Facilitating the Reform of Health Care and Long-Term Services and Supports Systems:

INTERVIEWS WITH STATE POLICYMAKERS ABOUT THE POTENTIAL ROLE OF AFFORDABLE SENIOR HOUSING PLUS SERVICES STRATEGIES

LeadingAge™
Center for Housing Plus Services

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The views expressed are those of the authors and are not those of the foundation.

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The LeadingAge Center for Affordable Housing Plus Services serves as a national catalyst for the development, adoption and support of innovative affordable housing solutions that enable low- and modest-income seniors to age safely and successfully in their homes and communities.

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Introduction

Over the past several years, policymakers; health, social service and housing providers; and consumer advocates have focused attention on potential strategies for helping lower income older adults age successfully in their communities. One emerging strategy involves linking affordable senior housing with health and supportive services. Strategies range from simply providing shelter to older adults who are homeless or transitioning from institutional to community settings to housing serving as a platform for the coordination, integration and delivery of services.

As part of a multi-pronged initiative to explore the value of these types of partnerships, researchers at the LeadingAge Center for Applied Research (CFAR) investigated the actual and potential roles that state governments could play in supporting housing plus services models. The research team interviewed health, social services and housing policy officials in seven states—California, Connecticut, Massachusetts, New York, Ohio, Oregon and Vermont—where CFAR had conducted previous case studies of promising housing plus services practices.[1] The purpose of the interviews was to gain an understanding of:

- Each state's perception of the potential role affordable senior housing could play in supporting the state's health and long-term care reform efforts.
- Strategies or activities the state may have explored or implemented in this area.

Interviews were conducted between June 2013 and August 2014. Some interviewees provided updates in summer 2015.

Although observations from the interviews cannot be generalized across all states, they provide insights into the perceptions and interests of policymakers, and the opportunities and challenges they may face, with respect to facilitating or implementing housing plus services strategies.

This summary reflects a snapshot of state activity at the time of the interviews. Given the rapidly changing nature of health policy and payment and delivery reform, it is possible that states may have changed course or initiated new activities since the interviews were conducted or updated.

Background

There are a number of reasons that states may have an interest in linking affordable senior housing with health and/or supportive services, including their desire to reform the long-term services and supports (LTSS) system, provide coordinated care to older people who are eligible for both Medicare and Medicaid, and meet the needs of the homeless population.

Reforming the Long-term Services and Supports (LTSS) System

States have a major responsibility for financing and delivering long-term services and supports to older adults and younger people with disabilities. This responsibility comes primarily through Medicaid, a joint federal and state health insurance program for low-income individuals.

LTSS spending accounted for just over a third of Medicaid expenditures in FY 2012 (Eiken et al., 2014). While states are required to cover nursing home care for Medicaid beneficiaries, most home and community-based services (HCBS) are optional. Since the 1980s, however, there has been a sustained effort at the federal and state levels to shift more care into the community in an attempt to lower costs, address consumer preferences,

[1] The case studies can be accessed here: http://www.leadingage.org/housing_plus_services_casestudies.aspx.

and ensure choice (Kay, 2012; Engquist, Johnson, Lind & Palmer Barnette, 2010; Musumeci & Reaves, 2014).

In 2011, the top five states in AARP's LTSS State Scorecard allocated an average of 62.5% of LTSS dollars to HCBS for older people and adults with physical disabilities, compared to a national average of 39.3% (Reinhard et al., 2014). Although there has been an overall rebalancing of the settings where LTSS are delivered, disparities still exist across populations. For example, 63% of Medicaid LTSS spending for younger people with disabilities nationwide goes toward HCBS, compared to just 28% for people over age 65 (Reinhard et al., 2014).

A variety of LTSS reform initiatives are currently taking place. Many states are shifting Medicaid-funded LTSS into managed care. As of July 2014, 29 states offered or planned to offer at least one managed LTSS program, an increase from eight states just 10 years earlier (Libersky, 2014). States are turning to managed LTSS to help reduce program costs and make those costs more predictable, and to create incentives that encourage LTSS providers to deliver more HCBS and less institutional care.

Forty-four states and the District of Columbia are currently participating in the Money Follows the Person (MFP) program, which began in 2008 and was expanded in 2010 by the Affordable Care Act. MFP is a federal demonstration that helps states increase their capacity to provide community-based long-term care and to transition older adults and persons with disabilities out of institutional settings.

The success of these transitions has varied tremendously. On average, the top five states in AARP's LTSS State Scorecard transitioned 13.1% of long-stay residents to HCBS settings, compared to only 5.3% in the bottom five states. One of the major barriers to transitioning individuals back into the community has been the lack of affordable and accessible housing (Reinhard, 2010; Stone, 2011). Therefore, states have a significant incentive to partner with housing agencies and providers to make quality shelter available to transitioning older adults and younger people with disabilities, and to collaborate with housing providers to ensure a successful and sustainable transfer to the community through shared care management and other joint service interventions.

Dual Eligible Reform Efforts

Approximately 9.6 million older adults and younger individuals with disabilities are dually enrolled in the Medicare and Medicaid programs. Almost 60% of this "dual eligible" population—5.7 million individuals—is age 65 or older (MedPAC and MACPAC, 2015).

Dual eligible older adults receive their acute and primary care coverage through the Medicare program. Three quarters of older dual eligible beneficiaries receive full Medicaid benefits, which include LTSS in nursing homes or HCBS settings in a majority of cases. The remaining 25% of older dual eligible beneficiaries receive partial Medicaid benefits that cover Medicare premiums, copays and other out-of-pocket costs. In 2010, 62% of the $284.5 billion spent on the entire dual eligible population was spent on older adults. The total $175.1 billion expenditure for dual eligible older adults included $105.3 billion from Medicare and $69.8 billion from Medicaid.

Dual eligible older adults are sicker and have more functional disabilities than their non-dual eligible counterparts and, therefore, are very costly to the Medicare and Medicaid programs (MedPAC and MACPAC, 2015). Although dual eligible older adults represented only 12% of all Medicare beneficiaries in 2010, they accounted for 21% of all Medicare spending. Similarly, dual eligible older adults made up only 8% of all Medicaid beneficiaries in 2010, but represented 21% of all Medicaid spending.

Existing service delivery mechanisms typically involve little or no coordination between the Medicare and Medicaid programs. As a result, dual eligible older adults and younger people with disabilities tend to receive fragmented and unnecessarily high-cost care. Since 2011, a number of states have been working with the Centers for Medicare and Medicaid Services (CMS) to test new financial alignment models designed to support better integration of acute care, primary care and LTSS for these populations. The goal of these models is to reduce

Medicare and Medicaid expenditures (with savings accrued to both the federal government and the states) and achieve higher quality outcomes. As of July 2014, as many as 1.5 million dual eligible beneficiaries were eligible to enroll in a dual eligible demonstration administered by each state and contracted through some type of managed care organization (Musumeci, 2014).

Given the large proportion of dual eligible older adults who are nursing home residents, states have the incentive to partner with housing agencies and providers. In particular, these collaborations could help ease nursing home transitions to community settings by making subsidized apartments or rental vouchers available.

A recent study conducted by the Lewin Group and LeadingAge found that 68% of older adults receiving assistance from the U.S. Department of Housing and Urban Development (HUD) were dual eligibles in 2008 (The Lewin Group, 2014). These individuals had more chronic conditions and greater health care and LTSS utilization rates than their dual eligible peers not receiving HUD assistance. These findings suggest that states could achieve greater efficiencies and savings through partnerships with housing properties that can provide prevention and health education activities, support care coordination and service integration, and promote patient activation and improved compliance with treatment regimens.

State Incentives to Target Homeless Individuals

States have been engaged in a number of efforts to link housing and services for homeless individuals. Medicaid reform initiatives have been a primary motivator for these initiatives. Moving homeless Medicaid beneficiaries, who often have significant physical and behavioral health needs, into stable housing is believed to be a key mechanism for better managing their health and use of high-cost emergency department and hospital services. Additionally, some homeless individuals may have entered institutional care because they were unable to manage their health and/or LTSS needs on the street or in a shelter.

Traditionally defined older adults (e.g., age 62+ or 65+) represent a small, but growing segment of the homeless population. Within the context of homelessness, however, "elderly" tends to be defined as age 50 and older because living on the street can cause premature aging. Although chronologically younger, the homeless "elderly" develop chronic illnesses and geriatric conditions more typical of someone who is much older (Brown, Thomas, Cutler & Hinderlie, 2013). The proportion of sheltered homeless individuals aged 51 to 61 grew from 18.9% in 2007 to 22.3% in 2010. Another 4.2% of the sheltered homeless population was aged 62 and older in 2010 (HUD, 2011). The latter group is expected to increase as the baby boomers age over the next 20 years.

Key Observations from Interviews

Much of the attention to the connection between affordable housing and health and/or LTSS has primarily been driven by Medicaid policymakers' interest in successfully implementing the MFP program.

All of the states interviewed are participating in MFP as a tool to help rebalance their LTSS systems. State interviewees consistently cited the lack of affordable, accessible housing as a primary barrier to moving individuals out of nursing homes. To access quality shelter for these transitions, states have pursued a number of strategies.

Several states—**California, Massachusetts and Ohio**—created some type of housing coordinator position within their MFP programs to help educate and train consumers, service providers and state agency officials about housing programs and opportunities. The coordinators also help direct cross-agency and cross-sector discussions and activities intended to increase the availability of affordable, accessible housing.

California, Connecticut, Massachusetts, Ohio and Oregon pursued and received awards from HUD's Section

811 Project Rental Assistance (PRA) Demonstration to support rental subsidies for MFP participants. The demonstration requires the state housing agency to enter into a formal partnership with the state Medicaid agency, with the goal of creating integrated, supportive housing options for people with disabilities.[2] Rental assistance funds are awarded to states that commit other funding sources, such as low-income housing tax credits, to cover capital costs.

State	Award for Rental Subsidy FY 2012 and FY 2013	# of Units Assisted
California	FY 2012 – $11.9 million FY 2013 – $11.9 million	335 283
Connecticut	FY 2013 – $4.1 million	150
Massachusetts	FY 2012 – $5.2 million	100
Ohio	FY 2013 – $12 million	508
Oregon	FY 2013 – $2.3 million	80

A **California** official suggested that the state's Department of Health Care Services' involvement with affordable housing was limited until relatively recently because Medicaid does not pay for shelter, except in nursing homes. Rebalancing efforts to move people into the community, however, created an awareness of the role that housing could play in achieving the agency's MFP goals, and the department's need to have formal relationships with housing agencies and organizations.

Ohio officials also cited the state's MFP program, called HOME Choice, as a catalyst for several housing-related initiatives. The program collaborates with local housing authorities to access housing choice vouchers (HCVs) to subsidize program participants' rent. The Cincinnati and Toledo Housing Authorities were awarded 160 Non-Elderly Disabled Type II Housing Choice Vouchers[3] in 2011 for individuals transitioning from institutional settings into the community. The MFP program worked with the two housing authorities to distribute the vouchers. The program also collaborated with the Cleveland Housing Authority to set aside 25 HCVs for program participants, and with the Athens Housing Authority to give program participants a preference for HCVs (Ohio Housing Finance Agency). Ohio's Department of Medicaid, the operator of the MFP program, is working with the Housing Finance Agency (HFA) to explore other ways to increase the supply of affordable housing units available to program participants. Examples of these efforts include:

- The two agencies are discussing a pilot with the state's Low-Income Housing Tax Credit program that would incentivize developers to create ultra-accessible units that are affordable to individuals at 18% of the area median income (AMI), the income level of many MFP participants whose only income source is Supplement Security Income. The Department of Medicaid would use state funds to provide rental subsidies that make up the difference between the rent level (50% of AMI) and the participant's income level (18% of AMI).
- The Kresge Foundation awarded a grant to help the state's Office of Health Transformation and National Church Residences, an affordable housing provider, explore a pay-for-performance/social impact bond strategy. The strategy calls for connecting Medicaid and housing funds to support the development and operation of housing for individuals with LTSS needs who otherwise would be in a nursing home. Savings generated from caring for people in a lower cost setting could potentially be leveraged to spur private investment in the creation of affordable, accessible housing opportunities.

[2] The Section 811 program is available only to individuals aged 18-62 at the time of admission.

[3] To learn more about the Non-Elderly Disabled Type II Housing Choice Vouchers program, see: http://aspe.hhs.gov/daltcp/reports/2014/Cat2Housinges.shtml

The exploration is ongoing.

- The Department of Medicaid and the HFA collaborate on the Home for Good program, which aims to prevent homelessness by providing up to two years of rental subsidies in two counties for MFP participants with a mental health or substance abuse disorder and a criminal record. Due to their criminal backgrounds, these individuals are generally not eligible for federal rental subsidies. The program is funded through grants from the Ohio Attorney General's Office, Ohio Department of Medicaid, and the Corporation for Supportive Housing. The Department of Medicaid uses state funds to provide the rental subsidy.

Connecticut's strategic rebalancing plan, which incorporates the MFP program and other initiatives, acknowledges that affordable and accessible housing is frequently a primary barrier to helping Medicaid LTSS consumers remain in or return to the community (Connecticut Department of Social Services, 2013). The state included housing and transportation supports as key components of its LTSS rebalancing effort. In one action, Connecticut switched from using federal Section 8 vouchers to state-funded rental subsidies for MFP participants because the supply of federal vouchers was not adequate–both in terms of number and implementation requirements– to meet the need. The state vouchers offer more flexibility in accommodating the needs of many MFP participants. For example, the vouchers have relaxed rules around credit issues and allow for a longer lease up time, giving a property time to make accessibility adaptations need by a program participant before they can move in. State policymakers felt it made greater financial sense to move an individual out of an institutional setting more quickly, rather than waiting until a federal voucher could be accessed and an appropriate apartment found.

Some states are pursuing broad authority to include housing-related activities in their Medicaid programs through Medicaid Section 1115 waivers and other statewide efforts.

Section 1115 waivers give states the ability to expand eligibility to groups not normally eligible for Medicaid, provide services not typically covered by Medicaid, and test service delivery systems that improve care, increase efficiency and reduce costs. Waivers are required to be budget neutral, which means waiver spending is capped at the projected level of spending absent the waiver. With approval from CMS, states are allowed to spend savings below the capped level on services that would not normally be matched with federal funding.

California's recent Medicaid 1115 waiver renewal request proposed six strategies for improving Medicaid quality and outcomes. One strategy called for improving access to housing and supportive services for vulnerable, high-need populations. California's proposal allows for tenancy-based care management services, which will help individuals identify and maintain housing. The state also proposes to establish regional housing partnership pilots that bring together a spectrum of stakeholders to help individuals access housing and needed community supports. These new services and activities would be supported through the Medicaid savings they would generate by helping the target beneficiaries better maintain their health and, thus, decrease their Medicaid utilization and costs (California Department of Health Care Services, 2015).

Soon after taking office in 2011, **New York's** governor created a Medicaid Redesign Team (MRT) to make recommendations that would reduce the growth of Medicaid spending while improving beneficiaries' health outcomes. The MRT "identified increasing the availability of affordable and supportive housing for high-need Medicaid beneficiaries who are homeless, precariously housed or living in institutional settings as a significant opportunity for reducing Medicaid cost growth" (New York State Department of Health). A supportive housing workgroup for the MRT recommended a number of housing-related initiatives.

New York planned to implement much of the MRT plan through its 1115 Medicaid waiver. In a waiver amendment request, the state proposed dedicating $750 million of the anticipated savings generated by MRT activi-

ties over five years to supportive housing activities. Half of the allotted funds would go toward capital projects, and the other half toward supportive housing services (New York State Department of Health, 2012). CMS denied New York's request to use any of the federal share of savings on capital and rental subsidy expenses. The state, however, went forward with investing state funds in supportive housing capital and rental subsidy activities based on the belief that it will recoup those funds through savings to the state's share of Medicaid dollars. The state has allocated $266 million over FY 2012-2015 to fund the construction of new units, and for rental and service subsidies to expand existing programs or pilot new ones.[4]

	Total	Capital	Rental/Service Subsidies
FY 2012-2013	$75 million	$46.7 million	$28.3 million
FY 2013-2014	$91 million	$36.4 million	$54.6 million
FY 2014-2015	$100 million	$40 million	$60 million
FY 2015-2016 proposed	$127 million	$47 million	$80 million*

*Includes $800,000 for tracking and evaluation of supportive housing initiatives.

Of the multiple initiatives funded by New York, only two small programs were created specifically for older adults. The Senior Supportive Housing Pilot Project provides funding to help affordable housing properties make accessibility improvements and provide support services that help older adults remain in their apartments. The pilot received $3 million in funding in FY 2013-2014 and $2 million in FY 2014-2015. The Homeless Senior and Disabled Placement Supportive Housing program provides subsidized housing for difficult-to-place older clients with disabilities who reside in New York City shelters. The program received $2 million in FY 2013-2014. In FY 2014-2015, the program was expanded to also serve individuals with disabilities and any other high-cost Medicaid beneficiaries in the shelter system and was awarded $5.1 million. Older adults can be served under many of programs created through the MRT, but these programs are targeted primarily to homeless individuals and/or individuals transitioning out of institutional settings.

Several states recognized the need to improve coordination across agencies, and created positions with responsibility for cross-sector communication and education and/or interagency workgroups on housing.

As mentioned above**, California, Massachusetts** and **Ohio** created a housing coordinator position in their MFP programs. The role of the housing coordinator generally includes educating and training housing and service providers and agencies about each other's programs. In addition, the role often includes facilitating discussions and activities around aligning housing and service agency programs and priorities to increase affordable and accessible housing opportunities.

Some states also created cross-agency workgroups to help increase awareness and to align resources and initiatives around the development of affordable housing opportunities.

Ohio has established the Ohio Housing and Homeless Collaborative to revive a similar coalition that previously existed in the state. The collaborative is an interagency workgroup with a mission to create a new comprehensive approach to addressing housing and homelessness in the state. The group is co-chaired by the Development Services Agency and the Department of Mental Health and Addiction Services. Participants include the Departments of Aging, Developmental Disabilities, Job and Family Services, Rehabilitation and Correction, Youth Services, and Veteran Services, and the Housing Finance Agency and Office of Medical Assistance. Like the former group it is reviving, the homeless population is a primary target of the collaborative's efforts.

[4] See MRT Supportive Housing Workgroup webpage for details: https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing_workgroup.htm

New York created a Supportive Housing Workgroup as part of its Medicaid redesign initiative. The workgroup includes 26 members, including representatives from state agencies; health, supportive service and housing provider organizations; and advocacy groups. The workgroup was charged with identifying barriers to the efficient use of available resources for the development of supportive housing, and exploring opportunities for investment of additional resources in supportive housing that will result in savings to the Medicaid program and improved services to targeted individuals. The workgroup made a number of recommendations that resulted in the allocation of $266 million over FY 2012-2015, as mentioned above.

Connecticut created an Interagency Committee on Supportive Housing to address the needs of the homeless population. The state also created an Interagency Council on Affordable Housing in 2012 to guide the implementation of a newly created Department of Housing. Representatives from the Office of Policy and Management and the Departments of Social Services, Mental Health and Addiction Services, Children and Families, Corrections, Economic and Community Development, Development Services, Education, and Aging serve on the council in addition to advocacy group representatives. The council has examined issues such as the prioritization of housing resources, enhancing coordination among and across housing systems, and housing needs of various populations in the state.

Massachusetts established an Interagency Council on Housing and Homelessness in 2008. Fourteen agencies participate on the council, including the Departments of Housing and Community Development, Veteran Services, Children and Families, Mental Health, Public Health, Transitional Assistance, Elementary and Secondary Education, Correction, Early Education and Care, Developmental Services and the Executive Offices of Health and Human Services, Elder Affairs, Administration and Finance, and Labor and Workforce Development. At the time of the interview, the interagency group was exploring the development of a comprehensive housing policy that targets elders, veterans, persons with disabilities, homeless families, and individuals with HIV. Interviewees noted two interagency accomplishments: efforts to integrate housing into the MFP program and the receipt of a Section 811 grant from HUD.

Housing activities related to health and long-term services and support reform efforts have focused primarily on non-elderly populations in several of the states interviewed.

Several states appear to have concentrated on addressing the housing-related needs of homeless individuals and/or individuals with behavioral health conditions. While these populations could include older adults, the main focus of the state initiatives is on the under-65 population.

California's proposed activities around access to housing and supportive services programs are targeted at individuals who are currently homeless or will be homeless upon discharge from an institutional facility. The state's activities center on helping homeless individuals overcome the barriers they often face when attempting to find and access affordable housing and maintain their housing once they are able to move in.

Some of the **Ohio** officials interviewed for this project stated that while the elderly population has been included in the various housing-related discussions and planning, the focus of the state's housing-related efforts has been primarily on the persons with disabilities population.

Only a small portion of the funds in **New York's** MRT housing-related initiatives is designated for older adult populations. A significant portion of the funds is targeted to homeless individuals and persons with behavioral health needs.

Some of the states interviewed have taken a broader view of health and/or long-term care needs and their relationship to housing for older adults.

Some states are planning for the future demands that older adults will place on their communities or they are considering older adults' broader health and wellness needs.

Connecticut has considered the availability of affordable housing options across the state as it plans for the needs of the state's future older population. In support of the state's rebalancing plan and to proactively prepare for growth, the state made town-by-town projections about the supply of and demand for long-term services and supports in 2025. The state hopes to work with towns to incorporate these forecasts into their community planning. Initially, the project looked just at nursing home supply. The state followed up to include projected need for affordable, accessible housing based on projections for future demand for long-term services and supports and the size of the homeless population.

Vermont has initiated a statewide health system reform effort aimed at reducing health care costs and improving the health of the state's population. The state is looking broadly at all populations and payers, and is not just focused on Medicaid. Medicare is participating in the state's health reform initiative through the federal Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration. This initiative is centered on a system of medical homes established across the state.[5]

Through the MAPCP demonstration, Vermont has incorporated Support and Services at Home (SASH), a program based in affordable senior housing, into its health reform efforts. SASH teams—consisting of a housing-based service coordinator and wellness nurse linked with community service providers—serve as extenders to the community health teams that support the medical homes. SASH assists Medicare beneficiaries in three primary areas, including wellness and prevention, chronic care management, and transition support after a hospital or nursing home stay. These activities can help prevent at-risk individuals from moving to a higher level of care. However, SASH focuses broadly on helping a range of older adults living in affordable housing—from well elders to those who are chronically ill and frail—maintain their health and quality of life.

Oregon has helped support the development of an affordable senior housing with services pilot initiative through a planning grant awarded through the State Innovation Models Initiative.[6] The pilot brings together providers of affordable senior housing, physical and mental health care, social service and LTSS in a formal collaborative designed to support older adults and persons with disabilities residing in 11 subsidized housing properties. Onsite health navigators help assess and coordinate residents' various health and social support needs. The navigators collaborate with onsite service coordinators and other staff from partner agencies to ensure that residents' comprehensive needs are addressed.

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[5] Advanced primary care (APC) practices, or "medical homes," take a team approach to care, with the patient at the center. APC practices emphasize prevention, health information technology, care coordination and shared decision making among patients and their providers. The goal is to improve the quality and coordination of health care services. Through this demonstration program, Medicare participates in existing state multi-payer health reform initiatives that currently involve both Medicaid and private health plans. The demonstration program pays a monthly care management fee for beneficiaries receiving primary care from APC practices. The care management fee is intended to cover care coordination, improved access, patient education and other services to support chronically ill patients. Additionally, each participating state will has mechanisms to offer APC practices community support and linkages to its health promotion and disease prevention initiatives.

[6] The State Innovation Models Initiative is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program beneficiaries.

Some states are considering partnerships between health/social services entities and housing as one strategy for successfully implementing their dual eligible demonstrations.

At the time of the interviews, states were in the early stages of implementing their dual eligible demonstration programs and did not have a great deal of experience or activity to share yet. However, some states were considering housing-related needs for dual eligible beneficiaries.

In **Ohio**, there was recognition that many dual eligible participants in the demonstration program currently reside in affordable senior housing properties and that health plans could collaborate with the properties to support residents. The state is considering a pilot activity that would examine the potential role that service coordinators with enhanced care management responsibilities could play in helping address the health and LTSS needs of program participants, improve participant outcomes and lower costs.

Interviewees in **California** recognized the value of health plans achieving Medicare savings for dual eligible participants. They noted that plans could potentially use a portion of these savings to cover services that are not traditionally reimbursed by Medicaid that could help people maintain their housing, increase access to home and community-based services, and avoid having to move to a higher-cost institutional setting.

In some states, interviewees indicated that affordable housing was viewed as part of a comprehensive strategy to address issues related to improving the health and social services systems, and spurring economic growth.

Connecticut's governor came into office in 2011 with a commitment to increasing affordable housing opportunities across the state as a way to help families find stability and employment and to drive economic growth. The governor dedicated $12.5 million of the almost $200 million budget for affordable housing initiatives in FY 2012-2013 to reinvigorating the state's Congregate Housing for the Elderly Program and supporting the development of 50 new units. The congregate housing program was established in 1985 as non-medical model to provide housing for frail older adults. The program provides grants or loans to construct or rehab congregate rental properties, and provides subsidies for both rent and congregate services to eligible residents. Congregate services include meals, light housekeeping, wellness program, emergency transportation, and service coordination. Some congregate properties layer on assisted living services for residents with higher needs.[7] The governor's budget also included $30 million to create 150 new supportive housing units, and $1.5 million in rental subsidies for scattered-site supportive housing. In FY 2014-2015, an additional $20 million was authorized to develop 100 new supportive housing units (Connecticut Office of Policy and Management, 2014).

Ohio's governor created the Office of Health Transformation in 2011 to "lead the Administration's efforts to modernize Medicaid, streamline health and human services programs, and improve overall health system performance" (Ohio Governor's Office of Health Transformation, 2013). A major component of the state's reform efforts involved increasing opportunities to serve older adults and persons with disabilities in their homes or other community-based settings rather than in nursing homes. The state recognized that a lack of affordable and accessible housing was a major barrier to moving individuals out of nursing homes or helping them to live in the community, and began exploring a variety of initiatives to increase housing options.

Massachusetts' state-funded Supportive Housing Program was developed in 1999 and is administered by local housing authorities and elder service agencies. Thirty-one sites across the state provide 4,500 low-income older residents with housekeeping, social services, medication reminders, shopping, laundry services and other supportive services. Each property has a service coordinator to manage the program and help older residents navigate the state's health and social service systems. One interviewee characterized this program as

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[7] For more information on Connecticut's Congregate Housing for the Frail Elderly program, see: http://www.leadingage.org/uploadedFiles/Content/About/Center_for_Applied_Research/Expanding_Affordable_Housing_Plus_Services/Connecticut%20case%20study%20-%20Final.pdf.

successful in helping older residents remain in their own communities rather than having to move to a nursing home. The biggest challenge to the program is the physical condition of the program's housing properties, which are 20-to-30 years old and in serious need of repairs and modifications to make them more accessible to residents with disabilities. Massachusetts unsuccessfully attempted to use "stimulus dollars" authorized by the American Recovery and Reinvestment Act of 2009 to support renovations and upgrades. The state recently developed an initiative to evaluate the performance of the Supportive Housing Program and is also exploring a "social innovation model" to encourage the private sector to invest in capital development and services.

Conclusion

Interviews with select health care, supportive services and housing policy officials in seven states provide important insights into policymakers' perceptions and actions regarding the linkage of senior housing with services.

The states were chosen for interviews because the research team had previously identified promising practices in the state linking affordable senior housing and health/LTSS services at the community- or state-level. Given this fact, the research team expected to find explicit policy interest in the potential for this strategy to lower health and/or LTSS costs and improve quality for vulnerable older adults in their respective states. Findings indicate, however, that most of the attention surrounding housing/services linkages has focused on the homeless population or younger people with physical disabilities or behavioral health problems. Furthermore, most of these efforts aim to find quality housing for these individuals. There appears to be limited attention to individuals who are already housed in the community and could potentially benefit from some type of health and/or supportive services linked with the housing property.

To the extent that policymakers are focusing on the older adult population, efforts revolve around finding housing placements for older nursing home residents. There appears to be little recognition that once these individuals have transitioned to a subsidized apartment, they might benefit from formal connections with service coordinators who are often employed by the properties and might help residents use integrated LTSS and primary care to avoid unnecessary acute care utilization.

The relative lack of interest in housing and services collaborations for the older adult population is not surprising, given the fact that states are not responsible for this group's acute and primary care, which is covered at the federal level by Medicare. At the same time, researchers assumed that states implementing dual eligible projects would have an interest in Medicare and Medicaid savings since, in theory, they stand to benefit from better financial and service alignment of these programs for both older adult and younger beneficiaries.

The interviews did identify one state—Vermont—where policymakers have recognized the vulnerability of senior housing residents and the potential for more efficient and higher quality care delivery to this population through partnerships between health and housing. First year results from an evaluation of this program have demonstrated the potential for this linkage to help minimize the growth in Medicare expenditures (RTI International and Leading Age, 2014). A fledgling interest in this strategy is further indicated by Oregon's pilot program, and by efforts under exploration in California and Ohio to allow the state, managed care plans and senior housing providers to experiment with formal partnerships between housing and services.

It is interesting to note that none of the policymakers interviewed indicated interest in or efforts focused on the potential role that affordable senior housing could play in managed LTSS initiatives in terms of helping individuals remain in their home and diverting transfers to nursing homes. One recent study found that service-enriched housing reduced the risk of nursing home placement for older residents participating in the intervention

(Castle and Resnick, 2014). These findings suggest that policymakers should view housing and services linkages as one mechanism for successfully balancing their LTSS systems.

Findings from these interviews indicate that activity focused on linking affordable senior housing with health and LTSS services at the state level is being driven primarily by Medicaid agencies within the executive branch. No potential or actual housing and services partnerships were identified as being catalyzed by concerns about housing policy for older adults. However, interviewees from Connecticut and Massachusetts did note that state funds have been allocated over the years to develop relatively small service-enriched housing programs designed to help low-income older adults successfully "age in place."

As health and LTSS reforms continue to roll out across the states featured in this paper, and in other states, it will be interesting to see the extent to which attention to housing and services linkages goes beyond finding shelter for homeless individuals and younger people with physical disabilities or behavioral health issues. There is a growing body of qualitative and quantitative evidence indicating senior housing as a platform for delivering and coordinating a range of preventive and primary health care and long-term care services may help states achieve their cost reduction and quality improvement goals.

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