Planning for success:

A Financial Analysis of the Supportive Housing Need in San Antonio

PRESENTED TO SAN ANTONIO LISC
AUGUST 29, 2019

CSH

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Executive Summary

To ease the trauma of chronic homelessness in San Antonio, progress must continue in a proven, cost-effective solution: supportive housing

The Charge: In an attempt to better understand the need related to homelessness in San Antonio, San Antonio LISC directing the development of this financial needs analysis to inform policymakers and guide the production of new units of supportive housing in the region. The plan includes the actual need for supportive housing, and the total cost of meeting the functional zero goals related to the housing and services components. CSH prepared this analysis through community stakeholder engagement, data gathering and analysis, and national best practices research.

The Need: The number of people with significant disabling conditions and long periods of homelessness has grown in San Antonio over the past several years. In order to escape the continuous and costly cycle of emergency room visits, incarceration and shelter stays, many highly vulnerable members of the community require supportive housing responsive to their particular needs.

the financial model establishes the unmet need for supportive housing using the best available demographic data, the turn-over rate in the current local inventory of supportive housing, and an estimate of the chronically homeless population over time. Combined, the data show the San Antonio region will need just over 900 additional supportive housing units over the next decade. Implementation will require periodic monitoring, which may result in changes to both need and cost estimates.

The Cost: Supportive housing is deeply affordable housing with ongoing wrap around support services attached. Extensive studies demonstrate that supportive housing is an effective and humane alternative to people with severe disabilities, including those with untreated or undertreated mental illness and addictions, who are living on our sidewalks, in our shelters, and cycling through our institutions. A strong evidence base also shows there can be significant financial savings to the community because it reduces emergency health care, public safety, Medicaid, other service costs, and institutional stays. Supportive housing requires significant coordinated investments to build and operate new units, lease existing units in the private market, and provide ongoing wrap around services to support successful tenancy.

This analysis draws on extensive cost modeling using locally derived data to estimate the total funding needed to add 900 units is approximately $215 million dollars over the next ten years. Ongoing operating and services investments after the first ten years are estimated at approximately $14 million per year.

A Shared Responsibility & Investment: A decision by the City of San Antonio and other regional authorities to create at least 900 units of supportive housing would represent the kind of focused goal setting and local leadership required to scale the supportive housing response needed. Achieving the goal will require partnership and investment well beyond the City. A plan must be developed which places significant emphasis on aligning local efforts with current regional and

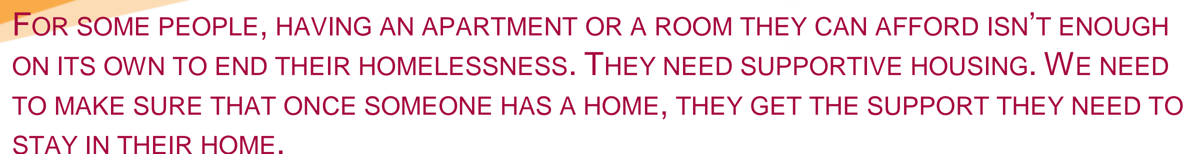
statewide supportive housing planning and development efforts, and identifies a critical role for private, philanthropic, health care, state and federal funding streams in achieving the 900-unit goal.

Building on Success: This analysis provides some information about other communities around the country that have taken on bold supportive housing plans and needed true inter-jurisdictional and cross-sector collaboration guided by clear outcome metrics. True multi-sector initiatives have led to significant expansion and improved alignment of the resources invested in ending homelessness in the community, and to annual outcomes that have routinely exceeded ambitious goals.

Implementation: This analysis does not provide specific recommendations needed for implementation of the unit goal. However, this analysis could be utilized as the starting point for a holistic regional plan.

Utilizing additional community input toward development of a community homeless plan, San Antonio will be prepared to: (1) develop a comprehensive road map spelling out the guiding values for project selection, the specific mix of supportive housing types, unit sizes, subpopulations prioritized, and geographic distribution that is needed; (2) oversee the development of specific projects; (3) provide real time tracking of progress toward the overall unit creation goal and plan outcomes, as well as the specific targets set out in the road map; and (4) at least annually reassesses the total community need for supportive housing.

Few communities around the country have set such goals related to the expansion of supportive housing. However, those that have are succeeding in ways that other communities are not. This analysis gives San Antonio and the surrounding region the starting point to turn the ambitious goal to create at least 900 units of supportive housing by 2029 into a reality.



FOR SOME PEOPLE, HAVING AN APARTMENT OR A ROOM THEY CAN AFFORD ISN'T ENOUGH ON ITS OWN TO END THEIR HOMELESSNESS. THEY NEED SUPPORTIVE HOUSING. WE NEED TO MAKE SURE THAT ONCE SOMEONE HAS A HOME, THEY GET THE SUPPORT THEY NEED TO STAY IN THEIR HOME.

Background

Supportive Housing

Supportive Housing is a proven solution to some of communities' toughest problems. It combines affordable housing with tenancy support services to help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing is more than affordable housing with resident services (a highly effective but less resource-intensive housing and services approach for people who can benefit from services but do not need them in order to access and remain in housing). Supportive Housing is an evidence-based intervention with specific staff-to-client ratios, approaches to services, and quality standards for housing and services operations.

Ideally, a community will agree upon locally adopted, minimal and ideal operating standards for supportive housing, transitional housing and other interventions for people experiencing homelessness.

The following is a summary of key aspects of the Dimensions of Quality supportive housing nationally, which can serve as a baseline to ensure outcomes are met when new units of supportive housing are produced. In some cases, local funders and providers in a given community might vary from these guidelines when making decisions regarding financing and implementation.

Priority Populations: Supportive housing is for people who, but for the availability of services, do not succeed in housing or but for housing, are unable to access the preventative and ongoing healthcare and human services they need. Supportive housing is not the solution for everyone who is experiencing homelessness. It is prioritized for those who need it most. Supportive housing is for people who:

- ✓ Are chronically homeless (people who are living with one or more disabling condition and who have experienced long or repeated episodes of homelessness). Have a combination of barriers to housing such as complex disabling conditions and extremely low incomes.
- ✓ Cycle in and out of institutions (e.g. jails, prisons, hospitals, skilled nursing facilities, and other licensed care facilities).
- ✓ Are being (or could be) discharged from institutions and systems of care.

Services: The services in supportive housing are intensive, flexible, tenant-driven, voluntary and housing-based. There is no requirement placed upon tenants to participate in services. The responsibility of engagement lies with the service provider to use evidence-based approaches such as motivational interviewing and assertive engagement to draw tenants into the services that they

are seeking. The core services in supportive housing are tenancy supports that help people access and remain in housing. Tenancy supports are delivered at staff-to-client ratios of 1-10 for scattered site supportive housing and 1-15 for clustered and single-site supportive housing. Tenancy Support Specialists are responsible for assisting with:

- housing search, documentation, and subsidy applications;
- helping to acquire furnishings, cleaning supplies, and household items;
- ensuring rent is paid and recertification's are completed;
- safeguarding that lease obligations are met and tenancy rights are upheld;
- providing conflict resolution and supporting moves to different apartments when necessary; and
- helping tenants to make connections in their communities. Tenancy supports also include varying degrees of transportation to appointments, assistance with medication adherence, health and safety education, substance use disorder supports, nutritional counseling, and money management. Tenancy Support Specialists help tenants access other community-based services such as peer supports, outpatient behavioral health services (mental health or substance use disorder services), primary care, and education and employment. They also make connections with staffs of hospitals, health clinics and hospice when tenants receiving acute medical and/or palliative care are in need of support at home.

Additional supportive housing service models include Intensive Case Management (ICM) and Assertive Community Treatment (ACT). These models integrate tenancy supports with traditionally clinic-based behavioral health services such as outpatient mental health through multidisciplinary teams. The mental health system funds these teams, most often, to adhere to specific fidelity measures. These models do not by definition require the delivery of pre-tenancy support services, but their low staff-to-client ratio affords services teams the ability to integrate pre-tenancy and tenancy support services.

Housing: The housing in supportive housing is affordable, not time limited (except, perhaps, in the case of recovery hours), and independent. Rather than screening people out, operators of supportive housing actively seek and "screen in" those who need it most. Tenants hold leases with property owners or service providers master lease units from property owners and sublet to tenants through a lease. The tenant initiates roommate arrangements rather than the service provider. Rent and utilities are capped at 30% of a tenant's income, generally. Supportive housing apartments should be in healthy communities with access to amenities. Whenever possible, tenants have independent kitchens and baths, though in some cases, single-room-occupancy buildings (housing with shared kitchens and/or baths), and/or micro-apartments (with shared kitchens) are used for supportive housing. There are three housing models of supportive housing. Communities should have a balanced array of each to allow prospective tenants to make choices about where they live.

- Scattered-site: Housing is rented anywhere in a community.
- Clustered: A limited number of apartments are set aside for people who need supportive housing within a larger rental development.
- Single-site: An entire housing development is for people who need supportive housing.

Any of these models can work well in urban communities. In suburban or rural communities where densities are lower, scattered-site and clustered housing are the most commonly used models.

Housing First: Supportive housing works best when combined with a Housing First philosophy. Housing First is an approach to serving people experiencing homelessness that recognizes a

homeless person must first be able to access a decent, safe place to live, that does not limit length of stay (permanent housing), before stabilizing, improving health, reducing harmful behaviors, or increasing income. Under the Housing First approach, anyone experiencing homelessness should be connected to a permanent apartment as quickly as possible, and programs should remove barriers to accessing the housing, like requirements for sobriety or absence of criminal history. It is based on the “hierarchy of need:” people must access basic necessities—like a safe place to live and food to eat—before being able to achieve quality of life or pursue personal goals. Finally, Housing First values choice not only in where to live, but whether to participate in services. For this reason, tenants are not required to participate in services to access or retain housing.

Programs using Housing First generally fall into two categories:

1) Supportive housing, which is an apartment made affordable through long-term rental assistance, paired with intensive services promoting housing stability.
2) Rapid re-housing, which connects a family or individual to an apartment affordable through short- to medium-term rental assistance, along with moderate services designed to allow that household to increase their income sufficiently to be able to afford the apartment over the long-term.

While Housing First recognizes housing is a necessary precursor to treatment, Housing First does not mean “housing only.” On the contrary, Housing First acknowledges social services and care coordination are necessary elements of housing stability and quality of life.

Housing First often utilizes these “core components”:

- Tenant screening and selection practices promote accepting applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services.
- Applicants are not rejected on the basis of poor credit or financial history, poor or lack of rental history, criminal convictions unrelated to tenancy, or behaviors that indicate a lack of "housing readiness."
- Housing providers accept referrals directly from shelters, street outreach, drop-in centers, and other parts of crisis response systems frequented by vulnerable people experiencing homelessness.
- Supportive services emphasize engagement and problem solving over therapeutic goals and service plans that are highly tenant-driven without predetermined goals.
- Participation in services or program compliance is not a condition of housing tenancy.
- Tenants have a lease and all the rights and responsibilities of tenancy.
- The use of alcohol or drugs in and of itself, without other lease violations, is not a reason for eviction.
- Funding promotes tenant selection plans for supportive housing that prioritize eligible tenants based on criteria other than "first-come-first-serve," including, but not limited to, the duration or chronicity of homelessness, vulnerability to early mortality, or high utilization of crisis services.
- Case managers and service coordinators are trained in and actively employ evidence-based practices for engagement, including motivational interviewing and client-centered counseling.
- Services are informed by a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of tenants' lives, where tenants are engaged in nonjudgmental communication regarding drug and alcohol use, and where tenants are offered education

regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if the tenant so chooses.

- The project and specific apartment may include special physical features that accommodate disabilities, reduce harm, and promote health and community and independence among tenants.

Housing First Evidence Basis

The federal government and many State governments recognize Housing First as an evidence-based practice. In fact, a settled and growing body of evidence demonstrates—

- Tenants accessing Housing First programs are able to move into housing faster than programs offering a more traditional approach.[1]
- Tenants using Housing First programs stay housed longer and more stably than other programs.[2]
- Over 90% of tenants accessing Housing First programs are able to retain housing stability.[3]
- In general, tenants using Housing First programs access services more often, have a greater sense of choice and autonomy, and are far less costly to public systems than tenants of other programs.[4]

Cost Evidence Base

The National Alliance to End Homelessness names supportive housing as the solution to the problem of chronic homelessness (National Alliance to End Homelessness, 2014). The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services recognizes supportive housing as an evidence-based intervention for people with behavioral health conditions (SAMHSA, 2014). When implemented with fidelity to national quality standards, a growing body of research shows that supportive housing can improve health and lower system costs for highly vulnerable people. By providing stable, affordable housing and tenancy support services, supportive housing can help improve health, foster mental health recovery, and reduce alcohol and drug use among formerly homeless individuals.

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[1] Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fishcer, S. Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First programs. 2003.

[2] Tsemberis, S. & Eisenberg, R. Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. 2000.

[3] Montgomery, A.E., Hill, L., Kane, V., & Culhane, D. Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH. 2013.

[4] Tsemberis, S., Gulcur, L., & Nakae, M. Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis. 2004; Perlman, J. & Parvensky, J. Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report. 2006.

The following chart illustrates the difference in local costs between supportive housing (as modeled in this report) and institutions that serve people who might need supportive housing.[5]

Intervention	2017 Cost	Duration
In-patient stay in Texas State Hospital	$2520	Per night
Emergency Department	$500	Per average visit
Bexar County Jail	$213	Per night
Supportive Housing	$59-64	Per night

Sources: Texas Health and Human Services, Center for Outcomes, Research and Evaluation (via Health Affairs), The Center for Healthcare Services (Equitas Project) and CSH.

[5] See Appendix A for additional detail on the evidence base for supportive housing.

Existing Supportive Housing in San Antonio

The Housing Inventory Count (HIC) required by the U.S. Department of Housing and Urban Development (HUD) shows that San Antonio has approximately 2,100 units of supportive housing currently operating in Bexar County. These units achieve an annual utilization rate of 99.6%, have approximately a 10% annual turnover rate, and serve the following populations.

- **2,230 individuals without children.**
- **470 households experiencing chronic homelessness.**

Characteristics of People in Need

Priority populations served by supportive housing appear earlier in this document. This section summarizes local data regarding those priority populations, with focus on those experiencing chronic homelessness (people who have a disabling condition and experience homeless for an extended period).

Data Sources: The primary data source used to understand the extent of homelessness in Bexar County and the demographics and needs of that population was the local Point in Time Count of Homelessness (PIT Report). People identified through the PIT include a census of people who are staying in emergency shelter, transitional housing, or living in places not meant for human habitation (e.g. unsheltered) on a single night. The most recent PIT was conducted in January of 2018.

While these data sources provide a good starting point in understanding local homelessness, they are necessarily incomplete. In particular, they may undercount those who are cycling in and out of institutions, those who are doubled-up or in other unsafe or unstable housing situations and some communities of color.

Why Supportive Housing?

"Stable housing is the platform from where people can address the challenges they face, from where they can pursue their goals for themselves and their families, and from where they can see and seize new opportunities."

--Matthew Doherty, Executive Director of the United States Interagency Council on Homelessness

Individuals: This analysis focused on adults experiencing homelessness in households without children ("individuals") which represent 91% (2,230) of those counted in the 2018 PIT count. Among individuals counted, 21% (470) were chronically homeless, which by definition includes long periods of homelessness and a disabling condition. Nationally, chronic homelessness is one of the fastest growing categories of homelessness. However, Local chronic homelessness is down in San Antonio over two years, which is a good indication that many of the baseline supports that are needed in a community are already present in San Antonio. Still, nearly fifty-five percent (55%) of all people sleeping outside reported a mental illness, chronic physical condition and/or substance use disorder, which indicates that those on the streets are extremely vulnerable and likely cannot exit homelessness without significant and appropriate resources.

Unit and Financial Modeling

The 900 Unit Goal

This analysis estimates the need for the creation of at least 900 new units of supportive housing. This represents a strong, directional target that will enable San Antonio to focus the leadership, resources and implementation activities needed to scale a response to meet the need. Few communities in the country have given themselves such a public goal, and those that have are succeeding in ways that others who remain focused on piece-meal efforts cannot. Houston has reduced chronic homelessness by 70 percent because of working toward clearly delineated goals. Los Angeles County engaged in a financial analysis similar to the one in this report and went on to generate the resources to end chronic homelessness by creating 10,000 supportive housing apartments over ten years.

In order to determine how much supportive housing a community needs, CSH first estimates the number of people who will experience homelessness and chronic homelessness over the course of a year. We estimate that 90 percent of people experiencing chronic homelessness and ten percent of all households experiencing homelessness will need supportive housing. We then review the annual turnover rates of the existing supportive housing stock to determine the number that will become available over the course of a year. We subtract this number of units from the total need to establish the gap. Essentially, the methodology used to establish the 900-unit goal uses the following formula: Annualized need – units available through turnover = new units needed.

Refinements to the exact number of units needed can and should be made on an annual basis to ensure that supply meets demand over time by taking into account **fluctuations in the rental housing market; new policies** that help or hinder unit creation; federal, state, and local resource alignment; and public support.

In 2019, the analysis prepared for this report and found a new need of 927 units. These estimates are based primarily upon a population of people in the San Antonio region who have one or more disabling conditions and have been living outside for an extended period. Many more people who are living in or cycling between institutions and the streets could live in their own homes and communities if they had supportive housing.

Financial Model Assumptions

In order to establish the costs of creating and operating 900 units of supportive housing over a ten-year period, a number of essential costs drivers have to be evaluated. The total costs differ depending on whether the supportive housing is created through development of new affordable housing units or by leasing units on the private rental market. The cost of newly constructed units includes the one-time capital cost of acquiring land and building the units and the ongoing cost of maintenance and operation of the building. Housing leased in the private market requires the ongoing cost of rental assistance to make the rents affordable to people with very low incomes. Both leased and developed units of supportive housing require the ongoing cost of providing support services to the tenants in the units. This plan's working assumptions for these costs are summarized here and described in detail in Appendix B.

In order to create a financial model that estimates the total dollar amount needed to create 900 units, CSH looked at national cost data and surveyed some local stakeholders to establish several

important assumptions about the costs of creating and operating supportive housing and the percentage of units to be built and leased.

Following are the working assumptions for each of these factors.

Cost Assumptions

Per-unit costs for newly constructed or rehabilitated housing

Uses	Units for Individuals
Capital Construction (one-time cost)	$120,000
Housing Operations (annual cost)	$7,000
Services (annual cost)	$7,200

Per-unit costs for housing leased in the private rental market

Uses	Units for Individuals
Rental Assistance (annual cost)	$9,192
Services (annual cost)	$7,200

Sources:[6]

- Capital cost estimates are averages based upon actual costs reported by SAHA and approved by stakeholder advisory groups. The traditional leveraged model involves the contribution of approximately $30,000 to $70,000 per unit in local development funds.
- Operating cost estimates are based upon a range of $6-8,000 provided by National Apartment Association related to bond financed projects.
- Rental Assistance estimate is based upon HUD's April 2019 fair market rents provided by SAHA.
- Service cost estimates are based on stakeholder input and reflect the cost of tenancy support services at 1-15 staff-to-tenant ratio with flexible service funding for people with specific needs not covered by community-based and Medicaid-paid services. (See appendix B for a detailed description of services.)

[6] Descriptions of capital, operating, rental assistance and services costs can be found in Appendix B. A detailed description of supportive housing services costs can be found in Appendix B.

Inflation Factor Assumptions

In order to model the cost of creating and operating 900 units of supportive housing over a ten-year period. Stakeholders vetted the following inflation factors and sources.

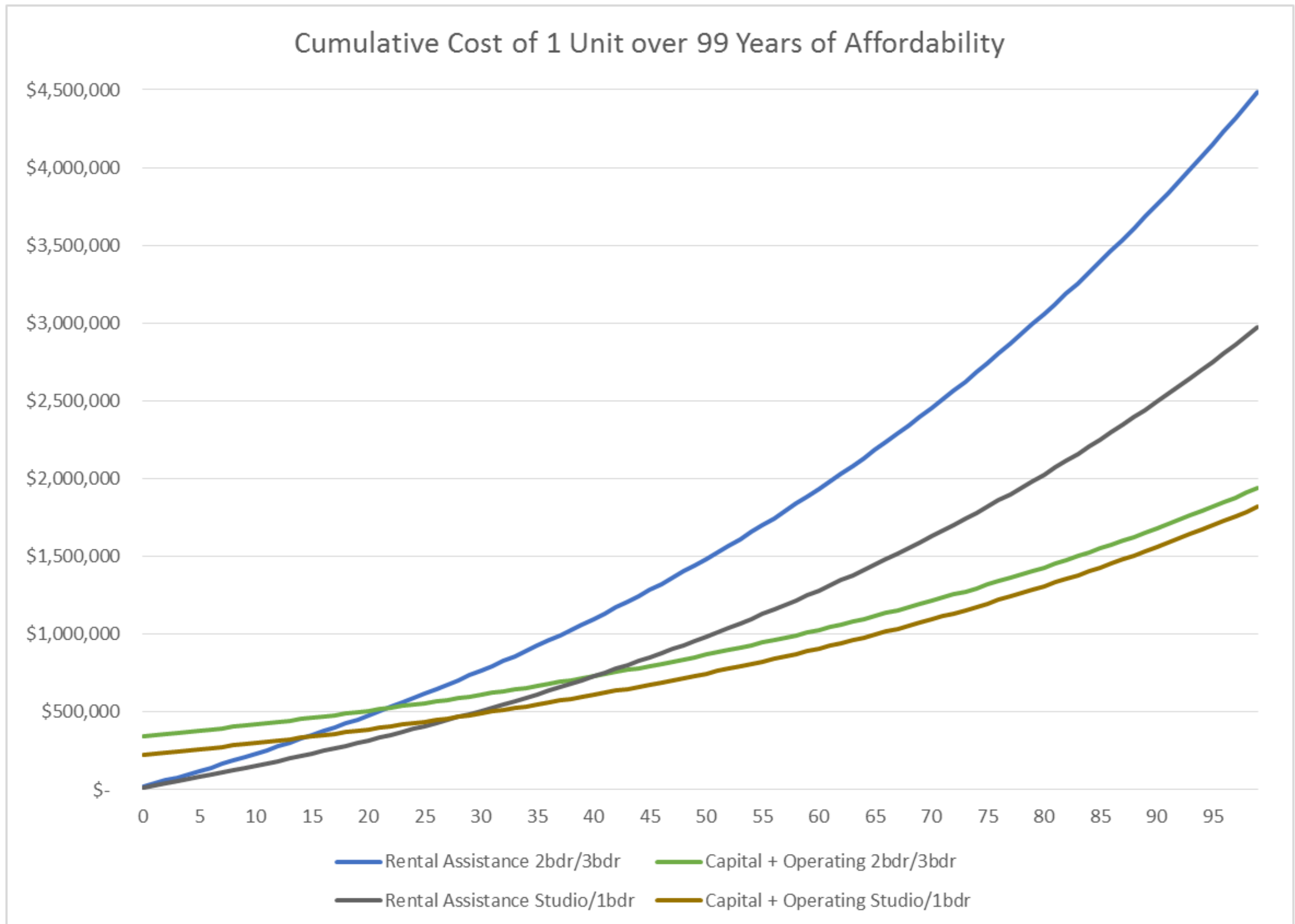
Cost Type	Inflation factor	Source
Capital	4%	National cost indexing surveys
Operating	2%	Consumer Price Index
Rental Assistance	1.6%	National increases in HUD's FMR rates over a 10-year period
Services	2%	Consumer Price Index

Assumptions about the percentage of units to be newly developed or leased in the rental market

Because of the variable cost factors for developed/rehabilitated and leased private market units, modeling for the 900-unit goal requires determining the number of apartments that can realistically be constructed and the number that can be leased in the private rental market over a ten-year period. This question can have a significant impact on total cost projections, funder capacity and the timing of creating new units. Stakeholders shared a number of opportunities and challenges related to each approach:

Unit type	Opportunities	Challenges
Apartments leased in the private market	**Lower up-front cost.***	**Lack of affordable apartments in the private-market, increased risk of loss of affordability over time**
	Potential to get people housed sooner.	**Screening criteria.**
	Increases tenant-choice about where to live.	**Property owners who are unwilling to rent to people with low incomes or complex rental histories.**
	Engages community members (property owners) in ending homelessness.	**Reductions in the affordable housing stock when "double-subsidizing" to increase affordability for people below 30 percent of area median income (AMI).**
Newly-developed units	**Creates housing stock needed to address affordability long-term.**	**Higher up-front cost.***
	Design can include space for services on-site and assistive technology.	**Takes at least two years for a project to move from concept to operations.**
	Property owners are willing to "screen in" those who need it most.	**Requires significant capitalized reserves to update systems during the required period of affordability.**

* Because the ongoing costs of providing rental assistance for private market units is greater than the annual operating costs of newly constructed supportive housing units, the total cost of leasing supportive housing units in the private rental market becomes significantly more expensive in the long run than building new units. Using the cost and inflation assumptions above, the ongoing cost of newly developed units becomes lower than the cost of leased units in year 30 for studio and one-bedroom units and in year 23 for two and three-bedroom units. The affordability covenant for most new publically financed affordable housing is 99 years. See chart below:



Financial Model

For illustration purposes, this report models the costs of creating 927 units based upon the assumption that 60 percent of the new unit will be developed/40 percent of the new units will be leased from existing housing stock.

Model 1: 60% developed/40% leased

Supportive Housing	**Developed** (60%)	**Leased** (40%)	**Total**
Studio/1-bedroom (Individuals)	556	371	927

Total cost over 10 years: $215 million
Total capital cost: $75 million
Combined, ongoing operating, rental assistance, and services for 927 units (at year 10 and beyond):
$14 million total annually (built up over time)
$15,100 per person per year
$41 per person per day

Note about per-person costs with different developed vs. leased configurations: Ongoing costs at year ten and beyond decrease in models with higher amounts of newly-constructed units because ongoing operating subsidies that pay for housing operations in publically-financed supportive housing are lower than the cost of rental assistance to secure housing in the private market.

Summary: Based on the best available current estimates of the various cost drivers for supportive housing and depending on the ratio of built to leased units, the total ten-year cost to achieve the 900-unit goal will be approximately $215 million. In years 10 and beyond, in order to maintain this inventory, there will be ongoing costs of approximately $14 million annually.

Definitions

Supportive Housing: an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities (USICH definition).

Permanent Supportive Housing: a combination of housing and services designed for people with serious mental illnesses or other disabilities who need support to live stably in their communities. It is a proven solution for people who have experienced chronic homelessness as well as people with disabilities (USICH definition).

Rapid Re-Housing: an intervention that rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services.

Housing First: an approach to housing that is centered on the belief that everyone can achieve stability in permanent housing directly from homelessness and that stable housing is the foundation for pursuing other health and social services goals.

Harm Reduction: an approach to services that is voluntary and focuses on reducing harm associated with certain behaviors, as that person works toward recovery.

Prevention: an intervention that provides housing assistance to households that are at risk for becoming homeless, who would become homeless but for this assistance, which can include rental assistance and/or relocation and stabilization services such as utility payments, mediation and case management.

Diversion: an intervention that provides assistance or support to divert a household from the shelter system. This approach encourages households to find alternative and safe living situations, such as staying with friends and family.

Transitional Housing: Buildings configured as rental housing developments, but operated under program requirements that call for the termination of assistance and recirculation of the assisted unit to another eligible program recipient at some predetermined future point in time, which shall be no less than six months.

Emergency Shelter: housing with minimal supportive services for homeless persons that is limited to occupancy of six months or less by a homeless person. No individual or household may be denied emergency shelter because of an inability to pay.

Developed: units that are either new construction or rehabilitation units that are created specifically to serve the desired supportive housing population. Developed units can be either single site or scattered site.

Leased: units that are utilized from the housing stock that is currently available in the community. Leased units may be master leased or leased directly by the supportive housing tenant with assistance from the service agency. Units may be a block of units within a single apartment complex, or scattered site units throughout the community.

Purpose-built or single-site housing: Apartment buildings designed to primarily serve tenants who are formerly homeless with the support services typically available on site.

Unit set-asides: Affordable housing owners agree to lease a designated number or set of apartments to tenants who have exited homelessness or who have service needs, and partner with supportive services providers to offer assistance to tenants. It is possible to have a single-site with unit set asides where some of the building is supportive housing and some is just affordable.

Scattered-site housing: People who are no longer experiencing homelessness lease apartments in private market or general affordable housing apartment buildings using rental subsidies. They can receive services from staff who can visit them in their homes as well as provide services in other settings.

Populations served by Supportive housing or Supportive housing tenants: Supportive housing is for those who would not be successful in their housing without additional supportive services, and for whom services would be less effective without stable housing. Permanent supportive housing serves those with long-term disabilities, including mental illness and addictions, who usually have long-term or cyclical homelessness in their background. Transitional housing serves those who require a level of intensives services, but not necessarily permanently and are at high risk of becoming chronically homeless. Tenants of supportive housing can include (though aren't limited to):

- People in early recovery including those exiting substance abuse treatment and detox
- People with acute medical conditions that require advanced care outside of a hospital setting
- Families whose head of household is disabled, including mental illness and addictions – often with involvement in the child welfare system
- People cycling through institutions such as jail, inpatient psychiatric care and hospitals
- Survivors of domestic or sexual violence engaged in safety- and trauma-focused services
- Other distinct subpopulations, like transition-aged youth (aged 18-25) and veterans

Appendix A: Evidence Base for Supportive Housing

Following are additional examples of the evidence base for supportive housing.

Bud Clark Commons (BCC), a supportive housing development in Portland, has 130 apartments that are prioritized for people with long experiences of homelessness and complex health needs. In the year before they moved into BCC, residents on Medicaid averaged total monthly health care costs of $1,626. In the year after moving in, average costs were $899 per month, a 45% decline. Total Medicaid cost reductions were greater than $.5 million in the first year.[7]

Similarly, a supportive housing project in Washington State, 1811 Eastlake, is nationally recognized for its documented success in improving health outcomes and reducing Medicaid costs by housing people experiencing chronic homelessness who have severe alcoholism and high use of crisis services. A research study on the project was published in the *Journal of the American Medical Association* (Larimer, et al., 2009)[8]. Ninety-five tenants of 1811 Eastlake had total costs of $8,175,922 in the year prior to the study, which decreased to $4,094,291 in the year after enrollment, showing a 53 percent total cost rate reduction for housed participants relative to wait-list controls and historical data on service usage. Total emergency costs for this sample declined by 72.95 percent, or nearly $600,000 in the two years after the program's launch. The project also found that supportive housing tenants dramatically reduced alcohol use within 12 months of tenancy (24 percent fewer drinks per day and 65 percent fewer days intoxicated).

A cost benefit analysis of the Denver Housing First Collaborative examined system costs of 19 supportive housing residents for two years prior to, and two years post, housing (Perlman & Parvensky, 2006)[9] The post-period had 34 percent fewer emergency room visits, 40 percent fewer inpatient visits, 82 percent fewer detox visits, and 76 percent fewer incarceration days.

In a comprehensive examination of the evidence on supportive housing's outcomes, Rog, et al. (2013)[10], recommended that policy makers consider including supportive housing as a covered service for individuals with mental illness and substance use disorders.

For a more comprehensive listing of the evidence base for supportive housing, see this literature review compiled by CSH.

[7] Source: Joint Office of Homeless Services

[8] Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H. S., . . . Marlatt, A. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *Journal of American Medicine*, 1349-1357.

[9] Perlman, J., & Parvensky, J. (2006). *Cost Benefit Analysis and Program Outcomes Report.* Denver: Denver's Road Home.

[10] Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Gose, S. S., & Delphin-Rittmon, M. E. (2013). Permanent Supportive Housing: Assessing the Evidence. *Psychiatric Services in Advance*.

Appendix B: Detailed description of supportive housing costs

Financing to develop or rehabilitate new units of supportive housing in clustered or single-site settings can be thought of as a three-legged stool. With only two legs, the stool will not stand. The three legs are:

- Capital funds for new construction and rehabilitation.
- Operating subsidy to pay the difference between the cost of operating the rental housing and the total amount that tenants can pay in rent and utilities.
- Services funding to pay for tenancy support services.

When financing scatted-site housing in the private rental market, two types of subsidies are needed:

- Rental assistance to pay the difference between “tenant rents” and the market rent on an individual apartment.
- Services funding to pay for tenancy support services.

Capital Costs:
Capital costs make up the “bricks and sticks” of supportive housing. They cover acquisition, construction, and rehabilitation. Costs typically fall into three categories:

- Acquisition costs generally include land, buildings, and holding costs.
- Hard costs include items such as construction and rehabilitation work, offsite improvements (such as sewers, utilities, etc.), and building materials.
- Soft costs include fees and services such as architectural services, appraisals, engineering, legal costs, municipal fees, and permits.

Once a building is up and running, capital costs include the replacement of major structures and systems such as roofs, heating and cooling, and electric, and plumbing upgrades.

Capital Financing:
By definition, housing affordable to people below thirty-percent (30%) of AMI cannot generally support debt. Similar to requirements for a single-family-home mortgage, banks that lend to multifamily housing developers require proof of income (revenue) to make loan payments (debt service). When tenants with extremely low incomes pay 30 percent of their incomes toward rent and utilities, this doesn’t come close to covering the full cost of operations, and there is clearly no profit to pay debt service. When housing people with no or extremely low incomes, public subsidy is necessary to pay for capital construction and rehabilitation so that debt is not required in the operating budget. Modeling for this Plan is based on an average current capital cost of $120,000 per unit for studios and 1-bedroom apartments. This estimate is based upon actual costs reported by the Housing Authority and verified by several stakeholder advisory organizations. The traditional leveraged financing model, which includes a myriad of resources, involves the contribution of approximately $50,000 to $75,000 per unit in local development funds.

Operating Costs:
This cost category covers everything it takes to operate a building and generally falls into four categories:

- Fees and services include management fees, office supplies, legal services, accounting, taxes, insurance, and marketing.
- Maintenance and repair costs generally cover repairs, trash removal, supplies, pest control, grounds upkeep and landscaping, elevator maintenance, painting, carpets, and decorating.
- Utilities generally include heating and air conditioning, electric, common area utilities, water and sewer, and telephone.
- In the case of supportive housing, many providers also provide resident services, which provide an additional level of on-site (generally front-desk) staff to the operations and management of housing.

Operating Subsidies: Supportive housing ensures that tenants pay no more than thirty percent (30%) of their incomes toward rent and utilities (often referred to as the "tenant rent"). To fill the gap between what supportive housing tenants can pay and the cost of building operations, an operating subsidy is needed. Operating subsidies are generally considerably lower than rental assistance subsidies because they only fill the gap to cover costs rather than providing rents comparable to those in private rental market. Financial modeling for this Plan estimates a cost of $7,000 per unit in operating costs. This is based upon a range of $6-8,000 provided by the Housing Authority and related to bond modeling.

Rental Assistance: Rental assistance subsidizes the difference between tenant paid rent, based on income, and the market-rate rent on an apartment.

Rental Assistance Resources:
The largest program that provides this type of subsidy is the Section 8 Housing Choice Voucher (HCV) program. HCV subsidy limits (payment standards) are based on HUD-determined fair market rents (FMRs), which are designed to ensure that tenants renting in the private market will have access to forty-percent of the total units available in any Office of Management and Budget-defined metropolitan area. This goal is established to ensure a plentiful array of rental housing options while not driving local market rents to chase subsidy rates. Due to significant increases in the cost of rental housing, average rents throughout the region consistently exceed the payment standards, especially for studio and one-bedroom units. As a result, some portion of people with rental assistance are currently unable to find housing even with a subsidy. This lack of available market-rate units drives voucher holders to use their vouchers in developments that are already subsidized by capital financing to offer rents affordable to people at fifty and sixty percent (50 and 60%) of AMI. When supportive housing tenants use rental assistance designed for the private market in affordable housing, the result is a net loss in total affordable housing. Decreases in affordable housing lead to increases in homelessness and often additional disparities in access to affordable housing for people of color. In some markets such as San Francisco, homeless service providers have used enhanced rates on rental subsidies in order acquire rental units. While this approach has been successful for tenants using enhanced-rate rental assistance, there are now challenges in the fact that supportive housing programs generally rely on a fixed set of amenable landlords, and these landlords are now more reluctant to

house people with standard-rate vouchers. Rental assistance costs in the model are $9,192 per year ($766 per month) for studios and one bedrooms. These costs are based upon HUD's April 2019 FMRs.

Services

CSH estimates $600 per person per month ($7,200 per year) as a baseline cost for tenancy support services as a starting place for most communities. This estimate has been vetted and used widely by providers and funders of supportive housing and is increasingly the basis for actuarial studies to determine rates for new Medicaid tenancy supports benefits. This rate generally supports the costs of a full-time Masters-level Tenancy Supports Specialist or a Bachelors-level Specialist with supervision.

Tenancy Supports cost per tenant per year	Caseload	Total available for Tenancy Supports Specialist Salary and Benefits
$ 7,200	10	$ 72,000
$ 7,200	15	$ 108,000

By way of reference, multidisciplinary teams that follow fidelity standards to Intensive Case Management or Assertive Community Treatment can cost as much as $17,000 per person per year.

Tenancy supports are most effective when paired with community services such as out-patient mental health, substance use disorder services, education and employment, specialized children's services, primary care, and care coordination. However, these services are not always readily available to tenants of supportive housing, and many providers would like to be able to provide enhanced services directly in supportive housing. Community feedback consistently reinforced the need for additional services funding in the model to provide flexibility for these supplemental services.

Because Medicaid is an entitlement for people with incomes below 138% of the poverty level in Texas, theoretically, nearly all supportive housing tenants are eligible for Medicaid-reimbursed behavioral health and primary care services. Some might wonder whether tenants receiving these services also need tenancy supports. It should be noted that even at the highest potential level of service for people with the most complex needs, mental health out-patient services are reimbursed at a rate of $3,300 per person per year. This is clearly insufficient to provide both mental health services and tenancy supports, and with a significant number of people experiencing homelessness reporting behavioral health concerns, these services must be prioritized for their specialty focus. As well, other entitlement and mainstream-system funded services should be considered ancillary to the financial projections of this model and the financing of supportive housing services.

Although some community-based services are funded through entitlements, not everyone is eligible for or able to access these services. People who are undocumented or seeking citizenship, for example, are not eligible for Medicaid, which can present racial disparities for a subset of the target population who need health services. Many people who suffer from mental illness and addiction may be reluctant to or unable to travel to clinics to receive services, and/or they might be mistrustful of providers with whom they do not have immediate rapport closer to home. With additional, flexible services funds, providers with additional in-house expertise can supplement tenancy support services and provide their own behavioral health and/or nursing supports.

The caseload ratio for families needing supportive housing is the same as that of single adults, but providers often find that additional services are needed for children in families that have experienced the trauma of homelessness. Flexible funding allows providers to enhance their services plans to specialize in the services their clients need most, whether it be a child therapist, a supported-employment specialist, or a nurse.