does not include Moving to Work Demonstration (MTW). MTW is a program authorized in the 1996 Appropriations Act that allows PHA's to design and test innovative, locally designed strategies that use Federal dollars more efficiently, help residents find employment and become self-sufficient, and increase housing choices for low-income families.

From CY 2018 to 2023, there was less than a one percent decrease in HCV leased vouchers, while the number of HCVs on the street increased by 85.3 percent. Even though the number of vouchers has remained relatively the same, the number issued has increased, but a unit has not been found to execute the housing assistance contract.

Exhibit 57 shows HCV program admissions, end-of-participation (EOP) actions, and the difference between new admissions and those exiting the program. EOP is the number of households leaving the voucher program (i.e., ending participation).

Exhibit 57

Pennsylvania Housing Choice Voucher Program
New Admissions
CYs 2021-2023



Source: Developed by LBFC staff from information obtained from HUD.

During the most recent calendar year, 2023, there were 6,606 new HCV program admissions. An admission in a tenant-based program is the "effective date of the first HAP contract for a family (first day of the initial lease term). This is the point when the family becomes a participant

in the program."[132] That same year, there were 5,896 EOP actions. We calculated the difference to show the number of new admissions minus EOP actions for CY 2023, which was 710.

Lastly, the seven SPVs account for less than nine percent of total housing choice vouchers in Pennsylvania. SPV voucher programs, some with overlapping eligibility requirements, are described below.

Mainstream (MS) and Non-Elderly Disabled (NED) Vouchers are for households with non-elderly people with disabilities (18-62 years of age). Both voucher types are similar and can be tenant-based or project-based. Within NED are two voucher categories: Category I: non-elderly persons and families with disabilities, and Category II: persons leaving institutional care for community-based housing and services. PHAs are encouraged to work with community partners when applying for MS vouchers and use them in their community housing planning. NED Category II vouchers require PHAs to partner with either state Medicaid, health agency, or state Money Follows the Person Demonstration agency when applying for funding.[133] A household can be added to the PHA waiting list by referral or applying directly.

Family Unification Program (FUP) and Foster Youth to Independence (FYI) are vouchers for:

- Families for whom the lack of adequate housing is a primary factor in the imminent placement of the family's child or children in out-of-home care or the delay in the discharge of the child or children to the family from out-of-home care.

- Youth aged 18 to 24 who have left foster care or will leave foster care within 90 days and are homeless or at risk of becoming homeless at age 16 or older.

FUP family vouchers can be tenant or project-based and have no time limit. However, the housing voucher for youth is limited to 36 months unless they meet the requirements to receive an extension of assistance for up to 24 months under the Fostering Stable Housing Opportunities amendments. FYI, vouchers can only be tenant-based.

Under FUP and FYI, a PHA must partner with Public Child Welfare Agencies to provide supportive services for eligible youth. FUP and FYI referrals are added to the PHA HCV waiting list, after which the PHA determines HCV eligibility. Sixteen PHA's in Pennsylvania are administering

[132] 24 CFR § 982.4.

[133] The Money Follows the Person (MFP) demonstration supports state strategies to rebalance their long-term services and supports systems from institutional to community-based care. *See* https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html, accessed May 8, 2024.

FYI vouchers. Exhibit 58 shows the total number of current FYI vouchers administered in Pennsylvania by PHA. We were unable to determine the status of leased or unleased FYI vouchers.

Exhibit 58

PHA's Administering Fostering Youth Initiative (FYI) Vouchers
Effective date is on or before 10/31/2023

PHA	Total FYI Awards
Allegheny County Housing Authority	18
Allentown Housing Authority	2
Housing Authority of the County of Beaver	9
The Housing Auth of the City of Carbondale	3
Chester Housing Authority	15
Housing Authority of the County of Chester	15
Cumberland Co Redevelopment & Housing Authority	6
Housing Authority of the City of Dubois	5
Housing Authority of the City of Erie	24
Housing Authority of the County of Erie	4
Harrisburg Housing Authority	4
Housing Authority of the County of Lycoming	4
The Housing Auth of the County of Mifflin	1
Philadelphia Housing Authority	125
Scranton Housing Authority	1
Washington County Housing Authority	3

Source: Developed by LBFC staff from information obtained from HUD.

The HUD-Veterans Affairs Supportive Housing (HUD-VASH) program combines HUD's HCV rental assistance for homeless veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). The VA provides these services for participating veterans at VA medical centers (VAMCs) and community-based outreach clinics through VA contractors or other VA-designated entities. HUD-VASH program vouchers can be tenant- or- project-based, and veterans and their families are eligible. The initial need assessment is done through a VAMC (or designated provider), after which eligible veterans are referred to their local PHA to be issued a voucher or to select a project-based voucher unit.

Exhibit 59 shows the number of leased and unleased SPVs for MS, NED, Family Unification Program (FUP), and HUD-VASH.

Exhibit 59

Special Purpose Vouchers – MS/NED/FUP/HUD-VASH
As of December 2023

SPV Program	MS	FUP	NED	HUD-VASH
SPVs - Awarded	1,801	790	1,239	1,876
SPVs - Leased	1,281	543	1,100	1,517
Percent Leased	71.1%	68.7%	88.8%	80.9%

Source: Developed by LBFC staff from information obtained from HUD.

The Emergency Housing Voucher (EHV) program was established under the American Rescue Plan Act (ARPA) "to assist individuals and families who are homeless, at-risk of homelessness, fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking, or were recently homeless or have a high risk of housing instability."[134] EHVs are tenant-based only. HUD allocates EHV program funding to PHAs operating in areas with the greatest need while also considering the PHA's capacity and geographic diversity requirements.

PHAs must partner and enter a Memorandum of Understanding (MOU) with at least one CoC. HUD also requires PHAs to enter an MOU with all EHV referring agencies. The MOU must define a targeted population and include an introduction, goals, services to be provided to eligible applicants, PHA roles and responsibilities, CoC roles and responsibilities, third-party roles and responsibilities, and program evaluation. Also, the PHA must maintain a separate EHV waiting list. EHV program referrals can only be accepted from a CoC's CE system or other partnered agencies. Exhibit 60 shows the total number of EHV vouchers leased and on the street.

[134] *See* https://www.hud.gov/program_offices/public_indian_housing/ehv/about, accessed May 8, 2024.

Exhibit 60

Emergency Housing Vouchers
Leased and On the Street by Housing Authority
As of May 13, 2024

PHA	Leased	Street
Allegheny County Housing Authority	137	27
Allentown Housing Authority	41	3
Bucks County Housing Authority	56	6
Centre County Housing Authority	41	1
Housing Authority of the County of Chester	79	5
Housing Authority of the County of Dauphin	19	10
Housing Authority County of Delaware	45	10
Housing Authority of Indiana County	12	-
Lackawanna County Housing Authority	2	-
The Housing Authority of the City of Lancaster	34	1
Lancaster County Housing Authority	37	9
Housing Authority of the City of McKeesport	1	-
Montgomery County Housing Authority	94	17
Reading Housing Authority	29	9
Westmoreland County Housing Authority	29	3
Housing Authority of the City of York	37	54

Source: Developed by LBFC staff from information obtained from HUD.

A total of 17 housing authorities in Pennsylvania have leasing authority under HUD.[135] There are currently 693 leased EHVs and 155 on the street. Three housing authorities (Indiana County, Lackawanna County, and the City of McKeesport) do not have EHVs on the street.

The Stability Vouchers (SV) program is a new HCV to assist households experiencing or at risk of homelessness, those fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, and human trafficking, and veterans and families that include a veteran family member who meets one of the preceding criteria. SVs can be tenant- or project-based. HUD requires PHAs to establish a partnership through an MOU with a CoC or Special Victims Provider (SVP) and outline roles and responsibilities. According to HUD, CoCs and SVPs are responsible for:

- Assessing eligible households for SV and services, if needed.
- Referring eligible households to the PHA for SV.

[135] Chester Housing Authority is listed for Pennsylvania, however, the voucher information within the EHV dashboard is currently blank.

- CoCs may also assist referred households in completing and obtaining the necessary documentation for the SV application process.

PHAs are responsible for all PHA administrative responsibilities for the SV program in accordance with the SV Notice and the applicable HCV program regulations. PHAs are "required to work with community partners, including a local CoC, to determine the best use and targeting for SVs along with other resources available in the community."[136] PHAs must maintain a separate SV waitlist.

HUD has awarded SVs to five housing authorities (Allentown, Harrisburg, Union County, Columbia County, and Synder County) and partner CoCs. Each county was awarded five SVs; the CoC partner is Eastern PA CoC, except for Harrisburg, whose partner CoC is Harrisburg/Dauphin County.

[136] HUD, *Stability Vouchers Frequently Asked Questions*, 2023.

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SECTION VI HOSPITALS, HEALTH SYSTEMS, AND HOUSING

Fast Facts…

- *Homeless patients visit an ED an average of 5.8 times per year, which is roughly once every two months.*
- *Roughly 80 percent of emergency room visits made by homeless individuals are for illnesses that could have been treated with some form of preventative care.*
- *Hospitals and health systems in Pennsylvania are supporting and building programs to address social determinants of health, focusing on housing needs.*

Hospitals and healthcare systems are becoming increasingly involved in providing services to homeless individuals and creating more affordable housing opportunities. This section discusses their roles in providing healthcare and housing opportunities to homeless individuals with physical and behavioral health needs.

Key Findings:

1. Healthcare for homeless individuals who frequently use emergency departments (EDs) as primary care is more expensive for patients who have access to housing and preventative care. Homeless patients stay an average of 2.32 days longer in hospital care and cost approximately $1,000 per discharge than typical patients.[137]

2. While hospital interventions benefit homeless patients, a more cost-effective method of efficiently addressing their multifaceted needs is an investment in supportive housing.

3. Hospitals are crucial to investment in supportive housing, as they can realize significant cost savings. Several studies suggest that housing and supportive services that prevent homeless individuals from using an ED produce average annual cost savings between roughly $4,800 and $6,875 per person for hospitals that invest in such initiatives.[138,139]

A. Role of Hospitals and Health Systems in Housing Opportunities

Hospitals and health systems have a multifaceted impact on the lives of homeless individuals. This section describes how hospitals provide essential primary care to many homeless patients and their potential as investors in housing opportunities for those same patients.

[137] Hwang SW, Weaver J, Aubry T, Hoch JS. *Hospital Costs and Length of Stay Among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services*, 2011.
[138] National Alliance to End Homelessness, *Ending Chronic Homelessness Saves Taxpayers Money*, 2017.
[139] Committee on an Evaluation of Permanent Supportive Housing Programs for Homeless Individuals, *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*, 2018.

Emergency Departments (EDs) and Health Care for the Homeless

Homeless individuals with significant stress related to housing instability self-reported poorer mental health, elevated anxiety, and depression. These challenges collectively shorten the life expectancy of homeless individuals. A study of unhoused populations in Boston found an average life expectancy of 27.3 years less than housed persons.[140]

A lack of medical insurance, financial means, and general stability leaves these individuals with fewer options for viable healthcare. Homeless and housing-unstable individuals who are unable to receive and adhere to treatment plans are more likely to experience prolonged medical issues. Consequently, hospital EDs serve as primary healthcare providers for many homeless individuals without reliable access to a primary care physician (PCP) because they are required to treat anyone with a medical emergency regardless of insurance status.

ED utilization by homeless patients has increased by 80 percent over the last ten years.[141] Homeless patients are also more likely to be "frequent users," more than four visits a year, or "super users," more than 20 visits a year to EDs, and thus use more hospital resources. A study published in the International Journal of Emergency Medicine found that, on average, an individual experiencing homelessness visits the ED up to 5.8 times per year. In 2021, the same figure for the American population was 0.43 ED visits per person. For homeless individuals, up to a third of visits were associated with alcohol-related diagnoses and a quarter were associated with substance poisoning. Similarly, almost 75 percent of inpatient stays by homeless individuals begin in the ED, compared to 50 percent of stays for non-homeless patients.

Homeless individuals have a wide array of complex needs, including chronic health conditions and multiple psychosocial risk factors, such as mental illness and substance use disorders. Most EDs are not able to meet the more severe psychosocial needs of some homeless individuals. They also cannot assist them with long-term housing, substance abuse treatment, and mental health care.

Some research suggests addressing this issue at the ED level. As illustrated in Exhibit 61, one study published in the International Journal of Environmental Research and Public Health identified four touchpoints

[140] The Journal of the American Medical Association, *Mortality Among Homeless Adults in Boston: Shifts in Causes of Death Over a 15-Year Period*, 2013.

[141] Ku BS, Scott KC, Kertesz SG, Pitts SR. *Factors Associated with Use of Urban Emergency Departments by the U.S. Homeless Population*, 2010.

for recognizing and responding to homelessness in the ED and offered solutions:

Exhibit 61

Four Touchpoints of Homeless Patient Interventions

Touchpoint 1: Waiting Environment

- **Issue:** The high prevalence of trauma, substance use, anxiety, and other mental health conditions within the homeless population, long waiting times and waiting amongst other people can lead to agitation, anxiety, or departure from the ED.
- **Solution:**, Ensuring privacy and safety for homeless patients and staff education to enhance confidence in providing trauma-informed care.

Touchpoint 2: Identifying Homelessness among Patients.

- **Issue:** Identification of homelessness in EDs is typically inconsistent.
- **Solution:**, Hospital staff should be able to identify homeless individuals without passing judgment on the patient in lieu of standard administrative screening processes. This allows staff to offer referrals to appropriate support and housing services.

Touchpoint 3: Linking Homeless Patients to Community Services.

- **Issue:** Homeless patients should be linked to the necessary social and housing resources after being identified as homeless when they are in the ED.
- **Solution:** Within a hospital, this could include referrals to a social worker to address issues such as loss of ID, which can preclude access to accommodations, welfare benefits, or access to other types of support or refuge.

Touchpoint 4: Discharge Planning.

- **Issue:** Many healthcare professionals conduct discharge planning under the assumption that patients have stable home environments where they can complete their treatment or recovery.
- **Solution:** The ideal discharge option for homeless patients is a medical respite center that refers them to social supports, including other housing opportunities.

Source: Developed by LBFC staff from information obtained from the International Journal of Environmental Research and Public Health.

While these hospital interventions benefit homeless patients, expanding and investing in supportive housing is cost-effective for efficiently addressing their needs. ED overutilization strains the healthcare system and can lead to less effective patient care, as resources and staff are used to treat more patients. Homeless patients have an average of 2.32 days longer length of stay and approximately $1,000 increased hospital costs per discharge than typical patients.[142]

Developing interventions that address keeping homeless patients out of the ED is integral to improving the overall health of the homeless population and lowering healthcare costs. Helping the homeless avoid EDs is effective, considering that roughly 80 percent of emergency room visits

[142] Hwang SW, Weaver J, Aubry T, Hoch JS. *Hospital Costs and Length of Stay Among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services*, 2011.

made by homeless individuals are for illnesses that could have been treated with some form of preventative care.[143]

Research Suggests Cost Savings for Hospitals Through Housing Investments

In addition to being the most efficient way to improve the health of homeless individuals, supportive housing is more cost-effective for hospitals than continually housing homeless patients in the ED. Hospital systems investing in housing would benefit both hospital systems and homeless patients.

In November 2018, the Florida Housing Finance Corporation (FHFC) initiated a two-year pilot by Ability Housing entitled The Solution That Saves. A study using data collected from *The Solution That Saves* assessed the efficacy of providing Permanent Supportive Housing (PSH) to frequent crisis service users, including costs associated with healthcare and EDs.

The housing units consisted of a 43-unit apartment complex and 49 single units. During the study, hospital costs collectively incurred by the participants decreased by roughly 58 percent, from $6.5 million during the two years before access to housing to $2.7 million during the first two years in housing, resulting in a $3.8 million decrease in total costs to hospitals.

Other studies show that supportive housing that helps homeless individuals avoid using an ED produces average annual cost savings between $4,800 and $6,875 per person for hospitals that invest in such initiatives.[144,145]

Hospitals and health systems also have the resources for this type of investment. Research by the Democracy Collaborative finds that these institutions have an estimated $400 billion in investment assets that could be leveraged to advance housing development.

[143] Garrett DG, *The Business Case for Ending Homelessness: Having a Home Improves Health, Reduces Healthcare Utilization and Costs*, 2012.
[144] National Alliance to End Homelessness, *Ending Chronic Homelessness Saves Taxpayers Money*, 2017.
[145] Committee on an Evaluation of Permanent Supportive Housing Programs for Homeless Individuals, *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*, 2018.

B. Housing Investment in Pennsylvania

Hospitals and health systems in Pennsylvania have invested in affordable housing opportunities. This section discusses some of these initiatives and their impact.

Hospital and Healthsystem Association of Pennsylvania (HAP)

HAP is a membership services and public advocacy organization that represents 235 hospitals in Pennsylvania in government matters. HAP's member hospitals and health systems provide health services across the continuum of care. On March 15, 2024, HAP provided the LBFC with responses solicited from their membership organizations regarding how hospitals are supporting housing and health initiatives. Their response included some general initiatives and some specific programming.

HAP indicated that some of their member hospitals are supporting and building programs to address social determinants of health, focusing on housing needs through direct funding. One member hospital system reported a program that has supported the basic needs of more than 100 unique patients. HAP also indicated that hospitals are working with local school districts to identify families with significant needs, housing or otherwise, to better connect them with the appropriate resources and support. One member health system coordinated support for more than 300 students from one school district.

HAP also pointed to hospitals as partners for community initiatives that support housing opportunities, such as Habitat for Humanity. These programs provide essential home repairs, accommodations for medical needs, and lead abatement and prevention services.

HAP also cited some specific programs, as outlined below.

Housing Smart. As discussed in Section III of this report, Temple University Hospital launched the Housing Smart program in collaboration with Jefferson Health Plans, Keystone First, and Resources for Human Development, Inc. in 2020. Housing Smart intends to directly improve the health of homeless patients by providing them with housing subsidies and support services. The first group experienced a five percent decrease in ED visits, a 79 percent decrease in inpatient admissions, a 77 percent decrease in admissions for observation, and a 50 percent increase in outpatient appointments.

Highmark Health and Allegheny Health Network (AHN). In 2022, Highmark Health and AHN launched a multi-year

initiative that created a social care network that compensates nonprofits that address social determinants of health, such as food insecurity, transportation barriers, and housing. In the first year of the pilot, 20 non-profit Community-Based Organizations (CBO) serving Allegheny and Westmoreland Counties participated in the program and have the potential to earn value-based reimbursement (VBR).[146] As part of the network, Highmark Health clinical staff refers individuals to participating CBOs through its Community Support Platform. This digital database allows individuals to learn about local organizations' various services. Individuals participating in the pilot were more likely to have their needs met by securing the right resources through CBOs. In February 2024, the network expanded to include an additional 17 community-based organizations.

Transitional Living Center (TLC). The TLC is a residential treatment program that serves individuals who have severe mental health diagnoses and need housing within Lehigh County. It is a Lehigh Valley Health Network's (LVHN) Department of Psychiatry program. The hospital network offers a full continuum of mental health services, including inpatient, partial hospitalization, outpatient, home care, consultation-liaison, and emergency psychiatric services.

The TLC offers two levels of supervision at its residential sites. The high-care site is always supervised for residents who require a highly structured environment. The moderate-care site is supervised for 10 hours daily, Monday through Friday, eight hours on Saturday, and no supervision on Sunday. This setting is designed for residents who require limited supervision. The TLC fosters developing, recovering, and improving critical living skills by providing stable housing.

Penn Medicine Lancaster General Health, Frederick House

The Frederick House is a transitional housing facility operated by Penn Medicine Lancaster General Hospital (LGH) that provides short-term crisis housing for homeless individuals with medical complexities. It is primarily funded by a $250,000 grant from the US Department of Housing and Urban Development (HUD) and supplemented minimally by LGH. The program has an annual operating cost of $200,000.

The Frederick House location is an LGH-owned property near the hospital and accommodates up to three individuals at a time. Residents stay for one to three months, receiving one-on-one support to stabilize their medical conditions and facilitate their transition to more permanent housing solutions. Participants must meet HUD requirements regarding

[146] Reimbursement is also discussed in Section III of this report.

the medical issues preventing them from securing other housing and must possess the ability to live independently.

The program collaborates with various community partners to ensure comprehensive support for residents. This initiative emerged from the need identified within LGH's emergency department to address the unique challenges faced by homeless individuals requiring medical care. Despite some residents' feedback that the program is restrictive, Frederick House consistently maintains occupancy with at least one or two residents and has successfully assisted four patients during its operation.

There are no plans to expand the program to other LGH properties. The focus remains on optimizing the existing facility and leveraging its success to potentially influence broader healthcare and housing policy. LGH staff indicated to the LBFC that HUD has recognized Frederick House's innovation and is interested in exploring models like those of other healthcare systems.

WellSpan, Arches to Wellness Recuperative Care

Wellspan's recuperative care program, Arches to Wellness, provides medical respite to patients who require short-term transitional housing. This 30- to 45-day program addresses medical and social complexities while offering shelter, necessities, and access to community resources. Arches to Wellness operates at several Wellspan locations that have varying patient capacities. The program can serve 12 patients in York, four in Adams, four in Franklin, and two in Lebanon. Wellspan indicated to the LBFC that the locations typically have 90 to 95 percent occupancy. The program costs roughly $660 per patient for their stay.

Arches to Wellness supports more than 100 patients annually, leasing beds for patients in partnering shelters and personal care homes. The program has shown an 80 percent reduction in ED visits, and 71 percent of program participants are connected to permanent housing after their stay.

C. Other Housing Initiatives

In addition to housing investment initiatives in Pennsylvania, other hospitals and health systems nationwide have begun investing in affordable housing to support their communities and take advantage of long-term cost savings.

Accelerating Investments for Health Communities (AIHC)

In January 2018, the Center for Community Investment began working with NORC at the University of Chicago (previously the National Opinion Research Center) on the AIHC initiative. AIHC was designed to increase health system investments in addressing social determinants of health, emphasizing affordable housing.

From 2018 to 2021, AIHC assisted six hospitals and health systems nationwide to increase their investments in affordable housing and have advanced policies and practices that promote equitable housing solutions. The six hospitals and health systems were:

- Bon Secours Mercy Health.
- Boston Medical Center.
- CommonSpirit Health.
- Kaiser Permanente.
- Nationwide Children's Hospital.
- UPMC Health Plan.

The participating hospitals and health systems have advanced affordable housing by investing capital into development projects, creating grants, and offering surplus land to construct affordable housing. They have also developed local partnerships and advocated for affordable housing funding and policies. These six hospitals/health systems have:

- Dedicated over $31 million to create loans and grants for affordable housing development.
- Directly supported the development or preservation of more than 1,200 affordable homes.
- Secured $15 million in county American Rescue Plan Act (ARPA) funds and an additional $10 million in state funds to establish an affordable housing preservation loan fund.
- Collectively invested $3 million in a $9 million revolving loan fund and provided land for affordable housing.

Additionally, in November 2019, four AIHC-affiliated health systems participating in the Healthcare Anchor Network (Bon Secours Mercy Health, Boston Medical Center, CommonSpirit Health, and Kaiser Permanente) joined ten other health systems in pledging to invest over $700 million in place-based impact investing, which included financing affordable housing development.[147]

[147] Place-based impact investments are made with the intent to yield financial, social, and/or environmental returns as well as to address the needs of marginalized communities.

The Care Transitions Program, St. Joseph Health

The Care Transitions Program at St. Joseph Health in Humboldt County, California, provides a medical respite program for chronically homeless individuals. The hospital maintains 15 beds for homeless patients who do not meet the diagnostic criteria to be admitted to the hospital but are not well enough to return to shelters or the streets. While enrolled in the medical respite program, these individuals can recover in a safe transitional housing environment.

While in the transitional housing program, a social worker and nurse visit patients. The team provides medical education, life coaching, and expanded case management. Its members attend follow-up doctor visits with some clients or connect them with housing and other community resources.

Within its first few years, the program significantly reduced readmission rates and length of stay among the population served. The return on investment was so significant that the program has since been fully incorporated into the hospital's operational budget.[148]

Better Health Through Housing Program, University of Illinois Hospital & Health Sciences System (UI Health)

The University of Illinois Hospital, part of UI Health, operates several community health centers and clinics and is associated with the university's seven health sciences colleges. Through cost profiling, UI Health discovered that approximately 200 chronically homeless patients accounted for the upper ten percent of patient costs, with an annual per-patient cost of $51,000 to $533,000.[149]

In response, UI Health provided $250,000 of seed funding and financial investments from outside partners to develop the Better Health Through Housing program. The program is designed to provide roughly 25 chronically homeless individuals with stable housing and supportive services. It began accepting patients in November 2015.

UI Health observed a 42 percent decrease in the program participants' healthcare costs after receiving stable housing and supportive services. More recent assessments place the cost reduction at 67 percent when one outlier, an individual receiving end-of-life care, is excluded from the calculation. Additionally, the hospital has observed a 35 percent

[148] American Hospital Association, *Housing and the Role of Hospitals*, 2017.
[149] Ibid.

reduction in the use of its ED and an increase in patients accessing clinics for routine care after participating in Better Health Through Housing.

Housing For Health Program, Los Angeles County Department of Health Services

In November 2012, the Los Angeles County Department of Health Services established the Housing for Health division to expand access to supportive housing for patients who are homeless, have complex health conditions, or are high utilizers of the Department of Health Services. The Housing for Health program is funded by state funding, investments from community leaders and businesses, other Los Angeles County departments, and revenues from Measure H.[150]

The Housing for Health Program operates several initiatives with specialized purposes within the general goal of combating homelessness. These initiatives include, but are not limited to:

- Interim Housing (IH) Program: The IH program provides transitional housing for people experiencing homelessness, allowing them to access stable housing and connect with services to achieve permanent housing. The program offers two types of housing:
    - Recuperative Care for individuals recovering from an acute illness or injury who need stable housing and medical care.
    - Stabilization Housing for individuals with complex health or behavioral health conditions who require supportive services that are not available in most shelters.

Exhibit 62 shows some program statistics.

[150] Measure H, passed in Los Angeles County in 2017, imposes an all-purpose quarter-percent sales tax that generates funding to prevent and combat homelessness within Los Angeles County.

Exhibit 62

Housing for Health's Interim Housing Program Statistics
July-December 2023

156 days: Average length of stay among all interim housing participants.

4,232 interim housing clients served.

480 clients, or **30 percent** of all IH exits, were placed in permanent housing.

Source: Developed by LBFC staff from information obtained from the Los Angeles County Department of Health Services.

- In-Home Care: This program offers comprehensive caregiving services to people who have experienced homelessness and residing in permanent supportive housing in Los Angeles County. IHCG caregivers provide various types of support, including:
    - Grocery shopping and meal preparation.
    - Assistance with household chores.
    - Transportation to appointments.
    - Other personal care services.

From July 1 to December 31, 2023, IHCG provided services to 161 individuals.

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SECTION VII
HOUSING AND HEALTH INITIATIVES

Fast Facts…

- *PHFA has a new Health for Housing Investment funding priority.*
- *The Veterans' Trust Fund is funded mostly by private donations.*
- *Pennsylvania has many nonprofit organizations working to assist the homeless population with housing and health issues.*
- *Two programs allow counties to collect fees to impact affordable housing.*

This section outlines other initiatives and programs that impact housing and health, some within state government agencies or counties. Non-profit organizations also assist low-income and homeless individuals with an array of housing, shelter, and health supports.

Key Findings:

1. PHFA has recently implemented a Housing for Health Investment Initiative to distribute four—and nine-percent Low-Income Housing Tax Credits (LIHTC) to developers undertaking affordable housing projects.

2. Pennsylvania has over 700,000 veterans, the fourth-largest population in the nation. As of the 2023 Point-In-Time count, there were 826 homeless veterans in Pennsylvania.

3. In 2023, PA-211 received 375,430 housing requests, of which 91 percent were requests for shelters, rental assistance, and low-income housing.

4. The most common uses of Optional County Affordable Housing Trust funds were for producing new affordable housing, first-time homebuyer closing costs and down payment assistance, and home rehabilitation and repair.

5. From July 2022 to June 2023, Pennsylvania had 113,183 eviction filings. Statewide, the eviction filing rate, defined as the number of eviction filings per 100 rented homes, was 7.3. York County had the highest eviction rate, followed by Dauphin County.

In this section, we recommend that:

1. **The General Assembly should consider allowing all counties the flexibility to increase the amount of the maximum allowable fee for the optional affordable housing trust fund commensurate with their current recording fees and subsequently index the fee maximum for inflation.**

A. Pennsylvania Housing Finance Agency (PHFA) Housing Programs

PHFA, a state-affiliated agency created by the Housing Finance Agency Law of 1972, partners with a statewide network of over 67 housing counseling agencies across Pennsylvania. PHFA offers various mortgage and loan programs that assist homebuyers and homeowners with refinancing, home improvements, and foreclosure assistance, among other housing-related financial supports.

PHFA administers and underwrites projects that create, preserve, and maintain safe, decent, and affordable housing in Pennsylvania. It also conducts housing studies, promotes counseling and education for renters and homebuyers, encourages supportive services at apartments it has financed, administers rent subsidy contracts for the federal government, and advocates for decent, affordable shelter benefits.

Since 1972, PHFA has generated an estimated $17.6 billion in funding. This revenue has subsidized over 195,250 single-family home mortgages and constructing 103,328 rental units. PHFA has also distributed approximately $289 million to local housing initiatives and financially assisted 50,860 households facing foreclosure.

Pennsylvania Housing Affordability and Rehabilitation Enhancement (PHARE) Fund

Pennsylvania Act 105 of 2010 established the PHARE Fund to provide a mechanism for using state and federal funds to assist with creating, rehabilitating, and supporting affordable housing. The PHARE Act did not allocate funding toward any specific program but outlined requirements for fund allocations. Those requirements include:

- A preference to fund projects that target identified needs or meet specific goals, such as energy efficiency, green building standards, or comprehensive design strategies.

- Consideration of the geographical distribution of program funds to ensure that all commonwealth areas receive appropriate funding.

- Obligations to utilize at least 30 percent of the funds to assist households below 50 percent of the area median income.

The PHARE fund has three revenue sources: the Marcellus Shale Impact Fee, the Realty Transfer Tax Fund, and the National Housing Trust Fund.

Marcellus Shale Impact Fee (Act 13 of 2012). Pennsylvania imposes an annual impact fee on revenues from unconventional natural gas wells, including the Marcellus Shale formation that spans parts of Pennsylvania. The Public Utility Commission distributes impact fee proceeds to local governments and state agencies to support infrastructure, emergency services, environmental initiatives, and various other programs, including the PHARE fund, to help address housing needs in impacted counties in the Marcellus Shale region. Act 13 provides an annual allocation of $5 million from the impact fee into the PHARE program with the potential for additional revenues when funds remain following eligible disbursements to qualifying municipalities. Act 13 also stipulates that 50 percent of the awarded funds must be spent in fifth- through eighth-class counties.

Realty Transfer Tax Fund (Act 58 of 2015). Realty transfer taxes (RTT) are a one-time tax imposed by state and some local governments to transfer property ownership. The Pennsylvania Department of Revenue imposes a realty transfer tax of one percent of the value of the transferred real estate upon both the buyer and the seller. Under Act 58 of 2015, PHARE funding from the RTT fund is based on a formula that allocates the lesser of the following figures:

1. 40 percent of the difference between RTT collections for the previous fiscal year and the base year (FY 2014-15) estimate of $447.5 million, or
2. $60 million.[151]

RTT allocation is currently capped at $60 million annually to support affordable housing activities. As seen in Exhibit 63, Act 58's implementation in 2015 was the first time PHARE funding was available to all Pennsylvania counties.

[151] For example, total RTT revenues in FY 2022-23 were $644 million. Using this number with the formula yields $78.8 million, which means the lesser amount of $60 million was dedicated to the PHARE Fund.

Exhibit 63

History of PHARE

Year	Event
2010	Act 105 - Established the Pennsylvania Housing Affordability and Rehabilitation Enhancement (PHARE) Fund.
2012	Act 13 - Dedicated a portion of the Marcellus Shale Impact Fee for PHARE within eligible counties.
2015	Act 58 - Dedicated a portion of the RTT revenues to PHARE, making funding available to the entire state instead of just the counties impacted by Marcellus Shale.
2019	Pennsylvania legislature raises RTT funding cap to $40 million.
2022	Pennsylvania legislature raises RTT funding cap to $60 million.

Source: Developed by LBFC staff from information obtained from the Housing Alliance of Pennsylvania.

National Housing Trust Fund. The National Housing Trust Fund (HTF) was established under the Housing and Economic Recovery Act of 2008 to provide resources to develop, preserve, and rehabilitate housing for very low and extremely low-income households. The HUD administers the HTF at the federal level, while PHFA receives HTF funding on behalf of Pennsylvania. States must use at least 80 percent of each annual grant for rental housing, up to 10 percent for homeownership, and up to 10 percent for reasonable administrative and planning costs. HTF funding is derived from the earnings of government-sponsored enterprises Fannie Mae and Freddie Mac.

Exhibit 64 shows the HTF allocations to Pennsylvania (PHARE Fund) from FY 2018-19 through FY 2022-23.

Exhibit 64

HTF Funding Allocations to Pennsylvania
FYs 2018-19 to 2022-23

FY	PA Allocation
2018-19	$6,879,626
2019-20	9,729,334
2020-21	24,134,348
2021-22	25,998,644
2022-23	12,081,840

Source: Developed by LBFC staff from information obtained from the National Low-Income Housing Coalition.

HUD annually allocates HTF funds by formula using ratios of various figures, such as:

- The shortage of standard rental units in the state and the country.
- The number of very low-income renter households in the state and the country.
- The number of very low-income renter households paying more than 50 percent of income on rent in the state and in the country.
- The relative construction costs in the state.

PHARE Funding Priorities. PHARE has eight current funding priorities:

- ***Four Percent Tax Credit Projects:*** For projects that increase the availability of affordable housing to low and extremely low-income households.[152]

- ***Preservation and Rehabilitation:*** Rehabilitation of existing housing stock, including:
  - Owner-occupied rehabilitation.

[152] PHFA also offers nine percent tax credits, but they are not eligible to receive PHARE funding and are processed separately from four percent projects.

  - Demolition of blighted, abandoned, and otherwise at-risk housing.
  - Reclaiming brownfields and vacant land where housing was once for community green space.

- ***Rental Housing Creation:*** Development of new and affordable rental units, including:
  - Acquisition costs.
  - Pre-development costs.
  - Construction and significant rehabilitation.
  - Demolition where affordable housing development is the end goal.

- ***Homelessness Prevention:*** To address ongoing needs for individuals and families at risk for homelessness, including:
  - Rapid re-housing.
  - Rent/utility/transportation assistance.
  - Case management.
  - Landlord risk mitigation.
  - Short-term emergency shelter care.

- ***Innovative Housing Solutions:*** Pilot programs with unique and creative approaches to addressing unmet housing needs and historic disparities within housing, including solutions such as:
  - Eviction diversion and prevention programming.
  - Outreach and supportive services for tenants.
  - Legal assistance or representation.
  - Landlord/tenant mediation.
  - Magisterial District Judge partnership programs.
  - Creative housing solutions, including shared housing, elder cottages, etc., to address housing needs for at-risk communities.

- ***Homeownership:*** Development of affordable for-sale housing units for low-to-moderate-income households.

- ***Housing Counseling and Financial Education:*** Activities providing various types of housing counseling, including:
  - Pre- and post-purchase financial education.
  - Foreclosure prevention.
  - Other forms of direct client counseling to assist homeowners or renters.

Finally, PHFA's newest funding priority, the Health for Housing Investment, is discussed in greater detail below.

Health for Housing Investment. The PHARE Health for Housing Investment is a funding initiative prioritizing housing as an SDOH.

This initiative encourages housing and community developers, who may apply annually, to seek partnerships with hospitals or health systems to enhance health and housing conditions in Pennsylvania. Healthcare entities may include healthcare payers such as managed care organizations (MCOs) and other insurers, healthcare providers such as hospital systems, and health conversion foundations.[153]

The PHFA's investment comprises $10 million of PHARE funds to match the healthcare entity's capital contribution. Officially launched in FY 2023-24, PHFA was finalizing its application review for the Health for Housing Investment initiative at the time of this report; therefore, no funding awards data is available.[154]

The Health for Housing Investment is a supplemental capital investment for eligible applicants to PHFA's four and nine percent Low-Income Housing Tax Credits (LIHTC) programs. While both tax credits are federally authorized tax exemptions, the nine percent LIHTC is a competitive tax credit that generates more equity for developers than the non-competitive four percent tax credit. As shown in Exhibit 65, the four and nine percent tax credit programs also have varying application periods, requirements, and limitations.

Exhibit 65

Four Percent and Nine Percent LIHTC Programs Overview

Key Characteristics	Nine Percent LIHTC Program	Four Percent LIHTC Program
Overview	Federal Tax Credit; 15-year initial compliance period; an additional 25-year extended use period.[a]	Federal Tax Credit; 15-year initial compliance period; an additional 25-year extended use period.
Tax-Exempt Volume Cap Allocation	Not paired with an allocation of Tax-Exempt Volume Cap.[b]	Paired with an allocation of Tax-Exempt Volume Cap.
Competition for Funding	Competitive. PHFA will accept Intents to Submit and applications annually for competitive funding.	Not competitive. PHFA will accept Intents to Submit and full applications throughout a portion of the year and will have two separate due dates for non-competitive funding.
Eligible Fund Usage	Can be used for both construction and preservation projects.	Can be used for both construction and preservation projects.

[153] A health conversion foundation is a type of charitable organization that is created when a nonprofit healthcare entity is sold or transitions to a for-profit business. The proceeds from these transactions are transferred into the endowment of a foundation that maintains the general mission of the original entity.
[154] PHFA staff noted that health had previously been prioritized in the PHARE program, but FY 2023-24 is the first time it has been formalized as a funding priority.

Rehabilitation Requirements	Rehabilitation is required for preservation projects. At least two of the following four systems - electrical, HVAC, plumbing, and elevators - must necessitate replacement. Construction expenses must be at least 40 percent of the building's replacement value.	Rehabilitation is required for preservation projects: At least two of the following four systems - electrical, HVAC, plumbing, and elevators - must necessitate replacement. Construction expenses must be at least 40 percent of the building's replacement value.
Bond Test Requirement	Projects are not required to meet the 50 percent bond test.[c]	Projects are not required to meet the 50 percent bond test.
Expenditures Test Requirement	Projects are required to meet the 10 percent expenditures test.[d]	Projects are not required to meet the 10 percent expenditures test.
Application Limit	Developers are limited to applying for four nine percent LIHTC developments per application cycle.	Developers are limited to applying for two four percent LIHTC developments per application cycle.

[a] The compliance period is the initial 15-year period after the developer receives the tax credit. During this period, the tax credits can be taken away or "re-captured" if the property fails to comply with LIHTC regulations. The extended use period is the subsequent time after the compliance period in which the developer must agree to provide affordable housing for at least 25 years.
[b] The Tax-Exempt Volume cap limits the amount of tax-exempt financing activity within a calendar year.
[c] Under Internal Revenue Code (IRC) Section 42(h)(4)(B), developers applying for tax credits can obtain the four percent LIHTC if the project is financed with at least 50 percent tax-exempt bonds from a state's bond volume cap. If tax-exempt bonds are less than 50 percent of a project's financing, then the developer receives only part of the four percent LIHTC based on that percentage.
[d] To meet the 10 percent test for low-income housing tax credits, a development must incur 10 percent of its reasonably expected basis (REB) by the date prescribed by its state's tax credit allocating entity. An asset's REB is its total cost after including costs of improvements and tax benefits.

Source: Developed by LBFC staff from information obtained from PHFA.

As part of its initiative, PHFA has committed to setting aside at least one nine percent tax credit for eligible projects per application cycle. The project must include funding contributions from a participating healthcare entity towards capital financing in the form of a grant, loan, debt, or the contribution of land or existing structure. The minimum capital contribution from a healthcare entity is at least $100,000.

PHFA will match the capital contribution made by healthcare entities to a maximum of $2 million for nine percent LIHTC developments and $1.5 million for four percent developments. For instances where the healthcare entity's contribution is in the form of a land donation, PHFA will match up to 50 percent of the land's "as is" appraised value.

In the most recent application cycle, PHFA received nine letters of intent and six complete applications for the nine percent LIHTC program, with roughly $3 million in health entity commitments for project capital investments. These applications were from Philadelphia, Bucks, Allegheny, and Susquehanna counties. PHFA received no letters of intent or complete applications for the four percent LIHTC program. PHFA made its first award of $1.8 million in match-dollar funding to four projects in Philadelphia and Bucks Counties this July.

Home4Good Program

Home4Good is a joint initiative developed and operated by the Federal Home Loan (FHL) Bank of Pittsburgh and various state-affiliated housing agencies, including PHFA, to address unmet and critical needs in the existing Continuums of Care across Pennsylvania.[155] This is done by providing additional funding to local service organizations that assist the homeless and those at risk of homelessness. FHL Bank of Pittsburgh provides funding to its housing agency partners, who distribute those funds.

The Home4Good program in Pennsylvania operates as a block grant. Applicants apply annually for Home4Good grants through PHFA. Exhibit 66 includes the Home4Good funding allocations to Pennsylvania's CoCs between CYs 2018 and 2022.

Exhibit 66

Home4Good Funding Allocations to Pennsylvania CoCs
(CYs 2018 to 2022)

CoC	2018	2019	2020	2021	2022	2023
Beaver County	$59,850	$65,100	$75,000	$63,000	$50,000	$53,000
Bristol, Bensalem/Bucks County	52,500	52,500	75,000	52,500	50,000	50,000
Chester County	73,500	99,750	100,000	77,700	50,000	72,000
Harrisburg/Dauphin County	75,600	76,650	100,000	72,945	50,000	62,000
Lancaster City and County	105,000	95,600	100,000	88,046	50,000	83,000
Eastern Pennsylvania	514,188	519,002	525,000	470,400	204,000	428,000
Erie City and County	96,600	94,500	100,000	82,425	50,000	78,000
Scranton/Lackawanna County	120,750	121,800	125,000	106,575	50,000	100,000

[155] FHL Bank of Pittsburgh also operates the Home4Good program in collaboration with the Delaware State Housing Authority and the West Virginia Housing Development Fund.

Lower Merion, Norristown, Abington, Montgomery County	131,250	134,400	125,000	115,500	52,000	109,000
Philadelphia City and County	1,487,325	1,472,000	1,250,000	1,285,333	577,000	1,207,000
Pittsburgh, McKeesport, Penn Hills/Allegheny County	791,734	743,306	1,000,000	712,583	320,000	674,000
Reading/Berks County	126,000	126,000	125,000	112,350	50,000	104,000
Upper Darby, Chester, Haverford/Delaware County	210,500	215,250	225,000	189,000	85,000	179,000
Western Pennsylvania	405,803	325,250	425,000	360,544	162,000	341,000
Wilkes-Barre, Hazelton/ Luzerne County	181,650	72,188	75,000	110,250	50,000	104,000
York City and County	57,750	77,700	75,000	59,850	50,000	56,000

Source: Developed by LBFC staff from information obtained from PHFA.

B. Veterans' Housing Programs

According to the Pennsylvania Department of Military and Veterans Affairs (DMVA), Pennsylvania has over 700,000 veterans, the fourth-largest population in the nation. As of the Point-In-Time Count in 2023, 826 were homeless.[156] The DMVA administers several programs for homeless veterans and their families.[157]

Veterans' Temporary Assistance (VTA) Program

The VTA program provides eligible Pennsylvania veterans and their beneficiaries with financial assistance if they experience an unexpected financial hardship. The aid, up to $1,600 in 12 months, may be used for necessities such as food, shelter, fuel, and clothing.

The VTA is authorized in Title 51, Chapter 85 and enacted in 1988 as the Emergency Assistance Program until amended in 2016 to Veterans Temporary Assistance. Without General Assembly funding since 2017, currently, funding comes from the Veterans' Trust Fund (VTF), which has provided over $3.3 million in 2,250 grants over five years, as shown in Exhibit 67.

[156] A point-in-time count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January. HUD requires a point-in-time count for communities that receive federal funding for homelessness. CoCs completed the point-in-time count in January 2024, but the numbers have not yet been certified.

[157] HUD's Housing Choice Voucher program includes a special program voucher specifically for veterans, the HUD-Veterans Affairs Supportive Voucher, or HUD-VASH. HUD-VASH is discussed in Section V of this report.

Exhibit 67

VTA Grants Awarded
(FYs 2018-19 to 2022-23)

Fiscal Year	Number of Grants Awarded	Amount Awarded
2018-19	565	$798,636
2019-20	485	702,447
2020-21	324	468,549
2021-22	415	602,475
2022-23	461	686,134
Total	**2,250**	**$3,258,241**

Source: Developed by LBFC staff from information obtained from DMVA.

Eligibility guidelines require the applicant to have actively served in and been honorably discharged from the United States Armed Forces or have suffered a service-related disability.[158] Surviving beneficiaries become eligible if their veteran dies in service or is killed in action, but a surviving spouse must remain unmarried to be eligible.

Veterans' Trust Fund (VTF)

The VTF, through partnerships built by the DMVA with charitable organizations, veterans' service organizations, and county directors of veterans' affairs, assists and supports Pennsylvania veterans and their families.

The VTF, established in 2012, is a special, non-lapsing fund within the Pennsylvania State Treasury for which the DMVA is authorized to solicit and accept donations. Since its inception, the VTF has awarded over $82 million to over 100,000 servicemembers, veterans, and their families.

The VTF is funded by charitable contributions, with 100 percent of the money going directly to VTF grants for new, innovative, or expanded programs or projects that support Pennsylvania veterans and their families in need of shelter. The DMVA does not collect any money for the administrative costs, salaries, or contracts associated with administering this program. Funding sources include:

- Individuals who donate $5.00 (one year) or $10.00 (two years) when renewing their Pennsylvania driver's licenses or photo identification cards.
- PennDOT, which sells "Honoring Our Veterans" and "Honoring Our Women Veterans" license plates. For each plate sold, $15.00 is donated directly to VTF.

[158] Individuals receiving a dishonorable discharge or court-martial are excluded from SSVF eligibility.

- Individuals, businesses, and government agencies can make state tax-deductible grants, gifts, or charitable contributions directly to the VTF using the commonwealth's tax identification number, 23-6002830.
- Proceeds from the 2012 sale of the Scotland School for Veterans' Children.
- Fines related to wearing uniforms and insignia that misrepresent military service or honors.
- State Employee Combined Appeal campaign under the umbrella of The United Way of the Capital Region.

The VTF issues grants to charitable organizations, veterans service organizations, and county veterans' affairs offices for new, innovative, expanded programs or services that increase or improve services to veterans and their families in their counties or regions. Examples of eligible housing-related expenditures are programs that serve homeless and at-risk for homelessness veterans and their families and programs that provide safe housing for female veterans.

From FY 2018-19 to 2022-23, the VTF issued grants totaling $4,550,000 to 111 charitable organizations and 47 County Directors for Veterans Affairs over five years. Exhibit 68 illustrates the grants awarded.

Exhibit 68

VTF Grants[a]
FYs 2018-19 to 2022-23

Fiscal Year	Number of Grants Awarded	Amount Awarded
2018-19	27	$800,000
2019-20	26	800,000
2020-21	28	800,000
2021-22	46	1,350,000
2022-23	31	800,000
Total	**158**	**$4,550,000**

[a] Amounts awarded represent all eligible allowable expenditures, not solely those related to housing.

Source: Developed by LBFC staff from information obtained from DMVA.

PA VETConnect

PA VETConnect is a network of organizations that connects homeless veterans and their families to services such as health care, homelessness, food insecurity, financial assistance, employment, mental health

disorders, and substance abuse. The DMVA has indicated it is ready to collaborate with PA Navigate to better serve Pennsylvania veterans and their families (See Section III for information regarding PA Navigate).

Military Family Relief Assistance Program (MFRAP)

The MFRAP, signed into law as Act 2005-65, provides financial assistance through grants to eligible Pennsylvania service members, veterans, and their families. There must be a direct and immediate financial need due to circumstances beyond their control resulting from military service that did not result from misconduct. The maximum assistance that can be awarded is $5,000 in 12 months. An individual can apply on the DMVA's website. The MFRAP grants can be used for housing, food, childcare, utilities, medical needs, insurance, and vehicle payments, among other things.

The MFRAP is funded through voluntary, state tax-deductible donations or designation from Pennsylvania Personal Income Tax refunds. All money goes directly into a fund established at the DMVA and is used solely for relief grants and administrative costs.

From FY 2018-19 through FY 2022-23, $147,738 was distributed through 50 grants, as shown in Exhibit 69.

Exhibit 69

MFRAP Grants
(FYs 2018-19 to 2022-23)

Fiscal Year	Number of Grants Awarded	Amount Awarded
2018-19	14	$44,658
2019-20	5	16,000
2020-21	4	14,000
2021-22	8	17,000
2022-23	19	56,080
Total	**50**	**$147,738**

Source: Developed by LBFC staff from information obtained from DMVA.

C. Other Stakeholder Programs

Many nonprofit organizations throughout the state work to assist low-income and homeless people in navigating available programs that help

them obtain a healthy living environment and achieve good health. A brief search on Guidestar brought up 180 organizations in Pennsylvania that provide homeless services and 173 that provide homeless shelters.[159]

Throughout our work, we spoke to numerous nonprofit organizations that assist the homeless or those at risk of homelessness, several of which are highlighted below.

United Way/PA-211

PA-211 is a subsidiary of the United Way of Pennsylvania. The organization is a comprehensive resource for health, housing, and human services assistance and referrals, which includes:

- ***Basic Human Needs Resources***: Food banks, supplemental food and nutrition programs, shelters, rent, and utility payment assistance.
- ***Physical and Mental Health and Substance Abuse Resources***: Healthcare, vaccination, health epidemic information, crisis intervention services, support groups, counseling, a confidential path out of physical or emotional domestic abuse, addiction prevention, and rehabilitation programs.
- ***Employment Support***: Financial assistance, job training, and education programs.
- ***Support for Older Adults and Persons with Disabilities***: Home-delivered meals, transportation, and healthcare.
- ***Services for Veterans.***
- ***Reentry Help for Ex-Offenders.***
- ***Youth and Childcare Programs***: After-school programs, summer camps, mentoring, and protection services.
- ***Emergency Information and Disaster Relief.***

In addition, PA-211 is partnered with the Pennsylvania Emergency Management Agency, local Voluntary Organizations Active in Disasters, and other emergency management agencies to respond to localized natural disasters in Pennsylvania. PA-211 is also part of a national contact center network that responds to flooding, wildfires, hurricanes, and human-caused disasters.

Individuals and families in need can get help 24 hours a day, seven days a week, in more than 170 languages and dialects. There are three modes of access: phone (2-1-1), text messaging (898-211), or through 211's online database. All calls to PA-211 are free and confidential.

[159] GuideStar is a web-based source of information about nonprofit organizations in the United States. It collects, organizes, and presents data from the IRS and other sources to assist people in making informed decisions about nonprofits.

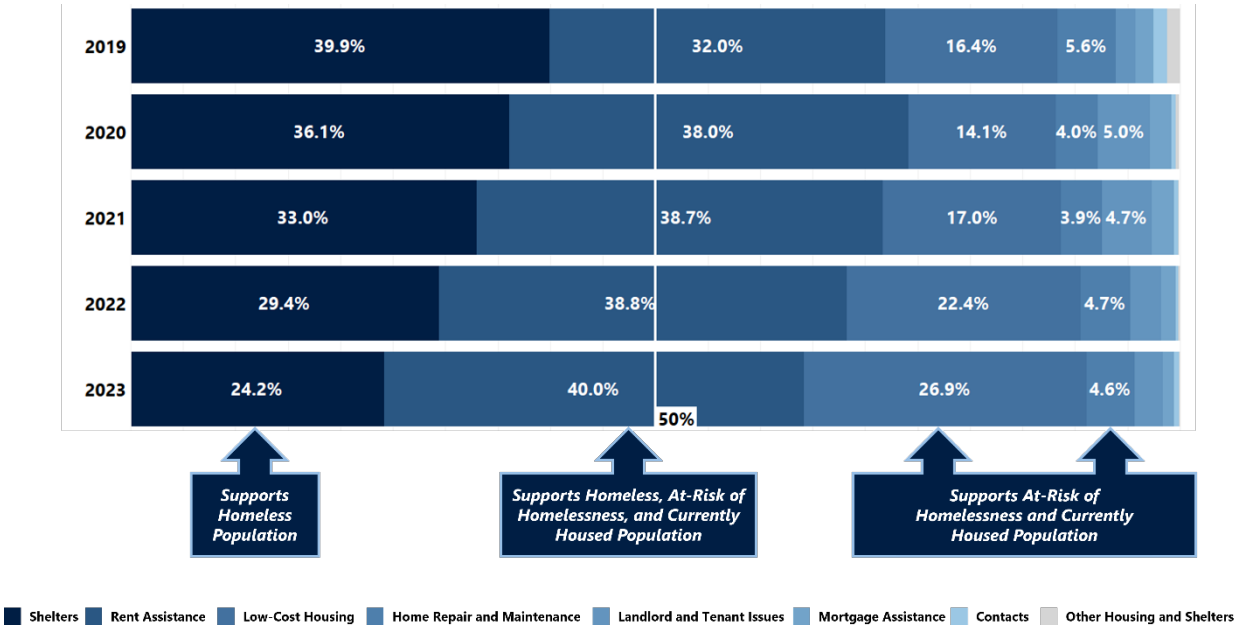
Trained specialists connect callers to vital resources, such as housing, utilities, food, employment and expenses, health, and mental health.

Through an online dashboard, PA-211 Counts, PA-211 tracks the community-specific needs of Pennsylvanians seeking resources in real-time and provides a snapshot of those needs across the commonwealth. The dashboard allows communities to search call data by zip code, district, county, and region to identify the requested resources. In CY 2021, PA 211 made over 131,000 connections to address and prevent homelessness.

To understand caller needs pertaining to housing and shelter across the commonwealth, we obtained additional data from PA-211. The housing and shelter category included data for shelters, low-cost housing, home repair/maintenance, rent assistance, mortgage assistance, landlord/tenant issues, contacts (for shelters and housing organizations), and other housing and shelter-related information. Exhibit 70 shows the percentage of housing and shelter-related calls and requests received by PA-211 between CYs 2019 and 2023.

Exhibit 70

PA-211
Percentage of Calls and Requests Related to Housing and Shelter
(CYs 2019 to 2023[a, b])



[a] Caller request data for CY 2019 is only available from June through December.
[b] Total housing request percentages include web-based requests.

Source: Developed by LBFC staff from information obtained from PA-211.

During our review period, the top three request categories were shelter, rent assistance, and low-income housing. The percentage of caller-identified needs from 2019 to 2023 decreased year-over-year within the shelter category. However, within the rental assistance category, caller-identified needs increased year-over-year during the same period. Lastly, caller-identified needs calls within the low-income housing category slightly decreased from 2019 to 2020, followed by an increase from 2020 to 2023. In 2023, PA-211 received 375,430 housing requests, of which 91 percent were requests for shelters, rental assistance, and low-income housing.

The average number of calls annually to PA-211 across the five years was 233,526, while the average number of total requests, whether from telephone, text, or website, was 289,685. Of those total requests, 176,688 (61.0 percent) were for housing and shelter.

Lastly, PA-211 performs the coordinated entry intake process for the Eastern PA CoC, Berks County CoC, Lancaster County CoC, Harrisburg/Dauphin County CoC, York County CoC, Chester County CoC, and partial intake for Western PA CoC.

Second Avenue Commons

Pittsburgh's Second Avenue Commons, which opened in 2019, collaborates with Pittsburgh Mercy, University of Pittsburgh Medical Center (UPMC), Allegheny County Department of Human Services, and Community Kitchen Pittsburgh. The organization serves those without permanent, stable housing and is part of a safety net serving adults on the spectrum of homelessness.

The Second Avenue Commons facility offers a variety of services and supports, including:

- Low-barrier emergency shelter with 95 beds, operated by UPMC Mercy.
- Drop-in day program, open Monday through Friday, for individuals to do laundry, obtain food, receive counseling, etc.
- A medical and behavioral health clinic staffed by UPMC.
- Forty-three single occupancy units for unhoused individuals with medical, addiction, or behavioral health needs.
- Professional kitchen with job training opportunities.
- Home base for street outreach workers.

The facility provides wrap-around services to address the complex issues facing those experiencing homelessness. Individuals are welcome to stay as long as they desire.

The $22 million facility was partly funded through donations from private companies, notably PNC Bank, UPMC, and the Highmark/Allegheny Health Network. The clinic is now supported by funding from UPMC; however, 95 percent of the individuals who receive services at Second Avenue Commons are enrolled in the commonwealth's HealthChoices program.

Project HOME

Operating for over 35 years, Project Home in Philadelphia provides various housing and housing supports, ranging from safe havens to over 1,000 units of permanent supportive housing. On behalf of the City of Philadelphia and through its Outreach Coordination Center, teams of outreach professionals from five nonprofit health and social service organizations provide 24/7 street outreach coverage for homeless individuals.

Project HOME offers services and activities through four components:

- ***Housing*:** Housing and support services are primarily for people who are unsheltered or at risk of becoming unsheltered and who generally have a history of mental illness or addiction.

- ***Opportunities for Employment*:** Project HOME provides computer classes, career training, job readiness workshops, life skills workshops, GED classes, adult basic literacy classes, and access to other resources to help residents improve their lives, gain employment, and pursue higher education. Additionally, residents have opportunities to learn new skills, enter or re-enter the workforce, and increase income with Social Enterprises.[160]

- ***Medical Care at the Stephen Klein Wellness Center (SKWC):*** The SKWC offers primary medical care, dental care, psychiatric services, nurse care management, individual, couples, and group counseling, peer-led outreach and care coordination, healing touch, and assistance with applying for health insurance.

- ***Education:*** The Honickman Learning Center Comcast Technology Labs (HLCCTL) reflects the understanding of the intrinsic link between lack of educational opportunity and poverty. At the HLCCTL, Project HOME provides educational programs that offer the most current computer literacy and equal opportunity learning to at-risk children, youth, and families.

[160] Social Enterprises is a group of small businesses that act as a supportive and skill-building environment for Project HOME residents. The businesses are fully staffed by residents, providing them with an opportunity to overcome barriers to employment.

With the aid of a $25 million grant, Project HOME is implementing the Estadt-Lubert Collaborative in conjunction with Penn Medicine, Temple, and Jefferson Health Systems. The collaborative is focused on those impacted by the opioid epidemic and has a three-pronged approach that includes integrated healthcare, permanent supportive housing, and employment and wellness. Project HOME expects the program to be financially stable within five years. It is working on a memorandum of understanding with its partner health systems to funnel any realized savings back to Project HOME.

NewCourtland

In Philadelphia, NewCourtland's supportive housing program, which started in 2019, aims to prevent people from returning to homelessness through coordinated health, housing, and social services. It has an interdisciplinary team consisting of a property manager, nurse, and housing coordinator located on-site at the housing properties, typically near one of NewCourtland's nursing facilities. The program helps residents' structure individualized goals around stabilizing their health, finances, and roles in the community. Forty-one people have participated in the program since 2019.

Most of NewCourtland's referrals come from community providers and, most commonly, from veterans' organizations, as about 90 percent of the program's participants have a military background. The program is a low barrier, meaning that the organization will take individuals deemed ineligible for other programs due to their criminal or poor financial backgrounds. Other programs may not take veterans with dishonorable discharges, or veterans may no longer be eligible for HUD-VASH vouchers because they were previously housed. A NewCourtland official explained that HUD guidelines may prevent individuals with criminal records or poor credit scores from participating in many housing assistance programs.

The program caps rent at 30 percent of participants' income. NewCourtland absorbs about $600 per unit per month (not including service coordination costs) to keep a resident housed instead of receiving the fair market rent. NewCourtland stated that its organization is willing to cover that difference because the cost of relocating individuals would be much higher.

Pathways to Housing PA

In 2008, the City of Philadelphia contracted with Pathways to Housing PA to help end chronic homelessness in the city. The program only accepts referrals from the city. It engages a housing first philosophy - a housing assistance approach that says the basic need for housing must

be met before other issues, such as physical and mental health, can be effectively addressed. Many Pathways participants have serious, chronic, and untreated medical problems that have often been neglected.

Over 600 individuals are housed through Pathway's Housing First program, which provides comprehensive wraparound services to support participants. Pathways rents vacant market-rate apartments in Philadelphia, helping to retain the tax base.

Pathways formed the Integrated Care Clinic to address medical needs, which include:

- Primary medical care.
- Behavioral Health and psychiatric care.
- Nurse care management.
- Peer-led outreach.
- Care coordination.
- Assistance with applying for health care benefits.

Pathways provides these services in partnership with Thomas Jefferson University Department of Family and Community Medicine and Project HOME's Stephen Klein Wellness Center.

Pathways also has an Assertive Community Treatment program, which consists of high-level treatment teams that serve about 80 people on the street with case management, psychiatric care, and peer specialists. Three of the eight teams specialize in substance abuse and opioid addiction.

According to Pathways, housing the homeless is less expensive than letting them remain on the street, stating that "it costs us less to house a person than it does to let them continue to be homeless. If you add up all the costs involved with a person living unsheltered (prison, ambulance services, police interventions, emergency department visits, medical and psychiatric hospitalizations, soup kitchens, shelter nights), it averages out to be much more than the cost of subsidizing rent and providing appropriate services."

D. Other Programs with Housing Impacts

While not directly in the healthcare sector, other initiatives impact an individual's ability to obtain safe, affordable housing, which can have a downstream effect on health. This section discusses three programs in the commonwealth: optional county affordable housing funds, county demolition funds, and eviction protection projects.

Optional County Affordable Housing

Act 1992-137 (Act 137), known as the Optional County Affordable Housing Funds Act, allowed 66 of the state's 67 counties (excluding Philadelphia) to raise revenues and establish county-operated trust funds for affordable housing. Act 137 stipulates that monies from the fund must be expended on projects and programs that improve the availability, accessibility, or quality of affordable housing and must be approved by the county commissioners or appropriate governing entity.

Affordable housing may be accessed through sale or rental to county residents whose annual income does not exceed the county's median income as established by HUD. Counties generate revenue for the housing trust fund by collecting a supplemental recording fee on deeds and mortgages in addition to base recording fees charged by the county recording office. Act 137 indicates that any supplemental recording fee may not exceed 100 percent of the base recording fee charged by counties on February 12, 1993, for non-first-class cities.

In 2005, the General Assembly repealed Act 137 and replaced it with an amendment to Title 53 (Municipalities Generally). Act 2005-49 (Act 49) reenacted the former law and added a provision permitting Philadelphia to establish and contribute to an affordable housing trust fund using deed and mortgage recording fees. Act 49 also allows Philadelphia to use these funds for housing activities, serving households with incomes up to 115 percent of the county median. Supplemental recording fees levied by Philadelphia were not permitted to exceed 100 percent of the base recording fee charged by counties on January 31, 2005.

Neither Act 137 nor Act 49 included formal procedural requirements for counties that opt to use an affordable housing fund. As a result, counties distribute, manage, and collect revenue for affordable housing trust funds differently.

The statute provides some operating guidelines for affordable housing funds. Counties with affordable housing trust funds must first deposit collected funds into the county general fund. Money collected from the fee can be allocated as follows:

- At least 85 percent of the money collected must be set aside in a separate account to fund the county's affordable housing efforts.
- A county may use not more than 15 percent of the collected funds for administrative costs.

Counties allocate these revenues to their affordable housing funds on a rolling basis. Some counties use additional revenue streams to supplement their affordable housing trust funds by collecting repayments on the following initiatives that utilize Act 137 funds:

- Mortgages for first-time homebuyers.
- Soft second mortgages.
- Loans extended to affordable housing developers.

Since Act 49 does not include any formal reporting requirements, there is a lack of accessible data regarding these funds. However, in 2019, the Pennsylvania Housing Finance Agency surveyed 29 of the 53 counties with affordable housing funds to provide updated information on their status.

As shown in Exhibit 71, counties reported the most common uses of funds were new affordable housing production (59 percent of surveyed counties), first-time homebuyer closing costs and down payment assistance (55 percent), and home rehabilitation and repair (55 percent). In addition, some counties allocated these funds towards homeless-oriented aid, such as homeless services (28 percent), shelter operations and maintenance (28 percent), and new shelter production (17 percent).

Exhibit 71

Common Uses for Act 137 Funds by Surveyed Counties
(CY 2019)

Use	Counties	Percent
New affordable housing production	17	59%
First-time homebuyer closing cost and down payment assistance	16	55
Home rehabilitation and repair	16	55
Federal/state match or leverage	14	48
Other emergency assistance and maintenance	10	34
Affordable housing operations and maintenance	9	31
Homeless services	8	28
Shelter operations and maintenance	8	28
Blight program/rehabilitation	7	24
Habitat Homeownership	7	24
Housing counseling	6	21
New shelter production	5	17
Emergency rental assistance	4	14
Home Accessibility	4	14
Other rental assistance	3	10
Fair housing	3	10

Source: Developed by LBFC staff from information obtained from PHFA.

The majority, 59 percent, of the surveyed counties accept applications on a rolling basis rather than holding a formal funding cycle. Other approaches include issuing a request for proposal with a deadline or maintaining a formal annual application cycle. Several counties integrate requests for Act 137 funding with requests for HUD, Community Development Block Grant, and HOME funding or tie the process to the county's annual budget cycle. Applications are accepted on an ongoing basis in counties with first-time homebuyers or homeowner repair programs.

Because 25 counties in the PHFA housing trust fund report reported the additional fee is at the maximum statutorily allowed levels, and because the maximum allowable fee had not been raised since implementation for Philadelphia in 2005 and all other counties in 1992, we recommend that the General Assembly consider allowing all counties the flexibility to increase the amount of the maximum

allowable fee commensurate with their current recording fees, and subsequently index the fee maximum for inflation.

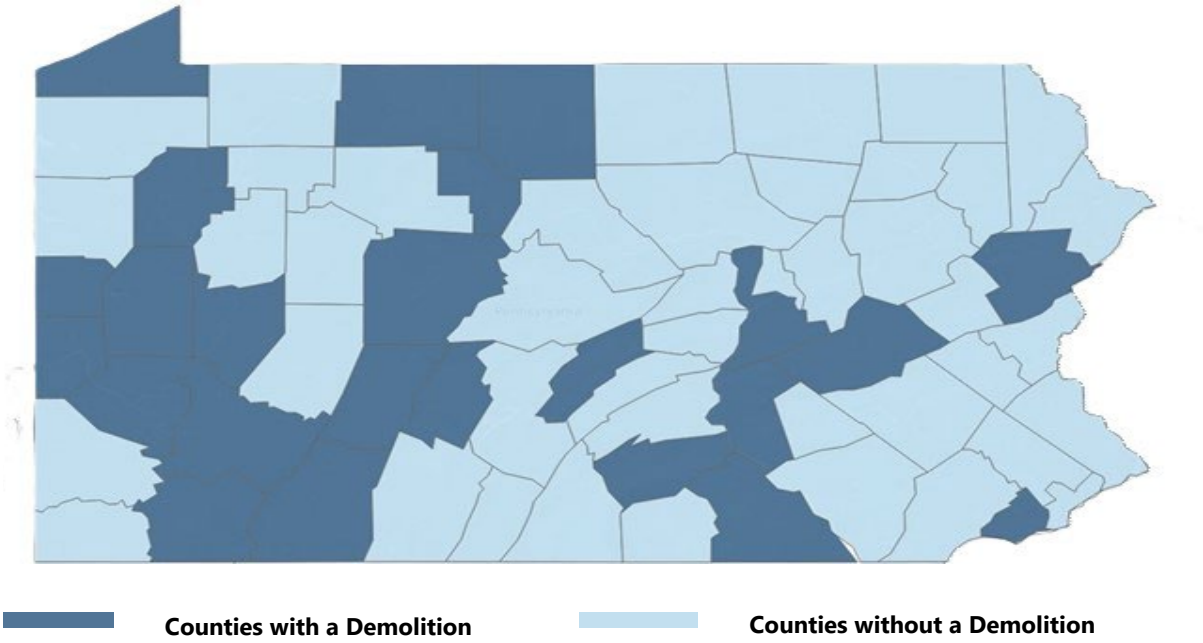
County Demolition Funds

Act 2016-152 (Act 152) allowed counties to charge and collect an additional fee, not exceeding $15, for deeds and mortgages recorded in the county to be deposited into a demolition fund. Monies collected from this fee may only be used to demolish blighted property. Blighted property is defined as an abandoned property that meets at least three of the criteria listed under section 5(d) of the Abandoned and Blighted Property Conservatorship Act of November 26, 2008 (P.L.1672, No.135). Primarily, blighted property is defined as any premises which, because of physical condition or use, has been declared a public nuisance in accordance with local housing, building, plumbing, fire, and related codes.

Exhibit 72 illustrates 25 counties that have established demolition funds and submitted annual reports to the Pennsylvania Department of Community and Economic Development (DCED).

Exhibit 72

Counties with Demolition Funds
(CY 2024)



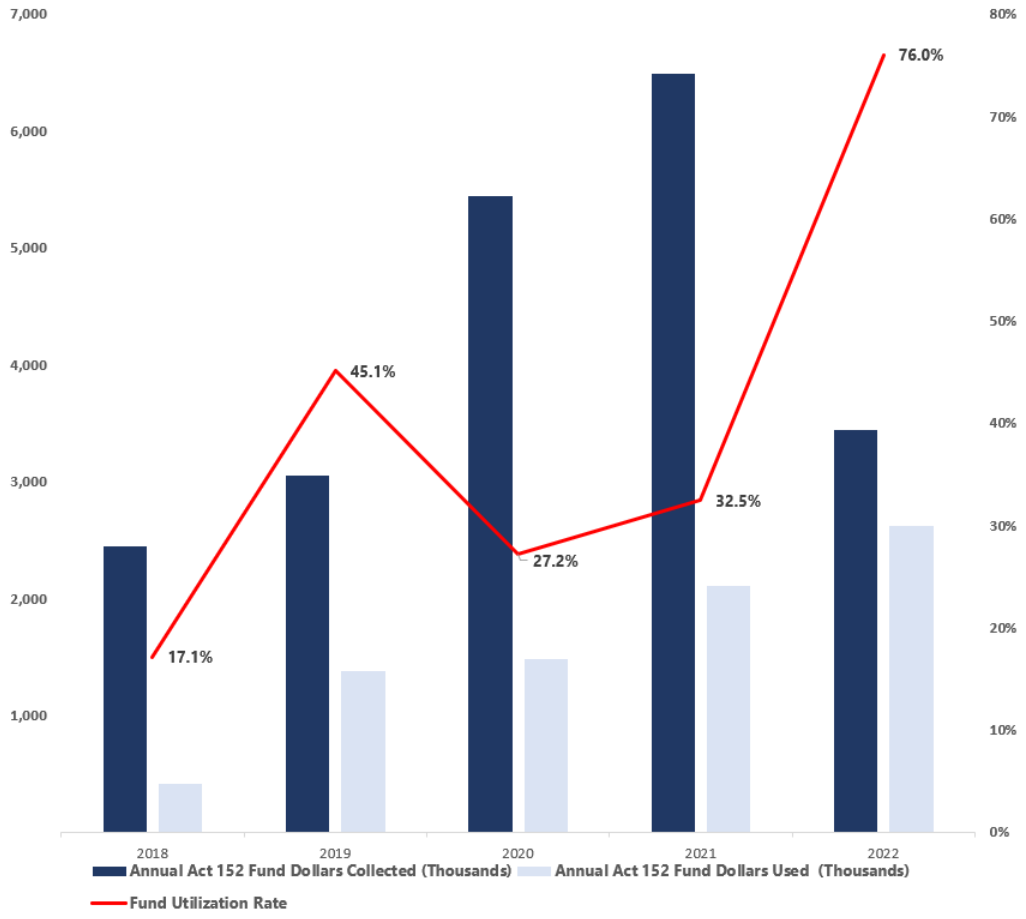
rce: Developed by LBFC staff from information obtained from DCED.

The reports detail the number of properties demolished and the cost of demolition per property. Since Act 152 became effective in 2017, counties with demolition funds have collected $21.2 million from fee increases and have demolished 398 blighted properties.

Most of these funds do not get dispersed in a fiscal year. As shown in Exhibit 73, the average fund utilization rate across all demolition funds since 2017 was 39.6 percent. Unused funds remain in the county's demolition fund and roll into subsequent fiscal years. Delaware, York, and Westmoreland counties have used the most funds for blight demolition, spending $1.7 million, $1.1 million, and $828,000 of Act 152 funds, respectively, since 2017.

Exhibit 73

Annual County Demolition Fund Collections (thousands) and Utilization Rate
(CYs 2018-2022)



Source: Developed by LBFC staff from information obtained from DCED

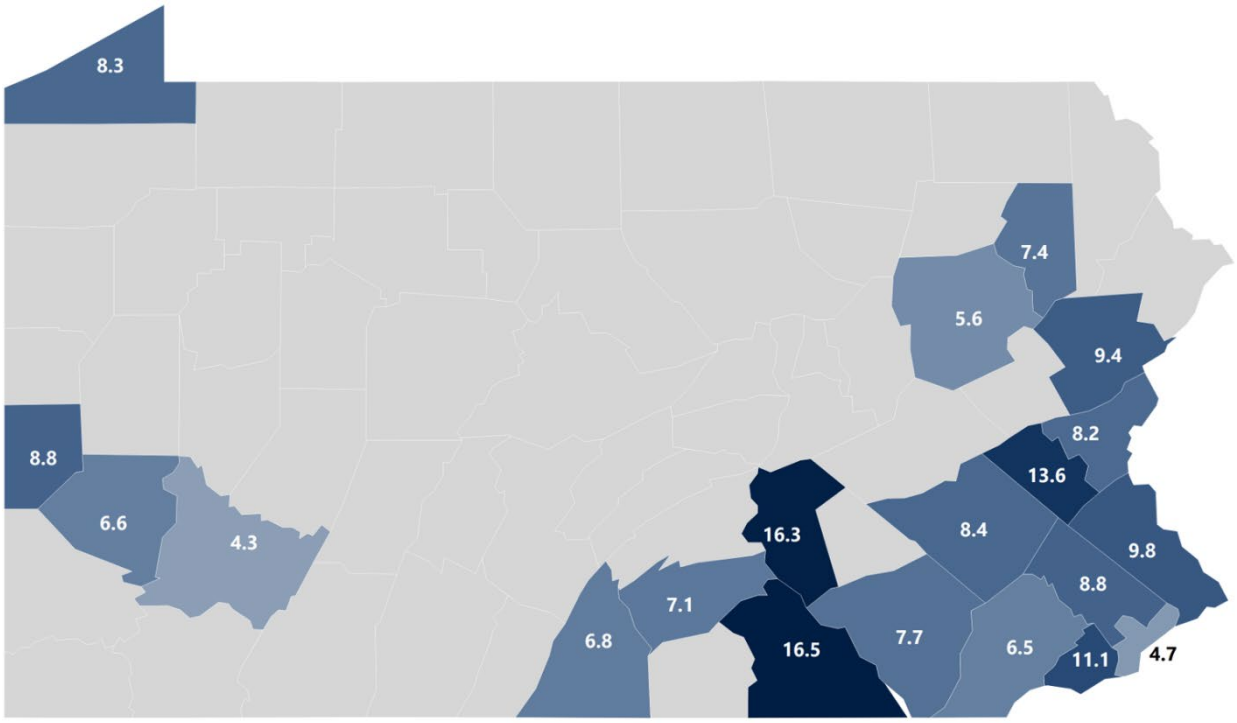
Evictions in Pennsylvania

Evictions pose a barrier to Pennsylvanians accessing stable housing opportunities and are one of the most common causes of homelessness. According to the Housing Alliance of Pennsylvania, more than a third of people experiencing homelessness report eviction as a cause of housing instability.

Pennsylvania had 113,183 eviction filings from July 2022 to June 2023. Statewide, the eviction filing rate, defined as the number of eviction filings per 100 rented homes, was 7.3. Exhibit 74 shows York County had the highest eviction rate, 16.5, followed by Dauphin County at 16.3.

Exhibit 74

Top 20 Counties with Highest Eviction Rates
(July 2022 to June 2023)



Source: Developed by LBFC staff from information obtained from the Housing Alliance of Pennsylvania.

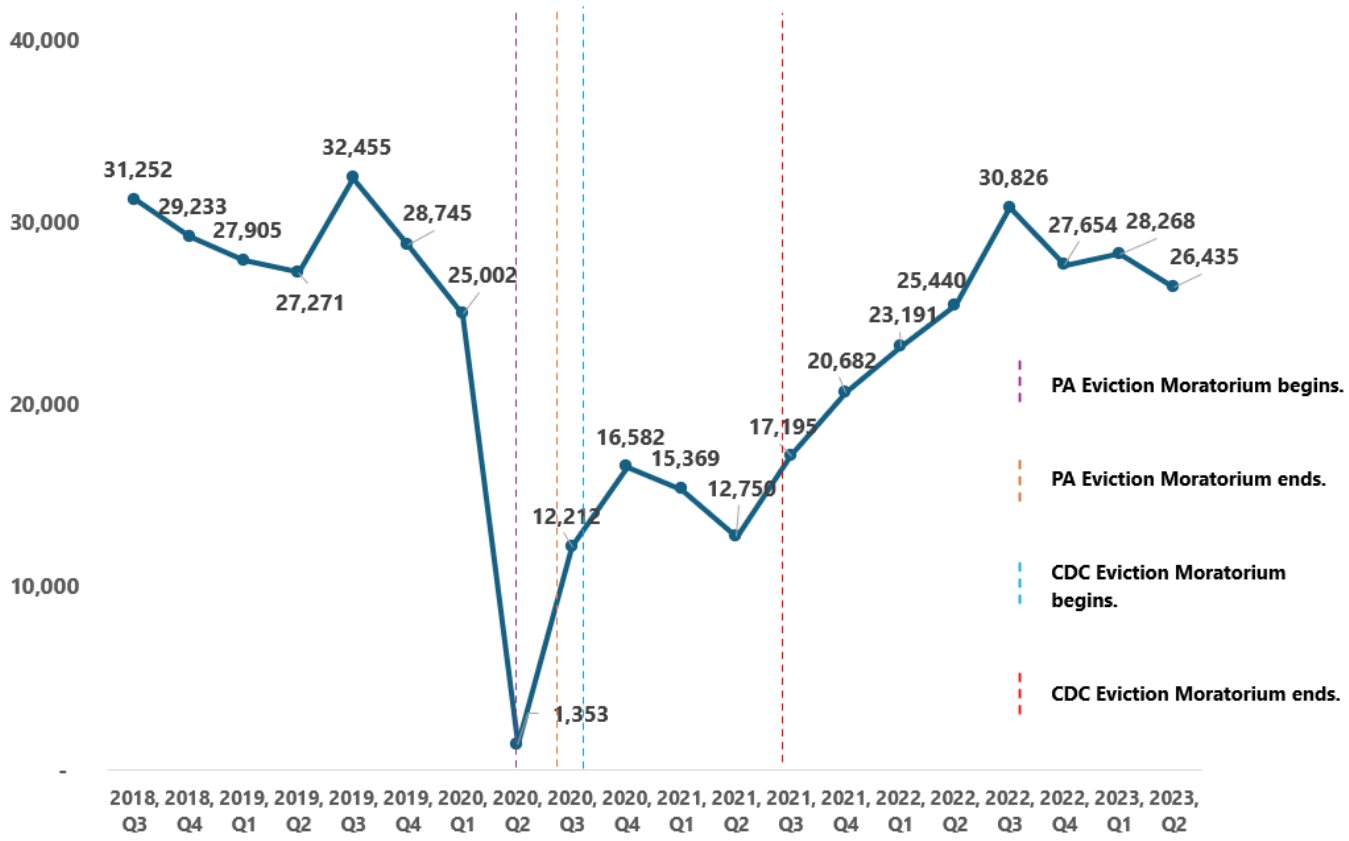
Because eviction protection was a public concern during the COVID-19 pandemic, the federal CARES Act prohibited evictions for nonpayment of rent from March to August 2020, with several more extensions at the state level. The Centers for Disease Control (CDC) issued another

moratorium in September 2020. The US Supreme Court ruled that the CDC moratorium would end in August 2021.

Exhibit 75 shows the number of evictions in Pennsylvania by quarter between the third quarter of 2019 and the second quarter of 2023.

Exhibit 75

PA Evictions by Quarter



Source: Developed by LBFC staff from information obtained from the Housing Alliance of Pennsylvania.

Individuals with eviction records have more difficulty finding housing, regardless of the outcome of their cases or the elapsed time since their last evictions. These challenges arise partly because there is no legal mechanism for sealing an eviction filing or expunging it from a tenancy record.

Landlords' inaccurate interpretations of eviction records and third-party tenant screening reports are also a barrier. Landlords screening a

potential tenant can access publicly available court files of any eviction cases in which the applicant was previously involved. This screening method can be error-prone, as landlords may not interpret certain case dispositions correctly or may encounter name-matching issues that can arise when accessing open databases with a substantial number of names.[161] This can lead to prospective tenants being wrongfully deemed high-risk, even if the court ruled in their favor or the landlord wrongly filed a notice.

Additionally, many landlords use third-party tenant screening reports to evaluate a prospective tenant's financial, rental, and criminal backgrounds. These reports access public records and employ name-matching methods and algorithm-based scores that studies have found to be inaccurate and unclear. [162]

[161] Advancing Pennsylvania's Housing Futures: Sealing Eviction Records for Housing Stability and Economic Prosperity, Community Legal Services of Philadelphia

[162] Porton, A., Gromis, A., & Desmond, M., *Inaccuracies in Eviction Records: Implications for Renters and Researchers*, 2020. Kleysteuber, Rudy. *Tenant Screening Thirty Years Later: A Statutory Proposal to Protect Public Records*, 2007. Kirchner, L., & Goldstein, M., *Access Denied: Faulty Automated Background Checks Freeze Out Renters, 2020*.

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SECTION VIII.
APPENDICES

Appendix A – House Resolution 2023-66

PRIOR PRINTER'S NO. 867 PRINTER'S NO. 1564

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 66 Session of 2023

INTRODUCED BY SMITH-WADE-EL, MADDEN, KINSEY, BURGOS, SANCHEZ, KAZEEM, HOWARD, STURLA, BELLMON, BOROWSKI, HILL-EVANS, PARKER, CEPEDA-FREYTIZ, KHAN, WAXMAN, INNAMORATO, OTTEN, KRAJEWSKI, BULLOCK, MAYES, FREEMAN AND GREEN, APRIL 10, 2023

AS REPORTED FROM COMMITTEE ON HOUSING AND COMMUNITY DEVELOPMENT, HOUSE OF REPRESENTATIVES, AS AMENDED, JUNE 13, 2023

A RESOLUTION

Directing the Legislative Budget and Finance Committee to conduct a study and issue a report on the impact of housing on health in this Commonwealth.

WHEREAS, Housing quality includes the physical condition of a home, adequate and appropriate utility service, the characteristics of the area in which a home is located and a home's affordability; and

WHEREAS, ~~Housing~~ ACCORDING TO THE UNITED STATES INTERAGENCY COUNCIL ON HOMELESSNESS, HOUSING is considered affordable when it costs less than 30% of a family's income; and

WHEREAS, ~~Nearly~~ THE UNITED STATES CENSUS BUREAU REPORTED IN THE AMERICAN COMMUNITY SURVEY THAT NEARLY 1.5 million Pennsylvania households spend more than 30% of their income on housing; and

WHEREAS, Nearly 29% of children in this Commonwealth live in cost-burdened households ACCORDING TO A 2022 SURVEY BY THE UNITED WAY OF PENNSYLVANIA; and

WHEREAS, An individual who identifies as an ethnic minority is more likely to live in unaffordable housing, which means the individual is also more likely to face associated health challenges; and

WHEREAS, ACCORDING TO HABITAT FOR HUMANITY INTERNATIONAL'S 2020 STUDY, HISTORIC DISCRIMINATION IN UNITED STATES HOUSING POLICY, PARTICULARLY DISCRIMINATION AGAINST BLACK AMERICANS, IS ONE OF THE CHIEF DRIVERS OF RACIAL INEQUITIES THAT PERSIST TODAY; AND

WHEREAS, The Federal Reserve Bank of Philadelphia reports a Statewide shortage of 253,981 rental homes that are both

affordable and available to people at or below 30% of median family income~~, often leading to homelessness~~; and

WHEREAS, People experiencing homelessness are more likely to have health problems than those who are well-housed; and

WHEREAS, Inadequate nutrition and medical care are associated with the lack of access to affordable housing; and

WHEREAS, Residents of highly impoverished, unsafe neighborhoods have an increased likelihood of adverse physical and mental health effects; and

WHEREAS, Substandard housing propagates infectious diseases through contaminated water, poor waste disposal systems and unsanitary conditions; and

WHEREAS, Substandard housing increases the risk of burns and other injuries from exposed or unconventional heating sources, unguarded windows and sills, broken glass, obsolete fixtures and other hazards; and

WHEREAS, Children and senior citizens are particularly vulnerable to the health effects of substandard housing; and

WHEREAS, More than 1,300 elderly Pennsylvanians have died from accidental falls in unsafe houses; and

WHEREAS, Dampness, unfiltered air, poor ventilation, a lack of heat and unclean or unsafe flooring contribute to respiratory and pulmonary conditions, including asthma; and

WHEREAS, Homes that are poorly weatherized or lack adequate utility service can contribute to ill health; and

WHEREAS, Statewide, 40% of the houses tested for radon have high levels of the carcinogenic gas ACCORDING TO THE DEPARTMENT

OF ENVIRONMENTAL PROTECTION; and

WHEREAS, Older houses are a source of childhood lead exposure and lead poisoning; and

WHEREAS, Because Pennsylvania has the second largest number of pre-1950 houses in the nation, lead remains a health hazard in our communities; and

WHEREAS, A growing number of agencies and organizations support research showing the direct effects of housing quality on health; and

WHEREAS, The United States Department of Housing and Urban Development, the Pennsylvania Safe and Healthy Homes Program, the Robert Wood Johnson Foundation's Commission to Build a Healthier America, the Housing Alliance of Pennsylvania, the Center for Housing Policy, the Urban Institute, the Brookings Institute and the Healthy Rowhouse Project ~~are among these entities~~ SUPPORT RESEARCH ON HOUSING QUALITY AND HEALTH; and

WHEREAS, Health care plans and providers in several states, including Texas, Arizona and Pennsylvania, are working to improve health care outcomes through housing; and

~~WHEREAS, Pennsylvania has begun to explore solutions through the Department of Community and Economic Development's Neighborhood Assistance Program; and~~

~~WHEREAS, The University of Pittsburgh Medical Center, Allegheny Health Network and Children's Hospital of Philadelphia are developing initiatives integrating housing and health; and~~

~~WHEREAS, The Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund provides significant aid to~~

~~households below 50% of median income and has made substantial contributions to improving the housing stock and health of thousands of Pennsylvanians; and~~

WHEREAS, Current State-specific data is required to better provide for housing and health benefits in this Commonwealth; therefore be it

RESOLVED, That the House of Representatives direct the Legislative Budget and Finance Committee to conduct a study and issue a report on the impact of housing on health in this Commonwealth; and be it further

RESOLVED, That the study include background information and data relating to housing conditions, including access to utility service, and health effects described in this resolution, a review of health-related housing initiatives across the nation and any other information or data deemed necessary or appropriate; and be it further

RESOLVED, That the study include an analysis of ~~the cost of~~ WHETHER THERE ARE MEDICAID health expenditures related to unmet housing needs~~, including Medicaid, Medicare and unreimbursed care provided by hospitals~~; and be it further

RESOLVED, That the study include an analysis of the health care cost savings achievable through addressing unmet housing needs; and be it further

RESOLVED, That the study include an analysis of the efficacy of particular interventions to address unmet housing needs, improve health outcomes and reduce health care expenditures; and be it further

~~RESOLVED, That the study include an analysis of disaggregated sociodemographic data related to health and housing; and be it further~~

~~RESOLVED, That the analyzed disaggregated sociodemographic data be made publicly available on Open Data Pennsylvania; and be it further~~

RESOLVED, That, in conducting the study, the committee consult other departments, agencies, organizations, entities or persons as necessary or appropriate; and be it further

~~RESOLVED, That the committee solicit input from other departments, agencies, organizations, entities or persons on barriers to, and best practices for, collecting demographic data; and be it further~~

RESOLVED, That the committee issue a report of its findings and recommendations to the House of Representatives within one year of the adoption of this resolution.~~; and be it further~~

~~RESOLVED, That the committee's report of its findings and recommendations include policy changes that the collected demographic data indicates are necessary to reduce disparities.~~

Appendix B – Frequently Used Acronyms

Acronym	Definition
ACA	Affordable Care Act
ACO	Accountable Care Organization
AHA	Allegheny Housing Assessment
AHS	American Housing Survey
AIHC	Accelerating Investments for Health Communities
AMI	Area Median Income
ARPA	American Rescue Plan Act
BH-MCOs	Behavioral Health Managed Care Organizations
BIL	Bipartisan Infrastructure Law
CABHC	Capital Area Behavioral Health Collaborative
CAHPS	Consumer Assessment of Health Providers and Systems
CAO	County Assistance Office
CAPER	Consolidated Annual Performance and Evaluation Report
CAPS	Customer Assistance Program
CARES	Coronavirus Aid, Relief, and Economic Security Act
CBCM	Community-Based Care Management
CBO	Community-Based Organization
CDBG	Community Development Block Grant
CDC	Centers for Disease Control
CE	Coordinated Entry
CHC	Community Health Choices
CHIP	Children's Health Insurance Program
CHFS	Cultivating Health for Success
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
CoC	Continuum of Care
COMPASS	Commonwealth of Pennsylvania Access to Social Services
DCED	Department of Community and Economic

	Development
DHS	Department of Human Services
DMVA	Department of Military and Veterans Affairs
DOE	US Department of Energy
DOH	Department of Health
ED	Emergency departments
EHV	Emergency Housing Voucher
EMSA	Eligible Metropolitan Statistical Area
EOP	End of Participation
ESG	Emergency Solutions Grant
FFS	Fee-for-Service
FMR	Fair Market Rent
FQHC	Federally Qualified Health Centers
FUP	Family Unification Program
FYI	Foster Youth to Independence
HAP	Homeless Assistance Program
HAP	The Hospital and Healthsystem Association of Pennsylvania
HAP	Housing Assistance Payment
HCBS	Home and Community-Based Services
HCV	Housing Choice Voucher
HEARTH	Homeless Emergency Assistance and Rapid Transition to Housing
HEDIS	Healthcare Effectiveness Data and Information Set
HIO	Health Information Organization
HMIS	Homeless Management Information Systems
HOME	Home Investment Partnership Program
HOPWA	Housing Opportunities for Persons with AIDS
HRSN	Health Related Social Needs
HSIs	Health Services Initiatives
HTF	National Housing Trust Fund
HUD	US Department of Housing and Urban Development
HUD-VASH	HUD-Veterans Affairs Supportive Housing
ILOS	In-Lieu-of-Services
LIHEAP	Low-Income Home Energy Assistance Program
LIHTC	Low-Income Housing Tax Credit

LTSS	Long-term Services and Supports
MCO	Managed Care Organization
MOU	Memorandum of Understanding
MFRAP	Military Families Relief Assistance Program
MA	Medical Assistance
MS	Mainstream
NED	Non-Elderly Disabled
NOFO	Notice of Funding Opportunity
ODP	Office of Developmental Programs
OLTL	Office of Long-Term Living
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
PATH	Projects for Assistance in Transition from Homelessness
PBV	Project Based Voucher
PHA	Public Housing Agency
PHARE	Pennsylvania Housing Affordability and Rehabilitation Enhancement
PHCF	Public Housing Capital Fund
PHFA	Pennsylvania Housing Finance Agency
PHOF	Public Housing Operating Fund
PHW	PA Health and Wellness
PSH	Permanent Supportive Housing
RRH	Rapid Re-housing
RSP	Revenue Sharing Plan
RTT	Realty Transfer Tax
SAMHSA	Substance Abuse and Mental Health Service Administration
SDOH	Social Determinants of Health
SLFRF	State and Local Fiscal Recovery Funds
SMI	Serious Mental Illness
SPC	State PATH Contact
SSO	Supportive Services Only
SPV	Special-Purpose Voucher
SUD	Substance Use Disorder
SV	Stability Voucher

TBV	Tenant-Based Voucher
TH	Transitional Housing
TTP	Total Tenant Payment
UFA	Unified Funding Agency
UPMC	University of Pittsburgh Medical Center
VA	US Department of Veterans Affairs
VAMC	VA Medical Center
VBP	Value Based Purchasing
VI-SPDAT	Vulnerability Index-Service Prioritization Decisions Assistance Tool
VTA	Veterans' Temporary Assistance
VTF	Veterans' Trust Fund
WAP	Weatherization Assistance Program
WHRP	Whole-Home Repairs Program

Appendix C – DHS Response to this Report

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

September 25, 2024

Mr. Christopher R. Latta, MBA
Executive Director
Legislative Budget and Finance Committee
P.O. Box 8737
Harrisburg, Pennsylvania 17105-8737

Dear Mr. Latta:

Thank you for providing a draft copy of the Legislative Budget and Finance Committee's (LBFC) report titled *The Impact of Housing on Health* and allowing the Department of Human Services (Department or DHS) to submit comments.

The Department offers a wide array of housing and health services through multiple authorities and funding sources, many of which are administered in partnership with counties, health care providers, and community-based organizations. We provide services to support individuals with disabilities and older adults in securing housing and maintaining stable housing, promoting life in the community instead of institutionalization. This year marks the 25th anniversary of the Olmstead Supreme Court Decision, and DHS remains committed to ensuring that Pennsylvanians with disabilities have the choice to receive state-funded supports and services in the community. We help Pennsylvanians remain in their homes or find new housing. In times of disaster, DHS serves as the lead agency for emergency support functions to provide critical mass care and sheltering support, coordinating with communities and sister agencies to meet human services needs during recovery efforts. Through our administration of the Emergency Rental Assistance Program, DHS has provided over $1 billion in rental assistance and housing stability services to over 276,000 Pennsylvania households who faced financial hardship during the COVID-19 pandemic, in partnership with all 67 counties. DHS also provides funding to counties through programs such as the Homeless Assistance Program to support individuals and families experiencing homelessness and housing crises, as well as those fleeing domestic violence.

Fundamentally, the high demand for housing supports highlights an urgent need to increase the supply of attainable, affordable, and accessible housing after years of insufficient development. Many communities report losing housing as use restrictions expire at income-based properties and due to emergencies like Tropical Storm Ida. Rents and home prices continue to rise due to the housing shortage and high demand. Although these challenges are not unique to the Commonwealth, it is essential to address housing access now to ensure a thriving future – one that provides opportunities for families and young adults to live and work in Pennsylvania, as well as support for people with disabilities and older adults as their needs change. According to the United Way of Pennsylvania, up to 29% of working households do not have adequate savings to cover unexpected emergencies, increasing the risk of eviction and homelessness.

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The lack of affordable, safe housing is particularly traumatic for children and families, who may be forced into unsafe living conditions, leading to trauma and difficulties in school. Education and community agencies identified 46,714 children and youth experiencing homelessness served by Pennsylvania Department of Education's Education for Children and Youth Experiencing Homelessness (ECYEH) Program during the 2022-2023 program year. It is vital that the Commonwealth prioritize building and preserving homes to address the housing shortage.

The Department offers the following general comments on this report.

The Department concurs with the recommendation that there is no centralized state lead for housing, which creates challenges in aligning activities and tracking measurable data and outcomes. While there are ongoing efforts to align stakeholders around housing and health opportunities, including close collaboration with other state agencies, progress is hindered by divided responsibilities and policies across state, municipal, county, federal, and private entities administering siloed programs. Governor Shapiro's Executive Order 2024-03, signed on September 12, directs the Department of Community and Economic Development (DCED) to convene stakeholders to deliver a Housing Action Plan within one year, and directs DHS to convene stakeholders, in partnership with the Governor's Office, to inform best practices, prevention, and coordination of services for Pennsylvanians experiencing homelessness. We look forward to working with our partners in the administration and the General Assembly on opportunities to collaborate and align stakeholders, including potential opportunities to increase housing supply, braid funding, and increase data sharing to measure impact and assess areas for improvement.

In a report of this scope, it can be challenging to cover the full depth and breadth of housing-related supports and services that may impact health under the Department's purview. The Department notes that this report covers a subset of the wider array, and below we share information on additional programs and initiatives related to housing and health.

Personal Care Homes licensed by the Department serve many individuals receiving Medicaid and Supplemental Security Income (SSI) benefits. While these individuals may not be in the Community HealthChoices waiver program, they still receive physical and behavioral health services through Medicaid. DHS administers a personal care home supplement to assist eligible residents with their care and housing costs. For individuals that need this level of care, the supplement assists with the cost of providing them a place to live, meals, supervision as well as assistance with personal care tasks.

The Department also provides a variety of housing-related supports through the Money Follows the Person (MFP) program, a Medicaid rebalancing initiative. The MFP program reimburses administrative activities and provides an enhanced federal match for an MFP participant's supportive services for their first year back in the community, resulting in savings to the state. DHS directs these savings toward removing barriers to transition from institutions and nursing facilities, as well as increasing and improving services. In 2025, the Community HealthChoices contract will require each Managed Care Organization (MCO) to have a housing coordinator focused on addressing housing needs. Many of these

initiatives and the Office of Long-Term Living's Nursing Home Transitions program help preserve individuals' housing status by supporting and keeping them in the community.

The Department appreciates the inclusion of the proposed *Bridges to Success: Keystones of Health* Section 1115 demonstration in the report. If approved and funded, this program would expand resources available to address a broader scope of health needs and challenges in the Commonwealth. It will increase the array of options available to address health-related social needs that can shape quality of life as well as health outcomes and spending. We would like to address a few points regarding the proposal to ensure clarity:

- With respect to the waiver's implementation status, the Department submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) on January 26, 2024, which is currently pending federal review. If approved, the Department will work with the General Assembly through the normal budget process to plan implementation. *Keystones of Health* provides new authorities to the state but does not create new spending obligations should the Commonwealth elect not to implement certain provisions. The Department would also engage in a comprehensive implementation planning process to determine program design.

- Regarding the report's question on rental assistance services in the context of the waiver, the Department notes that the goal of housing services is to establish and maintain housing stability. The Department intends to work with stakeholders to transition beneficiaries from short-term housing supports to permanent solutions when available, housing in units where the beneficiaries can sustain monthly housing costs, connecting to longer term services and supports, and supporting beneficiaries to gain and increase income. The Department is aware that other states have requested longer time periods for short-term housing supports to better align with standard terms of lease agreements. However, CMS has not approved a period longer than six months for any state as of this time. The Department has suggested to the US Department of Housing and Urban Development (HUD) and their contracted technical assistance providers that it would be helpful for HUD to issue clear policy guidance on braiding waiver authority housing services with their housing programs. The Department notes that HUD issued a new brief in August, Medicaid-Funded Housing Services Opportunities for Alignment and Coordination with Housing Resources within Homeless Coordinated Entry Systems. This brief notes that Medicaid coverage of housing-related services is fairly new, with likely progression in the development of alignment. The Department will continue to monitor and incorporate new federal guidance as it is made available.

- The report suggests that roles for MCOs and a third-party program administrator have already been determined. It is premature to describe program administration roles for Keystones of Health, as the first full year of the waiver will be dedicated to planning for implementation.

- The federal government mandates an independent evaluation of all Section 1115 waivers. This will occur regardless of Commonwealth requirements. The Commonwealth can use evaluation results to determine whether to propose

amendments, seek renewal, or end the program.

- It is helpful to include additional clarification on how the federal government defines budget neutrality for Section 1115 waivers focused on health-related social needs. Budget neutrality represents the final negotiated financial terms with CMS and provides the upper limits for federal Medicaid matching funds on waiver expenditures. These are federal matching limits based on spending authority, not spending obligations. DHS would not receive federal matching funds for any costs that exceed the caps negotiated with CMS. Therefore, DHS requested caps that would be higher than projected spending, which is a common practice to mitigate risk to the Commonwealth.

The Department offers the following comments on recommendations and findings:

- S-7: Due to the implementation of Community HealthChoices, services described in the report as targeted housing services are now included in administrative costs and can no longer be separated into claims as in the Fee-for-Service delivery system.

- S-10: The Department suggested revisions to differentiate between Revenue Sharing and Reinvestment. While some suggestions were incorporated, others were not, which may lead to misunderstandings about these initiatives. Characterizing these programs jointly is not accurate, as there are important distinctions between them in terms of their authorities and contract provisions under the Physical HealthChoices and Behavioral HealthChoices agreements.

- Recommendation 1 on pages S-11, 17, and Recommendation 2 on page S-2: The Department supports these recommendations and does track outcomes across DHS programs and services where we have authority and access to relevant data. However, due to the varied authorities, initiatives, service definitions, and target populations being served, outcome tracking is not uniform across all MCOs or initiatives. Additionally, tracking for Community-Based Care Management is limited because it is funded by administrative dollars, which allows limited control over required outcome measures. For Value Based Purchasing (VBP) and RSP, MCOs propose quality measures, however we acknowledge the opportunity to work with them to establish common health-centered outcomes measures.

- The Department had suggested for clarity that cost containment be used more widely throughout the report. While the report helpfully clarifies cost containment versus the concept of cost savings within healthcare on pages 16 and 51, elsewhere it still refers to “cost savings” in recommendations and findings. The Department has a strong record of successfully containing costs, particularly compared to the commercial market, and “cost containment” is a more accurate characterization. Based upon the LBFC clarification, we suggested that recommendation 7 on page S-2 be revised to state that DHS report on how the proposed *Keystones of Health* waiver helps control and contain healthcare costs, rather than implying cost savings. CMS requires an independent evaluation of waiver services.

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- On page 47, the report notes that MCOs experienced "excess revenue margins between 10-15 percent from unused capitation revenues" prior to the introduction of Revenue Sharing. The Department believes this figure is inaccurate and may have been conflated with medical loss ratios, which were around 85% and included the MCOs' administrative costs.

Thank you again for the opportunity to contribute to this important study and for your thorough examination of the intersection between housing and health. The Department sincerely appreciates the LBFC's comprehensive approach and your staff's dedication to understanding these complex and multifaceted issues. Through continued partnership, we look forward to addressing these challenges and advancing initiatives that improve access to affordable housing and health services, while upholding fiscal responsibility and delivering high-quality care across the Commonwealth.

Sincerely,

Valerie A. Arkoosh, MD, MPH
Secretary

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