Braiding and Layering Funding to Address Housing:
Older Adults and Persons with Disabilities

Introduction

Housing is a significant social determinant of health inextricably tied to economic factors, and vulnerable populations with higher needs but fewer resources are most likely be negatively impacted by poor housing conditions, residential instability, and unaffordable housing costs.[1] Seniors and persons with disabilities are particularly challenged when it comes to retaining healthy and safe housing and the ability to live independently and with dignity in the community of their choice. Moreover, longstanding inequities in housing, caused in part by historic discriminatory housing and lending practices, become more entrenched as communities age.[2]

Housing therefore directly impacts "aging in place," the ability to continue to live at home and within one's community safely and independently regardless of age, income, or functional ability.[3] Aging in place benefits individuals' physical and emotional health, and reduces costs for families, the government, and health systems.[4] For example, a study in Missouri found that participants in the state's aging in place program had better outcomes in cognition, depression, activities of daily living, and incontinence compared to residents in nursing homes.[5] Nationally, home- and community-based programs using Medicaid waivers that facilitated aging in place produced an average public expenditure savings of $43,947 per participant in 2002.[6] Yet, as the U.S. Department of Housing and Urban Development (HUD) notes, "The nation's existing housing stock […] is ill-suited to meet the housing needs of an increasingly older population that overwhelmingly wishes to age in place."[7]

The unique needs of older adults and persons with disabilities result in population-specific barriers that states and territories must address when enacting policies that address housing. The common types of barriers are closely interrelated: (1) increased care needs due to chronic conditions and/or new and emerging conditions, (2) limited availability of affordable housing that meets physical accessibility needs, and (3) insurance (public and private) and other subsidy limitations for housing-related costs. However, various federal, state, and local funding streams may be braided and layered by health agencies to create new funding mechanisms that improve existing programs and create new ones from evidence-based models of care. State and territorial health agencies (S/THAs) can use these funding mechanisms to address existing barriers in each respective state's housing and health infrastructure.

This white paper describes strategies for braiding and layering funding sources to improve access to healthy, safe, and stable housing. These funding strategies are divided into three categories: (1) medical/supportive services, (2) housing and physical structure development, and (3) supportive housing and hybrid programs. The document explores several strategies for each section, and each strategy includes an overview of the approach, a related case study, and strategic implementation tips.

Braided and Layered Funding: Medical/Supportive Services

States, territories, and localities provide medical and supportive services to older adults and persons with disabilities to enable independent living. Jurisdictions often provide these services through Medicaid waiver programs, the Centers for Medicare & Medicaid Services' Program of All-Inclusive Care for the Elderly (PACE), and through locally-administered in-home caregiver programs that assist individuals with household tasks and other care needs. These programs have unique funding structures, with some braiding and layering federal funding streams and others using a combination of public and private sources. Below are descriptions of these programs, relevant case studies, and key takeaways. Strategies for implementing these funding programs are also discussed below for S/THAs seeking to utilize similar programs.

Medicaid Waiver Programs

Overview and Funding

While Medicaid is governed by a substantial body of federal law, states and territories have significant power in determining their "program eligibility, optional benefits, premiums and cost sharing, delivery system and provider payments." [8] [9] States and territories can seek greater flexibility for their Medicaid funds by applying for waivers to certain federal requirements under sections 1115 and 1915 of the Social Security Act.[10] In some instances, these waiver programs address issues closely related to health, including housing, rather than focusing solely on the provision of direct healthcare services.

Among other requirements, Medicaid waivers must demonstrate "budget neutrality," meaning that the cost of activities in the waiver will be no greater than what they would have been in the absence of the waiver.[11] For example, the 1915(c) home- and community-based waiver permits states to provide home- and community-based services—like necessary environmental modifications, security deposits to obtain a lease, moving expenses, and essential household furnishings—to individuals who would otherwise be institutionalized in settings such as hospitals, nursing homes, or intermediate-care facilities.[12] The average per capita cost of this program must be equal to or less than the average per capita costs under the state Medicaid plan without the waiver.[13]

Other commonly used waivers are the 1115 demonstration waiver (for experimental, pilot, or demonstration projects to validate and evaluate state-specific policy approaches to better serve Medicaid populations) [14] and the 1915(b) "Freedom of Choice" waiver (used to target specific populations through managed care health plans).[15]

Overall Strategy

States can use Medicaid waivers to improve housing for older adults and persons with disabilities by crafting smaller, more tailored programs that use state and federal Medicaid funding in conjunction with services provided by community-based organizations that are equipped to understand local needs. These organizations may promote care coordination and reduce duplication of services, which would otherwise not be possible in a complex, siloed system of care.[16] Waivers also allow states and territories to experiment with different programs to support housing that would otherwise not be possible under traditional Medicaid rules and regulations.

Case Study: 1915(c) Waivers

Louisiana has used a 1915(c) waiver to fund its Permanent Supportive Housing (PSH) program, initially as part of the state's disaster recovery efforts after Hurricanes Katrina and Rita.[17] The program combines deeply affordable rental housing and voluntary, flexible tenancy supports for very low income individuals with substantial, long-term disabilities, prioritizing individuals transitioning from institutions and homeless individuals or households.[18] The program provides supports on a timeline of tenancy—pre-, move-in, and ongoing—to ensure a successful transition into permanent housing. The program is also a collaboration between two state agencies, the Louisiana Department of Health and the Louisiana Housing Corporation, with each agency managing different facets of the program.[19] As of 2017, the program had a 94% retention rate, 54% of the participating households had improved income, and homelessness rates dropped 68% in the population served. Additionally, in 2011-2012, Medicaid acute care costs in the area served were initially reduced by 24% and there have been statistically significant reductions in inpatient hospital stays and emergency room use for adult tenants post-housing. [20]

Strategic Implementation Tip

State and territorial health officials with authority over Medicaid can apply for 1915(c) waivers to support housing and braid/layer this funding with other federal funding sources in collaboration with other state and local agencies. Officials without authority over Medicaid can collaborate with state Medicaid directors to identify shared priorities and opportunities.

Largely due to the expansive slate of services included in Louisiana's PSH program, the 1915(c) waiver serves as just one part of the program's comprehensive funding structure, which braids and layers various federal and state funding sources such as the Medicaid State Plan, the Low-Income Housing Tax Credit Program, the HUD Community Development Block Grant program, and funding from the Department of Veterans Affairs.[21] Each funding source is targeted toward a unique facet of the program. For example, the state uses the Low-Income Housing Tax Credit Program to provide incentives for developers to set aside 5%-15% of units for PSH within mixed-income, multi-family projects, and uses funds from HUD's Section 811 Project Rental Assistance program) to assist program participants up to the age of 62. The funds from the 1915(c) waiver primarily pay for long-term services and supports, including tenancy supports.[22]

Key Takeaways

Louisiana's PSH program has thus far successfully braided and layered various funding sources to reduce the number of persons experiencing homelessness among its target population. This program braided and layered Medicaid funding through a 1915(c) waiver along with funding supports from Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, Veterans Administration, and the US Department of Housing and Urban Development. As of 2016, the state has had a 68% reduction in homelessness among its target population. Health outcomes have also been positive, with an initial 24% reduction in Medicaid acute care costs in 2011-2012 and statistically significant reductions in in-patient and emergency room visits for adult tenants post-housing.[23] Because of the program's complexity, both providers and participants have needed ongoing technical assistance to navigate the various components' rules and requirements. Program directors have questioned whether using Medicaid and other funds flexibly could made less complex.[24] There have also been practical challenges, such as trouble finding enough affordable housing and the lack of flexibility in funding rules and regulations (e.g., age limits in the Section 811 program and rules restricting housing size and number of bedrooms allowed under HUD funding).

Program of All-Inclusive Care for the Elderly

Overview and Funding

The Program of All-Inclusive Care for the Elderly (PACE), provides comprehensive medical and social services to frail, community-dwelling older adults, most of whom are dually eligible for Medicare and Medicaid benefits. Under this program, participants receive coordinated in-home care, enabling them to age in place rather than enter institutionalized settings.[25] Services normally exclude housing costs such as rent but include all Medicaid- and Medicare-covered benefits, such as adult day care, dentistry, emergency services, home care, and meals.[26] These supportive services, while not directly addressing housing-related costs, address barriers to aging in place and enable older adults and persons with disabilities to stay in their homes longer and more safely.

The PACE program is funded by both Medicare and Medicaid through monthly Medicare and Medicaid capitation payments paid to the PACE provider for each program participant. Medicare-enrolled participants not eligible for Medicaid must pay additional monthly premiums out of pocket that are equal to the Medicaid capitation amount. However, there are no other deductibles, coinsurance, or any other type of cost-sharing for participants.[27]

Overall Strategy

Studies have found PACE to be an effective model for enabling older adults to age in place, and positive outcomes for PACE participants include shorter hospital stays, lower mortality rates, and better self-reported health and quality of life.[28] Moreover, costs for PACE participants have been estimated to be 16%-38% lower than Medicare fee-for-service costs and 5%-15% lower than costs for comparable Medicaid beneficiaries.[29] As of 2020, 137 PACE programs are operational in 31 states, serving over 54,000 participants.[30] However, further research is needed to fully determine the effect of this PACE program expansion. For example, there have been early indicators that quality of care may be lower under for-profit providers, although program participants have expressed high satisfaction with their care.[31]

Case Study: Cherokee Elder Care Program

The Centers for Medicare & Medicaid Services has recognized Oklahoma's Cherokee Elder Care program as a strong PACE program.[32] This program began in 2008 as both the first tribal PACE program and the first PACE program in Oklahoma. Like other PACE programs, the Cherokee Elder Care Program is led by a primary care physician and other professional staff who assess participant needs, develop care plans, and deliver services. Since program costs are covered by both Medicare and Medicaid, the Cherokee Nation worked with the state of Oklahoma to include PACE in the state Medicaid plan, enabling the program to contract with the Oklahoma Department of Health and Human Services to provide and be reimbursed for services.[33]

Strategic Implementation Tip

PACE programs can support older adults who are dually-eligible for Medicare and Medicaid. State and territorial health agencies can incorporate PACE into their Medicaid state plans where applicable, support efforts to leverage state funding to braid and layer, and encourage adoption of PACE at the local and tribal levels.

Key Takeaways

The collaboration between the Cherokee Nation and the state of Oklahoma is an example of how the PACE program expanded from a community program to a state program in an area previously without such programs, providing a viable opportunity for S/THAs to support and promote similar programmatic innovation. State and territorial health agencies can use grants for pilot programs, funded through state

budget allocations and later braided with Medicare and Medicaid funding, to encourage program development in targeted areas. Other collaborative efforts with potential PACE providers could include providing technical assistance and/or outreach to managed care organizations that may also be interested in the benefits of PACE or other similar programs. However, S/THAs may want to exercise some caution and increased oversight to manage concerns that the insertion of financial interests (e.g., private equity firms looking for new investment opportunities) may compromise quality.[34]

In-Home Supportive Services

Overview and Funding

Since the ability to age in place depends in part on the ability to maintain oneself at home, states and territories have implemented programs that pay caregivers to help older adults and persons with disabilities continue to live at home. Currently, 42 states allow some family members to play this role and be reimbursed for time spent taking care of their loved one under certain circumstances.[35]

While the funding structures for home care and in-home supportive services programs vary, many programs use Medicaid, state funds, or a combination of both. And while Medicaid rules limit the ability of spouses, parents of minor children, or other legally responsible relatives from receiving payments for providing support services, states may use Medicaid waivers to work around these requirements.[36] It is also possible for a state or territorial agency (e.g., a department of health or social services) to use a combination of Medicaid and state funds directly allocated through the state budget for these programs.

Overall Strategy

In-home supportive services programs have been credited with empowering participants and providing financial support for family caregivers who may be forgoing other income to care for their relatives.[37] Through braided and layered funding strategies (e.g., utilizing federal, state, and county funds), states and territories can develop or bolster such programs to support aging in place. Each state will vary in its approach, the following case study provides one example of braided and layered funding.

Strategic Implementation Tip

Partnerships between public health and Medicaid can support IHSS-style programs to support caregivers of older adults and persons with disabilities.

Case Study: California's In-Home Supportive Services

California's In-Home Supportive Services (IHSS) program helps fund caregiving and assistance for individuals who are over the age of 65 or disabled or blind. After an initial assessment from a county social worker, each program applicant is authorized for a certain number of paid caregiver hours.[38] Notably, the program also allows family members to be paid for provided care. As of October 2020, there are almost 640,000 authorized California IHSS recipients with a total of over 70 million authorized hours, approximately 110 average hours per recipient.[39]

Caregiver payments make up the bulk of the California IHSS budget and vary by county because the state pays based on county-negotiated rates.[40] The program is primarily funded through the state's Medicaid program, subjecting it to federal Medicaid rules, and is also funded with enhanced federal reimbursement through the Community First Choice Option Medicaid waiver.[41] In the 2017-2018 California state budget, the effective federal reimbursement rate for IHSS was approximately 54%, with the remaining costs being covered through other braided and blending funding sources, including state and county budgets. Historically, the state has paid 65% of non-federal program costs, and counties have paid the remaining 35%.[42]

Key Takeaways

California's IHSS program is expansive and pays for in-home care for millions of eligible individuals. Because counties are responsible for administering California's IHSS program and negotiating rates for caregivers, those rates can vary substantially and may reduce the availability of qualified caregivers across counties. Ensuring consistency in quality while also allowing for county-level flexibility are therefore important for replicability in other states. The IHSS program is also vulnerable to state budget fluctuations.[43] To ensure ongoing success, states and territories may need to stabilize this budget through braiding and layering funding with other sources (e.g., Medicaid waiver programs and federal grants).

Strategic Implementation Tip

State and territorial health agencies can build and foster relationships with other state/territorial and local housing officials to coordinate the provision of housing with necessary services that residents may need to live independently.

Medical/Supportive Services: Strategic Implementation Considerations

S/THAs can pursue a variety of measures to fund medical/supportive services that enable older adults and persons with disabilities to age in place, such as Medicaid waivers, specific provider types like PACE, or county-run programs such as IHSS. These funding sources can be used separately or concurrently with other programs utilizing funds from federal, state, and county sources. These braided and blending funding sources also provide opportunities to partner with local community organizations to improve access to needed services for underserved areas and populations. States and territories wishing to braid and layer funds for medical/supportive services should consider the following recommendations:

- **Assess Current Needs and Community Partnerships:** Each jurisdiction must assess and address its population's unique needs through policy choices in the implementation of their programs. For example, individuals may have preferences for using family members vs. paid professionals as their caregivers, which may impact the decisions that jurisdictions make regarding compensation and income support for in-home care. S/THAs can leverage the expertise of community leaders and organizations through robust partnerships with communities to understand the needs and preferences of target populations.
- **Assess Current Flexibilities and Opportunities:** Most states have utilized an array of Medicaid waivers to build a patchwork system of medical/supportive services. To minimize unnecessary complexity, state and territorial health agencies could benefit from thoroughly evaluating both their existing waivers and their opportunities for coordination prior to developing new programs or using new waivers.
- **Create New Partnerships:** State and territorial health agencies can create new partnerships and bolster existing collaboration across multiple sectors (e.g., housing, healthcare, and community-based organizations) to promote linkages across entities and types of services/resources. For example, state and territorial health agencies can support information sharing for service providers to facilitate collaboration and reduce service replication.

Braided and Layered Funding: Housing and Physical Structure Development

Physical development or changes to existing housing infrastructure, such as building new affordable housing units or retrofitting older units to meet residents' needs, can improve health and well-being for older adults and persons with disabilities. States and territories often use existing federal or state funding programs that provide subsidies for new construction or rehabilitation of existing affordable

housing structures. Jurisdictions can also use these funding strategies to address historic housing discrimination against communities of color in federal, state, and local policies.

U.S. Department of Housing and Urban Development (HUD) funding has been central to creating new housing for older adults and persons with disabilities by providing capital advances for developers to subsidize affordable housing construction for these populations. In other areas, local housing authorities have effectively created their own programs to support residents' desire to age in place.

U.S. Department of Housing and Urban Development Funding Programs

Overview and Funding

Through the Section 202 Supportive Housing for the Elderly program, HUD pays private nonprofit organizations—such as developers—to construct, rehabilitate, or purchase structures where very low-income older adults can live independently. The program also provides rent subsidies for housing units in these structures to help make them affordable.[44]

The Section 811 program is similar, paying developers to build and subsidize housing with supportive services for very low- and extremely low-income adults with disabilities.[45]

Strategic Implementation Tip

State and territorial health agencies can serve as conveners for local and state housing authorities and, helping them share best practices and models for modifying homes to enable residents to safely age in place.

After they use HUD funding to finance supportive housing development, developers do not need to repay the advance as long as the project serves the intended population for 40 years. Section 811 also gives funding to state housing agencies, which then allocate the funds through partnerships with state health and human services and Medicaid agencies for rental assistance.[46] S/THAs can also use this funding to oversee the supportive programs that are part of Section 202 and Section 811. Both HUD programs are discretionary funding, requiring Congress to appropriate money for the programs and making them vulnerable to budget cuts.

Overall Strategy

Although HUD programs' policy and implementation directions are largely federally driven, states and territories still have opportunities to directly address housing using these funds. For example, the Section 811 rental assistance program requires state and territorial housing agencies to partner with their Medicaid and/or health and human services agencies to help extremely low-income persons with disabilities access housing and supportive services.[47] Accordingly, S/THAs can collaborate across state and territorial agencies to support braiding and layering HUD funding for existing or new programs to bolster these housing programs. Through this funding opportunity, S/THAs can reduce the pitfalls of siloed administration.

Case Study: Project Rental Assistance in Montana and Pennsylvania

Section 811's rental assistance program, called Project Rental Assistance (PRA), is a relatively new HUD funding mechanism. HUD conducted the initial demonstration in 2012, and participating states, including Montana, used PRA funding with varying levels of integration and involvement across state agencies.[1,48] In Montana, the Department of Commerce and the Department of Health and Human Services worked closely with the Missoula Housing Authority, which oversees a large portfolio of tax

[1] The following 12 states participated: California, Delaware, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Minnesota, Montana, Pennsylvania, Texas, and Washington.

credit properties. In total, Montana received $2,000,057 to cover a total of 81 units to house people with physical disabilities or severe mental illness who receive services through Medicaid waivers or are on waiting lists for Medicaid waiver services.[49]

By contrast, Pennsylvania used PRA funding to build on existing state programs that provide incentives to developers to build housing for extremely low-income individuals with disabilities. Pennsylvania's PRA program was administered through a partnership between the Pennsylvania Housing Finance Agency and the Pennsylvania Department of Public Welfare, who together provided implementation oversight.[50]

Key Takeaways

The Montana demonstration project yielded important lessons for the provision of future PRA programs under Section 811. The state's program successfully housed the intended population, but in lower quality housing and in less-resourced neighborhoods compared to other similar HUD programs, such as the traditional Section 811 program that utilizes capital advances. However, early evidence suggests that PRA residents are more likely to use case management services and less likely to use long-term inpatient care when compared with Medicaid beneficiaries not receiving HUD assistance.[51] Moreover, as Montana's program demonstrates, the population receiving HUD assistance may also be eligible for Medicaid programs that S/THAs may administer and oversee. As such, there is ample opportunity for states and territories to braid and layer HUD funding with existing Medicaid programs through further collaboration between S/THAs and housing authorities overseeing HUD programs and demonstration projects. Future implementation of PRA may benefit from these early lessons, especially in planning for property development in better resourced areas, maintaining access to case management, and improving collaboration and partnership between state and territorial agencies.

State and Local Partnerships

Overview and Funding

Local housing authorities or housing advocates can identify housing needs in the local community and leverage existing resources to provide immediate services and interventions for older adults and persons with disabilities. However, while HUD programs are normally allocated for in the federal budget, state-local partnerships use other sources of funding as they become available. For example, local organizations may use private funding, such as from grants or other donations, to start projects. Those organizations often later partner with the state or territorial housing authority and receive additional resources from the state budget to expand successful programs.

Overall Strategy

Since funding sources for state-local partnerships are far more varied than their federal counterparts, it is incumbent on state housing agencies, in partnership with health agencies and other state agencies, to identify high-performing and innovative programs with demonstrated success to ensure funding is used responsibly and effectively. Additional funding resources for expansion on a community-by-community basis, especially from private foundations or funders, may be used by S/THAs to promote locality-specific interventions to address housing. S/THAs can also integrate programs with demonstrated success into longer-term planning by including them in future Medicaid waivers (e.g., the 1915[b] waiver, as a required covered service in managed care health plans).

Case Study: Maine's Comfortably Home Program

Maine's Comfortably Home program is an effective home modification program that began at the local housing authority level and was later expanded through a partnership with the state.[52] First established

in 2015 by the Bath Housing Authority in Bath, Maine, the program offers no-cost home safety checks, minor maintenance repairs, and accessibility enhancements to eligible, low-income elderly and disabled homeowners to help them live independently and safely. During the pilot phase, the program provided services for 56 privately owned homes.[53] The program later received a grant from the John T. Gorman Foundation to replicate the model with four other Maine housing authorities. As of 2017, these additional communities implemented similar programs through funding from the Maine State Housing Authority.[54]

The Comfortably Home program had six key goals in mind: reduce falls, reduce home fire risk factors and actual fires, reduce hospitalizations, improve mobility and independence, reduce isolation, and help relieve financial burdens. The initial pilot program saw improvements in all goal areas. Moreover, subsequent partnerships with both other local housing authorities as well as the state housing authority indicates the feasibility of expansion.

By sharing its model with other localities and the state, the Comfortably Home program provided expertise to other local housing agencies that implemented the program to benefit their own respective communities. S/THAs can support locally-driven initiatives by engaging stakeholders and highlighting promising practices, and enabling replication across their jurisdictions.

Housing and Physical Structure Development: Strategic Implementation Tips

Federal HUD programs such as Section 202 and Section 811 have traditionally been effective funding mechanisms to promote construction and rental assistance for affordable housing units. Other local initiatives, such as Maine's Comfortably Home program demonstrate the power of community-led programs in improving in housing for older adults and persons with disabilities. The following are strategic considerations for other states and agencies that may wish to pursue such programs:

- **Convene Interagency Partners:** Partnering with other agencies can create linkages between service providers and improve service coordination for individuals. S/THAs can create forums to foster these partnerships across state and territorial government agencies.
- **Support Local Innovation:** S/THAs can encourage local authorities to consider health needs in increasing affordable housing for seniors and persons with disabilities. Successful local initiatives and local support for high-performing programs can provide evidence-based models to duplicate.
- **Link Housing and Social Services:** Property development and rental assistance for older adults and persons with disabilities may result in more positive health and wellness outcomes when linked with health and social services, necessitating further linkages and more braiding/layering of Medicaid or other funding that S/THAs can utilize for this cause. Subsequently including property development and rental assistance programs in Medicaid waiver programs, in combination with federal housing programs, provides opportunities for braiding and blending health-oriented funds with housing-oriented funds.

Braided and Layered Funding: Supportive Housing and Hybrid Programs

Both safe, affordable housing *and* medical/supportive services may be necessary to support and improve health and wellness for older adults and persons with disabilities who wish to age in place.[55] As a result, many states and territories have brought together these two components through supportive

housing and hybrid programs, with positive outcomes. For example, research shows that older adults in buildings with supportive housing were half as likely to enter nursing homes and less likely to go to the hospital when compared with older adults without such services.[56] Cost savings are also significant: one study found an average savings of over $6,000 a year in healthcare costs per person in a high-needs group when affordable housing is combined with intensive services.[57] The School of Nursing at Johns Hopkins University established just such a hybrid program, as did the state of California. In particular, California used emergency funding from FEMA and the Coronavirus Aid, Relief, and Economic Security (CARES) Act with state budget allocations to support homeless and other at-risk populations during the COVID-19 pandemic.

The Community Aging in Place—Advancing Better Living for Elders Project

Overview and Funding

The Community Aging in Place—Advancing Better Living for Elders (CAPABLE) Project was developed at the Johns Hopkins University School of Nursing to provide client-centered home-based interventions aimed at increasing low-income older adults' mobility, functionality, and capacity to enable them to live at home. As part of the program, a team of health professionals assesses the client's goals and provides individuals with health and medical services to improve functionality. The program also provides individuals with handy worker services, such as home modifications to improve home safety and empower the client to achieve personal goals.

CAPABLE has demonstrated health improvements and cost savings; the initial pilot study found an association between the program and improved physical functioning in study participants.[58] The pilot demonstration also suggested an annual Medicaid savings of approximately $10,000 per program participant.[59]

Funding for the CAPABLE program can be customized to whatever is available for the implementing agency. Although the initial pilot project in Baltimore was funded through NIH and then from the Center for Medicare & Medicaid Services Innovation Center, the 25 additional CAPABLE program sites have varying funding sources, including accountable care organizations, PACE, Meals on Wheels agencies, Medicaid waivers, and private philanthropy.[60,61] To support this diversity of funding schemes, the CAPABLE team based in the Johns Hopkins School of Nursing provides technical assistance for agencies implementing the program.

Overall Strategy

Based on the data from both the demonstration project and other sites, the CAPABLE program can effectively support aging in place, as both the health and wellness outcomes and cost savings in the Medicare and Medicaid programs are suggestive of success after implementation. The program team has made the following strategy recommendations for future expansion:

- Utilize current Medicaid waivers or implement as a Medicare benefit.
- Leverage existing benefits made available through the Affordable Care Act.
- Work with health organizations (e.g., accountable care organizations) to educate and assist with implementation/administration.
- Leverage flexibilities that already exist in Medicare Advantage plans, such as required wellness visits and function-focused assessments.[62]

By design, the CAPABLE program considers individual preferences and goals for care planning, and subsequently provides care to accomplish those goals. Moreover, because of the flexibility of program funding, it can be adapted to various existing funding situations in states. State and territorial health agencies can support these recommendations by encouraging partners to include the CAPABLE program model in Medicaid waivers and connecting with health organizations, such as managed care organizations or accountable care organizations. Inclusion as covered services in various insurance plans also provides an opportunity to braid and layer federal funding with private funds through privately paid premiums. S/THAs s may need to provide needed oversight and outreach for such expansion efforts.

Strategic Implementation Tip

State and territorial health agencies may leverage time-limited funding to support crisis needs for housing and social services through partnerships with state and local agencies and other stakeholders.

Project Roomkey and Project Homekey

Overview and Funding

While most supportive housing and other hybrid programs have traditional funding sources (e.g., grants, Medicaid waivers, and HUD programs), some were created in response to the severe strain wrought on existing housing and supportive systems due to the COVID-19 pandemic. In particular, because of the heightened risk of COVID-19 exposure for people experiencing homelessness (either living on the streets or living in large group shelter settings), the state of California developed Project Roomkey and Project Homekey to minimize this risk.

Project Roomkey aimed to provide housing options for people experiencing homelessness by identifying high-risk individuals (e.g., people with pre-existing conditions and older adults) and relocating them into non-group shelter settings such as hotels, motels, or self-contained trailers.[63] In addition to housing, the program provided support services, such as onsite oversight, security, meals, laundry, cleaning and sanitation, and linkages to medical and behavioral health.[64] A partnership of multiple state agencies administered and implemented the program, providing funding and technical assistance for participating counties to execute hotel/motel occupancy agreements and cover core support services.[2,65,66] The program is a coordinated effort by state and local agencies and community partners.

California then developed Project Homekey as the next phase of Project Roomkey. This project funds support programs, provides rental assistance for individuals facing homelessness, supports the development of new interim or permanent housing units (through the acquisition and redevelopment of hotels and motels), and stabilizes board-and-care homes and facilities (especially during the COVID-19 pandemic).[67]

Strategic Implementation Tip

Models like CAPABLE can be supported with a wide variety of funding sources, including Medicaid, ACA funds, private or Medicare managed care funds, or private philanthropy, to simultaneously adapt homes and provide supportive services.

The state legislature initially allocated $150 million for emergency homelessness aid for shelter support and emergency housing in response to the COVID-19 pandemic, which California subsequently used to

[2] These agencies include: California Department of Social Services, California State Department of General Services, California Business, Consumer Services, and Housing Agency, and the California Office of Emergency Services.

support Project Roomkey.[68] FEMA funds appropriated through the CARES Act then enabled the state and local governments to recoup 75% of the room and wraparound services costs.[69]

The state legislature allocated an additional $1.3 billion for Project Homekey on June 30, 2020. Of this, $600 million is available to cities, counties, or other local public entities (such as housing authorities or federally recognized tribal governments within California) to identify, purchase, and rehabilitate buildings for use as housing units. This funding consisted of $550 million from the state's allocation of federal Coronavirus Aid Relief Funds, which had to be spent by Dec. 30, 2020, and $50 million from the state's general fund, which must be spent by June 30, 2022.[70] California can use the other portion of the $1.3 billion more flexibly; for example, the state will use $300 million for general local homelessness support.[71]

Overall Strategy

Both Project Roomkey and Project Homekey exemplify the utilization of time-limited and situation-specific funding to address long-standing issues related to housing and wellness. While homelessness is certainly not an issue that solely affects older adults and persons with disabilities, older adults have heightened susceptibility to serious health impacts as a result of COVID-19 and therefore require additional precautionary services, such as secure housing with adequate social distancing and medical care. [72] These programs are particularly important to prevent homelessness and its attendant poor health outcomes for these populations.

Both Project Roomkey and Project Homekey have leveraged available federal funds to coordinate state and local efforts and incorporate the local communities' expertise. Notably, the programs have operated at the county level, with oversight and technical assistance from state agencies. Thus, state health agency leaders acted as key partners in the collaborative effort across multiple state and county agencies.

Key Takeaways

While Project Homekey is still far from completion, Project Roomkey has gone through its initial implementation process and the state has analyzed some of its outcomes.[3] The counties' varying approaches to implementation have led to varying levels of success. For example, critics of the program have argued that the pace of matching eligible individuals to available rooms has been too slow. Other challenges included slow contracting due to hoteliers' concerns related to liability and insurance, limited experience and training for hotel workers providing additional services to the housed individuals, and initial difficulty obtaining personal protective equipment.[4] However, there were still successes in the pilot. In particular, sites that partnered with local social services providers effectively provided meaningful wraparound services.[73]

Learning from Project Roomkey's successes and addressing its challenges can provide a basis for developing long-term housing solutions, even for states and localities with smaller capacities and budgets. States and territories can replicate Project Roomkey's model of using housing placement and wraparound services to address homelessness among vulnerable populations with significant financial

[3] Initial awards for Project Homekey were made in fall 2020, and the expenditure deadline was December 30, 2020.

[4] Los Angeles County had the goal of placing 15,000 individuals into housing, but as of early June 2020 only 3,600 individuals had been housed.

commitment from all levels of government and coordinated efforts by local jurisdictions and community partners to successfully address complex physical and behavioral health needs.[74]

Supportive Housing and Hybrid Programs: Strategic Implementation Tips

Supportive housing and hybrid programs combine medical and supportive services with physical housing adaptations to enable older adults and persons with disabilities to age in place. Community-based organizations or other local agencies can implement programs such as CAPABLE to meet the unique needs of community members. Larger scale programs that braid services and property development can also utilize suddenly-available funding. While Project Roomkey and Project Homekey are unique in their scale and use of COVID-19 funding, they do provide a relevant example of braiding and layering situation-specific federal funds with state allocations to address pre-existing housing concerns exacerbated by other external conditions (such as the global pandemic).

Although hybrid programs are sensitive to local capacities and needs, the following are common themes and considerations that may affect other jurisdictions wishing to implement this work:

- **Ongoing Support Is Essential:** Sharing tips and lessons learned and providing ongoing technical support for implementing organizations is necessary to ensure program replicability in other communities, whether or not this support comes from S/THAs or the originators of the specific program.
- **Funding Conditions Vary:** Program funding can come from multiple sources and therefore have different sets of attached conditions (e.g., deadlines for spending allocated funds or requirements to track and maintain specific levels of quality of care when receiving capitated funds) that S/THAs need to accommodate and closely track.
- **Community Partnerships Are Key:** External market conditions such as limited availability of modifiable housing units or pushback from the community can derail implementation of well-meaning programs. S/THAs must engage in the necessary groundwork of building partnerships and community support prior to rapidly implementing a program to prevent community-level opposition.

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