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The Journal of Affordable Housing & Community Development Law is the official quarterly publication of the Forum on Affordable Housing & Community Development of the American Bar Association. It is targeted toward attorneys and other housing and community development specialists. It provides current practical information, public policy, and scholarly articles of professional and academic interest.

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From the Editor-in-Chief

Tim Iglesias

As this politically and legally tumultuous summer ended, legal practitioners, advocates, and scholars in the fields of affordable housing, fair housing, and community development returned to their offices and communities where we continue to face the challenge of how to respond to the current situation. Because our commitments do not countenance cynicism and withdrawal, we rouse ourselves to recommit to and innovate in our own work and to support our colleagues and allies. We hope this issue of the Journal assists those efforts by offering fresh and useful insights, practical strategies to achieve our goals, and encouragement based upon well-grounded validation of the efficacy and value of our work.

In addition to our annual Law Student Legal Writing Contest winning article and numerous other pieces, this issue features a health and housing theme. As Secretary Ben Carson opines: “Homes and health are inextricably linked: they reflect two of the most basic needs of society and serve as an indicator of the strength of the nation.” The health and housing theme portion includes eight essays exploring a wide variety of housing programs, funding mechanisms, and regulatory and enforcement issues. Several Digest items also contribute to the theme. Special thanks to George Weidenfeller for suggesting the theme and for his support in identifying topics and authors.

We start out this issue with the Annual Meeting Update, in which program co-chairs Michael Hopkins of Bocarsly Emden LLP and Ian Adams of Kantor Taylor PC summarize the Forum’s recent annual meeting and give a portrait of Robert (“Bob”) S. Kenison, the very deserving recipient of this year’s the Michael Sher Award, who sadly passed away soon after receiving the award.

John Infranca, Associate Professor of Law at Suffolk University Law School, reviews Evidence and Innovation in Housing Law and Policy by Lee Anne Fennell & Benjamin J. Keys, eds. (Cambridge University Press 2018). In this book, scholars from multiple disciplines and methodologies and from all parts of the ideological spectrum respond to demands that housing law and policy be both evidence-based and innovative. Professor Infranca carefully summarizes all thirteen chapters of this hefty volume. While affordability is a common theme throughout the book, Professor

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Tim Iglesias is Professor of Law at the University of San Francisco School of Law. He is co-author of the Legal Guide to Affordable Housing Development Law (ABA 2011) and numerous articles. He welcomes comments from readers at iglesias@usfca.edu.
Infranca groups the chapters into three subthemes: how land use regulations reduce supply and drive up housing costs, community formation in relationship to both the individual home and urban redevelopment, and the relationship between housing and personal wealth. And he provides an insightful take on the book’s contributions to the field.

Two of the six Digest contributions advance the housing and health theme. Crystal Malone of HUD’s Region V office shares Contaminated Childhood: How the United States Fails to Prevent the Chronic Lead Poisoning of Low-Income Children and Communities of Color published in the Harvard Environmental Law Review. Through a detailed critique of civil rights statutes, case law, executive orders, rules, and policies, this article sounds the alarm about the inadequacy of our current lead poisoning prevention practices and proposes reforms, such as better prevention practices as well as more oversight, reporting, and enforcement. Alec Rubenstein of Robinson & Cole LLP shares Association of Changes in Neighborhood-Level Racial Residential Segregation with Changes in Blood Pressure Among Black Adults, which reports the results of a sophisticated 25-year study published by JAMA Internal Medicine. The study demonstrates a correlation between living in racially segregated neighborhoods and unhealthy blood pressure levels that verifies the physical damage wrought by racial segregation, but also offers hope that policies that reduce segregation will pay off with significant health benefits.

The remaining Digest entries concern residential integration, affordability, and mortgage credit access. Three summarize studies published by the Harvard Joint Center for Housing Studies. Expanding Access to Homeownership as a Means of Fostering Residential Integration and Inclusion, summarized by Crystal Malone, offers both policy and program proposals to address the financial and informational barriers that limit homeownership opportunities for low-income and minority families and individuals. Theresa Omansky of Emmet, Marvin & Martin LLP provides an overview of A Shared Future: Expanding the Toolbox: Promising Approaches for Increasing Geographic Choice, which evaluates both tenant-mobility strategies and site-based affordability strategies that King County Housing Authority utilized in its Moving to Work program. Together these strategies enabled approximately 31 percent of its federally subsidized households with children to live in low-poverty areas. Melinda Rubenstein of Emmet, Marvin & Martin LLP summarizes housing scholar Margery Austin Turner’s What Would It Take for Housing Subsidies to Overcome Affordability Barriers to Inclusion in All Neighborhoods? Based upon empirical validation of the value of housing choice, the article recommends a portfolio strategy combining investments in both affordable rental housing and accessible homeownership in ways calculated to be effective in four different types of neighborhoods: severely distressed low-income neighborhoods, stable low-income neighborhoods, emergent neighborhoods, and opportunity-rich neighborhoods. Finally, Theresa Omansky summarizes Professor Patricia A. McCoy’s recent article, Has the Mortgage Pendulum Swung Too
Far? Revising Access to Mortgage Credit, which provides specific recommendations to reinvigorate mortgage lending to minority and lower income borrowers based upon two successful programs, the Massachusetts ONE Mortgage program and the Community Advantage Program.

The interconnections between health and housing are myriad. The challenges are well-known and cumulative: an aging population, including many persons with disabilities; insufficient affordable housing; high health costs and hard-to-access services; heightened health risks in low-income communities; continued discrimination; and constrained public resources. The first essay in the housing and health theme is HUD Secretary Ben Carson’s contribution, Housing Law Is a Vehicle for Keeping Children Healthy—The HUD Approach. Empirical evidence demonstrates that lead harms children, particularly low-income children in substandard housing. This essay explains how HUD’s lead hazard control programs focusing on lead paint hazards can be successful and cost-effective by reducing childhood lead exposure, especially in collaboration with local communities. Secretary Carson then reaffirms HUD’s commitment to these programs and specifies actions HUD will take. This essay is both important and timely, especially given the recent critiques of HUD’s performance on this issue by HUD’s Office of Inspector General and the U.S. Government Accountability Office. (Thanks to Forum Chair Amy McClain and Forum Chair-Elect George Weidenfeller for soliciting this contribution.)

Affordable Housing and Resident Health by Roberta Rubin of the Massachusetts Department of Housing and Community Development and Andrea Ponsor of Stewards of Affordable Housing for the Future expertly frames the issues; provides an masterful overview of the landscape (including examples of partnerships between housing providers and health care stakeholders); and outlines critical legal issues that may constrain what housing providers can do to address the health needs of their residents. The authors start from the now-accepted facts that where one lives is an important social determinant of health, and the lack of affordable housing produces negative health consequences. These facts explain the current intense interest in using housing as a mechanism for the delivery of health care directly in homes and expanding the role of service-enriched housing to reduce medical costs. After a useful overview of needs and opportunities in the field, the authors present a detailed, comprehensive review of federal and state laws, programs, and policies in two parts: before the passage of the Patient Protection and Affordable Care Act in 2010 (ACA) (e.g., the Section 202/162 program, Section 811 program, and Medicaid) and since ACA’s enactment (with a helpful elucidation of ACA’s components and how they work to serve ACA’s goals). The article surveys promising initiatives within the broad universe of opportunities to connect the health care sector and state agencies with housing organizations to increase access to stable housing and improve health outcomes, including on-site services, investments in housing supply, and investments in community benefits. Then the authors carefully analyze the
potential legal complications to housing and health care collaborations using affordable housing capital and rental assistance programs and the LIHTC program, including federal and state privacy issues, limits imposed by laws governing housing finance, and constraints on targeted housing for persons with specific disabilities or health insurance imposed by civil rights and fair housing laws. This article is a “must read” for any attorney representing a funder, developer, or service provider involved in a health and housing collaboration.

One important dimension of housing and health connections is the provision of appropriate and affordable housing for seniors that can enable them to live “the good life in their golden years.” Three essays from organizations with decades of national experience tackle this issue. Approaches to Easing the Affordable Housing and Health Care Challenges Seniors Face, authored by Michelle Norris of National Church Residences, first frames the issues faced by the diverse subsets of seniors, then clarifies what Medicare and Medicaid actually provide, and identifies the gaps. While supporting the maximum amount of possible affordable senior housing production, Ms. Norris stresses that we need to serve seniors who will never live in affordable senior housing and offers four empirically validated strategies: (1) redefining “family” through intergenerational housing and accessory dwelling units; (2) funding service-enriched senior housing models, including through Pay For Success financing; (3) exploring Home for Life models to provide services to seniors who remain in their current homes; and (4) technology innovations, such as telemedicine, robots, iPads, and motion sensors.

In Integrating Health and Supportive Services in Affordable Senior Housing: New Models for Service Coordination, two leaders of Volunteers of America National Services (VOANS), Donna Thurmond and Sharon Wilson Geno, pick up the theme of combining services with housing as an important part of the solution. Ms. Thurmond and Ms. Wilson Geno explain how VOANS’ combination of senior affordable housing and its sophisticated service coordinator program both saves public resources and improves seniors’ health outcomes by careful management of chronic diseases and support for activities of daily living. The essay offers two case studies of VOANS’ impressive network of trained service coordinators at work.

Mark Angelini of Mercy Housing Lakefront contributed Housing as Healthcare: Practical Models to Create Social Impact in which he argues that greater integration of health and housing systems is necessary, and that the whole created by such integration is greater than the sum of its parts, enabling positive social impact that would not be possible otherwise. After explaining how the Affordable Care Act directly promoted this integration, Mr. Angelini shares his organization’s extensive practical knowledge in this endeavor in five categories: (1) linkage agreements with healthcare providers to deliver services; (2) integrating health services on-site at housing developments; (3) working with healthcare providers to house high utilizers of costly medical services; (4) adaptive reuse to
save hospital systems’ money by reutilizing exhausted assets; and (5) capital investment to reimagine how care can be provided to the benefit of the community.

Two essays explore creative strategies to finance the development of affordable housing with significant health benefits. Transit oriented development (TOD) improves environmental and community health by reducing regional congestion, air pollution, and greenhouse gas emissions. In Improving Health and Environment Through Place-Based Investing: The Healthy Neighborhoods Equity Fund, Maggie Super Church of the Conservation Law Foundation and Kathy McGilvray of the Massachusetts Housing Investment Corporation report on the Healthy Neighborhood Equity Fund (HNEF), a successful financing partnership that will help enable TOD reach its potential in the Greater Boston Area of building 76,000 new housing units in train station areas by 2035. The problem the partnership solves is the need for long-term patient, low-cost capital in the funding mix. The essay explains how NHEF attracted a mix of public, private, and philanthropic investors, including state and federal agencies, foundations, banks, and a local hospital to invest in the fund by empirically demonstrating projects’ expected environmental and community health outcomes and by offering risk-adjusted financial returns to investors. The essay provides detailed description of HNEF’s capital structure and investment terms and profiles a particular HNEF-funded development, Bartlett Station project in Boston.

In The Massachusetts PFS Story: Social Innovation Financing as a Catalyst for Change?, Joe Finn of the Massachusetts Housing and Shelter Alliance, Singumbe Muyeba of the Massachusetts Housing and Shelter Alliance, and Thomas Brigham of the Massachusetts Alliance for Supportive Housing and the Social Innovation Financing Pay for Success Program first explain the Pay For Success (PFS) financing model, a new way for governmental agencies and nonprofits to collaborate to deliver outcome-based solutions serving public objectives with greater accountability. They then present the successful results of this model, both at a program level in the use of permanent supportive housing to reduce the use of emergency medical services, inpatient hospitalization, and corrections services by homeless people, and at a systemic level by reshaping the public services delivery system. They share lessons learned and address some concerns of PFS model skeptics, such as potentially high transaction costs.

Finally, Justin R. La Mort of the Mobilization for Justice in New York City, contributes Public Housing and Public Health: The Separate and Unequal Protection of Private and Public Housing Tenants’ Health in New York City. This essay first provides a brief but instructive overview of the various laws and regulations that aim to protect human health by ensuring housing is habitable. Mr. La Mort then demonstrates how due to the different regulatory arrangements implementing these policies in the private market versus public housing (including different complaint procedures and legal exemptions), private market housing tenants reap the benefits of
these laws while public tenants suffer neglect and endure lack of heat and hot water and higher exposure to lead and mold. He reviews efforts to change these disparities and articulates general principles to improve the conditions of public housing based upon what has worked for private market tenants.

Derek Waller, a law student at the University of Minnesota Law School, won the Forum’s 2018 Law Student Legal Writing Competition with his excellent article Leveraging State and Local Antidiscrimination Laws to Prohibit Discrimination Against Recipients of Federal Rental Assistance. This well-researched and carefully drafted article addresses the problem of voucher holders being unable to use their vouchers to obtain housing due to landlords refusing to accept them. The article begins with a comprehensive and insightful categorization of federal, state, and local laws that prohibit discrimination against recipients of federal rental assistance. It proceeds with a detailed case study of voucher-based discrimination in Minnesota, concluding with pragmatic recommendations for designing and defending state and local laws to prohibit voucher-based discrimination.

In Why Does My Tax Lawyer Keep Saying We Need Nonrecourse Debt for My Low-Income Housing Tax Credit Project, Glenn Graff, Forum Governing Committee member and attorney at Applegate & Thorne-Thomsen, P.C., addresses a recurring question that arises in LIHTC transactions: Why does permanent debt generally need to be nonrecourse in transactions involving LIHTC? Mr. Graff explains the origin of the problem in the interaction of the LIHTC rules under Section 42 of the Internal Revenue Code and the partnership taxation rules. While not offering legal advice, the essay provides a detailed explanation of the solution and its rationale. The short answer is that third party nonrecourse debt gives a project the best chance to allow an investor to fully utilize all the tax credits by allowing the creation of “Partnership Minimum Gain,” but you will need to read the essay to understand what this means and why it is true.

Thanks very much to everyone who helped on this issue. I welcome any and all feedback from readers. Please email me at iglesias@usfca.edu.
From the Chair

George Weidenfeller

It seems like just yesterday that I was first appointed to the ABA Forum on Affordable Housing and Community Development Law Governing Committee, shortly after leaving the Department of Housing and Urban Development (HUD) in 2006 as Deputy General Counsel. With that personal reflection in mind, I now move into the position of Forum Chair—not something I had planned after a career at HUD, a decade in private practice, and as current in-house Counsel at the AFL-CIO Housing Investment Trust. I am also aware that the Forum is now twenty-five plus years old and is reaching a level of maturity that compels a look back—not so much to see where the Forum has been—but to consider where it is going.

Over the years the Forum has become a well-respected vehicle for attorney interaction and education. Many have taken advantage of the list-serv and the valuable information regularly provided and willingly shared by colleagues. While some interact with the Forum only during the annual conference in May, a large number are active in the Forum’s well-versed Practice Committees relating to HUD, the IRS, Fair Housing, Economic Development, and Legal Educators. The Journal, “beginner’s guides,” and books have been some of the most valuable resources provided by the Forum in recent years. Members of the Forum generally know well the advantages of belonging to the Forum. And it seems those benefits are often enjoyed by others—including those who are not members and even those who are not attorneys. Whatever the road traveled to get to it, the Forum has often been a useful resource in challenging times—and it would seem the times are always challenging in a practice relating to affordable housing and community development.

Considering that the recent tax act left the Low Income Housing Tax Credit (LIHTC) and New Markets Tax Credit (NMTC) largely intact and introduced the yet to be fully realized “Opportunity Zones,” and that the recent appropriations bill gave the HUD budget one of the largest increases ever, one could say these times are pretty good. However, the fact that the fight to retain the LIHTC and NMTC was intense—and sometimes on

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the verge of going the other way—and the fact that the administration pro-
posed serious cuts to a number of programs during the last budget cycle
and the current budget cycle mean the challenges ahead may be more severe
than ever with respect to essential financing to address critical needs. In ad-
dition to the necessary funding for housing and community development
programs, policies relating to civil rights, fair housing, the environment,
labor, and health care are all being reconsidered. We have recently seen
shifts in fair housing enforcement, proposals to reconsider rent regulations,
and challenges associated with the effective delivery of disaster relief.

As statutory and regulatory requirements for long standing programs
and policies are being reviewed, an opportunity is presented to engage
and cooperate with an administration that wants to cut “red tape,” facilitate
interaction with the government, and streamline the delivery of programs.
Past administrations have been receptive to input from the private bar on
policy and procedural initiatives, and it is critical that the private bar
stand ready to provide useful recommendations on how to most efficiently
and effectively deliver services and support to the ultimate beneficiaries of
the laws and programs at the heart of the affordable housing and commu-
nity development practice.

As the government looks to evaluate how it does business, the time is ripe
for the Forum to take a look at its future and to decide how it can best serve
membership needs and encourage non-members to join. Does the Forum
provide the support, information, and opportunities members envision?
Do members find the Journal informative and useful? Are the level and
means of communication sufficient? Does the Governing Committee reflect
its membership? Does the Governing Committee have the opportunity to
consider some of these more global issues, while addressing routine de-
mands? Is there enough interaction with members? How does the Forum re-
late to, interact with, or compare with other entities relating to the field?
What role should the Forum play with respect to policy, procedures, legisla-
tive issues, and initiatives? Should the Forum be more proactive or reactive?

Generally, the Forum has enjoyed a very positive relationship with
governmental entities—especially HUD and the IRS. In working with fed-
eral programs, could the Forum take a more compelling lead in matters
affecting not only our practice but those who benefit from the programs
private practitioners work with daily? For example:

• As program participants might grow frustrated with government
  responsiveness—due in large part to resource constraints—are there
  positive approaches the Forum could suggest to make program ad-
mistration more efficient, such as working with other groups or as-
sociations to address issues relating to closing RAD, health care, and
  FHA multifamily loans?

• As the cost of affordable housing seems to be ever on the rise, are
  there recommendations that the Forum could pursue to better ad-
  dress affordability, such as regulatory relief, risk sharing, and greater
and/or alternative engagements between the federal government and state and local partners—in particular state housing finance agencies and public housing authorities?

- Some have suggested exploring avenues to encourage other states to pursue initiatives such as Massachusetts’ development of a common set of loan documents for affordable projects using a variety of state and local funds. Is such an approach a realistic and worthwhile strategy for the Forum? Where does it start and how does it gain acceptance?

- As evidenced in this issue of the *Journal* with the contribution from HUD Secretary Carson (for which the *Journal* is very grateful), this administration is well aware of the nexus between housing and health care. While Secretary Carson emphasizes the need to address the dangers of lead-based paint, he also states that “Improving housing quality can have a dramatic effect on the health of residents, which in turn can improve their economic and educational status.” It is apparent then that the need for “healthy homes” goes well beyond the issue of lead-based paint. Health impacts all elements of a living environment—both for the young who benefit from a roof over their heads, food, and reliable health care, and for the elderly who want to be assured that their housing choices are in fact affordable as their need for assistance with daily living grows. The myriad links between a healthy living environment and educational advances of the young, age requirements for “elderly” housing, “independent living,” affordable assisted living, aging in place, evolution of traditional nursing homes into rehabilitation facilitates, and accessibility and reasonable accommodations for persons with disabilities are all considerations that will impact the financing, development, and management of housing going forward. Is it possible to develop a model to facilitate these linkages and make practical application of housing and health care programs more effective?

- The foregoing “health” concerns will, of course, also be impacted by technology, the shift from the suburbs to the cities, downsizing, ride sharing, driverless cars, infrastructure demands, and budget constraints—all distinct topics and issues that merit further study, discussion, and consideration but which are part of a holistic approach.

None of the foregoing is to suggest for a minute that the Forum is not now effective. In fact, it has been quite effective in achieving its core mission of communication, education, and interaction. The Forum has also shown its willingness to grow and expand—with the recent introduction of regional “Boot Camps,” the development of a Fellows program, expansion of its Law School Initiatives, regular publications, and consistent actions by Practice Committees to address current events. As useful as such tools and activities are on their own, they are rarely integrated into a long-range plan as strategies to achieve larger goals and objectives.
If nothing else, this discussion has identified many questions that could use answers. Other questions that need to be addressed are whether the Forum can and should continue as it has, whether that path is sustainable, and whether there are other approaches that would be more effective, inclusive, and take better advantage of opportunities. To consider the challenges ahead and the direction the Forum should pursue, the Forum is developing a Strategic Plan, which hopefully will not only consider directions to pursue but also—and perhaps more importantly—the means to accomplish the goals identified in the plan. The intent is not to have a plan that merely sits on the shelf, but rather a plan that actually lays the groundwork for achievable results and influences the direction of the Forum going forward. The Governing Committee has appointed a Strategic Planning Task Force. By the time this issue of the Journal is published, the Task Force should be well along with plan development. Anyone who has enjoyed the benefits of the Forum in the past and looks forward to continued meaningful interaction with colleagues in the affordable housing and community development practice is encouraged to actively engage with the Task Force and to contribute to the strategic planning effort underway.

If you would like to provide input into the strategic plan, please contact George Weidenfeller (gweidenfeller@aflcio-hit.com), Kelly Rushin (krushin@lilesandrushin.com), or Dan Rosen (DRosen@kleinhornig.com).
Forum Annual Meeting Update

Michael Hopkins and Ian Adams

The Forum on Affordable Housing and Community Development Law’s Annual Meeting was held May 23–25, 2018, in Washington, D.C. The conference kicked off at the Department of Housing and Urban Development (HUD) with remarks from HUD General Counsel Paul Compton and an opportunity for leadership in the HUD Office of General Counsel (OGC) to discuss OGC priorities with the private bar. Meanwhile, the Tax Credit Practice Committee held a deep-dive discussion on Qualified Opportunity Zones, introducing attendees to this new technical tool.

At the first plenary session, attendees heard from newly appointed HUD leadership about the priorities and agenda for HUD and its programs, including additional remarks from HUD General Counsel Paul Compton, Assistant Secretary for Fair Housing Anna Maria Farias, Assistant Secretary for Community Planning & Development Neal Rackleff, General Deputy Assistant Secretary for Public and Indian Housing Dominique Blom, and Deputy Assistant Secretary for Multifamily Housing Programs C. Lamar Seats.

Panels brought together a wide range of experts to talk about trending topics and recurring themes in the affordable housing, fair housing, and community economic development practice areas. HUD-related topics included disaster recovery efforts, RAD conversions, and the latest news in FHA-insured multifamily housing, including suggestions on ways to improve the FHA closing process. Tax topics included the effect of the Tax Cuts and Jobs Act on transactions, Income Averaging, and the new trend of combining 9% and 4% tax credits in low income housing tax credit developments. A Community Economic Development Practice Clinic offered an inside view into attorney/client discussions of obstacles and solutions for local developments in Washington, D.C., and fair housing experts discussed civil rights and rights to housing beyond the Fair Housing Act.

On the final morning of the conference, the Forum convened a plenary in honor of the 50th anniversary of the Fair Housing Act. Lisa Rice, president and CEO of the National Fair Housing Alliance, and Faith Schwartz of Housing Finance Strategies reflected on this important milestone and the current state of fair housing in the United States.

As always, attendees enjoyed catching-up with old friends and building new relationships at our Wednesday Speed Networking Event and Thursday Night Reception.

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Michael Hopkins (mhopkins@bocarsly.com) and Ian Adams (iadams@kantortaylor.com) served as Program Co-Chairs of the 2018 Annual Meeting. Ms. Hopkins is a partner in the Bethesda, Maryland, office of Bocarsly Emden and Mr. Adam is an attorney with Kantor Taylor PC in Seattle.
We would like to thank the panel moderators and speakers for providing excellent content and our generous sponsors for hosting the receptions. The Forum will be conducting a Law School Initiative and Boot Camp in Boston on October 3–5, and we look forward to seeing everyone again at next year’s Annual Conference, which will be held May 22–24, 2019, in Washington, D.C.

The Michael Scher Award was presented at the Annual Conference to Robert S. Kenison, selected by the Forum’s Nominating Committee as an attorney who exemplifies the spirit and commitment that our colleague Michael S. Scher demonstrated in the field of affordable housing and community development law. It was an honor to have Bob and his family attend the Annual Conference luncheon to receive the award. It is with great sadness that we share that Bob passed away just a few weeks after the Annual Conference. He was a much-loved colleague and friend to many members of the Forum and he will be greatly missed. We send our sincere condolences to Bob’s family, friends, and former colleagues. In further recognition of Bob’s exemplary career in affordable housing and the contributions he made to people he knew and the countless beneficiaries of HUD programs who never knew him, the Journal is printing the nomination submitted on his behalf.

Nomination of Robert S. Kenison for the Michael Scher Award

Each year at the ABA’s Annual Affordable Housing and Community Development Forum’s Conference, the Forum presents the Michael Scher Award to an attorney who “exemplifies the spirit and commitment that Michael demonstrated in the field of affordable and community development law.” With the overwhelming support of HUD’s Office of General Counsel, we submit this nomination of Robert S. Kenison (“Bob”) for this award.

Although Bob retired from HUD over 10 years ago, his leadership and long-term role and contributions in affordable housing and community development initiatives continue to be felt and sustain HUD’s efforts in this field. First, to illustrate a little about Bob’s educational background, he received a B.A. from St. Anselm College, summa cum laude, 1960; LL.B. Harvard, 1963; Mid-Career Fellow at the Woodrow Wilson School of Public and International Affairs, Princeton University, 1972; HUD Representative at Dartmouth Institute in 1970; and Research Fellow, Yale Divinity School 1991. Before joining HUD, he served as a Peace Corps Volunteer in Urban Community Development in Columbia, South America from 1963–65.

To illustrate the massive role Bob played in the area of affordable and community development law, he started as a Public Housing staff attorney and rose through the ranks of Urban Renewal and Block Grants to become HUD’s Associate General Counsel for Assisted Housing and Community Development in 1977 and served in that role until 2007. He primarily provided and supervised legal advice on a broad range of pro-
grams, including CDBG, public housing, Indian housing, Section 8 (all varieties), Turnkey 3 and other Homeownership programs, Modernization programs (CIAP, CGP, Capital Fund), Development programs (UDAG, HOPE VI, and Mixed Finance), Section 202 Supportive Housing for the Elderly, Section 811 Supportive Housing for the Disabled, HOME, Homeless programs, Resident Initiative programs (TOP, ROSS, FIC), and countless other important housing and community development programs. Bob is the only official at HUD to have received three times the President’s Rank Award, the highest award for career Senior Executives, under President’s Reagan, Bush, and Clinton. With other members of his staff, he was a recipient of the Congressional Excalibur Award, in recognition of legal work to facilitate the role of religious providers in housing programs. He received the National Association of Housing and Redevelopment Officials (NAHRO) Memorial Award for demonstrated commitment to providing a decent home and suitable living environment for every American family. At HUD, he has received numerous awards and most significantly, a Curry Award (1993), the highest award presented in HUD OGC, and the FHA Commissioner’s Award (2007).

It is impossible to read through HUD’s Basic Laws for public housing and block grants and not see and feel the influence contributed by Bob in developing the legal basis of numerous programs. Equally visible is Bob’s hand and role in structuring guidance for these programs in the form of regulations and General Counsel opinions. Formidable was Bob’s presence in meetings with various Secretaries of HUD, who relied and benefited from his advice. Cooperation and consensus-building was Bob’s role both within the Department and with the ABA and trade associations. At HUD, he built a strong and collegial network across all program areas supported by his ethical principles and playful annual “It’s Trivial” parties, where he would as game show host challenge three HUD teams (the “A Team” of Lawyers, the “B Team” of Program Staff, and the “C Team” of Schedule C Political Appointees) to some of the deepest and most esoteric questions to be found on the face of the earth—but everyone loved it and it was always standing room only. Everyone anxiously anticipated Bob’s presentations on the “Heard from HUD” panel at the Forum’s annual meetings, where he would set the tone with various quotes or literary references and then go on to regale us with the latest and most insightful legal observations. Well-crafted and clear written guidance was a hallmark of Bob’s influence. Bob mentored many of the lawyer members of this ABA Forum and has left a lasting influence on HUD’s OGC Office of Assisted Housing and Community Development. After leaving HUD, Bob has shared his experiences and knowledge as an adjunct law faculty member at the University of Maryland Law School.

With admiration and gratitude for Bob’s contributions to the field of affordable housing and community development, his development of structures and concepts that have played an important and positive effect in this field, his efforts in creating and sustaining a vast number of programs,
his role in preserving resident rights, his contributions to this ABA Forum, his mentoring of legal students and staff at HUD, his standards of legal excellence that serves as a model to this legal community and his lifetime commitment to public service.

**Past recipients of the Michael Sher Award**

- 2007 Robert N. Ungerleider
- 2008 Chuck Edson
- 2009 Roger Clay
- 2010 Betty Park
- 2011 Alexander Polikoff
- 2012 Art Hessel
- 2013 Paul Casey
- 2014 Gordon Cavanaugh
- 2015 Jonathan Klein
- 2016 Paul Handleman
The thirteen essays that appear in *Evidence and Innovation in Housing Policy* grew out of a conference convened in June 2016 by the Kreisman Initiative on Housing Law and Policy at the University of Chicago. Edited by Professors Lee Anne Fennell of the University of Chicago Law School and Benjamin Keys of the Wharton School at the University of Pennsylvania, the volume brings together scholars from multiple disciplines and methodologies to confront a range of issues related to housing. Early chapters concentrate on how land use regulations, including historic preservation, constrain new development, reduce supply, and drive up housing costs. The book then shifts to focus on community formation in relationship to both the individual home and urban redevelopment more broadly. Later chapters examine the relationship between housing and personal wealth, as well as the roles that financial regulation and access to credit play in this regard. Concern for housing affordability runs throughout most of the essays.

The experience of reading *Evidence and Innovation in Housing Policy*, particularly in the early chapters, can sometimes feel like being at a rather quirky dinner party with guests jostling for control of the conversation. William Fischel offers an historical account of the role of homeowners in stifling new development; David Schleicher then draws on agglomeration economics to critique land use regulations that undermine transportation innovation; Richard Epstein decries inclusionary zoning on both economic and constitutional grounds before suggesting that we blow the whole regulatory system up; and Lior Strahilevitz calms things a bit by sharing an intriguing story about a senior community in Florida, but then quickly turns the story into a profound critique of historic preservation that poses deeper questions about the formation and preservation of community identity. As the book proceeds, authors with a more empirical orientation join the con-
conversation and the result works well as a collection with various and at times unexpected connections between chapters. In reviewing this rather dense collection, I will briefly summarize each of the thirteen chapters before highlighting a few themes that run across the volume.

In the first chapter, economist William Fischel briefly summarizes his influential “homevoter hypothesis” and its relationship to the restrictive land use regulations found in the most expensive regions of the United States. It was only during the inflationary period of the 1970s, Fischel observes, that homeownership became a strong investment vehicle, relative to stocks and bonds. Homeowners eager to defend the value of this investment became increasingly concerned with new development that might reduce their home values. Seeking some degree of cover, these homeowners worked with and within the burgeoning environmental movement of the 1970s to add layers of regulatory review that slowed new development. In Fischel’s account, rapidly rising home prices are not simply the result of restrictive land use policies, but in fact lead to greater restrictions on new development.

Fischel notes another important dynamic at play during the 1970s—the move of middle-class whites to the suburbs in the aftermath of the desegregation of city schools. At the same time, the civil rights movement increasingly sought opportunities for low-income and minority households in the suburbs. According to Fischel, suburban homevoters turned against growth, reasoning, he speculates, “If we have to take blacks and the poor along with everyone else, maybe we would prefer to have no growth at all.” Reluctant to advocate for such exclusion publicly, an alternative rationale for resisting growth arose—“[p]reservation of the environment by preserving open space.” This is a controversial claim, of course, but Fischel offers as evidence the fact that Massachusetts and New Jersey, the two states with the most significant requirements for local governments to accommodate low-income housing, “are also the states with by far the largest number of local initiatives to preserve farmland and other open space.” Ultimately, however, he hedges a bit on this provocative point, expressing reluctance to attribute too much to the backlash against civil rights and noting that politically liberal communities are often among the most resistant to housing growth.

Shifting from the cause of land use regulation to its effects, law professor David Schleicher argues that such regulations, and housing policies more generally, reduce the economic gains from a variety of transportation innovations—global positioning systems and real-time traffic information services like Google Maps, ride-sharing services like Uber and

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2. Evidence and Innovation in Housing Law and Policy 27 (Lee Anne Fennell & Benjamin J. Keys eds., 2017) [hereinafter Evidence and Innovation].
3. Id.
Lyft, and autonomous vehicles. The greatest gains from transportation innovations are achieved when they enable changes in land use and development patterns, but such changes are stymied by our existing regulatory regimes. Existing zoning regulations will result, Schleicher contends, in increasingly inefficient land use patterns in urban areas, reducing the gains from transportation innovations while simultaneously hindering further innovation. Schleicher’s discussion of specific transportation innovations and their potential effects on urban land use is fascinating. But what is most relevant to concerns about housing supply and affordability is his suggestion that those seeking to reform land use regulation “should focus on changing the political structure of decision making or incentives for homeowners.”4 He provides a frustratingly brief overview of some of the policy innovations he has proposed in earlier writings, including the adoption of citywide “zoning budgets” to enable greater density.5

Part I concludes with law professor Richard Epstein’s modestly titled “The Unassailable Case against Affordable Housing Mandates.” Epstein begins by noting his strong preference for systematic reductions of zoning restrictions, which would enable an increase in housing supply, over additional direct public subsidy. But his focus is on a critique of inclusionary zoning policies. Reflecting his somewhat unconventional view of takings,6 Epstein contends that if states want to impose affordable housing mandates on developers, they should “rent or purchase the units at market value, and then re-let or resell them at below-market prices” so as to ensure that public burdens are borne by the public as a whole.7 Epstein offers both economic and constitutional critiques of inclusionary zoning. With regards to the former, he argues that inclusionary zoning programs are likely to exacerbate housing shortages by constricting supply.8

4. Id. at 54.
7. EVIDENCE AND INNOVATION, supra note 2, at 65.
8. Epstein relies exclusively on a single study of inclusionary zoning, Benjamin Powell & Edward Stringham, The Economics of Inclusionary Zoning Reclaimed: How Effective Are Price Controls?, 33 FLA. STATE U. L. REV. 471 (2005). While that work focused on San Jose and is therefore relevant to his discussion of California Building Industry Association v. City of San Jose, 351 P.3d 974 (Cal. 2015), it would have been nice to see him discuss in depth the broader empirical literature on inclusionary zoning, which can take many forms. For one recent literature review, see LISA A. STURTEVANT, CENTER FOR HOUSING POLICY, SEPARATING FACT FROM FICTION TO DESIGN EFFECTIVE INCLUSIONARY HOUSING PROGRAMS (May 2016). Moreover, as Sturtevant notes, Powell and Stringham’s studies of inclusionary housing programs “have been
I admit to finding somewhat sympathetic Epstein’s contention that an explicit allocation of general revenue is arguably fairer than a cross-subsidy in the form of inclusionary zoning, which imposes all costs on the market-rate residents or the developers of a new building (although in many instances these are offset by a density bonus that permits a larger development). But, Epstein acknowledges, such an explicit allocation of funds sufficient to achieve the same level of affordable housing development (and in the same locations) is highly unlikely in practical and political terms given the variety of demands on local government budgets. At the very least, as the book’s editors note in the Introduction, Epstein’s chapter brings to the fore the important question of how the costs and burdens of achieving particular housing goals through specific interventions and innovations should be distributed.

In Part II, the volume’s focus shifts from land use regulation to the concept of community and the relationship between housing and community. In “Balancing the Costs and Benefits of Historic Preservation,” urban economist Ingrid Gould Ellen and sociologist Brian McCabe continue the debate over constraints on housing supply, one perceived cost of historic preservation. Focusing on historic districts in New York City, the authors provide new evidence on how preservation constrains development, “ultimately limiting economic growth, heightening economic segregation, and contributing to concerns about housing affordability.”9 While the density of historic districts in New York is similar to surrounding neighborhoods (due in part to the fact that the buildings in such districts were developed when zoning was less restrictive), they find that less new construction and redevelopment occurs in such districts.10 The authors conclude that the adverse effects of historic districts on citywide development will only grow more significant as new districts are established.

Ellen and McCabe also find that historic preservation can exacerbate economic segregation as designated neighborhoods see drops in poverty rates and increases in neighborhood incomes.11 As of 2012, the average household income in census tracts located entirely within a historic district was more than twice the income of neighborhoods entirely outside the districts. Ellen and McCabe’s sophisticated empirical analysis provides new evidence of precisely how historic designation restricts devel-

widely criticized for their lack of methodological rigor, and their results should be interpreted cautiously.” Id. at 8.

9. EVIDENCE AND INNOVATION, supra note 2, at 94.

10. Specifically, they find that “lots located inside historic districts were slightly less than three percentage points less likely to experience new construction compared to lots outside those districts but located in the same community district.” Id. at 98.

opment. Of equal value are the series of innovative suggestions they pro-
vide of mechanisms through which the historic designation process might
be redesigned to allow more explicit consideration of potential effects on
citywide planning and housing supply. Direct consideration of the effects
of preservation on housing supply might, they suggest, lead a local gov-
ernment to try to mitigate these effects by upzoning nearby areas. While
Ellen and McCabe’s proposed reforms are focused on New York City,
the procedural and substantive changes they outline provide insights
that could be tailored to other jurisdictions.

Law professor Lior Strahilevitz continues the discussion of historic
preservation, but changes directions in his intriguing account of “Historic
Preservation and its Even Less Authentic Alternative.” Taking as his start-
ing point the dubious historical marker on the Trump National Golf
Course commemorating the widely debunked “River of Blood” tale,
Strahilevitz poses a provocative question: “[i]s authentic history, in the
hands of imperfect human institutions, superior to the kind of fake history
commemorated at the Trump National Golf Club?”12 His conclusion is
“not by much.” For Strahilevitz, the selective preservation of authentic
history, driven by contemporary preferences and achieved at significant
cost is only marginally better than cheap and voluntary “contrived his-
tory.” As such, he questions whether there is any significant state interest
in the compelled preservation of historic property.

As an example of such “contrived history,” Strahilevitz examines in
deepth the fake history that pervades The Villages, a Florida retirement
community and the fastest-growing metropolitan area in the United
States. He suggests that the community’s contrived history, told in part
through dozens of historic plaques that recount a complex set of stories
about fictitious characters from a mythical past, might—in addition to
shaping the community’s identity—serve as a sort of “exclusionary ame-
nity” that helps explain the overwhelmingly white population of The
Villages, despite its location within a quite diverse region.

Strahilevitz is careful to note that he does not believe there is no distinction
between such fake history and genuine history. Rather he suggests that the
“problem is not that historical narratives are concocted; rather it’s that
when the preservation domain is scarce land, facts are preserved selectively
and the value choices underlying that selection are often obscured.”13 Given
the role of subjective contemporary judgments regarding whose history and
lives are valuable and what is worth preserving—a point made even more
clear in recent months with the controversies over Confederate monuments,
which he discusses tangentially—Strahilevitz boldly suggests that “perhaps it
would be much better to preserve buildings at random, to serve authenticity

12. EVIDENCE AND INNOVATION, supra note 2, at 109.
13. Id. at 117.
and fairness interests, and to leave space for future creativity.”14 The chapter raises thorny questions regarding how we assess the benefits of historic preservation and evaluate its effects on community identity.

Whether worthy of historic preservation or not, many urban church buildings have in recent years been converted into condominiums, a topic Georgette Chapman Phillips, a lawyer and business school professor, explores in “Losing My Religion: Church Condo Conversions and Neighborhood Change.” Phillips focuses on the effects that the sale of such churches can have on a local community, particularly when that community loses important nonreligious activities—community centers, food pantries, and programs for at-risk youth—sponsored by the church. In this way church conversions potentially differ from other types of redevelopment because they threaten a loss of both social capital and of specific social services. To address this loss, Phillips suggests the imposition of a fee on either the church or the developer, which would go toward replacing the lost social services. As she notes, such a proposal could face scrutiny as an exaction and as such would need to be carefully devised.

While sympathetic to a greater recognition of the valuable role religious institutions can play for non-adherents within the local community, I fear the practical challenges for such a proposal would be too significant. To impose the fee on the church, based on a valuation of the social and community services it provides (which must be adequately distinguished from activities that might mix religious formation and community service) could prove both difficult and controversial. More promising is the suggestion of requiring developers to contribute a set fee to local social service agencies. But of course such a fee would have to be considered in light of other benefits a local government might wish to exact from the new development, such as affordable housing. I am also not convinced that one could ensure that such a fee, if paid by a developer to an existing non-profit, would necessarily benefit the community within which the development occurs, perhaps raising questions for whether an adequate “nexus” exists for the exaction to pass muster.

Perception of one’s local community takes center stage in sociologist Matthew Desmond’s contribution, “How Housing Dynamics Shape Neighborhood Perceptions.” As Desmond notes, it is widely recognized that a variety of factors, including race, influence how individuals perceive urban neighborhoods. Nonetheless, there has been little study of how housing dynamics might also shape such perceptions. Desmond, drawing on a survey of Milwaukee renters, studies three such dynamics: the reasons for a residential move, the strategies used to find housing, and the quality of an individual’s dwelling. He examines how these dynamics affect two main outcome variables: renters’ trust of neighbors and perception of suffering within their neighborhood. Desmond finds that “city

14. Id. at 118.
dwellers who relocated to their neighborhood after an eviction, who found their apartment through a nonprofit or government agency, and who experienced long-lasting housing problems harbored lower evaluations of their neighborhoods.”15

In light of his findings, which suggest that individuals who exercise greater control over their housing and neighborhood choice are more likely to perceive their neighborhood favorably and more likely to be participate actively in their community, Desmond offers a pair of suggestions for policy makers. First, increasing the supply of temporary housing at the city level may allow for more deliberate housing searches, boosting levels of community trust. Second, the implementation and enforcement of source-of-income discrimination laws would also expand housing and neighborhood options.

Shifting from the community back to the household level, Part III turns to mechanisms through which housing might enable wealth building. In “Behavioral Leasing: Renter Equity as an Intermediate Housing Form,” law professor Stephanie Stern explores a modest step towards providing renters with some of the benefits of homeownership, including asset building. Renters at four affordable housing developments in Cincinnati are able to earn “renter equity credits” by paying rent on time, actively participating in the residential community association, and completing an assigned property upkeep task. They can earn up to $10,000 in savings credits over a ten-year period; the money cannot be accessed during the first five years. The program requires no additional subsidy, but is instead funded through higher occupancy and reduced turnover and maintenance costs at the developments. Stern notes that the renter equity program has been limited to just a few sites and there are questions regarding whether it is “scalable.” However, as she suggests, its most significant contribution might be in providing a blueprint for further innovations in housing forms between homeownership and rentals. Furthermore, as Stern’s careful case study reveals, such innovations might arise organically through the work of local service providers.

Homeownership has long been seen as a source of stability and financial security in retirement, but as economist Christopher Mayer observes, the finances of older Americans are increasingly precarious amid growing debt, low savings, and fewer households with defined benefit retirement accounts. The U.S. Census Bureau reports that in 2011 the median net worth, excluding home equity, for individuals aged 65 to 69 was only $43,921. The vast majority of the elderly own their home and rely upon it to face expenses. However, Mayer’s research finds a significant increase in the number of individuals with a mortgage at or near retirement age. In addition, households aged 66–71 had an average mortgage debt of $55,000 in 2013, nearly the triple the amount in 1992, despite minimal change in

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15. Id. at 152.
real home equity. These and other alarming findings suggest that households are entering retirement with significantly more debt, raising concerns for their long-term financial stability.

In “The Rise and (Potential) Fall of Disparate Impact Lending Litigation,” law professor and economist Ian Ayres, lawyer Gary Klein, and economist Jeffrey West explain how discriminatory lending practices can undermine opportunities to build wealth through homeownership. They note that disparate impact theory provides litigants with a mechanism for combating the effects of implicit racial basis in the context of discretionary decision-making. It is, they argue, “especially well suited for application to loan transactions, because it can be thoroughly investigated based on the lender’s own data records.”16 Lenders apply algorithms to specific underwriting variables, but the lender’s policies often allow a final price to be set based on additional non-objective factors, left to the discretion of loan brokers. Because the lender’s datasets are designed to capture those variables relevant to setting loan terms, determining whether the exercise of discretion results in a disparate impact relies on ascertaining “after controlling for the variables that the lenders themselves have gathered and evaluated, whether minority borrowers were more likely than non-minority borrowers to be charged higher credit costs.”17 Lenders themselves might then be liable for creating a system that allowed for the exercise of discretion to disproportionately impose high costs and predatory terms on minorities.

The chapter traces the history of disparate impact litigation, providing a careful analysis of the evidence plaintiffs put forth in notable cases establishing that the exercise of discretion led to less favorable mortgage terms for African American and Hispanic borrowers. But the authors caution that recent decisions have limited such claims. The Supreme Court, in Wal-Mart Stores, Inc. v. Dukes,18 made it exceedingly difficult, in situations involving discretionary decision-making, to establish commonality and to bring a class action. While the Court affirmed the availability of disparate impact claims under the Fair Housing Act in Texas Department of Housing & Community Affairs v. Inclusive Communities Project, Inc.,19 Ayres, Klein, and West argue that it severely limited such claims via robust causation requirements and that it expanded the scope of available defenses.20 As

16. Id. at 232.
17. Id.
20. There is significant ongoing debate regarding the implications of Inclusive Communities. See, e.g., Amy M. Glassman & Shanellah Verna, Disparate Impact One Year After Inclusive Communities, 25 J. AFFORDABLE HOUS. & CMTY. DEV. L. 11 (2016) (“[I]t appears that courts are focusing on the ‘robust causality requirement,’ dismissing cases that cannot identify a causal link between a practice and a harmful impact against a protected class.”); Lauren Clatch, Inclusive Communities and
such, although they contend that litigation remedies are necessary to address new forms of discrimination in the provision of housing credit, the authors concede that there is significant uncertainty regarding whether such claims can still be successfully pursued. As such, they suggest, government regulators “especially the CFPB” are the most likely source for the “disparate impact discipline of lenders.” Given the current leadership of the Consumer Financial Protection Bureau, this is hardly a reassuring premise.

Part IV of the volume focuses on the relationship between housing and the financial system. In “Household Debt and Defaults from 2000 to 2010: The Credit Supply View,” economists Atif Mian and Amir Sufi provide a careful and detailed empirical defense of the argument, which continues to face some criticism, that the expanded availability of credit helped fuel the housing boom and bust. After examining new evidence in support of “the credit supply view,” which contends that “an increase in credit supply unrelated to fundamental improvements in income or productivity was the shock that initiated the household debt boom and bust,”21 they identify a few remaining open questions regarding the rise in house prices in the early 2000s. In particular, it is not entirely clear to what extent originators of mortgage credit either preyed on home buyers with full knowledge the bubble was unsustainable or whether they believed house prices would continue to rise. Mian and Sufi also suggest the need for additional research regarding the feedback effects through which house prices drove further consumption and aggressive borrowing.

Mian and Sufi’s discussion of the role of credit supply is nicely complemented by the next chapter, which focuses on the role that representations and warranties made by loan originators played in this expansion of credit. Focusing on the securitization process, law professor Patricia McCoy and economist Susan Wachter, in “Representations and Warranties: Why They Did Not Stop the Crisis,” examine why the representations and warranties made by originators failed to prevent a significant deterioration in underwriting standards. In principle, violation of these representations and warranties subjects originators to put-back risk—the forced repurchase of a securitized mortgage. Following a quick review of the history of mortgage securitization and the role and scope of representations and warranties, McCoy and Wachter examine why these mechanisms failed to prevent mortgage loan defaults and the financial crisis. They contend that in years leading up to 2008, “representations and warranties contributed to the overheating of the cycle by giving false assurances to...

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21. EVIDENCE AND INNOVATION, supra note 2, at 258.
investors while failing to deter the race to the bottom in lending standards.” Following the crisis, enforcement of representations and warranties resulted in an overtightening of credit and a reduction in the demand for housing, slowing the recovery. As such, they suggest a number of procedural and systemic reforms to representations and warranties designed to “right-size the enforcement of these provisions while endowing them with deterrent effect,” thereby reversing this procyclicality. McCoy and Wachter’s account is both intriguing and convincing.

The volume’s concluding chapter, “When the Invisible Hand Isn’t a Firm Hand: Disciplining Markets That Won’t Discipline Themselves,” outlines a series of regulatory reforms designed to better discipline markets and deter bad behavior. In a book focused on innovation in housing policy, economists Raphael Bostic and Anthony Orlando suggest caution and propose mechanisms for checking potentially dangerous financial innovations. Bostic and Orlando frame their chapter by recounting the history of Black Friday in September 1869, when a speculative bubble led to a nationwide financial crisis. In the process, they examine the early development of credit rating agencies and the evolution of the model through which issuers pay the rating agencies, leading to rather obvious conflicts of interest. Bostic and Orlando glean lessons from this historical account regarding how and why markets failed to discipline themselves at the level of investors, boards of directors, and customers. They propose a series of reforms at each of these levels, including reforming credit rating agencies to remove the existing conflict of interest; returning investment banks to the partnership form and rendering owner-managers personally liable for losses; and expanding financial literacy programs and government support for community banks, which can better provide access to safe loans. Bostic and Orlando’s chapter is illuminating for two reasons. As noted, it provides a final word of caution regarding the dangers of innovation in housing, particularly financial innovation. In addition, it deftly invokes an historical account to both critique gaps in the regulatory reforms that followed the recent housing crisis and to propose further reforms.

The volume’s chapters are incredibly rich and offer countless other theoretical and empirical insights too numerous to detail in this brief review. The twin themes of evidence and innovation appear throughout the book in various guises. Chapters offer evidence in the form of both quantitative empirical analyses and detailed case studies. The chapters address innovation in a variety of ways. A number suggest innovative policies, such as Ingrid Ellen and Brian McCabe’s chapter proposing ways in which historic preservation decisions might better take into account the costs of preservation, Georgette Chapman Philip’s suggestions for addressing the loss of neighborhood social services when churches are converted.

22. Id. at 305.
23. Id.
into condos, and Stephanie Stern’s discussion of renter equity programs. David Schleicher warns that existing land use regulations diminish the benefits of certain innovations and potentially stymie further innovation. Richard Epstein suggests greater attention must be given to distribution of the costs and burden associated with policy innovations. Other chapters provide innovative analyses, such as Matthew Desmond’s examination of how residents’ housing search experiences, and the quality of their own housing, can affect their perceptions of the neighborhood in which they live. And still others, like the final chapter by Raphael Bostic and Anthony Orlando, sound notes of caution regarding the dangers of financial innovation and efforts to skirt existing law.

Much as this volume seeks to break down disciplinary and methodological silos, it suggests that policy makers will benefit from efforts to break down their own silos. As Ellen and McCabe recommend, preservation commissions should be in dialogue with planning commissions to better ascertain the potential costs of preservation decisions; or as Schleicher asserts, those focused on transportation innovation would benefit from thinking more carefully about land use regulation.

Overall, the authors' diverse disciplinary backgrounds and methodological approaches result in a collection that blends, both among and within individual chapters, historical, economic, legal, and empirical analyses. One criticism of the volume is that while connections between the chapters exist, the reader largely must make them herself. The collection would benefit from more cross references between chapters (there are a few), as well as more sustained discussion, either in an extended introduction or a concluding chapter, of the connections between chapters. Relatively, given the volume arose out of a conference, it would have been helpful to have some discussion of the broader lessons participants drew from the convening. Those caveats aside, this excellent volume will prove a worthwhile addition to the library of academics and policy makers alike. As it provides in one place an introduction to the work of many of the leading scholars writing on housing issues, all or part of the book would also be very useful as a text in a law, urban economics, or housing policy seminar. And one welcome innovation is that the entire book is open access and therefore available free to all via Cambridge University Press.

True to its title, Evidence and Innovation in Housing Law and Policy, provides evidence that should inform and innovations that might inspire both legal reforms and new housing policies. It leaves to its readers the challenging task of making evidence-based policy innovations a reality.

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Expanding Access to Homeownership as a Means of Fostering Residential Integration and Inclusion

Christopher Herbert
Harvard Joint Center for Housing Studies (2017)

The author of this article seeks to provide ideas of ways to expand the range of housing choices available to lower-income and minority families and individuals by addressing access to homeownership. The article discusses the current barriers to homeownership, evaluates existing policies, and provides policy recommendations aimed at expanding access that would foster greater socioeconomic and racial/ethnic integration of communities. The author’s recommendations are premised on the idea that efforts to make homeownership more attainable have the potential to foster residential integration and inclusion as well.

Current barriers to homeownership include affordability, access to credit, and informational deficits. Policies providing down payment assistance and the mortgage interest deduction are evaluated as each relates to the affordability of owning one’s own home. For low-income and minority renters, access to credit may be constrained by weaker credit histories, less stable employment histories, and higher debt levels, all of which make meeting typical underwriting standards difficult. A lack of information and knowledge is also a challenge in the homebuying process for many individuals in these groups.

The author recommends (1) changes to federal income tax policy as it relates to the mortgage interest deduction and savings, (2) increased support for education and counseling relating to homeownership, (3) broadening policy considerations for maintaining and modifying duty-to-serve obligations that affect mortgage lending, and (4) targeting and potentially expanding funding for down payment assistance. These recommendations address financial and informational barriers with the intent to ultimately foster greater socioeconomic and racial/ethnic integration. Homeownership and its benefits still remain an important aspiration of the vast majority of Americans.

Contributors: Crystal Malone, U.S. Department of Housing & Urban Development; Alec Rubenstein, Robinson & Cole, LLP; Melinda Rubenstein, Emmet, Marvin & Martin, LLP; and Theresa A. Omansky, Emmet, Marvin & Martin, LLP
Contaminated Childhood: How the United States Fails to Prevent the Chronic Lead Poisoning of Low-Income Children and Communities of Color

Emily A. Benfer

Children and adults exposed to lead, a neurotoxin, regularly experience an elevated risk of disability, permanent brain damage, and potentially death. The laws governing prevention of lead poisoning in federally assisted housing and, where applicable, private housing, are erroneously named and wholly inadequate, perpetuate racial disparities and socioeconomic inequality, and contribute to the social determinants of poor health. The author of this article presents a historical overview of lead poisoning in the United States, examines the legislative history of lead poisoning prevention policies, describes how the federal government has yet to fulfill the promises of major civil rights laws as they relate to health justice, and suggests future policies that truly would prevent lead poisoning among low income children and communities of color. This article proposes reform measures that would end the lead poisoning epidemic affecting our country.

Poverty, discrimination, and environmental racism significantly influence individual health outcomes and increase a child’s likelihood of being poisoned by lead. Those exposed to environmental hazards, such as lead, are commonly found in low-income communities, and the burden of poverty and related adverse health effects disproportionately affect communities of color. Federally sanctioned discriminatory practices are largely responsible for the high concentration of poverty and the risk of lead poisoning in communities of color.

This article provides a detailed analysis of civil rights laws, relevant case law, executive orders, rules, and policies applicable to the lead poisoning epidemic. Proposed reforms include addressing the prevention practices to identify lead hazards before children are poisoned and increasing enforcement, oversight, and reporting requirements. To protect future generations of children from lead poisoning, a commitment to permanently remove toxic metal from every home and community is necessary.

Association of Changes in Neighborhood-Level Racial Residential Segregation with Changes in Blood Pressure Among Black Adults

Kiarri N. Kershaw, Ph.D., Whitney R. Robinson, Ph.D., and Penny Gordon-Larsen, Ph.D.
177(7) JAMA Internal Medicine 996–1002 (2017)

Exposure to neighborhood-level racial segregation has been found to have a negative effect on blood pressure. In this study of 2,280 black adults, a correlation was found between increased systolic blood pressure, the pressure in your blood vessels when your heart beats, and increased exposure to neighborhood-level racial residential segregation. Conversely, researchers found a correlation between decreased exposure to neighborhood-level
racial residential segregation and reduced systolic blood pressure of more than 1-mm Hg.

The purpose of the study, known as the Coronary Artery Risk Development in Young Adults (CARDIA) study, was to examine the association of changes in neighborhood-level racial residential segregation with changes in systolic and diastolic blood pressure over a 25-year period. The participants in this study were both male and female adults living in high-segregation, medium-segregation, and low-segregation neighborhoods. The segregation scores that were determined also accounted for age, sex, and field center. The data clearly showed a difference in systolic blood pressure when comparing members of high-segregation and low-segregation neighborhoods. As such, the results reveal a correlation between a decrease in exposure to racial residential segregation and lowered systolic blood pressure. The authors display data that shows that policies to reduce segregation may truly have significant health benefits.

What Would It Take for Housing Subsidies to Overcome Affordability Barriers to Inclusion in All Neighborhoods?

Margery Austin Turner
Harvard Joint Center for Housing Studies (April 4, 2018)

This article examines the various reasons why housing subsidies should enable lower-income families to live in the neighborhoods of their choice and why policymakers, when addressing affordable housing in their communities, should target portfolio strategies that focus on diversity of investments and neighborhoods. The author explains that within the same city, life expectancies can differ by as much as twenty years between individuals living in rich versus poor neighborhoods. The Moving to Opportunity experiment showed that children whose parents left high-poverty neighborhoods and moved to lower-poverty neighborhoods were able to achieve better outcomes as young adults than their peers who stayed in high-poverty neighborhoods. Historically, both rental housing developed for low-income families managed by private entities and public housing managed by public housing agencies have been concentrated in central cities, often in low-income neighborhoods. More recently, the Low Income Housing Tax Credit (LIHTC) has been used to develop affordable housing in suburban locations, giving low- and moderate-income renters the possibility of moving to high-opportunity neighborhoods. Creating ways for lower-income families to move into higher-opportunity neighborhoods also provides access to good schools and a safe and healthy environment. Not all cities or communities are alike, so a portfolio strategy combining investments in both affordable rental housing and accessible homeownership will help address the needs of households with income ranging from extremely low to moderate levels. The article makes a number of recommendations. It argues that investments in severely distressed and stable low-income neighborhoods
should focus on providing safety, improving schools, and facilitating access to jobs while also renovating and preserving the affordable housing stock. In emergent neighborhoods, the article explains that investments should focus on protecting the existing subsidized housing stock while also adding to it by providing subsidies to individual households, property owners, and community partnerships that will help to keep the housing stock affordable. Finally, in opportunity-rich neighborhoods, the author contends that strategies should focus on using housing subsidies to expand affordable housing options, using LIHTC to increase the supply of affordable rentals, working with public agencies to acquire existing properties and make them available for rental at below-market rents, and enabling low- and moderate-income homebuyers to purchase homes in these communities.

Has the Mortgage Pendulum Swung Too Far?
Revising Access to Mortgage Credit

Patricia A. McCoy


Since the financial crisis, lenders are more risk averse and households with FICO scores below 700 have a harder time getting a mortgage loan. While mortgage originations have increased since the first quarter of 2014, there has been a pullback in credit to creditworthy minority and lower-income borrowers. Mortgage lending to lower income and minority borrowers has been disproportionately affected as these households tend to have lower credit scores, wealth, and incomes. This article examines both demand and supply side factors affecting mortgage lending. Demand-side factors, which explain the reduced demand for homeownership, include increased foreclosures and decreased demand in young adults who have student debt and are marrying and bearing children later. Supply-side factors include lenders’ additional credit overlays and restrictions beyond Fannie Mae, Freddie Mac, and FHA standards and overall conservative business practices that restrict loans to the safest borrowers in order to avoid the high cost of servicing distressed loans. Structural changes to the industry are needed, and proposals on how to remedy and reinvigorate mortgage lending, especially to minority and lower income borrowers, include reforms in the role of federal government in mortgage lending; flexible lending standards, such as shared appreciation mortgages designed to replace down payment requirements and 15-year fixed rate mortgages; and affordable monthly payment programs. This article focuses on the Massachusetts ONE Mortgage program, which employs lower monthly payment obligations of borrowers (monthly payments are up to 25 percent cheaper than FHA mortgages) and no mortgage insurance requirements to expand the number of eligible borrowers and reduce the risk of default, as well as the Community Advantage Program (CAP), which emphasizes low down payments at near-prime interest
rates to low and moderate income borrowers. These programs aim to offset the risk of default by using low down payments and monthly payments. Both the CAP and ONE Mortgage program use high touch education and counseling, such as pre- and post-purchase counseling, and encourage participants to improve their credit profiles. In sum, the author suggests making safe and affordable credit a policy goal, rooting out and balancing market and regulatory practices that exacerbate swings in the housing finance cycle, and using counter-cyclical tools to moderate the mortgage lending cycle.

A Shared Future: Expanding the Toolbox: Promising Approaches for Increasing Geographic Choice

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Harvard Joint Center for Housing Studies (April 2017)

Evidence has shown that access to high-quality neighborhoods has a positive impact on the educational and economic success of children. This paper examines how federal subsidies can be used to provide families with broader geographic choice through tenant-based mobility strategies and site-based affordability strategies. Tenant-based mobility strategies aim to expand demand for and access to opportunity areas, while site-based affordability strategies aims to increase deeply subsidized housing options available in opportunity areas. An assessment of local conditions and characteristics is necessary to determine which strategies are most likely to improve access to high-quality neighborhoods given the region and market. This paper considers the multiple approaches of King County Housing Authority (KCHA), a Moving to Work (MTW) public housing authority with a jurisdiction spanning thirty-eight suburban cities and towns in the Seattle area, to increase neighborhood options for its program participants. As a result of these efforts, approximately thirty-one percent of KCHA’s federally subsidized households with children live in low-poverty areas.

In terms of tenant mobility strategies, KCHA has focused on two approaches to increasing the interest in and access to high-quality neighborhoods for Housing Choice Voucher (HCV) families that work hand-in-hand: the implementation of small-area payment standards and intensive mobility counseling. KCHA’s participation in the MTW program has given it increased flexibility to use small-area payment standards for HCVs, in which the subsidy levels more closely match market prices, allowing HCV households to access high-opportunity markets with higher costs and KCHA to issue more vouchers. KCHA also funded a local community-based organization to offer intensive mobility counseling to families with elementary school aged children interested in moving to higher-opportunity schools and utilized this Community Choice Program to provide participants with services such as housing counseling, financial assistance for pre- and post-move needs, housing search assistance, and post-move counseling and services.
The site-based affordability strategies employed by KCHA include: (1) acquiring and preserving a portfolio of workforce housing to preserve long-term affordability in workforce housing for markets with rising housing costs, providing mixed-income communities through project based subsidies, and offering access to opportunity markets for households with tenant-based vouchers; (2) purchasing smaller apartment complexes for conversion to public housing using financial resources saved from demolishing obsolete public housing in high-poverty neighborhoods while renovating other projects through conversion to project-based HCVs and LIHTC financing; (3) matching project-based HCV subsidies with non-profit sponsored affordable housing in opportunity neighborhoods, thereby layering rental subsidies to serve extremely low income households; and (4) layering project-based HCVs on affordable housing units being developed under inclusionary and incentive zoning and tax exemption programs to make units available to households with lower incomes than those targeted by such programs.
As a former neurosurgeon, I am all too familiar with the effects of lead exposure on the developing brain. Childhood lead poisoning is a clear example of how substandard housing can adversely affect the health of disadvantaged populations. Ever since national level data have been available, children in poor households have been found to be at the highest risk of lead exposure, with black children being at greatest risk among this group. The reduction in childhood lead exposure over the past decades also represents an example of a public health success story resulting from the efforts of sustained and coordinated actions by federal, state, and local governments and non-governmental organizations.

Over the past several years, the importance of the housing stock to the nation’s economy has become increasingly evident. Housing, as a financial and national asset, has never been more important. At the U.S. Department of Housing and Urban Development (HUD), we play a unique role at the intersection of health and housing. Homes and health are inextricably linked: they reflect two of the most basic needs of a society and serve as an indicator of the strength of the nation. Substandard housing affects communities through wealth depletion, an increase in abandoned properties, and housing instability. While unhealthy and unsafe housing continues to affect the health of millions of people from all income levels, geographic areas, and walks of life, susceptible and vulnerable populations (such as children, the poor, minorities, and people with chronic medical conditions) are disproportionately impacted by inadequate housing. Furthermore, low-income persons are more likely to lack resources for preventive measures in the home, and deferred maintenance can lead to the development and persistence of residential health hazards. Improving housing quality can have a dramatic effect on the health of residents, in turn improving their economic and educational status.
The lead hazard control programs at HUD are unique in the federal government. Unlike many housing rehabilitation programs that focus on major renovations with health and safety as a secondary concern, the lead hazard control programs are intentionally focused on making homes safer for children and families to live in using established assessment and hazard control methods that result in proven benefits\(^1\) and cost savings.\(^2\) These programs play an important part in reducing the nation’s health care costs and have a demonstrated history of success. They meet critical needs in communities where no other resources exist to address substandard housing that threatens the health of the most vulnerable residents.

Through the concerted efforts of laws, regulations, policies, and programs to remove lead from house paint, gasoline, food containers, and consumer products, to support blood-lead surveillance in children, and to target interventions to create lead-safe housing, the geometric mean blood lead level in children ages 1–5 fell from 15 g/dL (micrograms per deciliter) in 1976–1980 to 0.84 g/dL in 2013–2014.\(^3\)

Lead-based paint is the major source of children’s lead exposure. The ingestion of lead-contaminated house dust and residential soil contaminated by the spread of deteriorated paint, and the grinding and weathering of the paint into dust inside the home and outside on the soil, are the major pathways for exposure. House dust, which can be contaminated by small particles of lead-based paint or track-in of lead-contaminated soil, is a major pathway of lead exposure for children who live in older, poorly

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Due to past use of lead in paint, housing age is a key predictor of the risk of lead exposure. HUD’s American Healthy Homes Survey (AHHS) found that only 2.7% of housing built from 1978 to 1998 contained one or more significant lead paint hazards. In contrast, 11.4% of housing built from 1960 to 1977, 39% of housing built from 1940 to 1959, and 67% of housing units built before 1940 contained one or more significant lead paint hazards.

Examining the nation’s housing stock, the AHHS found that 37 million homes have lead-based paint and 23 million U.S. homes have significant lead-based paint hazards. This survey found that the majority of homes built before 1940 with at least one child under age 6 living in poverty have significant lead-based paint hazards; the prevalence of lead paint hazards in these homes nationally was 57% (260,000). For these families living in homes built between 1940 and 1959, the prevalence of lead paint hazards was 54% (288,000), and for homes built between 1960 and 1977, the prevalence of lead paint hazards was 18% (150,000). Therefore, pre-1960 homes, particularly low-income homes with at least one child under age 6 present, provide an appropriate primary target for lead hazard reduction efforts.

The cost benefits of removing lead paint hazards in older housing is evidenced by a report from the Pew Charitable Trusts in 2017, which concluded that eradicating lead paint hazards from older homes of children from low-income families would provide $3.5 billion in future benefits, or approximately $1.39 per dollar invested, and protect more than 311,000 children. About $2.8 billion of those benefits would accrue to roughly 244,000 of the 4 million children born in 2018. The other $670 million in benefits would accrue from protecting approximately 67,000 additional children who are expected to be in those homes over the next ten years. The total benefits include $630 million in federal and $320 million in state and local health and education savings and increased revenue.

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6. The latter year is when the Consumer Product Safety Commission banned lead-containing paint from being used in consumer products, including house paint (16 CFR 1303, 42 Fed. Reg. 44199, Sept. 1, 1977; amended since); the rule went into effect in early 1978.
The primary federal law orienting the response to addressing lead paint hazards in housing is the Residential Lead-Based Paint Hazard Reduction Act of 1992, which is often referred to as Title X because it was enacted as Title X of the Housing and Community Development Act of 1992 (Pub. L. 102–550). This statute represented a sweeping new approach to the lead-based paint problem mandating a comprehensive response that would correct lead paint hazards in most older, i.e., pre-1978 housing nationwide, including:

- Establishing the HUD lead hazard control grant program, which focuses on lead hazard control in older privately owned, low-income housing;
- Training and certifying workers and firms doing housing rehabilitation, remodeling, renovation, repainting, and maintenance in most older housing (40 CFR Pt. 745, subpts. E and Q);
- Certifying of lead paint inspectors, risk assessors, and abatement contractors working on most older housing (40 CFR Pt. 745, subpts. L and Q);
- Establishing the federal Lead Disclosure Rule, under which HUD and the Environmental Protection Agency require the disclosure of known information on lead-based paint and lead-based paint hazards before the sale or lease of most older housing (24 CFR Pt. 35, subpt. A, and 40 CFR pt. 745, subpt. F);
- Establishing requirements that owners or managers of most older housing that is financially assisted by the federal government or sold by the government evaluate and control lead paint hazards (24 CFR, Pt. 35, subpts. B through R);
- Defining and establishing standards for lead in paint, dust, and bare soil at most older housing (24 CFR Pt. 35, subpts. A and B; 40 CFR Pt. 745, subpts. E, F, and L); and
- Establishing Occupational Safety and Health Administration construction worker protection regulations (29 CFR 1926.62).

Implementation of Title X has enabled HUD to develop, demonstrate, and promote measures to correct lead-based paint-related health and safety hazards in the home environment that affect children, particularly of low-income families. Leveraging HUD’s authority to enforce its Lead Paint regulations promulgated under Title X has been shown to be an effective primary prevention tool to further efforts to protect children from

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8. Exempt from Title X and thus from the housing-related regulations issued under its authority is pre-1978 “housing for the elderly or persons with disabilities or any 0-bedroom dwelling (unless any child who is less than 6 years of age resides or is expected to reside in such housing).” (42 U.S.C. § 4851b(27)).
exposure to dangerous lead paint. The outcome of these activities is to ensure that America’s children grow up in affordable, healthy, and safe homes that enable them to reach their full potential. For example, in our enforcement of the Lead Disclosure Rule, our focus has been to protect current and future residents, specifically children, by settling with property owners or managers and requiring testing for and abating any lead hazards found, while requiring them to pay a reduced penalty in return for their lead safety work, which is not mandated by the law or statute. This 20-year approach has resulted in creating hundreds of thousands of lead-safe and lead-based paint-free units, protecting nearly three-quarters of a million children, while benefiting the community and the landlords through higher market value of properties and decreased liability.

In addition, implementation of Title X at the federal level has served as a catalyst for local communities to develop policies that prevent children from being exposed to lead. Local communities have implemented additional innovative policies to expand efforts to reduce lead poisoning. Although many of these policies have focused on providing care for children with an elevated blood lead level, several have adopted policies that promote housing-based primary prevention. For example, New York City (Local Law 1 (2004)), Rochester, New York (Lead-Based Paint Poisoning Prevention (2005)), Massachusetts (Lead Poisoning Prevention Act (1971)), and Maryland (Reduction of Lead Risk in Housing Act (1994, 2012)) have adopted additional policies that proactively address lead in rental homes in their communities rather than waiting to act until a child had already been poisoned.

Targeting lead hazard control to older housing and at-risk populations is critical to sustaining and expanding positive outcomes and long-term benefits and for continued progress in reducing exposure to lead paint hazards.

As Secretary of HUD, I am committed to:

• Strengthening protections for children by implementing a faster response when a young child is exposed to lead-based paint hazards in an older HUD-assisted home, including lowering the Department’s action threshold for lead in a child’s blood;

• Targeting lead hazard reduction to the highest risk homes and communities to best use the available resources;

• Holding HUD-assisted older housing providers accountable for adhering to lead paint safety rules—federal, state, and local—as required by HUD in the Lead Safe Housing Rule as a condition of their accepting assistance (24 CFR §§ 35.145 and 35.150);

• Working directly with local governments to develop lead paint hazard reduction strategies;

• Establishing partnerships with community organizations, local health agencies, faith-based organizations, and private philanthropies to raise awareness about the dangers of exposure to lead-based paint, including by conducting local “Build a Healthy Neighborhood” events around the country and by sharing data to identify pre-1978 housing units with high potential for lead based paint hazards;

• Building and expanding local workforce development for lead hazard control work; and

• Expanding research into improving the efficacy and cost effectiveness of lead-based paint hazard identification and control methods.

HUD is uniquely positioned to continue to promote national efforts to ensure that families have decent, safe, and affordable housing. We have also learned from our experience that targeting building deficiencies that contribute to a multitude of health and safety hazards is more cost effective than implementing interventions on a hazard-by-hazard basis. This whole-house, multi-risk-factor “healthy homes” approach (authorized by 12 U.S.C. §§ 1701z-1 and 1701z-2) is both cost effective and supported by studies on the return on investment for intervention programs. Housing interventions can be selected and implemented strategically to address multiple health and safety hazards.\textsuperscript{10} For example, sealing cracks around the foundation of a home may help to prevent moisture intrusion and the movement of pests into the home, thereby potentially reducing the risks for adverse health outcomes, such as asthma stemming from multiple exposure sources, lung cancer associated with radon intrusion, and childhood lead poisoning from moisture-induced deterioration of lead paint on walls. Reported findings demonstrate that intervention programs on lead poisoning prevention, reducing asthma triggers in the home, and the installation of smoke alarms, for example, produce a strong return for every dollar invested.\textsuperscript{11}


As Secretary, being smart about promoting efficiencies and cost savings in HUD’s investments ensures that we are good stewards of taxpayer dollars. We must constantly evaluate our programs to ensure that we are delivering services effectively and efficiently to HUD’s constituents and responding to today’s challenges with the best practices and technologies. Focusing our efforts to break the link between home-based health hazards and associated health impacts shifts the focus from patient to prevention and will help to unlock the potential of children and families nationwide.
Affordable Housing and Resident Health

Roberta Rubin and Andrea Ponsor

A growing body of research on the social determinants of health has highlighted the importance of stable, safe, and healthy affordable housing to health outcomes. At the same time, many housing providers have come to appreciate the importance of quality, affordable health care to residents’ ability to remain stably housed, particularly those residents who are elderly or have disabilities. Recent federal efforts to address health care spending and insurance through the Patient Protection and Affordable Care Act (ACA) have made this a fertile time for innovation and experimentation, particularly as the U.S. population is aging and health care needs and costs are growing. Housing providers and health care stakeholders have new opportunities for collaboration to improve health and housing outcomes both by expanding access to quality, healthy affordable homes and by creatively delivering and expanding access to services and supports in homes. This Article will provide an overview of the landscape and examples of partnerships between housing providers and health care stakeholders and will outline certain legal issues that may constrain what housing providers can do.

Background

An Expanding View of Health

A growing body of research around the impacts of housing and the surrounding neighborhood on life outcomes increasingly has led academics, policy makers, practitioners, and lay people to recognize that the place one calls home significantly impacts physical, emotional, and economic well-being. Housing has been recognized as one of the “social determinants of health”—the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness, shaped by economics, social policies, and politics, all of which impact individual and communal health outcomes. Particularly within the context of chronic homelessness, research has demonstrated that providing hous-

ing and services to individuals who are high users of public services produces both improved outcomes for the individuals and a reduction in expenditures on health care and emergency public services. Legal directives to serve persons with disabilities in the most integrated setting appropriate to their needs have resulted in a policy shift toward community-based care, requiring more creative approaches to health services. Mission-oriented housing providers serving elderly and disabled residents have recognized their residents’ need for enhanced services, particularly as elderly residents age in place. Growing costs and medical needs of this high utilizer population together with constrained financial resources to address these needs have caused policy makers, insurers, and health care systems to explore opportunities for reducing health care costs and hospitalization, including strategies to help seniors age in place and to deliver in-home health care and services.

Many of the health and housing strategies explored to date have focused on housing as a mechanism for the delivery of health care directly in homes or have demonstrated the role of service-enriched housing in reducing medical costs. This broader view of health and the role of stable affordable housing may open the door to new collaborations that not only deliver health care and services at affordable housing properties, but could also increase access to housing, expand supply, and improve neighborhoods. As housing practitioners explore these new collaborations, they should be cognizant of legal limitations affecting the ability of affordable housing capital and rental assistance programs and the federal Low Income Housing Tax Credit (LIHTC) program to support housing models that are closely tied to the delivery of health care or the reservation or targeting of units to persons with specific disabilities or health insurance.


3. According to HUD statistics for Section 202 HUD-assisted elderly housing, the median age of residents around the country is 76, increasing from 72 in 1983. Thirty-eight percent of residents have one or more disabilities. See Bill Brauner, A First Look at Supportive Housing for the Elderly (Section 202) Housing in Massachusetts (Sept. 2016) (citing Barbara A. Haley & Robert W. Gray, Section 202 Supportive Housing for the Elderly: Program Status and Performance Measurement at 5, U.S. Dep’t of Housing & Urban Development, Office of Policy Development and Research (June 2008), https://www.huduser.gov/portal/publications/sec_202_1.pdf; PowerPoint, Section 202 Supportive Housing Program for the Elderly, Office of Multifamily Housing Programs, HUD (Mar. 18, 2014), https://cedac.org/wpcontent/uploads/2016/06/Section-202-Briefing_FY-2014.pdf), available at https://cedac.org/wp-content/uploads/2016/06/Sec-202-paper-final-10-5-16.pdf (last accessed May 13, 2018). Massachusetts data from Section 202 projects with Project Rental Assistance Contracts shows that 21% of residents were age 85 or more. Id.
The Need and the Opportunity

The need for more affordable housing is clear. In 2016, 20.8 million households (47% of all renters) were rent burdened, paying more than 30% of their monthly income toward rent.4 Approximately 11 million households paid more than half of their monthly income toward rent.5 High housing costs leave renters with little money for other essentials such as food, childcare, and health care. In 2016, the median renter in the bottom quartile had only $488 left per month after rent for essentials like food, health care, utilities, and transportation.6

With millions of rent-burdened households and a growing number of low-income families, the need for affordable rental units and rental assistance is growing, but the resources are not. From 2001–2015, the number of very low-income households, those making less than 50% of the area median income, grew by 4.3 million, of which 2.6 million are new extremely low-income households, those making less than 30% of the area median income.7 Federal rental assistance has not kept pace—the number of very low-income households receiving rental assistance grew by only 600,000 in that same period. Today, only one in four of those families eligible for rental assistance receives it.8 Among very low-income households, a near-record 43% have worst case housing scenarios where they pay more than 50% of their income in rent or live in inadequate conditions.9

High housing costs can cause dangerous tradeoffs, particularly for households that include the elderly, children, or those with chronic medical conditions. For instance, between 2000 and 2007, very low-income families experienced increased spending on housing and an increase in the most severe form of food insecurity.10 Poor nutrition can exacerbate existing health conditions and impede development in children. Other research has shown that individuals who have trouble paying their mortgages or rents experience higher prescription-drug non-adherence, self-

5. Id.
6. Id. at 5.
7. Id.
9. Id.
reported health issues, and lower food security, and they are at a higher risk for depression than their peers who live in affordable housing.¹¹

Unaffordable housing has a pronounced and lasting negative impact on children as well. Recent research has shown that housing instability, including being behind on rent, multiple moves, and homelessness, is associated with adverse health among children in low-income households.¹² Unaffordability can drive households toward substandard or crowded housing. Children who live in substandard housing have increased rates of asthma, increased exposure to lead, and higher rates of childhood accidents.¹³ Children who are homeless or unstably housed have higher rates of mental health problems and often have higher incidence of emergency room visits and less access to basic preventative care.¹⁴ When lack of affordability leads a family to live in crowded conditions, research has shown an impact on a child’s mental health, higher risk for childhood injuries, elevated blood pressure, respiratory conditions, and exposure to infectious disease.¹⁵ Conversely, research has found that children in low-income families that receive housing assistance are more likely to have access to adequate nutritious food and to meet composite criteria for a “well” child.¹⁶ The opportunity to improve outcomes for low-income children is significant in HUD-assisted housing, where more than 1,857,000 households include children.¹⁷ LIHTC units are also home to a significant number of families with children. Approximately 28.7% of all LIHTC units include at least one person under the age of 18, though in some states the percentage is much higher.¹⁸ Strategies that connect worst case needs


¹⁴. Id.


¹⁶. March et al., supra note 10.


households with stable affordable housing may help reduce long-term health care expenditures, positively impact other social determinants of health, and improve broad life outcomes, particularly among children.

Through 2030, more than 10,000 people per day will reach age 65 in the United States alone.\textsuperscript{19} Over the next 20 years, nearly 40% of individuals 62 or older will have assets of $25,000 or less.\textsuperscript{20} The number of senior renter households will more than double from 2010 to 2030—from 5.8 million to 12.2 million.\textsuperscript{21} Housing the lower income segment of this growing senior population will be a challenge. There is already a shortage of more than 7.4 million rental homes for extremely low-income families.\textsuperscript{22} As the general renter population has grown and as the senior renter population ages, the demand for scarce affordable rental units and rental assistance will grow. The aging population is also likely to shift the demographics of assisted units. Across the portfolio of HUD-assisted rental homes, approximately 35% or 1,756,630 households are headed by someone 62 or older.\textsuperscript{23} Among LIHTC units, approximately 26% are already occupied by households headed by someone 62 and over.\textsuperscript{24}

An increasing senior population may mean new opportunities for health and affordable housing collaboration and experimentation. Aging residents are more likely to have chronic conditions and frequent medical needs. Analysis and estimates indicate that more than 90 percent of seniors have a chronic medical condition and that more than 80% of seniors have multiple chronic conditions.\textsuperscript{25} These chronic conditions can lead to higher rates of hospitalizations and readmissions and other negative outcomes that may be improved through housing-related interventions. Also, the systems that provide services to elders with chronic, long-term health

\begin{itemize}
  \item \textsuperscript{23} Picture of Subsidized Households, supra note 17. In Section 8 project based rental assistance, approximately 49% of all units are households headed by someone 62 and over. In the Section 202/PRAC program, all households are headed by someone 62 and over or their spouse.
  \item \textsuperscript{24} Understanding Whom the LIHTC Serves, supra note 18.
  \item \textsuperscript{25} Chronic Care: Making the Case for Ongoing Care, ROBERT WOOD JOHNSON FOUNDATION (Feb. 2010), available at https://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583.
care needs tend to focus on age rather than type of disability as a condition of eligibility, making it easier to reconcile eligibility targeting with fair housing concerns, as discussed below.

While the need for affordable rental homes is overwhelming, lessons learned from demonstrations to date and the growing body of evidence around the impact of stable, affordable housing on health and health care expenditures help to make the case for creative solutions to increase and enhance the supply with new investment partners. Affordable rental housing developments are fertile ground for further demonstration and collaboration with the public and health care sector because of the potentially high concentration of Medicaid and Medicare beneficiaries and high utilizer populations.

In general, federally assisted or restricted affordable rental housing is reserved for low-income, very low-income, or extremely low-income households. “Low-income” is defined as a household income below 80% of the area median income (AMI), while “very low-income” is defined as income below 50% of AMI and “extremely low-income” is defined as income below 30% of AMI. HUD calculates AMI for metropolitan areas and on a national non-metropolitan basis and publishes AMI and the derived income limits annually. Medicaid eligibility for most individuals is determined, at least in part, based on how the individual’s or family’s Modified Adjusted Gross Income (MAGI) compares to the national Federal Poverty Level (FPL) published by the Department of Health and Human Services. In states that have expanded Medicaid eligibility, households with MAGI below 133% of FPL may be eligible for Medicaid. In non-expansion states, eligibility will be based on a lower income threshold and other non-income factors. AMI and FPL are not aligned, but given the income restrictions on affordable housing and the demographics described above, there is a strong likelihood that there will be a concentration of Medicaid beneficiaries in many affordable housing properties.

As noted above, a significant percentage of affordable housing units are occupied by seniors. Those residents over 65 and some younger individuals with disabilities may also be eligible for Medicare coverage. Given the low

28. 42 C.F.R. Part 435, Subpart B.
income levels of many of the senior residents of affordable housing properties, some properties restricted to or serving a large number of seniors may have high concentrations of residents enrolled in both Medicaid and Medicare (dual eligible).\textsuperscript{30} Compared to the average Medicare beneficiary or an individual who is eligible only for Medicaid, dual-eligible beneficiaries have significantly greater need for acute care and medical services, long-term care, and other non-clinical supports and services. Full-benefit dual-eligible individuals have more chronic conditions on average than all other Medicare patients.\textsuperscript{31} Full-benefit dual-eligible individuals also tend to have worse health outcomes, including significantly higher re-hospitalization rates for several ambulatory care sensitive conditions, compared to all other Medicare beneficiaries.\textsuperscript{32} The high service needs of this particularly vulnerable population suggest that home based strategies may offer further opportunity for both improved health outcomes and cost savings.

\textbf{An Evolving Landscape: Changes in Policy and Practice Prior to the Affordable Care Act}

\textit{Early Initiatives in Federally Assisted Housing—Supportive Services for Elderly and Disabled Households; Congregate Housing Services Program}

For nearly 60 years, HUD has provided funding for supportive housing, first for elderly households\textsuperscript{33} and later expanded to serve non-elderly persons with disabilities, initially under the Section 202/162 program\textsuperscript{34} and subsequently its successor, the Section 811 program designed to provide supportive housing for non-elderly persons with disabilities.\textsuperscript{35} Much of the housing developed under the Section 202/162 and Section 811 pro-


\textsuperscript{32}. \textit{id.}


\textsuperscript{34}. \textit{id.}, as amended by Section 162 of the Housing Act of 1987, Pub. L. No. 100-242, 101 Stat. 1815, enacted Feb. 5, 1988. Section 162 modified several aspects of Section 202 with respect to housing for non-elderly persons with disabilities, including changes in operating subsidies and development cost limits and eliminating cost containment requirements.

grams consisted of small group homes with supportive services, often serving persons with developmental disabilities or chronic mental illness.36

First authorized as a demonstration program in 1978,37 and currently authorized as an ongoing program,38 the Congregate Housing Services Program (CHSP) provides supportive service funding for Section 202 projects, federal public housing, and certain other types of housing developments assisted by either HUD or the U.S. Department of Agriculture’s Rural Housing Services division. CHSP is intended to help meet the needs of frail elderly persons, persons with disabilities of any age, and temporarily disabled persons who otherwise would be at risk of institutionalization. Funds may be used to pay a portion (generally up to 40%) of the cost of creation or significant expansion of a broad range of supportive services, including case management/service coordination, personal care, and preventive health services. Some elderly/disabled housing developments have utilized CHSP for many years to serve an increasingly frail low-income elderly population.40 For example, Jewish Community Housing for the Elderly, an organization operating several large elderly housing communities in the Greater Boston area whose residents have an average age of 83, has utilized CHSP since 1994 to provide service coordination, meal services, escorts to medical appointments, medication management, and personal care services, helping residents to age in place.41

Medicaid

Medicaid provides health care coverage for eligible low-income people through a program jointly administered and funded by the states and the federal government.42 Medicaid is administered by the states in accor-


36. Id.


39. For more information regarding eligible programs and program requirements, see 24 C.F.R. Part 700 (HUD programs), 7 C.F.R. Part 1944 (USDA programs), and HUD Handbook 4640.1 REV-1.

40. HUD has not solicited or funded new applications under CHSP since 1995 but has extended expiring grants on an annual basis. See https://www.hud.gov/program_offices/housing/mfh/progdesc/chsp.


dance with plans approved by the Centers for Medicare & Medicaid Services (CMS). The federal government matches a portion of the state’s eligible Medicaid expenditures. The match, called Federal Medical Assistance Percentage, ranges from 50% to 74% and is based on income so that states with lower per capita incomes have higher matches.43

Prior to the enactment of the ACA, Medicaid only required states to cover pregnant women and children under 133% of the FPL,44 children ages 6–18 in households with incomes at or below the FPL through Children’s Health Insurance Programs (CHIP), and disabled adults or adults 65 and older who were eligible for Supplemental Social Security. About two-thirds of states have also chosen to implement the “medically needy” option to serve eligible persons, including elderly and non-elderly disabled adults, who exceed the SSI income standards but meet state-specific medically needy income limits. Persons with high medical or long-term expenses who “spend down” their income on those expenses also may qualify if, after medical expenses, their income falls below the state medically needy income limit.45 However, many lower income individuals remained ineligible for Medicaid and were underserved by the private health insurance market. With more limited eligibility for lower-income households, the potential universe of Medicaid beneficiaries at


many affordable housing properties was smaller and the opportunities for collaboration less obvious. In addition to the limited eligibility, other key historical limitations have been the prohibition of federal Medicaid payment for room and board expense outside of an institutional setting\textsuperscript{46} and the requirement that Medicaid be available statewide to all eligible beneficiaries unless certain limited waivers are granted.

While the passage of the ACA and the large population that began to reach retirement age in 2011 have brought increased focus to opportunities at the intersection of housing and health, cross-sectoral partnerships and demonstrations are not new. Prior to the passage of the ACA, states had the option of covering a variety of services as “rehabilitation services,” particularly for individuals with mental illness.\textsuperscript{47} For several decades, states also have had the option to cover personal care services offering support with activities of daily living and “Instrumental Activities of Daily Living,” including meal preparation, transportation, medication management, and other supports.\textsuperscript{48} In addition, Medicaid waivers offered a path for authorization of new delivery models connecting health and housing. Two key waivers, Section 1115 Research and Demonstration Projects and Section 1915(c) Home and Community Based Services (HCBS), are still utilized and remain important for health and housing partnerships, although the statutory bases for providing HCBS are broader and offer greater flexibility under the ACA.

Under Section 1115 of the Social Security Act, the Department of Health and Human Services (HHS) may approve demonstration projects that give states flexibility to design and improve their programs in order to evaluate state specific approaches to better serving Medicaid populations.\textsuperscript{49} Section 1115 demonstrations must be aligned with Medicaid objectives. They must be budget neutral and are typically approved for an initial five-year period, extendable upon request for up to an additional three to five years, depending on the populations served.\textsuperscript{50} Under a Section 1115 waiver, a state may use a new delivery system or way in

\textsuperscript{46} See 42 U.S.C. § 1386n (i).

\textsuperscript{47} Rehabilitation services are broadly defined to include defined to include “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts . . . for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.” 42 C.F.R. § 440.130(d). See Smith et al., supra note 45, at 11; see also Kaiser Commission on Medicaid and the Uninsured, Medicaid’s Rehabilitation Services Option: Overview and Current Policy Issues (Aug. 2007), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7682.pdf (last accessed May 21, 2018).

\textsuperscript{48} Id.

\textsuperscript{49} 42 U.S.C. § 1315.

\textsuperscript{50} About Section 1115 Demonstrations, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.
which people can access health care or offer services not typically covered
with a goal of reducing Medicaid costs and/or improving the quality of
care.51 Notably, under Section 1115, HHS can grant waivers related to el-
igibility and benefits, as well as waivers to permit long-term services and
supports to be delivered through capitated (fee capped) managed care.52
Some states have sought 1115 waivers to allow them to expand Medicaid
eligibility in a more limited way than the broad expansion permitted
under the ACA.

A waiver under Section 1915(c) allows states to develop programs that
allow people to receive long-term care services and supports in their
homes or communities rather than in an institution. Almost all states use
Section 1915(c) waivers that allow them to offer home and community-
based medical services and nonmedical services, including home health
aides, personal care, and case management.53 Under these waivers, states
can also make services available to specific groups at higher risk of institu-
tionalization, such as elderly or disabled individuals, rather than the popu-
lation as a whole. Section 1915(c) waivers are limited, in that waiver pro-
grams must demonstrate that the total cost of providing HCBS waiver
services to all waiver participants will not cost more than the total cost of
providing care to a similar population in an institutional setting. They
must also ensure that services follow a person-centered plan of care. The
ACA allows states to target HCBS programs to particular health needs
and services in their state service plans and to offer HCBS services to indi-
viduals with incomes above 150% of the FPL in specific circumstances,
eliminating case-by-case waivers.54

Complementing the Medicaid waiver program, the Money Follows the
Person (MFP) Rebalancing Demonstration initiative, authorized by Con-

51. Janet Viveiros, Affordable Housing’s Place in Health Care, CENTER FOR HOUSING
POLICY (June 2015), available at https://www.nhc.org/publication/affordable-
housings-place-in-health-care-opportunities-created-by-the-affordable-care-act-
and-medicaid-reform/.

52. 42 U.S.C. § 1315. For a helpful description of the current landscape, see Sec-
tion 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and
org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-
current-landscape-of-approved-and-pending-waivers/.

53. Home and Community-Based Services, 1915(c), CENTERS FOR MEDICARE & MED-
index.html.

54. In 2005, CMS first allowed states to include Home and Community Based
Services in their state plans, but did not permit targeting specific populations or
serving people with incomes above 150% FPL, so uptake by the states was low.
See Vivieros, supra note 51, at 4 (citing Corporation for Supportive Housing, Sum-
mary of the Improved 1915i Medicaid Home and Community Based State Plan Amend-
gress in the Deficit Reduction Act of 2005 (DRA),\(^{55}\) provided grants between 2007 and 2016 to help states shift from reliance on institutional care toward a system of community-based supports, increasing the use of HCBS while providing for quality assurance and quality improvement. While, as outlined below, the ACA extended and expanded the MFP program, grantee states began working with MFP demonstration programs prior to passage of the ACA, and the lessons learned from those demonstration programs are valuable in crafting future initiatives. According to a 2017 Report to the President and Congress regarding the effect of the MFP (MFP Report),\(^ {56}\) one of the key accomplishments of the MFP demonstration was to help states establish, for the first time, formal transition and rebalancing programs for Medicaid beneficiaries residing in long-term institutional care.\(^ {57}\) The MFP Report noted that state agencies experienced challenges in developing these programs due to the need to coordinate program functions and processes across agencies and providers, as well as the scarcity of both affordable and accessible housing and community capacity to provide HCBS. In the face of these challenges, the MFP Report found that “MFP has been the catalyst to interagency collaboration between health and housing to help individuals in institutions to locate and secure affordable and accessible housing, a key achievement of this demonstration.”\(^ {58}\)

**Community Benefits Pre-ACA**

Originally, hospitals were able to claim tax-exempt status if they simply provided care to patients unable to pay, but over time the Internal Revenue Services (IRS) replaced that requirement with the more general requirement that the hospital provide a “community benefit.”\(^ {59}\) Ambigu-


\(^{57}\) Id. at 16.

\(^{58}\) Id. at 16–17.

\(^{59}\) See Rev. Rul. 69-545, 1969-2 C.B. 117 (replacing the “indigent care” standard with what is now known as the community benefit standard: whether hospitals promote the health of a broad class of individuals within the community); see also Rev. Rul. 83-157 (holding that a hospital without an emergency room may still qualify for exempt status if it provides other forms of community benefits promoting the health of a broad class of persons).
ity around what counts as a community benefit drove conservative behavior, with hospitals disinclined to make investments in housing that would not “count” toward their community benefit obligations. However, the understanding of community benefits has evolved over time. Some states began issuing community benefits guidelines for hospitals and health maintenance organizations as early as the mid-1990s. In 2006, the IRS began a study of community benefits at more than 500 nonprofit hospitals, and beginning in 2009 (reporting tax year 2008), through revision of Form 990 (a filing required of charitable organizations), the IRS began requiring nonprofit hospitals to provide regular, detailed information regarding their charitable activities. However, as detailed below, revisions to community benefits requirements under the ACA have set the stage for new and innovative collaboration with the health care industry.

Initiatives to Address Chronic Homelessness

Spurred in part by increasing recognition that chronically homeless individuals are heavy users of a wide spectrum of public services, communities around the country began exploring ways in which housing and health care funders and providers can come together to provide community-based support for chronically homeless individuals. For example, the Community Support Program for People Experiencing Chronic Homelessness (CSPECH), a collaboration begun in 2006 between the Massachusetts Behavioral Health Partnership and the Massachusetts Housing and Shelter Alliance, provides permanent supportive housing through a combination of Medicaid-funded services and housing assistance from other federal and state funding sources.

60. For example, the Massachusetts Attorney General first issued Community Benefit Guidelines for Non-Profit Acute Care Hospitals in June 1994, followed by Community Benefit Guidelines for Health Maintenance Organizations in February 1996. These Guidelines evolved over time, with the last pre-ACA updates issued in 2009. Following enactment of the ACA and associated IRS requirements, as well as updated statewide health priorities, the Massachusetts Community Benefit Guidelines were substantially revised and updated for a transition/interim launch in fiscal year 2018 to be fully effective in fiscal year 2019. Both the 2009 and 2018 guidelines are available at https://www.mass.gov/service-details/community-benefits-guidelines (last accessed May 15, 2018).


63. A recent report evaluating health data for individuals who entered the CSPECH program between state fiscal years 2007 and 2013 found significant decreases in average per-person health care costs that more than offset the cost of CSPECH
The Patient Protection and Affordable Care Act and Changes to Support Health and Housing Partnerships

As discussed above, growing health care costs, lagging outcomes, and a large aging population have driven a shift in the focus of health care stakeholders even before the ACA. In recognition of the challenges that it faces, the health care sector has increasingly adopted the “Triple Aim” of (1) improving the individual experience of care; (2) improving the health of populations; and (3) reducing the per capita costs of care for populations.64 The Triple Aim would improve the quality of care while reducing costs, but as Berwick et al. noted, only a tiny portion of health care organizations in the United States adopted these aims.65 Seeking to address these and other challenges, Congress passed the ACA in 2010. The ACA reflects a more holistic view of health care and seeks to provide flexibilities that allow the health care sector to pursue the Triple Aim.

The ACA has three goals.66 First, it seeks to make affordable health insurance available to more people. Second, for those low-income people likely unable to afford health insurance, the ACA expands the Medicaid program to cover all adults with income below 133% of the Federal Poverty Level (FPL). Finally, the law aims to help lower costs and increase access by supporting innovative medical care delivery methods. While the ACA made myriad changes to health care and insurance law in pursuit of these goals, we focus here on those changes most relevant to housing stakeholders seeking to work with the health care sector to improve outcomes and increase the supply of and access to affordable housing. We note that while changes made through the ACA provide opportunities for new demonstrations and partnerships, some innovation has been stymied by legal challenges and the threat that Congress would repeal the ACA. It is unclear whether health care stakeholders will view the failure of attempts at a partial repeal in 2017 as a sufficient indicator that key provisions of the law will continue for the foreseeable future and pursue the full flexibilities of the law, though there seems to be significant activity.


65. Id.

Medicaid Expansion

Expansion of Medicaid coverage is a key element of the ACA and one of the most impactful changes for residents and operators of affordable housing seeking new collaborations. The broad eligibility and increased participation Medicaid offer a new scale for experimentation.

State expansion of Medicaid under the ACA is voluntary, but for participating states Medicaid eligibility is extended to all households under 65 with incomes at or below 133% of the FPL. For those states that choose to expand eligibility, the federal government matched 100% of the state’s spending for these newly eligible people from 2014–2016 with the federal match declining incrementally until it reaches 90% in 2020. As of April 2018, 33 states have adopted the Medicaid expansion. Medicaid now covers approximately one in five people in the United States.

Delivery Models

In order to understand the opportunities that may evolve from Medicaid expansion, it is helpful to understand the primary models for delivering services and coordinating payments for Medicaid beneficiaries.

(1) Fee for Service. Under the traditional fee for service model, the state Medicaid program pays the health care provider for each service. The nature of fee for service agreements may not incentivize care providers and organizations to establish large-scale partnerships that address broader health needs and the social determinants of health, though providers may still have interest in providing services on site at housing or pursuing other arrangements.

(2) Managed Care. The Managed Care model uses a managed care organization (MCO) to offer services directly or contract with other providers. States contract with one or more MCOs for managed care in designated geographic areas that may be regional or statewide. Contracts tend to run for one to four years. MCOs receive a predetermined per beneficiary rate from the state called a capitated rate, which does not fluctuate based on the services actually used.


69. Health Insurance Coverage of the Total Population, HENRY J. KAISER FAMILY FOUNDATION, available at https://www.kff.org/other/state-indicator/totalpopulation/?currentTimeframe=0&selectedDistributions=medicaid&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D.

70. Viveiros, supra note 51, at 2.
Managed care pre-dates the ACA, but as discussed below, cost savings policies in the ACA are driving capitated rate approaches. Nationally, more than 68% of Medicaid beneficiaries are enrolled in MCOs.71

(3) Integrated Care. An Integrated Care model employs organizations that offer a wide variety of health and social services through one system. Integrated organizations are also typically paid at a capitated rate.

New Approaches and Demonstrations

Overall, the ACA creates incentives for states to deliver quality health care through innovative approaches. The ACA pushes health care organizations to move from the traditional health care treatment approach to a more preventative approach.

One such new model is the Accountable Care Organization (ACO) and Medicare Shared Savings Program (MSSP). ACOs are voluntary networks of providers that coordinate care from various providers for Medicare patients.72 Rather than doing away with the traditional fee for service payment structures, the ACO/MSSP approach offers participants an opportunity to share in any savings they realize, provided that certain quality targets are met.73 This incentivizes providers within the ACO to share information and make investments likely to generate savings while maintaining or improving quality of care. ACOs could have a strong incentive to partner with housing organizations that can deliver non-medical services, particularly if those organizations can demonstrate their ability to share information and impact the health of residents.74 Housing organizations with established and systemic resident services programs, particularly those with robust data collection capabilities, are best positioned to enter such collaborations.

Dual Eligible Demonstrations

The ACA established the Medicare-Medicaid Coordination Office (MMCO), an office within CMS, to coordinate care for dual eligibles, or Medicare-Medicaid enrollees. Like other ACA initiatives, the MMCO

74. Viveiros, supra note 51, at 5.
was established to improve care and lower costs.\textsuperscript{75} The MMCO launched the Financial Alignment Initiative, a series of demonstrations to test new approaches that address the siloed contracting and reimbursement issues that result in fragmentation of care delivery of Medicare and Medicaid benefits.\textsuperscript{76} The demonstrations included both a capitated model and a fee for services model. As of 2016, 13 states were participating.\textsuperscript{77} Given the large population of dual eligible seniors, these demonstrations offer opportunities for partnership and learning. Although early results are inconclusive, experiences from states with a longer history of an integrated approach indicate that integrated approaches could yield improved outcomes including a reduction in emergency department visits and hospital admissions.\textsuperscript{78}

**Reimbursement Policies**

In addition to expanded coverage, the ACA expands the types of providers eligible for Medicaid reimbursement, authorizing new coordinated models of care under Medicaid and enhancing existing models.\textsuperscript{79} CMS has also issued rule changes that authorize Medicaid reimbursement to nonmedical providers of services recommended by doctors or other licensed practitioners. Previously, only doctors or licensed practitioners themselves could be reimbursed for providing services.\textsuperscript{80}

Since the passage of the ACA, CMS has issued guidance clarifying which housing-related services can be reimbursed for disabled persons, those with chronic illness, and those experiencing chronic homelessness

\textsuperscript{75}. About the Medicare-Medicaid Coordination Office, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/.


\textsuperscript{78}. Update on Demonstrations for Dual-Eligible Medicare-Medicaid Beneficiaries, supra note 76.

\textsuperscript{79}. Dep’t of Housing and Urban Development, Leveraging the Health and Housing Nexus, EVIDENCE MATTERS (Winter 2016), available at https://www.huduser.gov/portal/periodicals/em/winter16/highlight1.html.

through waivers and, while in place, the Money Follows Person program.\textsuperscript{81} Reimbursable activities fall into three categories: individual housing supports (housing search assistance, move-in assistance), tenancy sustaining services, and state level collaborative activities related to housing. Through state level collaborations, state agencies can provide data to housing agencies to support the development or availability of housing for Medicaid eligible individuals; however, limitations under housing funding programs and fair housing law may create limitations on how new units are developed and operated. While this guidance on reimbursable activities will help open the door to new partnerships, it does not alter the prohibition on federal financial participation for room and board expenses, which continues to be a barrier to the development of new housing and the provision of more permanent rental assistance.

Other more technical changes in the ACA may also motivate new partnerships. The Hospital Readmissions Reduction Program, for example, reduces payments to hospitals with excess readmissions of patients within 30 days of discharge for designated conditions.\textsuperscript{82} This new policy provides hospitals and payors incentive to ensure that patients have stable, healthy housing upon discharge.

Enhanced Emphasis on IRS Mandated Community Benefits from Non-Profit Hospitals and HMOs

The ACA also seeks to enhance the impact of tax-exempt hospitals in addressing the needs of communities, particularly through the community benefits that tax-exempt hospitals are required to provide. The ACA addresses ambiguity around what counts as a community benefit by requiring that hospitals conduct a community health needs assessment (CHNA) to guide their activities. Recently, the IRS issued clarifying guidance noting “...some housing improvements and other spending on social determinants of health that meet a documented community health need may qualify as community benefit for the purposes of meeting the community benefit standard.”\textsuperscript{83} Based on these clarifications, housing-related activities that are provided primarily to address an identified community health need and improve health can be considered a community benefit. Community need will generally be identified through a CHNA or by a request from or partnership with government or community orga-

\textsuperscript{81}. Leveraging the Health and Housing Nexus, supra note 79 (citing Vikki Wachino, CMCS Informational Bulletin, Coverage of Housing-Related Activities and Services for Individuals with Disabilities (June 26, 2015), available at https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf). As noted earlier, the MFP Program has ended, although awarded but unexpended grant funds may still be used through federal FY 2020. See supra note 55.

\textsuperscript{82}. Id.

nizations. It is important to note that, even if the CHNA identifies a need for housing, investments expected to generate a return, such as low interest loans or investments for the acquisition or construction of housing, are not considered community benefits.84 However, a variety of housing supports may qualify.85

This focus on addressing need without a return may limit the impact that a hospital’s community benefit strategy has on affordable housing supply or supporting community development, but could provide clarity on collaborations and investments that will be attractive to hospitals. Collaborating in ways that maximize investment and impact in communities may require housing organizations to create relationships with multiple departments within a hospital system, because community benefits officers can be housed within different departments within each hospital organization and are often organizationally separated from leadership making investment and real estate decisions.

Promising Collaborations between Housing Providers and the Health Care System

There is a broad universe of opportunities to connect the health care sector and state agencies with housing organizations to increase access to stable housing and improve health outcomes, but many of these opportunities are still nascent. This section will highlight select promising initiatives and briefly outline strategies that may better position housing organizations for partnership.

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84. On the other hand, grants and interest-free loans may be problematic under the Low-Income Housing Tax Credit Program, discussed below. If funds flow to a tax credit owner entity in the form of a grant, either the grant will be treated as taxable income or the basis on which the credit is calculated will be reduced with respect to certain costs financed with the grant. For a helpful, brief discussion of the tax treatment of grants in projects receiving federal tax credits, see Mark Primoli, *The Tax Effect of Grant Money in Rehabilitation Tax Credit Projects*, IRS Tax Brief (updated Apr. 23, 2018), available at https://www.irs.gov/businesses/small-businesses-self-employed/the-tax-effect-of-grant-money-in-rehabilitation-tax-credit-projects (last accessed June 10, 2018) (analyzing the tax treatment of grants under the federal historic tax credit program). Loans bearing interest at a below-market rate may also trigger adverse tax consequences, depending on whether the lender is a governmental entity or charitable organization and whether the loan is seller financing. See Steven L. Paul, *The Low Income Housing Tax Credit* 102–03 (2017 ed.), *Klein Hornig LLP*, available at http://www.kleinhornig.com/wp-content/uploads/2017/10/Low-Income-Housing-Tax-Credit-Outline.pdf (last accessed June 10, 2018).

On-Site Services

On-Site Services and Supports in Collaboration with an MCO

National Church Residences, a national nonprofit organization that develops and operates homes for seniors and also operates home health care services, is working with an area MCO to provide enhanced services for the MCO’s Medicaid-Medicare dual eligible members who reside in select National Church Residences properties. In order to improve health outcomes and increase independence for dual eligible MCO members residing in National Church Residences’ housing, the MCO charges a per member per month fee that is used to help offset the cost of a resident services coordinator who helps residents connect with services and supports and who communicates with the MCO about member needs. Limited wellness services, such as flu shots and blood pressure checks, are also provided on-site. The MCO and National Church Residences collaborated to develop a measure scorecard to track expected outcomes. The parties continue to look at ways to grow and be innovative through this unique and strategic partnership.

While enhanced resident services and communication about resident health care needs may raise privacy and compliance issues around resident data, National Church Residences benefits from its own experience in delivering home health services as it designed this offering. Unlike some other affordable housing providers, it is experienced in partnering with health plans, assessing HIPAA obligations and compliance, and billing for health care services.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) provides a wide range of medical, social, recreational, and wellness services to eligible participants, with the goal of enabling program participants to age in community with HCBS. PACE is a joint federal/state program combining Medicare and Medicaid funding. In Massachusetts, it is administered by the Executive Office of Health and Human Services, the designated PACE State Administrative Agency, which is also the agency that administers state’s Medicaid program, MassHealth. PACE programs around the Commonwealth feature interdisciplinary teams of health care and social service professionals; an individualized health care plan for each participant developed with participant and (when appropriate) family input;

86. See What is PACE?, MASS.GOV, https://www.mass.gov/service-details/what-is-pace.
87. See MassHealth, MASS.GOV, https://www.mass.gov/topics/masshealth. PACE is a joint Medicare Medicaid program authorized under both Title XVIII (Medicare) and Title XIX (Medicaid). A person may enroll in PACE either as Medicare only, Medicaid only, as a dual eligible, or entirely private pay. For information regarding PACE eligibility, see 42 C.F.R. § 460.150.
and a “PACE Center” that offers medical care, physical rehabilitation facilities, social work offices, and an activities center offering social and recreational activities. HCBS offered for members include meals, personal care, social services, respite care, and transportation, among other medical and non-medical services. To be eligible for PACE, in addition to age and location criteria, an individual must be certified by the state as eligible for nursing home care, live in the community (not a nursing home), and be able to live safely in community.

The Sisters of Providence (SoP), a faith-based organization, are the historical sponsors of the nonprofit Sisters of Providence Health System in Springfield, Massachusetts. Recently, on its 27-acre campus in West Springfield, Massachusetts, SoP has made space available for a PACE program operated by Mercy LIFE offering coordinated care to eligible elders and people with disabilities over 55. SoP applied for and received a commitment of LIHTC and capital assistance from the Massachusetts Department of Housing and Community Development (DHCD), as well as funding from the City of West Springfield, to create 36 affordable housing units for seniors. Working closely with DHCD and the Commonwealth’s Executive Office of Elder Affairs to address potential fair housing issues, SoP plans to implement a preference for applicants who meet PACE eligibility criteria (as verified by the PACE provider organization), with the goal of enabling individuals to live in a community-based setting notwithstanding health needs that would qualify them for nursing home care.

Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing Program

The Fiscal Year 2014 Consolidated Appropriations Act authorized a housing-with-services demonstration in HUD assisted properties serving low-income elderly residents to test models that demonstrate the potential of stable, service-enriched housing to delay or avoid the need for nursing home care. In January 2017, HUD selected 38 properties for a treatment group that will receive three years of grant funding to support an Enhanced Resident Services coordinator and a part-time wellness nurse.

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88. *Who is Eligible for PACE?*, Mass.gov, https://www.mass.gov/service-details/who-is-eligible-for-pace. To be PACE-eligible, an individual must be 55 or over; if less than 64 years of age, the individual must meet Social Security Act Title XVI disability standards. PACE participants must also agree to receive health services exclusively through the PACE organization. An individual who meets the income and asset guidelines for MassHealth eligibility may be eligible for MassHealth, which may pay the PACE premium.


The nurse will have face-to-face interaction with residents to understand their situation, answer questions about self-management of the condition of their diseases, assist with medication self-management, assist with communications with physicians, and monitor residents after their return from a hospital or rehabilitation stay. Participating sites are expected to foster collaboration and enter into partnership agreements with key area partners, including Area Agencies on Aging / Aging and Disability Resource Center (AAA/ADRC), the local home health agency, the local mental health services agency, and other local health and/or service provider agencies. The demonstration notice of funding availability required that all service providers be Medicaid and/or Medicare providers with the capacity to bill for services or be associated with an AAA or an ADRC.

The demonstration is designed to produce evidence on aging in place; transitions to institutional care; and housing stability, well-being, health outcomes, and health care utilization associated with nursing home placement and high health care costs. Data will be collected for two pools of properties, one pool that previously had a service coordinator and another that did not have a service coordinator. Within each pool, a treatment group will have a wellness nurse and a control group will not. This ongoing demonstration program may provide helpful evidence that will support further collaboration to support enhanced service coordination and on-site health care services.

**Investments in the Housing Supply**

**MCO Investments in Supply**

Many MCOs recognize the need for affordable housing to serve individuals with high medical costs and those who are homeless or have unstable housing and are seeking multiple approaches to address the need. In Maricopa County, Arizona, the Treasury Department at United Health Care (UHC) has used its capital reserves to underwrite short term, low-interest loans to a developer to rehabilitate previously modest market rate housing units. UHC worked with the state Medicaid authority and the Department of Insurance to direct $22 million to Chicanos Por La Causa (CPLC), a nonprofit developer, for investment in affordable housing. UHC and CPLC have previously partnered to create an electronic referral system that provided comprehensive data to CPLC for United


Healthcare’s members and reinforced the extensive overlap between CPLC clients and United Healthcare’s members. The two entities also created the myCommunity Connect Center, a pilot through which UHC funded social, medical, and behavioral services delivered by CPLC staff. Recognizing the importance of stable housing to health outcomes, UHC and CPLC have expanded their collaboration under the myCommunity initiative to acquire, develop, and operate multifamily housing in the Phoenix area. Using a low interest loan from UHC, CPLC has acquired and renovated 500 apartments. Up to 20% of the units are to be reserved for UHC enrollees at affordable rents. These rents are expected to be cross-subsidized by market rents on the balance of the units. In addition to the capital and operating costs, UHC also provides a variety of services to these enrollees living in PSH. However, these services are delivered through a separate managed care contract. The separate nature of the capital investment and managed care contract highlights the challenges of creating partnerships that cross different business units and funding streams within health care organizations. A change in the managed care contract could mean that residents are later served by a different provider. It also means that there is the potential for realized savings under the managed care contract that may not have been leveraged in the capital investment. One challenge of fully leveraging potential MCO savings for investment in the creation of units is that the relatively short nature of MCO contracts, often three to four years, does not align with the much longer nature of housing and real estate investments.

While UHC has in other contexts invested in LIHTC properties, this investment by UHC differs in that it did not utilize LIHTC. This non-LIHTC financing allowed the acquisition and renovation to move faster and to implement preferences for units that may not have been permissible under LIHTC or other affordable housing programs. The structure of this loan as an investment of capital reserves presented other challenges, however, including approvals of insurance regulators and reconciling the different timelines that MCOs and affordable housing organizations have for investment.


94. Innovative Models in Health and Housing, supra note 92.

ACO Support of Housing

Hennepin Health, a county-run Accountable Care Organization (ACO) serving the Minneapolis area, has targeted a high-cost population and seeks to reduce health care costs by investing in services like housing. Stakeholders expect that through the ACO structure, savings can be used to support capital or operating subsidy for affordable housing serving the chronically homeless.96 Strong public funding for housing for this population through the state’s Group Residential Housing program, in conjunction with loans from the Minnesota Housing Finance Agency and in some cases LIHTC and project based vouchers, have supported a significant increase in the number of units serving the chronically homeless, moving the county closer to functionally zero chronic homelessness. In light of this progress, Hennepin Health has chosen to use some of the health care costs savings that it shares under the ACO structure to employ housing specialists and augment services in primary care clinics to assist members to access and maintain housing during periods when their mental illness and/or substance use disorders may result in behaviors that threaten their housing stability.

Healthy Futures Fund

In order to improve community health by building cross-sector partnerships, the Local Initiatives Support Corporation (LISC) in partnership with Morgan Stanley and the Kresge Foundation formed the Healthy Futures Fund (HFF). HFF brought together grant, loan, and equity capital to develop integrated housing and health services.97 The $200 million fund supported the development of affordable rental homes with integrated health services and federally qualified health care centers (FQHC).98 Grant and loan funds complemented LIHTC funds to finance affordable rental properties, and new markets tax credits (NMTC) were packaged with loan funds to supplement the federal grant that the Human Resources and Services Administration (HRSA) within HHS provides for FQHCs.

In Washington, D.C., HFF helped finance the Conway Center, operated by So Others Might Eat (SOME). The Conway Center is located at a transit hub and includes a 37,000 square foot FQHC, a pharmacy, 182 units of supportive housing, 20 units of housing for adults participating in a substance abuse treatment program, and SOME’s employment training center.99

96. Innovative Models in Health and Housing, supra note 92.
LIHTC, bond financing, and D.C. Housing Trust Fund money were used to finance the supportive housing, while LISC, Morgan Stanley, CityFirst Bank, and D.C. Housing Enterprises all contributed NMTC allocations to finance the FQHC, retail space, and the twenty additional units of housing. Structures like HFF provide a more familiar approach by using conventional affordable housing and community development financing programs, but may still present some of the challenges discussed below if stakeholders wish to provide preference for certain populations when leasing the LIHTC units.

**Community Benefits**

One comprehensive example of using Community Benefit investments in housing comes from Portland, Oregon, where five hospitals and a nonprofit health care plan came together to provide a $21.5 million Hospital Community Benefit Obligation grant to support the development of 379 units of affordable supportive, respite care, and transitional housing.100 The housing is being developed by Central City Concern (CCC), the largest provider of supportive housing in Portland. CCC also provides physical and behavioral health services to homeless adults and has extensive experience developing affordable housing. This housing is being developed in connection with a FQHC and commercial space. The decision to work together was aided by the prior successful collaborative experience among the hospital systems.

CCC leveraged the capital investment from the hospital systems with equity investment from other sources generated by LIHTC, as well as proceeds from a capital campaign to minimize the debt required for the development, making it more feasible to service the debt with affordable tenant rent contributions and possibly a rent subsidy. CCC’s role as a primary care provider may allow it to leverage funding for those services as further ongoing operational support for the properties.

It is worth noting that, in addition to providing critical financial leverage, the use of Hospital Community Benefit Obligation grants helped to avoid problems arising from the differences in spending and investment horizons that emerge when housing and health care organizations attempt to tie transactions to savings in services provided to the population being housed. Health care organizations investing in housing often want to demonstrate the return on their investment by relating the amount and source of their investments to savings realized through managed care contracts or other captitated fee or savings driven models. In the case of managed care contracts, the opportunities for demonstrable savings may run for the term of the contract, which is often only a few years. Affordable housing investors, in contrast, typically are making investments of at least fifteen years, the initial LIHTC statutory compliance period; even

100. *Innovative Models in Health and Housing*, supra note 92, at 1.
when shorter term, non-LIHTC investments are viable, developers still are typically looking for a minimum investment term of five to seven years. These different horizons create challenges in combining savings-driven investments from health care organizations with traditional affordable housing sources, since a typical affordable housing financing transaction does not offer an obvious exit strategy for a health care investor in the first three-to-five years. Further, with a shorter investment horizon, savings-driven investments from health care organizations alone are unlikely to offer the stable capital needed to create long-term affordable housing.

In the Portland example, the nature of the investments as charitable donations meant that the success of the project from the equity investors’ perspective was not dependent on documenting health care savings over a short time period. This, in turn, avoided the potential for conflict between health care and housing equity investor requirements. However, as discussed in detail below, the use of LIHTC will present a host of considerations for the financing and operation of the property.

**Strategies That Facilitate Collaboration**

In order to build effective partnerships with the health care sector, housing organizations will need to learn to communicate with this sector, demonstrate their ability to create trusted relationships with residents, and consistently collect and utilize data. Many of the promising partnerships outlined above grew out of long-term relationships that began with smaller, service or tenant support partnerships. Those existing partnerships help housing organizations develop two competencies that are key for building future partnerships: the ability to communicate across sectors and the ability to identify one or more partners within health sector organizations. Housing organizations that have successfully formed partnerships with the health care sector emphasize the challenge of learning to speak the same language. Organizations seeking to establish partnerships should consider resources for learning about funding streams and terminology critical to the health sector. The second challenge is identifying the right stakeholders within a health care organization. As noted in the examples above, partnerships can grow out of direct service delivery, community benefits obligations, or even investment of reserves and funds controlled by a health care system’s treasury function. In many systems, each of these areas may have a different decision maker. Identifying senior leaders that can help navigate across the organization to form the most impactful partnership is another challenge.

While establishing strong relationships and good communication with residents requires time and multifaceted approach, a systems approach to resident services coordination can help establish relationships with tenants, identify the needs of the community, and effectively target services to the community. Resident services coordinators can also play an important role in collecting data on resident services outcomes, though housing providers should consider what releases are needed to gather and share...
data, including non-health related data. By providing residents with access to supportive services, the mission-driven developer members of Stewards of Affordable Housing for the Future (SAHF) have found that service-enriched housing offers opportunities to residents that can help them improve their lives and live independently with dignity. With support from the MacArthur Foundation, SAHF created a Community of Practice (CoP) related to systems of enhanced resident service coordination. The CoP developed a consistent framework that can be used by practitioners, service providers, policymakers, funders, and investors in addressing resident services coordination. The Resident Services Coordination System Framework includes elements that outline effective implementation of a systems approach to resident services coordination. A systems approach to providing resident services will create a process to identify what services and partnerships may benefit the residents and build the infrastructure to support health sector partnerships.

Legal Considerations for Housing and Health Care Collaborations

Privacy Issues

While it may appear that the most effective way to serve an individual is to enhance communication among the individual, family members, health care providers, property managers, and resident coordinators, housing providers seeking to assist residents in meeting their health care needs must be careful to safeguard personal information that may be protected under federal or state law.

a. HIPAA compliance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) addresses the security and privacy of individual health data. The U.S. Department of Health and Human Services (DHHS), which is charged with implementing HIPAA, has issued regulations prescribing standards, requirements, and implementation specifications under HIPAA (referred to below as the HIPAA Regulations). Under the HIPAA Regulations, protected “health information” means any information that:

(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.


102. 45 C.F.R. Parts 160, 164.

103. 42 U.S.C. § 1320d(4); see also 45 C.F.R. § 160.103.
Under the HIPAA Regulations, “health information” includes any such information, including genetic information, whether oral or recorded in any form or medium. HIPAA and the HIPAA Regulations further define “individually identifiable health information” to include health information created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Not all persons or entities receiving health care information are covered under HIPAA, and disclosure of protected health information by property managers or resident services coordinators could only constitute a HIPAA violation if their employer is a HIPAA-covered entity, or a business associate of a HIPAA-covered entity. Under HIPAA, the standards prescribed through the HIPAA Regulations apply to “covered entities,” which include (1) a health plan; (2) a “health care clearinghouse” that processes information so it can be transmitted in a standard format between other covered entities; and (3) a health care provider who transmits any health information in electronic form in connection with a variety of health-related transactions, including injury reports, health care payment and remittance advice, health plan eligibility, referrals, and initial injury reports. HIPAA standards also apply to a “business associate” of a covered entity—any person who provides various services to a covered entity, where the provision of the service involves the disclosure of protected health information, as well as subcontractors hired by business associates. A “hybrid” legal entity that performs both HIPAA-covered and non-HIPAA-covered functions may have special obligations to ensure that the covered portion of the business does not disclose HIPAA-protected information to the non-covered portion of the business.

While health information received by a management agent or resident services coordinator with respect to a particular resident could constitute “individually identifiable health information,” a typical housing provider is not a HIPAA-covered entity. However, when owners, property managers, or resident service coordinators take on new or expanded roles with respect to HIPAA-protected health information, particularly in properties where enhanced service coordination may involve frequent communica-

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104. 45 C.F.R. § 160.103.
105. 42 U.S.C. § 1320d(6); see also 45 C.F.R. § 160.103.
106. See 45 C.F.R. § 160.103 and 45 C.F.R. § 160.300, respectively, for definition of covered entity and applicability of compliance requirements.
108. See 45 C.F.R. Part 164. Accordingly, the HIPAA regulations require that a “health care clearinghouse” that is part of a larger organization implement policies and procedures that protect the electronically protected health information of the clearinghouse from unauthorized access by the larger organization. 45 C.F.R. § 164.308(ii)(A).
tions to and from medical service providers, they should consult a HIPAA expert to determine whether they may be subject to HIPAA requirements and, if so, what protections they need to put in place to safeguard protected health information.

b. Federal Privacy Act

The Federal Privacy Act of 1974 and other federal statutes governing HUD programs restrict disclosure of certain personal information about the people served in HUD programs. HUD regulations setting forth general HUD program requirements require recipients of HUD assistance, including public housing authorities and private housing owners receiving assistance under mortgage and loan insurance programs, to comply with Privacy Act restrictions governing the collection, maintenance, use, and dissemination of personally identifying information, including Social Security numbers, employer identification numbers, any information derived from those numbers, and income information. Accordingly, even if an owner is not a HIPAA-covered entity, other privacy compliance requirements may apply, making it important to safeguard sensitive personal information of program participants.

c. State Privacy Laws

It is also important to be mindful of state privacy laws, which may be broader in scope than HIPAA and may also provide a private right of action. For example, Massachusetts’ Fair Information Practices Act (FIPA) imposes a duty to safeguard “personal data” on any person or entity that contracts with or has an arrangement with a state agency whereby it holds personal data as part of or as a result of performing a governmental or public function or purpose. “Personal data” is broadly defined to include any information concerning an individual that, because of name, identifying number, mark, or description, can be readily associated with a particular individual (with exceptions for certain information relating to law enforcement).

111. See, e.g., 24 C.F.R. § 5.212.
112. See also Dep’t of Housing and Urban Development, Notice PIH-2014-10, issued Apr. 30, 2014.
113. MASS. GEN. LAWS c. 66A; see also MASS. GEN. LAWS c. 93H and implementing regulations at 940 MASS. CODE REGS. §§ 27.00 et seq., governing the collection, maintenance, and disclosure of personal information.
114. MASS. GEN. LAWS c. 66A, § 1.
115. Id.
sonal data that may include health information as well as other personal identifying information.\textsuperscript{116} The Massachusetts courts have broadly interpreted FIPA to offer strong protection for medical files or information that are of a personal nature and relate to a particular individual.\textsuperscript{117} Indeed, a recent Superior Court decision found that FIPA would prohibit disclosure of information that would \textit{indirectly} identify named individuals, and a diagnosis relating to those individuals, by disclosing their residence in a group home for which eligibility is limited to persons with developmental disabilities.\textsuperscript{118} In addition, states may establish a private right of action for interference with an individual’s privacy by statute\textsuperscript{119} or case law.\textsuperscript{120}

\textit{Limits Imposed by Laws Governing Housing Finance}

Historically, there has been a clear legal separation between public programs funding housing assistance for low-income households and programs funding health services. As a result, several of the federal programs most commonly utilized to fund affordable housing around the country impose limits on the type of services that can be provided in housing that is assisted under those programs. This Article addresses constraints affecting three major federal programs that support the development of affordable housing: the Low Income Housing Tax Credit program, tax-exempt bonds (often combined with LIHTC), and the HOME Investment Partnerships program. Practitioners should also be aware, however, that additional restrictions may apply under other funding programs, both federal and state.

\textsuperscript{116} These include local housing authorities, nonprofits serving as regional administering agencies with respect to federal and state rental vouchers, additional nonprofit Area Agencies on Aging used to support home and community based supportive and nutrition services, Aging Services Access Points that administer supportive services designed to help elders remain independent and in their own homes, and service providers acting on behalf of the state’s Department of Mental Health.


\textsuperscript{119} See, \textit{e.g.}, MASS. GEN. LAWS c. 214, § 1B.

\textsuperscript{120} See, \textit{e.g.}, Hill v. Nat’l Collegiate Athletic Ass’n, 14 Cal. 4th 889 (1994); Loder v. City of Glendale, 14 Cal.4th 846, 890–91 (1997) (holding that a person claiming an actionable invasion of privacy under the state Constitution must show (1) a specific, legally protected privacy interest; (2) a reasonable expectation of privacy; and (3) conduct constituting a serious invasion of privacy).
a. Low Income Housing Tax Credits and Tax-Exempt Bonds

The Low Income Housing Tax Credit (LIHTC), created as part of the Tax Reform Act of 1986, provides a credit against federal income taxes for taxpayers that develop (through new construction or substantial rehabilitation of existing buildings) qualified rental housing in which at least the statutorily required percentage of units is both income-restricted and rent-restricted. Although the amount of LIHTC allocated to a state to support projects in any given year is limited by statute, HUD has recognized that the LIHTC program remains the “most important resource for creating affordable housing in the United States today.”


122. Since 1987, the amount of the credit has fluctuated based on a calculation using the applicable federal rate of interest on mid-term and long-term debt under IRC Section 1274(d). However, the credit rates are commonly referred to as the “4% credit” and the “9% credit” because those were the applicable percentages in the first year of the program; the actual percentages have tended to range between 3% to 4% and 8% to 9%, respectively.

123. The amount of credit for which a development may qualify is based on a number of factors, including the types and amounts of costs incurred as part of the project, the proportion of the building(s) that is both income- and rent-restricted, and certain other adjustments to “basis” required by the tax code. See IRC § 42(c), (d) and 2016; 26 U.S.C. § 42(c), (d) and 2016. § 42(c), (d) and 2016.

124. Property may qualify based on either the “20–50 test,” which requires 20% or more of the residential units in the project to be both rent-restricted and occupied by individuals whose income is 50% or less of area median gross income, or the “40–60 test,” which requires 40% or more of the residential units in the project to be both rent-restricted and occupied by individuals whose income is 60% or less of area median gross income. See 26 U.S.C. § 42(g)(1). These are minimum thresholds, and a project may contain a higher percentage of qualifying residential units.

125. Credit may be taken only with respect to a “qualified low-income building” that is part of a “qualified low-income housing project” at all times during the statutory compliance period. See 42 U.S.C. (c)(2).

126. LIHTC provisions were added almost at the last minute in response to concerns about the impact on affordable housing development of provisions of the legislation that eliminated or restricted certain tax deductions relating to rental real estate. Those deductions previously had supported the development of thousands of affordable rental units, and similar to any tax deduction, were available to any taxpayer that met the statutory and regulatory requirements. In contrast, an aggregate LIHTC ceiling is allocated to states based on population, with a minimum allocation for states with small populations. See 42 U.S.C. § 42(h); see also Paul, supra note 84; Brandon Weiss, Residual Value Capture in Subsidized Housing, 10(2) Harv. L. & Pol’y Rev. 521 (2016).

The population-based housing credit amount allocated to a state must be competitively allocated to projects based on a qualified allocation plan adopted by the state’s housing credit agency.\textsuperscript{128} However, state housing credit agencies may also approve additional “4% credits” in projects financed with certain tax-exempt bonds\textsuperscript{129} subject to a “volume cap” (a limit on the aggregate amount of tax-exempt private activity bonds that may be issued by a state in any calendar year) under the IRC.\textsuperscript{130}

The Internal Revenue Code generally allows LIHTC to be calculated based only on the qualifying portion of a building that meets IRS requirements for a “residential rental property.”\textsuperscript{131} Treasury Regulation § 1.42-9(b)\textsuperscript{132} establishes the general rule that a residential rental unit must be available “for use by the general public.” The regulation goes on to state explicitly that “any residential rental unit that is part of a hospital, nursing home, sanitarium, lifecare facility, intermediate care facility for the mentally and physically handicapped is not eligible for credit under section 42.” Treasury Regulation § 1.42-11(b) distinguishes between residential rental property and health care facilities by focusing on the nature of the services provided: “If continual or frequent nursing, medical, or psychiatric services are provided, it is presumed that the services are not optional and the building is ineligible for the credit, as is the case with a hospital, nursing home, sanitarium, lifecare facility, intermediate care facility for the mentally and physically handicapped.” The IRS has applied the same standards in determining whether property qualifies as “residential rental property” for purposes of determining project eligibility under both Section 42 (LIHTC) and Section 142 (tax-exempt bonds).\textsuperscript{133}

Although a facility that provides continual or frequent nursing, medical, or psychiatric services will not qualify as a “residential rental project” under IRC Sections 42 and 142, the IRS has issued guidance allowing proj-

\textsuperscript{128} See 26 U.S.C. § 42(m).

\textsuperscript{129} Specifically, “exempt facility bonds” issued pursuant to 26 U.S.C. § 142, which authorizes the issuance of such bonds to finance “qualified residential rental projects” meeting the 20–50 or 40–60 test.

\textsuperscript{130} 26 U.S.C. § 42(h)(4); 26 U.S.C. § 146.

\textsuperscript{131} See 26 U.S.C. § 42(d)(4). The calculation of eligible costs may take into account the cost of common areas provided as comparable amenities to all residential rental units in the building, as well as a small portion of community service facilities that also provide services for certain nontenants. See 26 U.S.C. § 42(d)(4)(C).

\textsuperscript{132} 26 C.F.R. § 1.142-9(b).

\textsuperscript{133} This IRS treatment is consistent with the legislative history. 2 H.R. CONF. REP. No. 841, 99th Cong., 2d Sess. II–89 (1986), 1983–3 (Vol. 4) C.B. 89, states that the phrase “residential rental property” generally has the same meaning under both § 42 and § 142(d).
ects to qualify, notwithstanding the provision of a variety of health-related “supportive services,” as long as “continual or frequent medical, nursing or psychiatric services” are not available.\(^{134}\) In Revenue Ruling 98-47,\(^{135}\) the IRS considered the eligibility for tax-exempt bonds of a complex comprised of three buildings (Buildings X, Y, and Z) containing similar housing units. Each of the buildings made available significant non-housing services to residents, including meals, laundry, housekeeping, 24-hour emergency call service, planned social activities, and scheduled transportation services. In addition, Building Y provided assistance with medication management, as-needed consultation with a nurse, and assistance with activities of daily living, but did not provide continual or frequent nursing, medical, or psychiatric services. Building Z provided all the services available in Building Y, but also had registered nurses on duty 12 hours per day, licensed practical nurses on duty 24 hours per day, and licensed nurses’ aides available 24 hours per day. The IRS determined that Buildings X and Y would qualify as “residential rental property,” but Building Z would not because of the “continual” nursing services provided.\(^{136}\)

Subsequent to Revenue Ruling 98-47, the IRS issued private letter rulings with respect to supportive housing and assisted living facilities financed under both Section 42 and Section 142. As described below, in each case, the nature and frequency of the nursing, medical, or psychiatric services available in the facility was deemed the appropriate standard for determining whether the facilities qualified as residential rental property.

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\(^{134}\) IRC § 42 expressly contemplates that residential rental property may furnish supportive services. Section 42(g)(2)(B) excludes from the calculation of “gross rent” (subject to statutory restrictions) certain fees for supportive services designed to enable residents to remain independent and avoid placement in a hospital, nursing home, or intermediate care facility for the mentally or physically handicapped, where the fees are paid to the owner of the unit by a governmental program of assistance (or charitable organization) and are not separable from rental assistance provided by the program (or charity). Section 42(i)(3) provides that a unit will not be considered to be used on a “transient basis” (and therefore ineligible for LIHTC) if it contains sleeping accommodations and kitchen and bathroom facilities and is located in a building used exclusively as transitional housing for homeless individuals in which a governmental entity or qualified nonprofit provides such individuals with temporary housing and supportive services designed to assist them in locating and retaining permanent housing. See 26 U.S.C. §§ 42(c)(1)(E); 42(i)(3)(B)(iii).


\(^{136}\) In this mixed-use complex, Buildings X and Y would not fail to qualify as residential rental property because of Building Z. Id.
In one of the earlier private letter rulings analyzing service-enriched housing, the IRS considered the boundaries of “residential rental property” in the context of supportive housing for a targeted homeless population. In Pvt. Ltr. Rul. 9814006, the IRS considered the status of single room occupancy housing serving homeless individuals, located at a site with independent and physically separate facilities for an alcohol and substance abuse center. The IRS found that the property qualified as residential rental property where the services were optional and the housing was not targeted to individuals in need of constant medical and psychiatric attention.

Subsequently, in Pvt. Ltr. Rul. 199994044, the IRS considered an assisted living complex designed to serve persons with chronic disabling conditions, including but not limited to persons with quadriplegia and/or mobile ventilator-dependence, requiring physical assistance to be provided by non-licensed personal care assistants. A registered nurse consultant would be available during the week, but not 24/7; other health-related services included “health maintenance activities” and medication assistance. The IRS found that the facility would qualify as residential rental property.

The IRS elaborated on the distinction between service-enriched assisted living and a care facility providing disqualifying “continuing or frequent” nursing services in Pvt. Ltr. Rul. 200038001. In that ruling, the IRS found that an assisted living facility qualified as residential rental property notwithstanding the availability of health-related services and the presence on-site of certified nurse’s aides or home health aides 24 hours per day, 7 days per week, as well as a licensed practical nurse and a registered nurse 8 hours per day, 7 days per week. Noting that a tenant who required 24-hour nursing care was required to move to another facility, the IRS found that the services provided were not “on a continuing or frequent basis as in a nursing home” and, accordingly, did not prevent the property from being a qualified residential rental project.

139. See also Pvt. Ltr. Rul. 8945036 (residential elderly housing property occupying a separate condominium unit in the same building as an intermediate care nursing facility where services included assistance with activities of daily living and medication management but no professional medical or nursing care); Pvt. Ltr. Rul. 8944042 (elderly housing offering optional supportive service package but no medical or nursing services other than emergency assistance).
141. These included pre-packaged medication intake assistance; medication record maintenance; emotional support assistance; equipment assistance; vital signs collection; physical assessments; and additional assistance with daily living needs, record keeping, first aid treatment, health monitoring, and medication administration.
Finally, it is worth noting that the Internal Revenue Code was amended in 2008 to provide that occupancy restrictions or preferences that favor tenants with special needs who are members of a specified group under a federal or state program that supports housing for such a specified group do not automatically cause a project to fail to meet the “general public use” requirement of the LIHTC program.\textsuperscript{142}

b. Federal HOME Program

The HOME Investment Partnerships Act of 1990\textsuperscript{143} established a block grant program to help state and local jurisdictions develop and support affordable rental housing and homeownership affordability. Funding is provided on a formula basis to “participating jurisdictions”—units of state and local government that comply with statutory and regulatory requirements.\textsuperscript{144} Participating jurisdictions, in turn, are charged with developing a housing strategy and distributing financial assistance based on housing need, with emphasis on participation by the private sector, and must provide local matching funds.\textsuperscript{145}

Similar to the Low Income Housing Tax Credit program, the HOME program distinguishes between “housing” that is eligible for HOME assistance and “facilities” that are ineligible.\textsuperscript{146} However, HUD’s Office of Community Planning and Development (which administers the HOME program as well as funding for homelessness assistance programs under the McKinney-Vento Homelessness Assistance Act of 1987, as amended\textsuperscript{147}) has issued guidance clarifying that HOME funds can be used in a variety of service-intensive settings. For example, HUD Notice CPD 94-01\textsuperscript{148} expressly contemplates the use of HOME funds to support group homes with live-in supportive service providers. Similarly, HUD Notice CPD 01-01\textsuperscript{149} clarifies that HOME funds may be combined with

\textsuperscript{144} See 42 U.S.C. §§ 12746–12747.
\textsuperscript{145} See 42 U.S.C. §§ 12750–12752.
\textsuperscript{146} HUD regulations at 24 C.F.R. § 92.2 state: “Housing includes . . . permanent housing for disabled homeless persons, transitional housing, single-room occupancy housing, and group homes. . . . Housing does not include . . . facilities such as nursing homes, convalescent homes, hospitals, residential treatment facilities . . . .”
\textsuperscript{149} HUD Notice CPD 01-01, Guidance on Combining Program Funds of the McKinney Act Programs and the HOPWA Program with the HOME Program (Jan. 17,
a variety of HUD sources providing capital, operating, and/or rental assistance for supportive housing serving homeless persons with disabilities as well as persons with HIV/AIDS. Local social services funding can satisfy the 25% local match requirement under the HOME program, which cannot be used to fund supportive services.\textsuperscript{150}

\textbf{Civil Rights, Fair Housing, and Constraints on Targeted Housing}

Over time, the federal government has taken numerous steps to prohibit discrimination against persons with disabilities in housing. While the term “fair housing” is often used broadly to refer to the body of law prohibiting housing discrimination, it is important to bear in mind that the body of law governing civil rights in housing includes not only the Fair Housing Act (discussed below) but other legislative, regulatory, and judicial mandates as well.

When the Fair Housing Act (FHA) was initially adopted in 1968,\textsuperscript{151} disability was not included among the protected classes covered. However, discrimination against persons with disabilities has been prohibited in federally assisted housing since enactment of the Rehabilitation Act of 1973.\textsuperscript{152} Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability in programs and activities receiving federal financial assistance.\textsuperscript{153}

As amended by the Fair Housing Amendments Act of 1988 (FHAA),\textsuperscript{154} the FHA now also prohibits discrimination,\textsuperscript{155} not only in publicly owned

\textsuperscript{150}. Id. at 9; see also 24 C.F.R. § 92.220(a)(10), providing that matching contributions, which must come from non-federal sources, may include:

The direct cost of supportive services provided to families residing in HOME-assisted units during the period of affordability or receiving HOME tenant-based rental assistance during the term of the tenant-based rental assistance contract. The supportive services must be necessary to facilitate independent living or be required as part of a self-sufficiency program. Examples of supportive services include: case management, mental health services, assistance with the tasks of daily living, substance abuse treatment and; counseling, day care, and job training and counseling.


\textsuperscript{153}. See 29 U.S.C. § 701.


\textsuperscript{155}. Prohibited activities include not only refusal to sell or rent, but also discrimination in the terms, conditions, or privileges or sale or rental, as well as “otherwise mak[ing] unavailable or deny[ing] a dwelling to any buyer or renter because
but also in most privately owned housing, on the basis of disability. In addition, since 1988, under HUD regulations implementing Section 504, at least 5% of the total dwelling units in a HUD-assisted multifamily housing project (but not less than one unit) are required to be accessible to persons with mobility impairments, and at least 2% of the total dwelling units (but not less than one unit) must be accessible for persons with hearing or vision impairments.

The FHA, as amended by the FHAA, requires housing providers to make reasonable accommodations in policies, practices, or services to enable a person with a disability to have an equal opportunity to use and enjoy a dwelling. HUD regulations extend this requirement to use and enjoyment of public and common areas. In addition, the FHA requires a landlord to permit, at the tenant’s expense, reasonable modifications of existing premises that are occupied or to be occupied by a person with a disability, if such modification is necessary to afford the person full enjoyment of the premises. Additional requirements relating to architectural access are imposed under the Architectural Barriers Act of 1968. These laws impose a variety of requirements, including architec-
tural design to promote accessibility in covered multifamily dwellings, that are critical to serving the needs of persons with disabilities, but are beyond the scope of this Article.

Following close on the heels of the FHAA, the Americans with Disabilities Act of 1990 (ADA)\(^\text{163}\) prohibits discrimination by any state or local “public entity”\(^\text{164}\) against any qualified individual with a disability (Title II) as well as discrimination in any places of public accommodation, including social services programs.\(^\text{165}\) HUD regulations implementing Title II prohibit discrimination by private entities receiving federal financial assistance under any HUD program or activity.\(^\text{166}\) The IRS, through regulation as well as inter-agency agreements with HUD and the Department of Justice (DOJ), has extended this prohibition to projects receiving LIHTC assistance.\(^\text{167}\) Although only public entities themselves are liable in a private right of action for Title II violations,\(^\text{168}\) any such violations would constitute a breach of the owner’s duties under HUD rules. An adverse final decision by HUD, substantially equivalent state or local fair housing agency, an adverse judgment by a federal court, or a judgment enforcing the terms of a settlement agreement or consent decree, could result in loss of LIHTC.\(^\text{169}\) In addition, a housing owner providing social services programs may be directly liable for violations under Title III.\(^\text{170}\)

Under implementing regulations issued by the DOJ (the ADA Regulations), public entities are required to administer services, programs, and activities in the most integrated setting appropriate to the needs of qual-

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164. Public entity is broadly defined to include any department, agency, special purpose district, or other instrumentality of a state or local government. See 42 U.S.C. § 12131(1).

165. The term “qualified individual with a disability” means an individual with a disability who, with or without reasonable modifications to rules, policies or practices, the removal of architectural, communication or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity. See 42 U.S.C. § 12131(2).

166. See 24 C.F.R. § 8.4.


168. See 42 U.S.C. § 12133; see also 28 C.F.R. § 35.170 (describing process for complaints of “discrimination on the basis of disability by a public entity” (emphasis added).

169. See LIHTC MOU, supra note 167.

ified individuals with disabilities. The preamble to these regulations defines the “most integrated setting appropriate to the needs of qualified individuals with disabilities” to mean “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.” While the intent of these laws and regulations is to expand the ability of persons with disabilities to access, use, and enjoy housing, the integration mandate, as interpreted by HUD, DOJ, and the courts, at times presents challenges to serving individuals with complex service needs effectively.

a. Olmstead decision

In a landmark 1999 decision, *Olmstead v. L.C.*, the Supreme Court reaffirmed the requirement set forth in the ADA Regulations that a public entity administer services, programs, and activities in the “most integrated setting appropriate to the needs of qualified individuals with disabilities,” finding that “[u]njustified isolation . . . is properly regarded as discrimination based on disability.” The Court in *Olmstead* also recognized that the ADA Regulations permit public entities to resist modifications to their programs that “would fundamentally alter the nature of the service, program, or activity.” Thus, public entities must balance the mandate to avoid institutionalization and isolation of persons with disabilities against resource limitations and the needs of others receiving services.

b. Department of Justice Olmstead Guidance

Interpreting the Supreme Court’s decision in *Olmstead*, the Department of Justice Civil Rights Division has issued guidance (DOJ Integration Guidance) providing an expansive description of settings that may be considered “segregated.”

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171. 28 C.F.R. 35.130(d); see generally 28 C.F.R. Part 35.
172. For an excellent and more detailed discussion of the tension between civil rights laws and supportive housing initiatives targeting persons with specific types of disabilities, see Henry Korman, *Clash of the Integrationists: The Mismatch of Civil Rights Imperatives in Supportive Housing for People with Disabilities*, 26 St. Louis Univ. Pub. L. Rev. 3 (2007).
174. Id. at 592, 595–96.
175. Id. at 597.
176. Id. (quoting ADA regulations at 28 C.F.R. § 35.130(b)(7) (1998)).
177. For more information about the *Olmstead* decision and its progeny, including decisions in the Circuit Courts of Appeal and enforcement actions by the Department of Justice, see https://www.ada.gov/olmstead/index.htm.
Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings . . . include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals’ ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.179

However, the DOJ Integration Guidance also describes the characteristics of “integrated settings” to include those that “provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities” and repeatedly notes that Olmstead prohibits “unjustified” or “unnecessary” segregation. ADA Title II and Title III regulations both specifically permit the provision of separate benefits and services when necessary to individuals with opportunities, accommodations, and services that are as effective as those provided to others.180 Depending on the nature and severity of a person’s disability, service-enriched housing may offer the best opportunity to live in the greater community.

Because federal law specifically contemplates age-restricted housing,181 and because the services in housing for elderly persons generally are not based on a specific diagnosis or type of disability, the “integrated settings” mandate is not generally a significant barrier to development of integrated housing and service models serving elderly households. In contrast, the lengthy history of segregating persons with disabilities in institutional settings,182 coupled with the fact that many state systems of care for non-elderly persons are diagnosis-based,183 can make it harder to provide

179. Id., Response to Question 1 under “Questions and Answers on the ADA’s Integration Mandate and Olmstead Enforcement.”
180. See 28 C.F.R. § 36.202(c) (Title III—public accommodations and services); 28 C.F.R. § 35.130(b) (Title II—state and local government services).
182. In the ADA’s statement of findings and purpose, Congress noted that “historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.” 42 U.S.C. § 12101.
service-enriched housing designed to serve high-need non-elderly persons with disabilities. Thus, the challenge for housing providers—and, in particular, for collaboration between housing and health care providers seeking to serve non-elderly persons with significant need for supportive services—is to select residents most in need of services and provide for their social and health care, without running afoul of federal judicial, statutory, and regulatory mandates to serve individuals with disabilities in the “most integrated setting appropriate to their needs.”

c. HUD Guidance

The tension between the obligation to serve persons with disabilities in an “integrated setting” and the desire to create service-intensive housing to accommodate particularly high-need populations of persons with disabilities is further highlighted under HUD regulations and guidance governing a variety of federally assisted housing programs.

i. HUD Statement on the Role of Housing in Achieving Olmstead Integration Goals; HUD 504 Guidance

In a published Statement on the Role of Housing in Accomplishing the Goals of *Olmstead* (the HUD Statement), HUD indicated that, while general preferences for individuals with disabilities who are transitioning from or at serious risk of entering an institutional setting are permissible, preferences targeting individuals with specific disabilities may be authorized only as *Olmstead* “remedial actions.” According to the HUD Statement, such preferences require legal review by HUD’s Office of Fair Housing and Equal Opportunity absent federal statutory authority under a targeted program such as Housing for People With AIDS, Section 811 (targeted housing for persons with disabilities), Section 202 (elderly housing), or certain McKinney-Vento programs supporting persons with disabilities.184 Recognizing that the DOJ is the agency charged with enforcing the integration mandate of the ADA, as interpreted by the Supreme Court in *Olmstead*, the HUD Statement expressed HUD’s intent to align its policies with those of other federal agencies, including DOJ, in enforcing its own integration mandate under the FHA and Section 504.185

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184. Statement of the Department of Housing and Urban Development on the Role of Housing in Accomplishing the Goals of *Olmstead*, at 7–8, http://portal.hud.gov/hudportal/documents/huddoc?id=OlmsteadGuidnc060413.pdf (last accessed May 14, 2018). HUD’s Statement notes that HUD interprets the Fair Housing Act and its Section 504 regulations, but does not interpret the nondiscrimination requirements administered by other agencies, including the Department of Justice, which is the agency authorized to interpret Title II of the ADA. *Id.* at 2.

185. *Id.* at 2 (citing HUD’s Section 504 regulations at 24 C.F.R. §§ 8.4(d), 9.130(d), and 9; citing HUD’s FHA regulations at 24 C.F.R. §§ 100.70(a) and 100.70(c)(4)).
The HUD statement echoes the DOJ Integration Guidance in characterizing housing as a “segregated setting” if it is “occupied exclusively or primarily by individuals with disabilities,” even if the housing would otherwise serve the integration mandate of *Olmstead*. Permanent supportive housing is offered as an example of an integrated setting, but only where it consists of “scattered-site apartments” or “apartments for individuals with various disabilities scattered throughout public and multifamily housing developments.” Additional HUD guidance on Section 504 requirements applicable to federally assisted housing acknowledges that housing that is different or separate may be permissible “when it can be demonstrated that such segregation is necessary in order to provide persons with disabilities housing that is as effective as housing that is provided to others,” but again strongly suggests that units should be scattered site or, if located within a project, should be interspersed throughout the building or buildings comprising the project.

The standard articulated in the HUD Statement is, arguably, more constrained than the standards articulated in DOJ’s guidance and in CMS’s guidance on home- and community-based settings under the ACA and Medicaid waivers, discussed below. Nevertheless, HUD’s Section 504 guidance recognizes that, for some persons with intensive disability-related needs, service-enriched housing models may offer the best opportunity to live in community housing that is as effective as housing provided to others, rather than in an institution such as a nursing home. The analysis is fact-specific and ultimately depends in large part on whether a particular setting in fact supports community integration rather than isolation.

In addition, the FHAct prohibits actions that “restrict or attempt to restrict the choices of a person by word or conduct in connection with seeking, negotiating for, buying or renting a dwelling so as to perpetuate, or tend to perpetuate, segregated housing patterns, or to discourage or obstruct choices in a community, neighborhood or development” based on disability. Unlawful actions include assigning any person to a particular section of a community, neighborhood, or development, or to a particular floor of a building, based on disability. Recipients may not subject individuals with disabilities to rules that do not apply to other residents, such as rules restricting their use of the housing or their ability to interact with individuals without disabilities.

186. *Id.* at 6.
187. *Id.*
189. *See infra* notes 216–22 and accompanying text.
ii. Section 8 Regulations

(a) Project-Based Housing Choice Voucher Program

HUD regulations governing the tenant-based Housing Choice Voucher program allow administering agencies to adopt a preference for admission of families that include a person with disabilities, but prohibit PHAs from adopting a preference for admission of persons with a specific disability.190 However, HUD regulations governing project-based vouchers, while reiterating and incorporating by reference the prohibition in the tenant-based voucher regulations against preferences for persons with a specific disability, explicitly authorize administering agencies to “give preference to disabled families who need services offered at a particular project,” provided that:

(i) The preference is limited to the population of families (including individuals) with disabilities that significantly interfere with their ability to obtain and maintain themselves in housing,

(ii) Who, without appropriate supportive services, will not be able to obtain or maintain themselves in housing; and

(iii) For whom such services cannot be provided in a nonsegregated setting.191

Owners are permitted to advertise a project as offering services for a particular type of disability, as long as the project is open to all otherwise eligible persons with disabilities who may benefit from the services provided at the project.192 Practitioners may need to educate project sponsors and help them think through the implications for their tenant selection policies and service model, particularly where the offered services, such as care coordination, could benefit a broader range of persons with disabilities than the sponsor had originally envisioned.

(b) Project-Based Rental Assistance

Separate HUD regulations193 govern the Project-Based Rental Assistance (PBRA) program, a separate form of Section 8 rental assistance originally provided primarily in connection with new construction or substantial rehabilitation.194 While the statutory provisions originally authorizing PBRA have since been repealed, owners of projects under the public housing and Section 8 moderate rehabilitation (Mod Rehab) programs also now

190. See 24 C.F.R. § 982.207(b)(3).
191. 24 C.F.R. § 983.251(d).
192. Id.
194. For a general discussion of PBRA and a listing of legal authority associated with renewal of PBRA, see HUD web page, Renewal of Section 8 Project-Based Rental Assistance, at https://www.hud.gov/hudprograms/rs8pbra (last accessed May 22, 2018).
have the option to convert their rental assistance to PBRA under the Rental Assistance Demonstration (RAD) program.\textsuperscript{195} HUD PBRA regulations mirror HUD’s regulations governing tenant-based housing choice voucher assistance, allowing an owner to adopt a preference for admission of families that include a person with disabilities, but prohibiting a preference for admission of persons with a specific disability, without any provisions specifically authorizing a preference for disabled families who need services offered at a particular project.\textsuperscript{196}

In addition to admissions and occupancy issues, PBRA properties seeking collaborations to deliver services on site may have limitations in the financial resources and staff support that can be provided to such collaborations. HUD regulates the operating expenses of PBRA properties.\textsuperscript{197} Direct services are not permitted operating expenses and HUD has permitted only properties serving the elderly and disabled to include service coordination expenses as a budgeted operating expenses.\textsuperscript{198} Where service coordination or other services are not permitted as an operating expense, housing operators must look to other sources or surplus cash, which is calculated and distributed no more than semi-annually, as a funding source.\textsuperscript{199}

\textit{iii. HOME Program}

HUD regulations under the HOME program allow a participating jurisdiction to establish a preference for individuals with special needs, such as homeless or elderly persons or persons with disabilities. The HOME regulations also allow the participating jurisdiction to provide a preference for a specific category of individuals with disabilities if the specific category is identified in the participating jurisdiction’s consolidated plan\textsuperscript{200} and if, in the case of tenant-based rental assistance, “necessary to provide as effective housing, aid, benefit or services as those provided to others in accordance with 24 CFR 8.4(b)(1)(iv).”\textsuperscript{201} Owners of rental


\textsuperscript{196} See 24 C.F.R. § 5.655(c)(3).

\textsuperscript{197} See 24 C.F.R. § 880.601(e).

\textsuperscript{198} See DEP’T OF HOUSING AND URBAN DEVELOPMENT, THE MANAGEMENT AGENT HANDBOOK (4381.5), Chapter 8, available at https://www.hud.gov/sites/documents/DOC_25241.PDF.

\textsuperscript{199} See 24 C.F.R. § 880.205.

\textsuperscript{200} A jurisdiction receiving certain HUD formula grant funding must file a “consolidated plan” with HUD in accordance with 24 C.F.R. Part 91. Covered programs include the Community Development Block Grant program, the Emergency Solutions Grants Program, the HOME Investment Partnerships program, the Housing Opportunities for Persons with AIDS program, and the Housing Trust Fund program. See 24 C.F.R. § 91.2.

\textsuperscript{201} 24 C.F.R. § 92.209.
housing assisted with HOME funds may establish a limitation or preference for persons with disabilities who need services offered at a project, subject to the same criteria as apply under the Section 8 regulations described above.202

iv. HUD Guidance—Chronic Homelessness

Under the McKinney-Vento Act, as amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009,203 in order to be considered “chronically homeless,” an individual or family must have an adult head of household (or a minor head of household if no adult is present) with a chronic mental or physical illness or disability.204 HUD has issued several notices and policy briefs regarding the assessment and prioritization for assistance of chronically homeless persons, which leave some room for interpretation regarding the extent to which programs may focus on individuals with particular disability-related service needs. For example, HUD’s Coordinated Entry Policy Brief, which mandates that local Continuums of Care prioritize assistance based on vulnerability and severity of service needs,205 prohibits the overall coordinated entry system from targeting a category of people with a particular disability, but indicates that individual programs, including McKinney-Vento funded projects, may restrict access to people with a particular disability or characteristic. The Policy Brief goes on to state that eligibility criteria must be limited to those required by federal or local statute or by funding sources.206 This reference to “funding sources” could be read as broadening the general rule that disability-specific admissions preferences be applied only where expressly authorized by federal statute or executive order207—but that remains somewhat unclear.

HUD guidance relating to chronic homelessness also leaves room for interpretation as to the ability of a housing provider to make inquiries about disability and to establish priority based on a particular disability.

204. The specific conditions listed include “a diagnosable substance use disorder, serious mental illness, developmental disability (as defined in section 1012 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions.” 42 U.S.C. § 11360(2)(A)(iii).
206. Id. at 4–5.
207. See 24 C.F.R. § 9.130(c) (allowing a specific class of individuals with disabilities to be excluded from a HUD program if the program is limited by federal statute or Executive Order to a different class of individuals).
Under HUD’s regulations implementing the FHA prohibition against discriminatory conduct,\(^{208}\) it is generally unlawful to make an inquiry regarding whether a person has a disability or to make inquiry as to the nature or severity of a person’s disability. However, provided the same inquiries are made of all applicants, it is permissible to inquire whether an applicant “is qualified for a dwelling available only to persons with handicaps or to persons with a particular type of handicap” or whether the applicant “is qualified for a priority available to persons with handicaps or to persons with a particular type of handicap.”\(^{209}\) CPD Notice 14-012, which offers guidance on the prioritization of chronically homeless and other vulnerable homeless persons in permanent supportive housing, requires that Continuums of Care utilize a standardized assessment tool, but cautions that protections should be in place to ensure civil rights compliance and that the assessment tool “should not seek disability-related information that is unnecessary for determining the need for housing-related services.”\(^{210}\) In responding to frequently asked questions on Notice 14-012, HUD warns that “Some assessment tools might . . . prioritize specific disability-types which would not be consistent with fair housing requirements.”\(^{211}\)

The same FAQ guidance also states that the assessment tool “can make certain considerations for specific disabilities provided that no housing decisions are made solely on the basis of a specific disability.”\(^{212}\) The guidance then goes on to indicate that a program that receives funding for supportive services from the federal Department of Health and Human Services requiring that all participants have a serious mental illness may prioritize persons with a serious mental illness for admission to the program—which would appear to effectively allow housing decisions to be made on the basis of a specific disability, at least where a federal agency would so require as a condition of services funding.\(^{213}\)

\(^{208}\) 24 C.F.R. Part 100.

\(^{209}\) 24 C.F.R. § 100.202(c).


\(^{212}\) Id. at 13.

\(^{213}\) Id. Housing providers also need to be aware that certain HUD funding programs, for example, in a project receiving HOME funding, require amendment of a local administrative plan in order to establish local preferences.
d. Medicaid Waiver Guidance

The final rule issued by CMS in 2014\textsuperscript{214} (HCBS Rule), addressing the requirements applicable to home and community based settings under the ACA and Medicaid waivers in the context of the Olmstead “integrated setting” mandate, may offer the most helpful guidance to practitioners seeking to design a program of service-enriched housing that complies with the various integration mandates. In the final HCBS Rule, CMS established flexible criteria:

...to ensure that individuals have the opportunity to receive services in a manner that protects individual choice and promotes community integration. Individuals who are elderly and/or disabled who commented made it clear that their personal rights should not be curtailed because of where they live or because there is a need to receive HCBS.\textsuperscript{215}

Recognizing that individual needs vary, CMS chose not to require the separation of the housing provider from the provider of HCBS, provided that individuals have selected the setting from among setting options identified and documented in the individual’s person-centered service plan; the setting is based on the individual’s needs, preferences, and available resources; and the individual has the information required to make an informed choice among his residential options.\textsuperscript{216} A qualifying setting must be integrated into and support full access of individuals to the greater community and optimize individual initiative, autonomy, and independence, and the individual must enjoy the tenant protections generally available under the jurisdiction’s landlord-tenant law.\textsuperscript{217} A variety of additional conditions are described, although many are subject to modification as long as the modification is supported by a specific assessed need and justified in a person-centered service plan.\textsuperscript{218} While the HCBS Rule cautions that settings in close proximity to institutional settings often are segregated from the larger community and may themselves be “institutional in nature,” states are given the opportunity to describe how such settings meet the HCBS Rule requirements. CMS expressly declined to adopt a blanket rule disqualifying such settings as HCBS, despite some pressure to do so.\textsuperscript{219} Based on public comment, CMS elected not to utilize the term “disability-specific housing complex” included in an earlier draft

\begin{itemize}
  \item 215. Id. at 2947.
  \item 216. Id., 42 C.F.R. § 710(a).
  \item 217. Id.
  \item 218. Id.
\end{itemize}
of the rule, focusing instead on whether a particular setting has institutional qualities and characteristics so as to isolate individuals from the broader community.220

Summary of Themes
Across the various federal regulations and guidance interpreting and applying the FHA, Section 504, and the ADA, a few consistent themes have emerged that can serve as a road map for practitioners seeking to create housing opportunities that improve health and housing outcomes for persons with disabilities:221

• The Olmstead decision requires that persons with disabilities have the opportunity to receive services in the most integrated setting appropriate to their needs. The intensity of an individual’s service needs is highly relevant to the appropriateness of a particular setting.

• A preference for persons with disabilities may be appropriate in housing designed to serve persons with disabilities that significantly interfere with their ability to obtain and maintain themselves in housing, where those individuals would not be able to obtain or maintain themselves in housing without appropriate supportive services, if the services could not be provided in a nonsegregated setting. For purposes of this analysis, cost, and the feasibility of providing comparable services may be taken into account.222

220. See id. at 2974.

221. While this discussion has focused on DOJ and HUD guidance, it is important to note that similar issues would affect housing assisted under the LIHTC program. Treasury regulations at 26 C.F.R. § 1.42-9 require LIHTC properties to be rented in a manner consistent with the FHA, while noncompliance of these properties with LIHTC provisions is required to be reported to the IRS by state housing finance agencies under 26 U.S.C. § 42 (m)(1)(B)(iii). Under a Memorandum of Understanding among the Department of the Treasury, HUD, and the DOJ dated August 11, 2000, the IRS recognized the responsibility of HUD and the DOJ for enforcing various provisions of the FHA, and the three agencies agreed to coordination about FHA enforcement, technical assistance, and training. See https://www.novoco.com/sites/default/files/atoms/files/mou_081100.pdf (last accessed May 14, 2018).

222. As the Supreme Court noted in Olmstead,

[W]e recognize, as well, the States’ need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States’ obligation to administer services with an even hand. Accordingly, we further hold that the Court . . . must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State’s obligation to mete out those services equitably.

• Preferences for persons with specific disabilities raise more complicated issues, particularly if the preference is not dictated by a federal statute, Executive order, or funding stream. However, a preference for persons in need of the services to be provided is permissible, as long as it is clear that the individual retains the power to accept or decline services.

• In a property financed using LIHTC, particular attention must be paid to the continuity and frequency of any medical or nursing services provided. Because provision of “continual or frequent nursing, medical, or psychiatric services” will render the affected building(s) entirely ineligible for the credit, the financial consequences of crossing that particular line would be devastating to the project and any project sponsor providing tax credit guaranties.

• Whether a particular setting is “segregated” or “institutional in nature” will depend on a variety of factors. Informed consent, individual autonomy, and access to the broader community are all key factors in determining whether a setting would, in fact, be considered “community-based.” It is important to tailor the preference to the services provided and/or particular features of the housing (accessible design and other architectural features), not to a particular diagnosis. Sometimes, a project sponsor has a vision for a housing model to address the needs of persons with a particular disability or class of disability, but may have difficulty articulating why the services or architectural features to be offered would not be of equal benefit to other persons with different disabilities. Reframing preferences in terms of service needs and services offered, and/or the need for accessible design and other architectural features at a property, rather than medical diagnosis, can be challenging for both housing providers and health care practitioners, particularly where the original vision for a project grew out of the perceived need to help a particular, disability-specific population avoid institutionalization. Attorneys can serve a key role in fair housing compliance by helping project sponsors to articulate a clear connection between occupancy preferences (if any) and the range of services and design features to be offered.

• Positive relationships between housing and service providers require a common understanding about roles and responsibilities. This, in turn, requires each party to make the effort to learn about the legal, practical, and policy issues affecting the other(s). It is essential that all involved be able to work collaboratively and think beyond the boundaries of the systems in which they have historically operated.

Funding and Administrative Challenges: Beyond Silos

As described above, housing and health care providers often face communication challenges, because each sector is heavily regulated and uti-
lizes its own voluminous set of acronyms. Even within federal and state government, working across sectors can require agencies to develop new vocabularies and a common understanding of the challenges and opportunities affecting their respective sectors.

One example of cross-sector work, driven by the requirements of a federal program, is the Section 811 rental assistance demonstration program created under the Frank Melville Supportive Housing Investment Act of 2010, which amended Section 811 of the 1990 Act to provide for a new form of project-based rental assistance as a means of funding supportive housing for non-elderly adults with disabilities in properties that are subsidized through LIHTC, HOME, or another state or federal program. Assistance may be made available only to projects for which both the state agency responsible for health and human services programs and the applicable state agency designated to administer or supervise the administration of the state plan for medical assistance under Title XIX of the Social Security Act have entered into agreements (1) to identify the target populations to be served by the project; (2) to set forth methods for outreach and referral; and (3) to make available appropriate services for tenants of the project. Units assisted through Section 811 PRA at a multifamily housing project cannot exceed 25% of the units at the project.

In most cases, the rental properties to which Section 811 PRA subsidy is attached were not previously designed for operation as supportive housing. As a result, many properties that are potential sites for Section 811 PRA do not have on-site case management, service coordination, assistance with activities of daily living, or other supports that a person with severe disabilities may require in order to remain stably housed. Particularly because the Section 811 PRA program caps rents at a lower level than many other federal project-based rental subsidy programs, this creates a barrier to participation by property owners concerned about their ability to support tenants with such intensive service needs.

In implementing its Section 811 program, to help assure that program participants would receive the services and supports they need, the Massachusetts Department of Housing and Community Development (DHCD) negotiated an interagency service agreement (ISA) with several

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224. Section 811(b)(3)(A).
225. Section 811(b)(3)(D).
other state agencies, each of which was a potential referral source for potential Section 811 PRA tenants. In addition to the Massachusetts Executive Office of Health and Human Services and MassHealth (the Commonwealth’s Medicaid agency), parties to the ISA included the Massachusetts Department of Mental Health (DMH); the Massachusetts Department of Developmental Services (DDS) (which oversees a system of services and supports for individuals with intellectual disabilities); the Massachusetts Rehabilitation Commission (responsible for vocational rehabilitation services, community services, and eligibility determination for the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) federal benefits programs); and the Executive Office of Elder Affairs (which oversees certain programs for nonelderly individuals age 55 and over). The ISA not only described a detailed mechanism for referrals of eligible households by the various agencies, but also identified specific sources of supportive services funding, including Medicaid waivers. Priority in referrals is given to individuals who are residing in a long-term care facility or homeless. While program implementation continues to face numerous challenges, developing the ISA proved useful in helping to ensure that program participants will be well supported as they move from an institutional setting to permanent housing in community.

A more comprehensive interagency collaborative effort in Massachusetts arose from state legislation that in 2012 directed 18 public and quasi-public agencies, with responsibilities covering a broad range of housing and human service arenas, to enter into a memorandum of understanding creating an action plan to coordinate the procurement and availability of community-based supportive services, capital subsidies, and operating subsidies for new and existing housing available to residents with very low and extremely low incomes.228 This legislation also required that (1) the action plan establish benchmarks to assess financial savings to the Commonwealth resulting from the avoidance of institutionalization, shelter, or nursing care due to the availability of community-based housing supportive services; and (2) the agencies identify and determine methods and procedures for eliminating barriers and reducing fragmentation for the provision for community-based supportive services and affordable housing. As detailed in the final report of the Commonwealth’s Interagency Supportive Housing Steering Committee and Working Group, the initiative far exceeded the legislative mandate, creating well over 1,000 units of permanent supportive housing over a three-year period.229 This interagency initiative is continuing under the auspices


229. See Building on Success: Interagency Supportive Housing Initiative, COMMUNITY ECONOMIC DEVELOPMENT ASSISTANCE CORP. (June 2017), available at https://cedac.org/
of the Commonwealth’s Interagency Council on Housing and Homelessness (MA ICHH). In 2017, a total of 25 state agencies entered into an amended and restated Community Housing and Services Memorandum of Understanding to guide the work of the Supportive Housing Production and Services Committee of the MA ICHH.

The Action Plan of the Committee remains a work in progress, but as outlined in the Committee’s FY18 recommendations,230 key components will include needs assessments for the various populations and subpopulations represented by constituent agencies, coordination of financial resources among agencies with different federal and state funding streams, elimination of barriers and reduction of fragmentation through cross-agency education and data sharing, and ongoing work to establish benchmarks to assess financial savings.

As the agencies have continued this work, it has become critical for agencies representing different sectors to learn from each other regarding the financial, statutory, and regulatory constraints that impact their respective work. One of the most fundamental challenges lies in the dichotomy between the “person-centered” approach mandated by the ACA and federal regulations governing Medicaid HCBS231 and the inherently “place-based” focus of housing providers. While agencies with a health care focus must pay attention to the particularized service needs of an individual, including the individual’s right to choose his or her service provider, agencies overseeing the expenditure of capital and operating assistance for rental housing developments seek assurance that the population to be served in those developments will have the necessary supports in place to sustain successful tenancies. While there is common ground—particularly with respect to the need for place-based service coordination to assure that residents are able to access available medical and non-medical services—cross-sector education and dialogue is key to moving forward with cross-agency initiatives.

The very nature of housing as a capital asset drives housing agencies and providers to plan for time frames that stretch far beyond the duration of a typical service arrangement (or the funding commitments that will support the services). Public and private lenders providing loans with a term of 20 to 40 years or more seek assurance that ongoing revenues—whether from tenant-paid rents, rental subsidies, or service dollars—will suffice to cover all costs needed for continued operation, including


231. See supra notes 54–55 and 217–19 and accompanying text.
any services essential to meet commitments to residents and public agencies. LIHTC equity investors likewise seek assurance of ongoing operating feasibility before investing significant capital in a project. Moreover, after 15 to 30 years, the combination of expiring use restrictions and aging facilities means that housing typically requires significant recapitalization, often requiring extensive public investment to preserve affordability. Long-term preservation of these properties as affordable, service-enriched housing ultimately will depend on future availability of services and supports for the residents.

Another challenge to cross-sector coordination lies in the fragmentation at both the federal and state level with respect to funding rounds, reporting requirements, and data management. Generally speaking, funding for services from the federal Department of Health and Human Services (HHS) is not coordinated with funding for housing from HUD. While there have been some limited cross-agency supportive housing collaborations at the federal level, particularly relating to veterans, significant

232. For general background on affordable housing finance, see Ben L. Hecht, Developing Affordable Housing: A Practical Guide for Nonprofit Organizations (3d ed. 2006).


234. For example, the HUD-VASH program (established in 1992) combines HUD rental vouchers for housing with Veterans Administration (VA) supportive services to assist veterans who are homeless and their families. For more information on the HUD-VASH program, see U.S. Department of Housing Development–VA Supportive Housing (HUD-VASH) Program, https://www.va.gov/homeless/hud-vash.asp. A study comparing outcomes over a three-year follow-up period for homeless veterans with psychiatric and/or substance abuse disorders served through HUD-VASH program with outcomes for veterans served through VA intensive case management only, without housing vouchers, and outcomes for homeless veterans receiving standard VA care, found participation in HUD-VASH resulted in a 16% to 25% increase in days housed, about a 35% reduction in days homeless, and about a 15% increase in cost compared with standard VA care. See Robert Rosenheck et al., Cost-Effectiveness of Supported Housing for Homeless Persons with Mental Illness, 60(9) Archives General Psychiatry 940–51 (2003), available at https://jamanetwork.com/journals/jamapsychiatry/fullarticle/207801 (last accessed June 6, 2018).

Several years later, in 2003, HUD, HHS, and the VA launched a Collaborative Initiative to Help End Chronic Homelessness (CICH), under which awards were made to 11 jurisdictions to provide comprehensive housing and support services to chronically homeless veterans. The program provided funding for a set of five integrated core services at each site to be provided through local agencies: (1) permanent supportive housing, (2) mental health treatment, (3) substance abuse treat-
Different federal agencies utilize different data systems, which were not designed to work together. From 2014–2016, HUD’s Office of Special Needs Assistance Programs and the Office of HIV/AIDS housing, in collaboration with the U.S. Interagency Council on Homelessness and HHS, provided technical assistance to support states and local efforts to promote integration and collaboration between the housing and health care systems. However, this technical assistance is no longer available, and significant barriers remain to housing and health care coordination and systems integration.

**Conclusion**

An increased focus on cost savings and a more widely supported holistic view of health and health care continue to drive experimentation and collaboration to help control costs and improve outcomes by addressing...

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235. Researchers have also noted challenges resulting from fragmentation of services for dually diagnosed clients, with implications for health policy. See, e.g., Robert A. Rosenheck et al., *Closing Service System Gaps for Homeless Clients with a Dual Diagnosis: Integrated Teams and Interagency Cooperation*, 6 J. MENTAL HEALTH POL’Y & ECON. 77 (2003).

the housing needs of low-income households, particularly high utilizers or those at the greatest risk of high use. While collaboration and experimentation are not new, the ACA has not only created a potentially larger pool of Medicaid eligible households and granted more flexibility in how they are served, but has also continued the push toward capitated payments and outcomes driven approaches. By evaluating the population they serve, considering their service coordination and data collection capacity, learning key health sector payment concepts and vocabulary, and identifying potential partners in the market, housing organizations can better position themselves for collaboration with new partners.

Housing organizations interested in collaborating with government agencies, managed care organizations, hospitals, or health care systems to coordinate or deliver service on-site or to expand the stock of affordable housing should carefully consider the implication of these collaborations on their financing strategies and daily operations. Despite strong interest from MCOs in investing in housing, the shorter term—typically three to five years—of most managed care contracts creates a mismatch for housing investments that are typically fifteen years or more. MCOs and hospitals also frequently seek priority or set-aide units that may create fair housing or other compliance issues. When new initiatives bring services or enhanced service coordination on-site, housing organizations should ensure that they have trusted advisors to evaluate HIPAA exposures and other privacy requirements and to evaluate their agreements with health care partners in light of the legal constraints associated with any public funding or tax credits.

As health and housing collaborations become more frequent and successful models emerge, stakeholders and advocates should also reflect on what legal and policy changes may support implementation of impactful collaboration.
Approaches to Easing the Affordable Housing and Health Care Challenges Seniors Face

Michelle Norris

The Senior Tsunami—A Diverse and Complex Group

Who among us hasn’t heard the phrases “Silver Tsunami” or the “graying of America”? The Pew Research Center reports that 10,000 new seniors will be added to the population every day until 2030.¹ As we think about the demographic shift, it is easy to characterize the “senior” population as one big group. But looking closer at this large and growing segment of the U.S. population reveals a diverse and complex group that requires diverse options and solutions.

The age range of individuals commonly characterized as seniors is immense. For instance, you can get an AARP membership when you turn 50. You can enter a senior affordable housing community when you are 55. You are eligible for Medicare at 65. As becoming a centenarian becomes more and more common, the age range of a senior spans from 50 to 100+. That age range is incredibly wide and means that today we have three generations of seniors: the Greatest Generation (ages 90+, born in 1927 and earlier), the Silent Generation (ages 72 to 90, born 1928 to 1945), and the Baby Boomers (ages 53 to 72, born from 1946 to 1964). Imagine lumping a toddler, an adolescent, and a 30-year-old into the same age category! The three generations have very different life experiences and belief systems. They also reflect shifts in ethnic demographics as the white population declines and the African American, Asian, and Hispanic populations increase.²

We should all be aware of our internal assumptions when we use the term “senior.” A senior can be a work colleague, a marathon runner, your grandfather, or even your great-great grandfather! It is unrealistic to use a single label to address such a large and diverse group of incomes, health conditions, experiences, and needs. With the aging in America now span-

². U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States and States (June 2017).

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ning three generations, it is imperative that policy makers, businesses, and communities understand such diversity in the “senior” population in order to ensure there are adequate services and supports for all.

The fact is that those fortunate enough to have a very long life span also face increased odds that they will need support to live their lives well. In other words, they will need help with life tasks. These are commonly referred to as “activities of daily living” (ADLs). For those who live into their 80s, three out of four individuals will need assistance. Where will all that help come from? Unless the senior has long-term care insurance, which only one in ten Americans has, it is often a surprise that these costs are not insured by Medicare. Therefore, if seniors need help, they can pay for it out of pocket or seek help from a family member. Unfortunately, if the senior has limited family support and/or limited funds to pay for help, the common outcome is impoverishment and a new member in the growing class of Medicaid clients.

Indeed, the harsh reality is that the experience of growing older can be dramatically different based on a variety of factors: how healthy a person is; how much money that person has available; how many family members that person has maintained relationships with; and the proximity of where those family members live, among others.

While the senior population can be broken into many different subsets, one important division is simply this: those with means and those without. On one end of the spectrum are individuals who likely had a good education, reliable careers, and good health insurance. They are more likely able to enter this phase of life with resources to spend on travel, entertainment, and high-quality health care.

On the other end of the spectrum are individuals who have limited assets, increasing chronic conditions, higher health care costs, and increased poverty. As is always the case, the bell curve is real. Many seniors retire after having worked in lower wage jobs with limited health insurance and/or modest retirement plans. With increased longevity, these same seniors will now live for decades on fixed incomes with few resources to pay for the basic supports needed as they age. For such individuals, can we really call these the golden years?

This resource-constrained elder group is large and growing larger. In its 2015 report “Housing Costs and Financial Challenges for Low-Income Older Adults,” the Urban Institute found that only 18 percent of adults ages 65 and older work for pay, so most depend on government benefits, pensions, or their own savings.3 As compared with prior generations, today’s seniors have less and less money saved in pension plans,4 and the

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4. *Id.*
average 2015 monthly retirement payment was only $1,300. In addition, as of 2013, half of households headed by adults age 65 or older had less than $45,000 in accumulated financial assets. “The good life” we all desire in our retirement years is far out of reach for many of these seniors.

The tsunami wave of seniors also puts enormous pressure on Medicare and Medicaid. Many Americans think Medicare pays for Long-Term Services and Supports (LTSS), used by individuals with functional limitations and chronic illness who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medication. It does not. One payment source for LTSS is long-term care insurance. But only approximately nine percent of Americans have long-term care insurance, which can be expensive. Therefore, the major payer for LTSS is Medicaid, developed in 1965 as a safety net for the poor, not as a default long-term insurance program for the middle and working classes. However, because the fastest way to become poor is to be old and sick, seniors exhaust their savings and other assets to live, eventually qualifying for LTSS help through Medicaid. Medicaid now pays for forty percent of all LTSS in the United States.

Housing—a Health Care Solution

With these facts in mind, what can we do to increase the odds that more seniors will actually experience the good life in their golden years? One of the best resources to ensure a good quality of life is decent, safe, and affordable housing. It is the cornerstone to good health and wellness. The Brookings Institution released a report in March 2018 titled “Housing as a Hub for Health, Community Services and Upward Mobility,” which said, “We have learned that there is a strong relationship with substandard housing conditions and health... Housing conditions are a major social determinant of health.”

5. Id.
6. Id.
Today we have a huge demand for affordable senior housing and an equally huge supply problem. National Church Residences, where I serve, is the nation’s largest provider of affordable senior housing. We see the value of quality affordable housing every day. The safety and community in quality affordable housing reduces individuals’ stress levels. The watchful eye of the employees creates an adopted family environment. Paying an affordable rent allows a person to have enough funds for other expenses, such as healthy food, adequate medications, and necessary transportation. Affordable senior housing is a critical pathway to a longer, higher quality of life.

But as we know, affordable housing is not an entitlement. Just because you need it does not mean you are able to access it. Some of National Church Residences’ affordable senior housing communities have waiting lists that are three years long. Roughly three out of every four lower-income seniors have to wait, sometimes for years, to be able to move into a unit.

One simple solution is to build more senior housing. Indeed we must build as much as we can and continue to advocate for more funds to be available for programs such as the Department of Housing & Urban Development’s (HUD) 202 program. The HUD 202 program provides capital advances to private, not-for-profit sponsors to finance the development of housing for low-wealth elderly residents. Unfortunately, after over 50 years of building communities under the 202 program, the federal government stopped funding any new production from 2013 to 2017. Although a very modest amount was added in the FY2018 federal budget to allow for the development or rehabilitation of a small number of 202 communities, it is simply not enough. It is imperative that this unique low-income senior program is supported in future fiscal years. The HUD 202 program, along with the Low Income Housing Tax Credit program, will allow modest amounts of new construction, but it will likely be a drop in the bucket compared to the number of seniors who need affordable housing options.

Thus, the reality is that it is too late to think that we can simply build our way out of the affordable senior housing supply shortage. We must continue to build all of the additional affordable housing that we can, and in addition, we must address the needs of those seniors who will never gain access to these housing resources. We must not ignore the three out of four individuals who are waiting in line for affordable housing. The seniors who qualify for affordable housing but linger on long wait lists face impossible financial choices every day. For example, low-income seniors who live in affordable housing pay 30 to 35 percent of their income for housing. In contrast, the Urban Institute reported that seniors on the waiting list for affordable housing pay approximately 74 percent of their income for housing.10 How are seniors who receive an aver-

They face an Social Security payment of $1,300 and have no other income able to afford any investment in their own health if they spend $962 on rent and are left with only $338 per month for all other expenses?

Those left behind on housing wait lists are also at higher risk of declining health. A 2014 report from the Joint Center for Housing Studies of Harvard University found that seniors who spend more than half of their income on housing spend significantly less on food and health care than their counterparts with lower housing expenses. This is not because their food and health care needs are less. It is because they have less money to spend in these critical categories. The inability to afford things like healthy food and basic medical care exacerbates any chronic condition.

The shortage of affordable housing is therefore both a social justice issue and a health care cost containment issue. As mentioned earlier, if building our way out of the shortfall is only part of the solution, then we must seek other remedies that will address the needs of those seniors who are not able to find affordable housing. Such solutions must seek to help today’s lower-income seniors, as well as seek to ensure that modest-income seniors do not fall into poverty. Whether we are talking about a senior with or without financial means, a senior with or without close family, or a senior with or without access to affordable housing, there are several strategies that we must embrace and prioritize as a country in order to adequately look out for all senior citizens.

Solutions

Redefining family—The Institute on Aging reports that 65 percent of seniors receive their caregiving services from friends and family, with another 30 percent combining family caregiving and paid services. Yet, the demographic gap in family size, as well as increasing tendency for family members to live far from their senior relative, will strongly impact access to these traditional family supports in the future. By 2050, the ratio will plummet from seven possible caregivers per elder to three potential caregivers per elder. Our society must realize that we cannot rely only on the family of origin to provide long-term caregiving.

Quite simply, exposing our youth to seniors early and often is a simple but important part of the solution. For too long, our society has put more and more distance between youth and elders. We visit an elder in a nurs-

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ing home. We don’t live side by side. Our stereotypes of seniors (especially elder seniors) continue to be about issues such a slow driving, being hard of hearing, shuffled walking, etc.

Instead, we must embrace the idea that it will take a village to care for our elders and that means normalizing the day-to-day engagement with seniors, including living in communities with them. Already, we see creative models involving intergenerational housing and accessory dwelling units (ADUs) that provide secondary housing, such as a tiny house on single-family residential lots. One European intergenerational model in use at Judson Manor in Cleveland allows college students to live rent-free in a retirement community, requiring them to socialize with the seniors. This is a new kind of family keeping an eye on the seniors’ well-being and even boosting it through interactions.\(^15\) Will our society ever think that it is cool to be an elder? We should aspire to this goal even if only to ensure that we have enough caregivers in our communities!

*Service-enriched senior housing models*—One major aspect of the affordable housing problem facing seniors is the lack of affordable assisted living. Virtually all assisted living communities in the United States require payment from private sources, meaning they do not accept Medicare or Medicaid, and their rates are unaffordable for moderate- to low-income seniors. Ironically, the effect of this is that low-income seniors often go from living independently directly into very expensive nursing homes paid for by the Centers for Medicare and Medicaid Services.\(^16\) However, it is estimated that ten to twenty percent of all seniors residing in a skilled nursing facility (SNF) could live in less restrictive environments if there were affordable alternatives to SNFs that provided wraparound services, such as support with ADLs like bathing, taking medication, dressing, and transportation.

Over the last ten years, National Church Residences has worked with the Department of Housing and Urban Development and the Ohio Office of Medicaid to modify existing independent senior housing communities into buildings that have both independent living wings and assisted living wings (much like what many market rate developers are designing today). We successfully completed four such communities that combined Section 8 rental assistance to pay for the housing costs and a Medicaid waiver to pay for the assisted living services. These projects were major successes from all


perspectives, but the HUD financing was discontinued several years ago, preventing the ability to further replicate this model.

To prove the value of affordable assisted living, an independent Health Management Associates study in October 2012 reviewed the savings to Medicaid of the first of the National Church Residences’ affordable assisted living communities. The report found that using affordable assisted living saved $73.08 per individual per day. The latest statistics from the Centers for Disease Control reported 1.4 million people living in skilled nursing beds as of 2014. If just ten percent of those individuals (140,000) could move to affordable assisted living, at an individual savings of $73.08 per person per day, Medicaid could achieve a cost savings of $10.23 million a day or $3.7 billion per year, based on the 2012 calculation.

Once the HUD program was terminated, National Church Residences attempted to create a similar model without HUD funds. In 2013, we proposed a concept that would leverage this proven healthcare savings in a Pay for Success model. Generally, a Pay for Success model is any program in which an agreement is reached with a public-sector entity to pay for services that ultimately results in savings to the public sector. In this case, the project was set to take place at Stygler Village in Gahanna, Ohio, an existing 150-unit Section 8 assisted property. The proposal would utilize funding from the Ohio Department of Medicaid. It would allow for the preservation of 75 units as affordable independent senior housing and would convert 75 units into affordable assisted living units targeted at individuals who would otherwise be housed in SNFs.

Ultimately, National Church Residences did not receive approval from the Ohio Department of Medicaid to proceed with this program. At that time, Social Impact Bonds and Pay for Success models, both of which were part of this proposal, were still relatively new concepts. Today more and more such models are proving to be successful in a variety of settings and with a variety of populations. With such a clear positive impact on Medicaid cost savings and with increased pressure to find alternative housing options for higher acuity seniors, these innovative models are well suited for implementation.

Home for Life Models—For those seniors in the community who may never enjoy living in affordable senior housing or an affordable living community, we are called to serve them where they live.

My organization, National Church Residences, is working with a variety of health systems and health insurance companies on innovative ways to reduce costs experienced by seniors living with one or more chronic

health conditions. We have designed a program called Home for Life, which includes the use of enhanced service coordinators to help patients overcome barriers to getting healthy; utilizes a proprietary Care Guide database that includes assessment tools to help determine individual needs; and implements an organizational commitment to achieving the triple aim of excellent client satisfaction, quality service delivery, and lower costs to the health care system.

One example where we have applied this model is a pilot program begun in January 2016 at Adena Medical System, based in Chillicothe, Ohio. The Home for Life model was used to help 100 high-risk patients with chronic obstructive pulmonary disease (COPD). The patients were individually assessed by the service coordinator. A visitation system was then created in which seniors received regular visits based on acuity risk levels. The service coordinator team was committed to accessing the various social determinants of health, from transport needs to dietary guidance to health education. In one year of reporting, the program saved Medicare/Medicaid more than $874,000 and cut readmissions to the hospital from 33 to 14 percent of patients.19

Subsequently, Aetna and Molina Healthcare each acknowledged the immediate, measurable impact of the Home for Life program and its long-term promise as a sustainable model. Each of these insurance companies has partnered with National Church Residences to start its own Home for Life program for a subset of its clients.

The Aetna program consists of 300 patients who are part of the Aetna Medicare and Medicaid plan and have a primary care physician in Central Ohio Primary Care’s practice. National Church Residences began reaching out to these members in August 2017. Enhanced service coordinators make approximately twenty calls each week to ensure patients get to their primary physicians appointments and remove any barriers that would cause seniors to miss their appointments. Enhanced service coordinators provide more extensive services to 80 Aetna members, visiting them in their homes to formulate a personalized care plan for each person. This plan could include providing transportation, assisting with social services, monitoring adherence to medication regimens, assessing individuals’ living environments and implementing corrections to prevent falls, preparing nutritional programming, and providing other services.

The Molina project involves more extensive health management services for Molina members living in National Church Residences buildings. Molina pays National Church Residences to reduce hospitalizations and increase participation in preventative health screening for members in the program. Each patient receives a care management plan as an initial assessment, with annual assessments scheduled as follow-ups. National

Church Residences’ enhanced service coordinators communicate closely with Molina care managers to facilitate timely interventions in areas such as social services, transportation, medication adherence, and nutrition. Weekly coordination meetings are held between Molina and National Church Residences staff, quarterly Pilot Executive Steering Meetings are also scheduled with a group of senior executives from the two organizations in order to ensure support and the provision of resources, and National Church Residences’ enhanced service coordinators report a patient’s changes in health status to Molina within 24 hours of learning about a change.

National Church Residences also is providing Home for Life programs in partnership with the Osteopathic Heritage Foundation and with fire stations in three suburbs of Columbus, Ohio. Additionally, a partnership with Habitat for Humanity in Atlanta, Georgia, using Home for Life is expected to launch later in 2018, taking the Home for Life model out of Ohio for the first time.

Technology innovations—The Home for Life model is a high-touch, in-community solution that is proving valuable to enabling seniors to remain in their homes for life and stay out of higher cost institutional settings. But just as building more housing will only be part of the solution, so will models such as “Home for Life” be one part of the total solution. There simply are not sufficient staffing resources to provide Home for Life programs to every senior who would benefit from such services. Rather, technological advances, which are already entering the market, are critical to providing daily assistance to seniors in ways that complement a human touch.

Our country has a long history of being innovative and entrepreneurial at our core. We see social issues that need solutions and we innovate! Many of today’s leading innovations are happening in areas that address the needs of seniors: motion sensors for monitoring gait changes, robots that improve medication compliance, iPads that address safety and isolation, watches that monitor health indicators, and telemedicine programs to reach those in rural areas, just to name a few. Telemedicine programs are indeed one of the most encouraging impending solutions. Patients in rural areas can use telemedicine to communicate face-to-face and in real time with physicians, particularly specialists, who are located too far away for an in-person visit. The technology solutions are in their infancy but are emerging fast. They will indeed be a significant part of our overall strategic solution to allowing our country’s seniors to age in place with safety, dignity, and respect.

Conclusion

No matter what group or subgroup of seniors we are thinking about, the path of aging is complex. Unlike the path of childhood education, which some would say is fairly predictable, there are thousands of pathways for the aging process, depending on an individual’s frailty level, income level, family resources, and medical conditions. Very few families
plan on dealing with a senior’s need for housing and health care until a major health event happens, such as a stroke or heart attack or the occurrence of dementia or cancer. Then everyone asks the same three questions:

1. What does my elderly friend or relative need now?
2. Where is the best place to meet that need?
3. How do we pay for it?

The answers depend on the insurance the senior has, the savings and income he or she has, the number of friends or family members willing to share the burden of coordinating and assisting with care, and the proximity of those involved with caregiving to the senior receiving the assistance. The answers will also depend on whether the senior lives in or near poverty, as that drives his or her eligibility to receive certain government-funded resources.

No single solution can address the health and housing challenges facing all seniors. Yet every senior in our country deserves a unique pathway to a good quality of life as he or she ages. How do we create the multiple pathways that are critical for our country’s seniors to age with dignity and access to necessary services? We must utilize a large and diverse toolkit of options that can be customized for an individual senior’s situation. We must advocate and create more housing options. We must innovate and seek community-based engagement solutions. It will take a combination of trained health teams, a compassionate workforce, volunteers and family, innovative technology, and the willingness to experiment with creating funding solutions in order to address such a complex customer base and the particular circumstances each individual faces.
Integrating Health and Supportive Services in Affordable Senior Housing: New Models for Service Coordination

Donna Thurmond and Sharon Wilson Geno

Introduction

It is well-documented that the population of the United States of people 65 years and older is increasing and living longer. The senior population is currently 49 million and is projected to double to more than 98 million by 2060.1 Most people today will live past the age of 65 and many will surpass the age of 85 years, placing this population at risk of suffering from multiple chronic diseases during their lifetimes. Over the coming years, this drastic increase in the senior population will become a challenge for both the housing and health care systems. For low-income seniors, the issue will be whether the supply of affordable housing and services will meet their needs or not. Moreover, the cost to the government of providing increased health care services to a substantially larger number of low-income seniors has the making of a looming national crisis, unless changes are made to our delivery systems.

Volunteers of America National Services (VOANS), a subsidiary of Volunteers of America, is a national faith-based nonprofit organization that owns and develops housing for low-income populations in 42 states and Puerto Rico. In addition, VOANS also operates over 46 health care programs for seniors in nine states. These include skilled nursing, assisted living, adult day care, Program for All-Inclusive Care for the Elderly (PACE), and other services. Given this experience as both a senior housing and health care provider, VOANS understands that low-income seniors with multiple chronic illnesses are at risk for poor health outcomes. For more than 20 years, VOANS has been at the forefront of providing health

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and supportive services for its senior residents through service coordination practices, which link residents with ever-evolving services in the community. This article discusses VOANS’ experience, as a housing owner utilizing the U.S. Department of Housing and Urban Development (HUD) service coordinator program, to develop models that integrate preventative health and supportive services within its senior housing portfolio.

Housing Alone Is Not Enough

For many seniors, housing-related costs are their biggest expense. Approximately 44 percent of senior households spend 30 percent or more of their income on housing. The need for more affordable housing for this population, especially for those whose annual income is $12,000 or less, continues to rise, as many of those in this group are on fixed incomes. HUD provides options for approximately five million households (10 million individuals) through three of HUD’s major programs: housing choice vouchers, public housing, and multifamily housing. More than one-third of these households are headed by a senior (defined by HUD as an adult aged 62 years and over).

HUD’s multifamily housing consists of two programs: Section 202, serving primarily seniors, and Section 811, serving disabled adults. The Section 202 program provides nearly 400,000 affordable homes for seniors and is the only federal rental assistance program designed specifically to serve seniors. Nationally, most residents living in Section 202 housing are low-income, white, single women ranging in age from 70 to 80, of whom 68 percent are covered by both Medicare and Medicaid. While housing assistance helps low-income seniors become more economically stable, it alone cannot improve health and life outcomes without other services. Stabilized housing with the availability of supportive services for vulner-

3. 2017 Profile of Older Americans, supra note 1.
able residents can positively impact the quality of life and reduce high-cost outcomes.

**Keeping Seniors Healthy: Using Housing as a Platform Saves Resources and Improves Outcomes**

Managing seniors’ chronic diseases and providing support for residents experiencing limitations on activities of daily living (ADLs) could prolong their independence and mortality, which has the potential to save substantial resources in the Medicare and Medicaid systems. A chronic disease is considered a condition that will last for more than a year. Diseases such as “cancer, diabetes, hypertension, heart disease, respiratory diseases, arthritis, obesity, and oral diseases can lead to hospitalization, long-term disability, reduced quality of life, and death.” In the United States, chronic diseases are among the most common and costly health conditions. In fact, today, one in four adults has two or more chronic conditions while more than half of seniors have three or more chronic conditions. Seniors living with multiple chronic diseases and support for assistance with ADLs will receive treatments from different primary care providers, health systems, and other providers, resulting in a lack of communication due to the fragmentation of health services. An unintended consequence of this lack of coordination often places seniors at risk of poor health outcomes, such as adverse drug interactions and increased costs to the health care system. Moreover, some recent studies show that low-income seniors who live in affordable housing where services are available use fewer hospital and long-term services, thus reducing costs to the health care system.

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10. Id.
14. Id. at 12.
The HUD Multifamily Service Coordinator program is one strategy that can help seniors navigate these systems. In the 1990s, HUD funded the service coordinator program, allowing owners and/or management companies to hire or contract a social services staff person to provide residents with access to supportive services already existing in the community, such as transportation to medical appointments, immunizations, and benefits and entitlements. Service coordinators today provide intentional programing and target the needs of the residents by conducting individualized assessments of their social and health needs. The program helps improve residents’ transitions from the hospital or rehabilitation centers back to their homes.

With the increase in health issues and functional impairments of residents, the service coordinator program model has expanded its focus to include building closer relationships with health-related organizations and providing these types of services on-site. The future of HUD assisted housing is not a health care or nursing home model, which includes specific medical treatment, but rather a focus on offering preventative/health care management services to residents to enhance their independence and quality of life. The medical models, including nursing homes, hospitals, and other longer term treatments, are not only costly to the health care system, but research increasingly shows that integrating preventative services in affordable housing produces better outcomes.

**VOANS’ Senior Affordable Assisted Housing with Service Coordinators**

The VOANS portfolio is similar to many non-profit senior housing providers across the country, although larger. Seventy-one percent of VOA’s residents are women, and 29 percent are men. The racial and ethnic representation of these residents consists of Whites (71%), Blacks (22%), Asians (6%), and Native Americans (1%), including 18% Hispanic/Latino of any race. Almost one-third of the residents are age 80 and over. The residents are extremely low-income, with annual household incomes under $12,000. Over 80 percent of residents are also eligible for some type of publicly funded health insurance, and more than a third have been identified as dual eligible for Medicare and Medicaid benefits.

The five most frequently reported health conditions by residents are hypertension, arthritis, heart disease, diabetes, and lung-related issues. More than half of all residents have been identified as being functionally at-risk (unable to perform one or more activities of daily living) or frail (unable to perform three or more activities of daily living). The activities of daily living that residents report as being the most difficult to perform

17. *Id.* at 12.
include housekeeping, bathing, transferring from a wheel chair to another position, and meal preparation. This is similar to many senior assisted housing populations across America.

Today, VOANS employs 133 service coordinators located in 158 housing sites in 42 states and Puerto Rico, serving more than 9,067 residents. Ninety-five percent of VOANS’ senior residents use the service coordinator services. While residents’ levels of program participation vary widely across properties, on average a typical resident engages with their service coordinator or services arranged by the service coordinator approximately 22 times annually. The most common services provided through the service coordination program include meal deliveries, social enrichment programs, health and wellness-related programs, and home management services. Assistance with benefits and entitlements, educational programming, and resident advocacy are also highly utilized.

While service coordinators have always been encouraged to provide services that can help residents live healthier lifestyles, as more residents are living longer and becoming more frail, an increasing number of residents are not able to manage their chronic conditions well. This results in frequent hospital visits and transfers to nursing homes. As part of VOANS’ new protocols, all service coordinators are required to create and track individualized service and referral plans for residents, especially high-risk residents. High-risk residents have been identified as those who are frail or at risk of being frail, have a history of frequent falls, have frequent emergency room and hospital visits, manage three or more chronic diseases, or show signs of dementia. Focusing more attention on these high-risk residents requires a service coordinator to visit them more frequently, develop individualized service plans, and work closely with their primary care providers to ensure health-related appointments are kept.

With a more targeted focus on this high-risk population, the service coordinator program was able to decrease the number of move-outs for health-related reasons. Of the 8,653 residents enrolled in the service coordinator program last year, roughly 86 percent of all program participants continue to age successfully in place. The remaining 14 percent of residents enrolled in the service coordinator program left the property for the following reasons: death (363 residents); voluntarily opted to move to another independent housing community (315 residents); needed a higher level of care, such as a nursing home (315 residents); and moved to live with family or a group home (218 residents).

Volunteers of America’s Service Coordination Program Structure

Service Coordination: In order to be successful, service coordinators must build trust with residents so they can be linked to the services they need and desire. One full-time service coordinator generally can serve up to 100 households, operating similarly to a case manager by providing information, referrals, case management, advocacy, and access to socialization opportunities.
The service coordinator develops community partnerships and collaborates with social service agencies and health organizations to provide on-site services and programs most requested by residents. An individual assessment is conducted for all residents to determine their ADLs. Once this assessment has been conducted, the service coordinator reviews the results with the residents and discusses the possible services in the community that can improve their quality of life.

**Funding Structure:** Service coordinator programs are often funded by HUD through the HUD Multifamily Service Coordinator grant program. Unfortunately, this program has not expanded in many years and funding levels for existing service coordination programs has remained largely flat. Regardless, VOANS has tried to ensure that service coordination is available at as many sites as possible. Other sources include the properties’ operating expenses or residual receipts.

**Oversight and Supervision:** To ensure that the program is implemented in a coordinated fashion, a national framework for quality assurance was put in place to support and guide each service coordinator. This framework consists of both local and national staff to help the service coordinator address the needs of residents as well as to ensure HUD’s protocols are being followed. The supervision structure varies based on local affiliates of VOA, Inc. Approximately 70 percent of the service coordinators are supervised by the housing property managers. The other 30 percent are supervised by staff located off-site, often either the director of social services or the regional housing director of the local office. In a state where there is a high number of service coordinators, a lead service coordinator is also selected to provide supervision. Finally, in addition to the service coordinator supervisor and quality assurance staff, each service coordinator is assigned a mentor. The mentor’s role is to provide support and technical assistance to service coordinators assigned to them based on their region.

**Training:** VOANS provides all service coordinators with ongoing training through monthly webinars and annual in-person conferences, which provide Continuing Education Units (CEUs). VOANS’ service coordinators are members of the American Association of Service Coordinators (AASC), which also provides national training and professional guidance.

**Web-based Data Collection System:** Service coordinators are required to input all resident interactions and assessments into a web-based data collection system. This system allows service coordinators to record and track resident assessment data and other vital information in real time and to create service plans. The data collection system generates HUD-required reports, as well as resident and property-level reports on a variety of subjects (e.g., the most common health problems reported by the

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18. In addition to VOANS, VOA has 32 other local affiliates that provide a wide variety of services in 46 states.
residents and the most common types of services provided). These online service plans are intended to meet two goals: (1) to ensure that all residents have the support and services they need to successfully age in place and (2) to document high-risk residents’ service needs, program engagement, service utilization, and outcomes over time.

**Evaluation Process:** VOANS’ national staff analyzes the service coordination program data on a semi-annual basis and uses that data to monitor the program’s outcomes. The program performance data that is regularly reported includes, but is not limited to:

- number of residents in properties utilizing their service coordination program;
- number of residents with chronic health conditions and physical disabilities and other “risk factors” that place them at “increased risk” for health deterioration or death;
- number of residents participating in educational and preventive health-related and social services programs and services;
- number of residents participating in socialization activities;
- results of the resident satisfaction surveys;
- residents’ average length of stay and retention rates; and
- number of residents transitioning to a higher level of care.

The VOANS service coordinator program has changed and expanded over time based on our on-going evaluation of the data to increasingly leverage health-related services. VOANS has taken a preventive health approach by identifying and engaging frail and at risk of being frail residents in services before their problems turn into crises. VOANS trains the service coordinator to use non-clinical screening and assessment tools that have been researched and scientifically proven to assist with detecting issues that might be affecting the residents, such as depression, dementia, and social isolation. The Patients Health Questnaire-9 (PHQ9), for example, is an evidence-based assessment tool for screening depression. The service coordinators use this tool, based on the self-reporting of the residents, to make the appropriate referral.

**HUD’s Integrated Wellness in Supportive Housing (IWISH) Program**

VOANS, like other organizations providing service coordination, has increasingly seen preventative health services as an important intervention for seniors to achieve successful outcomes. Supports and Services at Home (SASH), located in Vermont, is a successful example of using housing as a platform to address the health and needs of residents. This program, composed of a care coordinator and a wellness nurse, is designed to connect seniors living in assisted housing with community health care and supportive services. SASH promotes greater care coordination, improves health status,
and decreases health care expenditures. The Department of Health and Human Services (HHS) and HUD evaluated the SASH program and compared health outcomes and service utilization with Medicare beneficiaries who did not participate in the program. The results showed that participants in the SASH model had a decrease in health care costs.

The positive outcomes of the SASH program laid the foundation for HUD’s Integrated Wellness in Supportive Housing (IWISH), formerly called the Supportive Services Demonstration grant. This three-year grant, awarded by HUD in January 2017, was aimed at helping low-income senior residents age in place and delay or avoid the need for nursing home care. The funding covers the cost of providing a full-time resident wellness director (service coordinator-type position) and a part-time wellness nurse.

The IWISH program will be evaluated independently to determine the impact of the enhanced service coordination model in the following areas: (1) success in aging in place in HUD-assisted property; (2) avoiding early transitions to institutional care; and (3) preventing unnecessary and often costly health care utilization, such as emergency room visits and hospitalizations. HUD selected an implementation group, consisting of the Lewin Group, the LeadingAge Center for Applied Research, and the National Center for Healthy Housing to help grantees with the program design.

The program provides a three-year grant program to produce data about the effectiveness of this enhanced supportive services model and to evaluate the value of enhanced service coordination and affordable housing on outcomes for this vulnerable population.

The VOANS team was thrilled to be selected for two of only forty grants awarded nationwide. Residents at our Rolling Oaks Apartments (Rocklin, California) and East Cliff Village Apartments (Santa Cruz, California) will receive both the assistance of a wellness nurse and a service coordinator during the grant period. While VOANS has been at the forefront of collecting data on the effectiveness of services in senior properties, the new demonstration will be evaluated based on a rigorous experimen-
tal research design developed by HUD and the U.S. Department of Health and Human Services (HHS) that uses random controlled testing to evaluate the achievement of outcomes.

**Case Studies in Enhanced Service Coordination**

The HUD IWISH model is just getting underway. However, VOANS has been using enhanced service coordination with preventative health programs in several properties for more than a decade. VOANS understood early on that residents need more than affordable assisted housing to improve their quality of life. Residents also need to have their basic needs met, including sufficient food, access to social relationships, financial stability, and access to health care. By creating both formal and informal partnerships, the service coordinator program helps ensure these basic needs are met. A typical service coordinator manages an average of 12 different partners providing on-site services. The most successful partnerships are with organizations that share the same vision and mission of the service coordinator program. The most frequently used and effective health-related partnerships include, but are not limited to, universities, pharmacies, home health agencies, and area agencies on aging. These partnerships are beneficial to the resident, property, and health service providers. Candleridge Plaza Apartments and Sunset Park Apartments are two examples of housing sites that exemplify effective partnerships.

**Clinical Rotation Site for Nursing Students at Candleridge Plaza Apartments**

Candleridge Plaza is a 100-unit apartment building located in Powell, Tennessee, with 102 senior residents. Sixty percent of the residents are managing three or more chronic diseases and 40 percent of those residents have mental and physical disabilities. Candleridge’s service coordinator was interested in providing wellness programs at the property to address residents’ chronic health issues. The service coordinator developed a partnership with the University of Tennessee Knoxville (UTK) College of Nursing to create a preventive health program. Initially, the university agreed to just provide nurses for the property’s annual health fair; however, as the relationship grew, the university discovered that Candleridge Plaza was a great site to help them address their mission of serving high-risk vulnerable populations in the community.

What started out as an informal relationship evolved into a formal partnership with a Memorandum of Understanding (MOU) outlining the activities and services offered by the College of Nursing. Today, Candleridge Plaza is a community classroom site for the nursing school’s Community & Public Health course, which includes a Service Learning Component. UTK College of Nursing and Candleridge produced a video to promote

23. The video can be found at https://servicelearning.utk.edu/service-learning.
the Service Learning Initiative, which involved students and housing staff. The following are some of the results of partnering with a health care service provider:

- 911 calls decreased by 10 percent;
- 99 percent of residents have obtained a primary care provider;
- 95 percent of residents are keeping their health-related appointments;
- ER visits have decreased by 10 percent; and
- 40 percent of the residents utilized the services offered by the nursing students, in addition to their regular primary care physician.

This win-win partnership helps to improve the residents’ coordination of care, medication management, and identification of potential health dangers. From the university’s perspective, this partnership provides these nursing students the opportunity to interact with older adults and help train the next generation of nurses. The students also learn more about the unique needs of older adults. As one student shared, “It’s great to see older residents functioning in their own homes, rather than in a rushed clinical hospital setting where they are at their worst, in a hospital bed!” During the nursing students’ rotations, they educate residents on health-related topics; provide basic health screening, such as blood pressure readings; and conduct other health assessments, including screening for immunizations and depression.

Dental Services at Sunset Park Apartments

Sunset Park is a 242-unit apartment building located in Denver, Colorado, with 246 residents. Forty-five percent of the residents are managing three or more chronic diseases and 30 percent of the residents self-reported having mental and/or physical health issues. Through the service coordinator’s assessment of the residents at Sunset Park, it was discovered that many residents needed dental services, but were unable to access dental services due to cost, lack of or limited dental insurance, limited transportation to appointments, or fear of the dentist.

In 2016, a partnership was created with the Dental Lifeline Network (DLN) to offer dental clinics at Sunset Park for its residents and the residents at the neighboring property of Sunset Towers. DLN is a national charitable organization whose mission is to improve the oral health of people with disabilities and people who are elderly or medically fragile and have no other way to get help. DLN accomplishes its mission by developing and coordinating collaborative relationships that provide essential resources for direct-service programs, especially charitable care. The benefit to residents of having this monthly dental clinic is having dental care provided at no cost and having their service coordinator schedule follow-up appointments and provide assistance with necessary paperwork. Between eight to ten residents are seen by the clinic each month.
for procedures that include cleanings, fillings, general work, and dentures. The only procedure not offered at this clinic is root canal surgery.

The dental clinic is open to all residents at both properties who either have Medicaid or no dental insurance and the services are free to those residents. A resident at Sunset Park who is a DLN patient recently stated, “With my outstanding medical problems, I thought I would never be able to afford dental services. I am so happy now that I am pain free. I don’t know what I would have done if Sunset Park hadn’t found a dental program.” DLN and Sunset Park have been able to successfully collaborate, and this has been and continues to be a partnership that meets a very important need of our residents.

Conclusion

While the need for more affordable housing for low-income seniors is increasing, housing can no longer be just bricks and mortar. It has to serve multiple purposes, such as being a focal point for providing health and supportive services for the community. As health providers have begun to realize that housing is a social determinant, we should begin focusing on strategies for linking housing with services that will improve the health outcomes of residents as well as decrease the number of unnecessary hospital visits and premature institutionalizations.

Through its IWISH program, HUD has stepped forward as a collaborative leader working with health providers to deliver enhanced services to seniors. It is hoped that the lessons learned from IWISH and other programs (such as SASH) that use the service coordination program as a base can produce outcomes to improve residents’ well-being and be cost-effective. While barriers, including funding, still exist for integrating health and supportive services in housing, VOANS continues to work on developing more health-related partnerships. VOANS hopes that lessons learned from IWISH and other programs be implemented in all senior properties so our residents can age in place and live long and healthy lives.
Housing as Healthcare: Practical Models to Create Social Impact

Mark Angelini

For more than 30 years, Mercy Housing Lakefront (MHL) has provided service-enriched housing to individuals and families, many of whom face tremendous health-related barriers to long-term stability, in Chicago and elsewhere in Illinois, Wisconsin, and Indiana. Among the residents served by the organization are working families, seniors, and people with special needs (i.e., veterans, those experiencing homelessness, individuals who are HIV positive or have AIDS, and those with disabilities), all of whom lack the economic resources to access quality, safe housing opportunities. Many of these individuals have acute medical needs, including mental health challenges, substance use disorders, and limited mobility, among others. Addressing these challenges requires individualized wraparound support, but MHL’s approach to helping them lead healthy lives always begins by providing them with a safe, stable, and affordable home that can serve as a foundation for a better life.

The reason for this is simple: housing is healthcare. As the Corporation for Supportive Housing stated in a 2014 report, access to safe, quality, affordable housing—and the supports necessary to maintain that housing—constitute one of the most basic and powerful social determinants of health. In particular, for individuals and families trapped in a cycle of crisis and housing instability due to extreme poverty, trauma, violence, mental illness, addiction or other chronic health conditions, housing can entirely dictate their health and health trajectory. For these populations, housing is a necessary precursor of health.1

This claim has been validated by numerous studies, finding that those who are housing insecure have elevated levels of stress, depression, and feelings of hopelessness2 and are unable to devote limited resources to

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essential needs like nutritious food. Often forced to live in substandard housing, they are disproportionately exposed to environmental hazards, such as mold and cockroach infestation or lead paint, all of which negatively impact their health, and are more likely than those who are stably housed to visit the emergency room for health issues that could have been treated with preventative care.

Without stable housing, medical interventions to address health challenges faced by low-income populations are unlikely to do anything more than temporarily alleviate the symptoms of housing instability. It is for this reason that healthcare and housing providers must work together to identify opportunities for collaboration. These partnerships benefit not only those served, but also the communities in which these relationships are formed. Through integration of health and housing systems, the whole is greater than the sum of its parts, enabling positive social impact that would not be possible otherwise.

Throughout its history, MHL has actively pursued such relationships with health providers, and in the process, has greatly enhanced the ability of the organization’s resident services department to empower residents to address their economic, educational, and community challenges. This is illustrated by the outcomes of MHL’s most recent annual resident survey (administered between August 1, 2017, and September 30, 2017), in which 95.4 percent of residents reported having health insurance; nearly 80 percent reported having a primary care physician; 86.3 percent indicated they underwent at least one preventative care checkup in the previous year; almost 70 percent reported no overnight hospital stays in the previous year; and 64.4 percent indicated that they exercised for 30 minutes or longer at least three days per week. With improved health, MHL’s residents, both adults and children, are empowered to overcome poverty, pursue educational and career opportunities, and achieve independence that would otherwise be out of reach. In fact, a recent analysis of 25,000

individuals/families living at Mercy Housing Lakefront properties and those of our sister organizations across the country determined that the average annual increase in income among these Mercy Housing residents was $814 in 2016 and $733 in 2017. This represents a drastic increase in each individual’s or family’s capacity to cover basic necessities and to invest in long-term stability.

A Paradigm Shift

While the integration of health and housing was not a novel idea in 2010 when the Affordable Care Act (ACA) was passed, the law fundamentally changed the way in which housing and healthcare providers work together. The first benefit of the ACA was the expansion of Medicaid to people with annual incomes below 138 percent of the federal poverty level, reducing the barriers to quality healthcare for low-income Americans, individuals with chronic mental illness or disabilities, and those with HIV, among others. This opened the door for millions of Americans to receive quality medical care at an affordable rate, reducing the “heat or eat” decisions that are endemic among those struggling with poverty. The second major benefit of the ACA was shifting the focus of healthcare delivery from procedures and volume of service provisions to service outcomes that achieve and sustain patients’ well being, incentivizing healthcare providers to find new ways to deliver services, to the benefit of the individuals being treated (and the housing providers who serve them).

This resulted in a more holistic approach to healthcare that rewards providers who treat the “whole person,” rather than simply addressing the symptoms of poor health. Because housing is the primary social determinant of health, the ACA created an environment in which it was in the best interests of healthcare providers to work with housing providers like MHL to develop comprehensive strategies to improve the health of low-income patients by addressing their housing instability. In the years since, MHL has prioritized financial and operational models that take advantage of this environment, identifying new ways to ensure that residents have access to the services needed to thrive, and gaining extensive practical knowledge of how to successfully integrate health and housing systems in the process.

This experience can be categorized in the following ways: (1) linkage agreements with healthcare providers to deliver services, (2) integrating health services on-site at housing developments, (3) working with healthcare providers to house high utilizers of costly medical services, (4) adaptive reuse to save hospital systems money by reutilizing exhausted assets, and (5) capital investment to reimagine how care can be provided to the benefit

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of the community. While the examples in the following sections are unique to MHL, they serve as case studies meant to provide practical knowledge for other individuals and organizations in the health and housing sectors.

**Linkage Agreements**

Among the least complex methods to integrate health and housing are linkage agreements between providers that establish formal partnerships that allow the housing provider to refer residents for specialized services. MHL has developed numerous linkage agreements with health and community-based organizations across its 52-property portfolio, which focus on coordinating on-site clinical services, on-site health education, and referrals to the appropriate healthcare provider, thereby promoting the continuity of healthcare for MHL’s residents.

One example of this is a partnership with Heartland Health Outreach (HHO), a Federally Qualified Health Center (FQHC) located in the Uptown neighborhood of Chicago. Near six of MHL’s permanent supportive housing properties, with studio housing for approximately 600 high-need residents, HHO focuses on providing primary, oral, and behavioral healthcare to people experiencing challenges such as homelessness or struggling with mental illness. Due to the proximity of the Uptown properties to HHO and having a shared target population, HHO is one of the primary providers of healthcare services to residents of MHL’s Uptown properties. MHL’s relationship with HHO improves the continuity of care for residents through referring residents to HHO’s health services and coordinating on-site services, such as primary care nursing services and HIV testing.

Another example of this is a partnership between MHL and Aurora Health Care (which recently merged with Advocate Health) in Milwaukee for the Safe Housing Environment (SHE) program. SHE provides a safe home environment and supportive services for pregnant and postpartum victims of domestic violence who are participating in the Aurora Safe Mom Safe Baby (SMSB) program. The program combines nurse case management, prenatal and perinatal care, and advocacy services to enhance the health and safety of abused pregnant women and improve birth outcomes. SMSB addresses the commingled problems of intimate partner violence during pregnancy and high-risk for poor birth outcomes and infant mortality, particularly among low-income women of color in Milwaukee.

Through referrals from Aurora, MHL provides residents with safe housing, a sense of community, support, education, and mentoring at St. Catherine Residence, which offers 164 supportive homes for low-income women and their children. During the first 18 months of their stay at St. Catherine Residence, clients are eligible for subsidized rent while receiving ongoing care management and support. Residents referred through SHE can remain at St. Catherine Residence for three years and have ongoing access to professionals trained in money management, substance abuse, family counseling, physical and emotional health, sexual
abuse and domestic violence, and other factors that could lead to a relapse into homelessness.

**On-Site Integration of Health Services**

Another approach to integrate health and housing services is to bring external health services within the housing development itself. In Kankakee, Illinois, MHL recently completed River Station Senior Residences, a mixed-use development that includes commercial space on the ground floor for a health clinic open to residents and members of the community. River Station was developed with the financial support of Presence St. Mary’s Hospital (now a part of the AMITA health system), and the health clinic will be operated by the hospital. The on-site clinic is part of an innovative model intended to provide St. Mary’s Medicare and Medicaid patients a convenient, inviting place to receive primary care services, while also helping keep the River Station seniors healthy and in their independent homes longer. This is in alignment with the goals of the Affordable Care Act, as the clinic will provide preventative care and community-based post-hospitalization care that reduce emergency room usage and repeat hospitalizations. This will allow the hospital to provide services at a much lower cost than in the emergency room and in a manner that improves patient satisfaction. River Station is contributing to several community revitalization goals and is a model for addressing the needs of aging populations in small U.S. cities. River Station adjoins a planned greenway along the Kankakee River, which will provide opportunities for active recreation, and is within walking distance of a grocery store, commercial businesses, and religious institutions.

In Danville, Illinois, MHL completed in 2017 a permanent supportive housing development called Cannon Place, which serves homeless veterans and their families. Through the U.S. Department of Veterans Affairs’ (VA) Enhanced Use Lease program, which allows the VA to lease its underutilized property to private sector partners to develop supportive housing for veterans, MHL was able to create 65 one-, two-, and three-bedroom apartments on the campus of the VA Illiana Health Care System. Through this partnership, residents are able to access medical services with minimal difficulty because Cannon Place is within walking distance of all health services provided by the VA. Additionally, through close collaborations with community health partners, enhanced services are available to members of the veterans’ families within the facility, thus creating a comprehensive system of care.

**Housing High Utilizers**

For individuals experiencing homelessness, every day is a struggle to access the resources necessary to survive, causing a wide range of medical issues that are often treated in an emergency room when the associated pain becomes too acute to ignore any longer, or when the person becomes incapacitated by illness. This poses a major challenge for healthcare providers,
as services rendered in the emergency room are among the most expensive forms of treatment. With nearly one-third of all visits to the emergency room made by people experiencing chronic homelessness,9 many of whom have complex medical needs (e.g., chronic health conditions, behavioral disorders), and the average cost of a visit being $3,700,10 it is logical that healthcare providers would work to reduce costs by partnering with housing providers to house these high utilizers. This not only benefits the individuals served, but also taxpayers because public insurers are no longer subsidizing the costs of expensive emergency room visits or paying for repeated treatments for chronic conditions.

To address the needs of Chicago’s chronically homeless population, MHL joined a collaborative called Better Health Through Housing several years ago, which is a partnership between the Center for Housing and Health, University of Illinois Hospital and Health System, and local housing providers. The goal of Better Health Through Housing is to “reduce healthcare costs and provide stability for the chronically homeless by moving individuals directly from hospital emergency rooms into stable, supportive housing.”11 Program participants are assigned a case manager who helps them with scheduling medical appointments and managing money, as well as referrals to other critical services. The initiative’s combination of healthcare, housing, and human services fosters a sense of home, independence, and self-determination to help speed individuals’ reintegration into the community, promotes long-term health, and reduces overall healthcare costs.

Currently, MHL is exploring two new partnerships with health providers to house those at risk of becoming high utilizers of costly health services, but with negotiations ongoing, identifying details have been removed. The first is a collaborative that will work at the intersection of housing, health, and the criminal justice system to eliminate systemic barriers to permanent housing and healthcare to promote successful reintegration into society for justice-involved populations. There is an urgent need for this type of partnership in the Chicago area: the lack of permanent housing options for justice involved populations leads to longer stays in Cook County Jail, is a barrier to successful community reintegration, and leads to recidivism. The collaborative will map systemic barriers in the housing, health, and criminal justice systems and identify existing interventions, including new models for financing housing, that can be scaled. Core to our effort will be building alternative financing models.
with a local property investment manager. We will then produce a “road map” that will include policy, program, and financing recommendations across all three systems at the county level.

The second partnership is with another Chicago-based social services provider and, with funding from the Department of Health and Human Services Offender Reentry Program, will build on established reentry services for individuals exiting the justice system. MHL’s partner will provide participants with risk, needs, and employment assessments; behavioral interventions; case management; pro-social activities; wraparound supports (including housing); and job placement and retention services. In addition, the proposed program would incorporate career planning services, supported by labor market data, and employer career pathways to provide participants the support needed to achieve in-demand and industry recognized credentials, employment, and job retention. To ensure that participants have a stable foundation, MHL will provide two units of housing at a centrally located, transit-accessible property in Chicago under a master lease agreement to be used as transitional housing for the duration of the program. After completing the program (and contingent upon unit availability and income limits), participants will have the opportunity to assume a lease at the property, allowing for a smooth transition to quality permanent housing at an affordable, below-market rate.

Adaptive Reuse

As healthcare systems increasingly focus on ambulatory care, hospitals across the country are no longer being used in the same ways they once were and, in many cases, are being decommissioned entirely. This is particularly true in rural communities, which saw 83 hospitals disappear between January 2010 and January 2018. While renovating outdated hospitals for continued medical use may not be feasible for current medical needs and patient expectations, these facilities are ideal for conversion to affordable housing. In addition to being generally well-constructed and located in amenity rich neighborhoods, adaptive reuse is likely to result in significant cost savings while supporting the core mission of the health provider. These projects are frequently cornerstones in community revitalization efforts, as they occupy large tracts of land that would not be redeveloped otherwise.

In 2011, MHL completed one such project, which converted Milwaukee’s historic Johnston Medical Center into 41 apartments for chronically homeless, low-income, and disabled individuals. In addition, MHL developed 43 apartments through new construction on an adjacent parcel of land for extremely low-income individuals at high risk of homelessness,

with a building connector linking the two facilities. Renamed the Johnston Center Residences, the combined facility features green design elements, including a solar hot water heater, green roof and outdoor green space, resident lounges, laundry facilities, an exercise room, and computer lab, providing residents with a modern living environment in which intensive on-site case management services are easily accessible. Through the redevelopment of the medical center, MHL created 10+ permanent jobs, injected $12.7 million into Milwaukee’s economy, and helped to create and modify policies and procedures in county and state government around supportive affordable housing.

MHL is currently exploring the possibility of several new conversion projects with various nonprofit hospital systems, which would involve the adaptation of historic medical facilities that are no longer functional for their original use. One of these potential projects, summarized below, is still in the planning stages, and identifying details have been removed as a result. However, the model itself is worth discussing within the context of mutually beneficial partnerships between health and housing providers. Although purchase price has not yet been negotiated, the health provider has agreed to give MHL control of the property at no cost while MHL secures approvals and financing. It is advantageous for the health provider to do this, because turning over control of the property to MHL for conversion to housing will prevent the health provider from continued carrying costs on the vacant building, which are significant, and from an eventual expensive tear-down if it were to retain ownership. While selling the property to a purchaser in the private sector would similarly allow the hospital to avoid ongoing carrying costs and/or the costs associated with demolition, it is unlikely to also result in a mission-consistent reuse of the property. Because MHL intends to convert the building into supportive housing serving those in need in a manner consistent with the hospital system’s values, the organization is able to provide the value of maintaining an important social mission of the hospital system that a purchaser driven by profit would be unable to deliver.

For MHL, this arrangement will allow for greater investment in the property during the conversion to housing, resulting in higher quality finishes and amenities, and in enhanced service delivery to residents after the project is completed. Finally, the community in which this facility is located would reap the rewards of the partnership, as a vibrant, service-enriched housing option would be created in place of a deteriorating vacant building or empty lot. As with any affordable housing project, the potential for NIMBY pushback exists, but we are partnering closely with the hospital system and conducting extensive outreach to existing stakeholders in the community to convey the benefit gained by adding high-quality housing to the area to serve its high-need population. This is consistent with our approach to every project, and we have found that proactively working with the community generally results in outcomes that are satisfactory to all stakeholders, thereby diffusing NIMBYism.
Investment as Community Benefit

The final intersection between housing and health at which MHL has worked is coordination with health systems to develop financing models that allow health providers to reimagine the ways in which ambulatory care can be delivered to members of the community, while also supporting the development of quality affordable housing. River Station Senior Residences, mentioned previously as an example of the on-site integration of health and housing services, was possible only because of a $330,000 capital investment from Presence St. Mary’s Hospital. This investment served as the final piece of construction funding, clearing the way for the deal to close. In addition, the health system is paying rent for the on-site health clinic, enabling MHL to support a portion of the debt needed to borrow as part of the construction capital stack. This type of investment addresses an identified community health need and fulfills the health system’s obligation as a non-profit to provide community benefit through housing. Without investments like these, non-profit health providers are at risk of losing their tax-exempt status. MHL is currently meeting with other non-profit health providers to underscore how partnering with the organization to develop housing opportunities can help protect their tax-exempt status.

Conclusion

The most significant “data point” in predicting an individual’s current and future well-being is his or her zip code, as multiple studies have identified large discrepancies between wealthy and poorer communities not only in terms of current well-being, but also life expectancies.13 In fact, the danger of living in the “wrong” (i.e., poorer) neighborhood is so severe that one such study referenced them as “hot spots of death.”14 At the same time, our health systems and taxpayers are massively weighed down by ever increasing consumption and cost of healthcare services. Many significant, costly, and life-impairing chronic health conditions (e.g., obesity, diabetes, respiratory ailments) are affecting more Americans across wider age spans, and, as a result, the resources required to treat these largely preventable conditions continue to increase. Without intervention, these individuals have severe limits placed on both their quality of life and on the positive contributions they can make to our economy and to society at-large.

The combination of spatially determined quality of life and the subsequent enormous cost burden leaves us with a societal condition that is


both economically unsustainable and morally questionable. As daunting as the task is, the solution is not hard to envision: channel more capital to the prevention, rather than treatment, of avoidable chronic conditions, starting with enhancing the most significant social determinant of health—turning low-quality, dangerous, relatively expensive housing into high-quality, safe, and affordable housing.

Once stably housed, focused attention can be paid to addressing the unique health needs of each individual through initiatives like MHL’s Community Health Worker (CHW) Program, a soon-to-launch pilot program, in partnership with Blue Cross and Blue Shield of Illinois and the Washington Square Health Foundation. Designed to address health disparities and increase self-efficacy among formerly homeless residents with chronic health conditions such as hypertension, high cholesterol, and diabetes, the program will establish a team of community health workers providing services to three permanent supportive housing properties in Chicago. Community health workers will have characteristics and experiences like the individuals they serve and may include MHL residents, allowing for peer-based programming that effectively reaches an extraordinarily vulnerable population and empowers them to better manage their health. Through a partnership with local health providers, community health workers will receive approximately 50 hours of initial training to ensure that they have the foundational skills necessary to effectively support program participants, followed by ongoing clinical guidance from a nurse or nurse practitioner.

In the not-so-long-run, by investing in housing and supportive services like the CHW program, we can make our communities more vibrant places to live and help those members of the community who are currently struggling and marginalized to achieve the original American dream: life, liberty, and the pursuit of happiness as families have more funds to direct toward savings, healthy food, clothing, and the education of their children, who will be far more school-ready living in safe, quality housing.

This benefits families like Latisha Laceys, an MHL resident who lived in six apartments in 14 years before finding MHL. Forced to move repeatedly because of low-quality housing with issues like infestation and lead paint, Latisha’s children began to display the signs of “toxic stress,” negatively impacting their emotional and behavioral development. Now


housed at MHL’s Lofts on Arthington, Latisha and her sons have been sta-
bilized, and, for the first time, are able to look to the future with a feeling of hope. With further integration of the health and housing sectors, we can help more families like Latisha’s and eliminate the zip code as a marker of what kind of life is available to our fellow Americans.
Improving Health and Environment Through Place-Based Investing: The Healthy Neighborhoods Equity Fund

Maggie Super Church and Kathy McGilvray

Introduction

Healthy Neighborhoods Equity Fund (HNEF) is a pioneering $22 million private equity fund for Transit-Oriented Development (TOD) in Massachusetts. TOD is a type of community development that includes a mixture of housing, office, retail, and/or other amenities integrated into a walkable neighborhood and located within a half-mile of quality public transportation. Some of the benefits of TOD include:

- Reduced driving and, therefore, lowered regional congestion, air pollution, and greenhouse gas emissions.
- Walkable communities that accommodate active and healthy lifestyles.
- Increased transit ridership and fare revenue.
- Potential for added value through increased and/or sustained property values where transit investments have occurred.
- Increased access to jobs and economic opportunity for low-income people and working families.
- Expanded mobility choices that reduce dependence on automobiles, reduce transportation costs, and free up household income for other purposes.¹

MetroFuture, Greater Boston’s regional growth plan through 2030 developed by the Metropolitan Area Planning Council (MAPC), identified TOD as a key ingredient for a sustainable, equitable, and prosperous region. In 2012, MAPC estimated that transit station areas could accommodate more than 76,000 new housing units and space for more than 130,000 new jobs by 2035.² Achieving this level of growth would yield substantial

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benefits as compared to a more dispersed growth scenario, including fewer vehicle miles traveled, lower housing and transportation costs, increased economic vitality, and higher transit ridership. Between 2000 and 2010, the region added more than 15,000 new housing units near transit.\textsuperscript{3} MAPC estimated that the rate of housing development needed to double in order to achieve the full potential of TOD in the region.\textsuperscript{4} A further study commissioned by MAPC identified financing, particularly long-term patient equity, as a key barrier to achieving TOD build-out targets.\textsuperscript{5}

HNEF is meeting this need by providing patient, low-cost capital for mixed-income, mixed-use projects near public transportation that have demonstrated potential to improve environmental and community health, while also providing attractive risk-adjusted financial returns to investors. HNEF has attracted a mix of public, private, and philanthropic investors, including state and federal agencies; foundations; banks; and a local hospital, Boston Medical Center. The fund uses an innovative investment screening tool that integrates over fifty qualitative and quantitative measures to assess the likely impact of the project on environmental and community health and tracks neighborhood-level change over the ten-year investment period. To date, HNEF has approved and/or closed $19.36 million in investments in seven projects, leveraging an additional $131 million in financing and supporting the creation of 552 new units of mixed-income housing and 138,000 square feet of new retail and commercial space. Together, these projects will create more than 1,260 construction jobs and 150 permanent jobs in low- and moderate-income neighborhoods.

HNEF Sponsors

HNEF was launched in 2014 through a unique partnership between the Conservation Law Foundation (CLF) and the Massachusetts Housing Investment Corporation (MHIC). MHIC has 27 years of experience investing in low-income neighborhoods through multiple investment funds, and CLF has decades of experience advocating for healthy communities and environmental justice across New England. CLF and MHIC are joint sponsors of HNEF, and each organization brings specific skills, strength, and expertise to the table.

CLF is New England’s oldest and largest environmental advocacy organization. CLF’s mission is to protect New England’s environment for

\textsuperscript{3} Id.
\textsuperscript{4} Id.
the benefit of all people. CLF uses the law, science, and the market to create solutions that preserve natural resources, build healthy communities, and sustain a vibrant economy. Whether it’s cleaning up polluted land and water, improving transit access, or reducing greenhouse gas emissions, CLF’s work creates lasting benefits for people and communities.

At the same time, CLF recognizes that environmental policy has a powerful effect on markets, shaping incentives, risks, and rewards. The markets program has long served as an incubator of solutions that integrate research, assessment, community outreach, and investment. Program scope and efficacy are guided and assessed using carefully designed metrics to document performance, improve program and market design, and ensure complementary deployment of market-based and more traditional policy and regulatory approaches.

For HNEF, CLF worked closely with MHIC on raising capital, fund structuring, and pipeline development, and took the lead in developing HealthScore, the HNEF impact scorecard. CLF is also responsible for reviewing pipeline projects for conformance with HNEF’s healthy community goals and monitoring health outcomes and other community and environmental impacts over the ten-year life of the fund. In addition, CLF is leading an independent longitudinal research study exploring the relationship between neighborhood development and health in nine communities in eastern Massachusetts in collaboration with numerous public, non-profit, academic, and community partners, with support from the Robert Wood Johnson Foundation.

MHIC was founded as a non-profit organization in 1990 by a consortium of banks to fill a critical gap in meeting the credit needs of affordable housing developers at a time when the real estate market was in turmoil. MHIC’s mission is to be an innovative private financier of affordable housing and community development, providing financing that would not otherwise be available and extending the impact of that financing to ensure the broadest possible benefit. In fulfilling this mission, MHIC has provided over $2.6 billion of financing throughout New England to help build and sustain healthy communities. This financing has helped create or preserve over 22,000 affordable housing units and over 5 million square feet of commercial space in low-income communities.

MHIC’s financing programs are designed to build and sustain healthy communities. The organization’s initial focus was on meeting the critical financing needs for affordable housing. In 2003, MHIC initiated its New Market Tax Credit (NMTC) program to address the broader unmet needs of low-income communities, providing financing for health care facilities, non-profit organizations providing critical services such as childcare and workforce development, business expansion, and neighborhood revitalization. In 2008, MHIC launched the Neighborhood Stabilization Loan Fund (NSLF) to prevent deterioration of neighborhoods hardest hit by the foreclosure crisis. The HNEF product was a natural progression for MHIC, de-
veloped in partnership with CLF in response to an unmet need for patient capital for TOD projects in transitional real estate markets.

For HNEF, MHIC took the lead on capital raising and fund structuring, creation of legal documents, financial modeling, and project pipeline development. MHIC currently manages HNEF and leads project underwriting, while its HNEF Committee reviews project recommendations jointly made by MHIC and CLF and recommends the final selection of investments to the MHIC Board of Directors. MHIC is responsible for closing and managing approved investments. MHIC’s asset management department (with over $1.2 billion in assets currently under management) works to ensure the long-term success of HNEF investments.

**Regional Context**

Massachusetts is characterized by a strong regional economy and real estate market, but is also marked by pockets of intense poverty and a high degree of racial and income segregation. Since 1990, the number of poor people in Massachusetts has grown by one-fifth, while the number of Massachusetts residents living in high-poverty neighborhoods has increased by nearly one-third. Furthermore, between 2000 and 2009–2013, the share of renter-occupied households spending more than 30 percent of their income on rent increased from 39.2 percent to 50.6 percent in greater Boston. This has become an urgent economic development issue, threatening the state’s competitiveness as growing numbers of individuals and families are unable to afford the combined costs of housing and transportation.

In addition to economic concerns, Massachusetts faces significant environmental challenges related to land use, transportation, and Greenhouse Gas (GHG) emissions. In 2014, the transportation sector was the largest single contributor to GHG emissions, representing 39 percent of total emissions. While Massachusetts has made significant progress over the past decade, transportation has now surpassed power plants as the state’s largest source of GHG emissions. For these reasons, the future environmental health of the region will be determined in part by the extent to which new development occurs in neighborhoods with access to transit, jobs and services that allow people to walk and bike more and drive less.

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Finally, Massachusetts faces considerable challenges with respect to preventable chronic disease and health disparities that are driven in part by neighborhood conditions. In spite of Greater Boston’s status as a world leader in health services and research, the state has seen an alarming rise in obesity and chronic disease over the past several decades. According to *The State of Obesity: Better Policies for a Healthier America*, released in August 2017, Massachusetts’s adult obesity rate is currently 23.6 percent, up from 15.3 percent in 2000 and from 10.1 percent in 1990.\(^8\) In 2010 alone, Massachusetts spent $30.9 billion on chronic disease.\(^9\)

These impacts are especially acute in low-income neighborhoods and communities of color. A 2017 study by the Massachusetts Department of Public Health found that Black non-Hispanics had nearly five times the rate of diabetes-related emergency department visits compared to white, non-Hispanics; similarly, Massachusetts adults with an annual household income of less than $25,000 have three times the prevalence of diabetes as compared to those with an annual household income more than $75,000.\(^10\) The study further noted that

> the conditions in which people live, learn, work, and play do not offer equal access or opportunity. . . . For example, a history of policies rooted in structural racism have resulted in environments in which there are inequities in access to healthy foods, safe spaces for physical activity, walkable communities, quality education, housing, employment, and health care services. The health implications of this are evident in the fact that Black and Hispanic residents of Massachusetts are consistently and disproportionately impacted by prevalence of all chronic disease, as well as the related deaths and high acute care utilization. Healthy people cannot exist in unhealthy environments.\(^11\)

These kinds of health disparities, driven in part by neighborhood conditions, have resulted in a shocking 33.5-year difference in life expectancy at birth between residents of two nearby census tracts in Boston.\(^12\) These data underscore the urgency of financing solutions that are explicitly aimed at addressing health disparities through investment in healthy neighborhoods.

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10. *Id.*
11. *Id.*
HNEF Mission and Capital Structure

In response to the challenges outlined above, HNEF is designed to support mixed-income, mixed-use TOD projects in historically disinvested neighborhoods, where access to conventional private equity investment is limited or non-existent. The fund provides low-cost capital for projects with demonstrated potential to deliver economic, environmental, community, and health returns. The HNEF capital stack includes a blend of public, philanthropic, and private investors. This allows HNEF to provide patient lower-cost equity to high-impact projects, while also providing substantial risk protection and attractive risk-adjusted returns to private investors.

- **Class C**: Publicly sourced funds, which do not have any return requirements, make up 9 percent of the fund ($2,000,000). This includes $1,000,000 from the Commonwealth of Massachusetts of Affordable Housing Trust Funds which had initially capitalized MHIC’s NSLF program (see above) as top-loss funds, but which were not required to be tapped due to that program’s success. The Commonwealth agreed that MHIC could transfer those funds to HNEF as a Class C investment. The balance of the Class C funds was sourced from a Financial Assistance Award MHIC received from the Community Development Financial Institutions (CDFI) Fund. The Class C funds are top-loss funds that require no return.

- **Class B**: Investments by MHIC, backed by program-related investments (PRIs) and guarantees from foundations, make up 22 percent of the fund ($5,000,000) and have modest return expectations of 2 percent, with some upside potential. MHIC’s Class B investment was sourced from a $1,000,000 PRI from the Boston Foundation, a $3,600,000 PRI from Northern Trust, and $400,000 of MHIC’s capital.
The Robert Wood Johnson Foundation and Kresge Foundation each provided a $1,800,000 guaranty of the Class B investment.

- Class A: Socially motivated economic investors make up the balance of the fund ($15.35 million) and have a higher target return of 8 percent and upside potential. These investors include banks; high net worth impact investors; and one local hospital, Boston Medical Center. The public and foundation funds provide substantial downside risk protection to Class A investors, allowing the fund to invest in neighborhoods where the market is not yet proven, but where community impacts will be the greatest.

**HNEF Investment Terms**

HNEF is designed to provide patient gap financing for transformative transit-oriented development projects that promote economic, environmental, and community health improvements. Because many of the communities in which HNEF invests are in the early stages of transformation, it is critical that the investment is more patient than traditional development equity, which typically requires a 15 percent to 20 percent return within 3–5 years. HNEF equity can be invested for up to 10 years and targets a 10 percent Internal Rate of Return (IRR) from projects. While each project is somewhat different, approximately one-third of HNEF’s return is expected to be generated from annual cash flow distributions, with the balance of the return from the residual value when HNEF exits the deal, either at sale, refinancing, or via a put and call arrangement with the developer. Project sponsors must have a defined plan to take out HNEF equity at the end of the investment period. Investments will typically be made at construction loan closing and, as mentioned, can have a term of up to 10 years. HNEF will typically take an ownership position in the project partnership as a limited partner or investor member, though it also has the flexibility to provide funding through other structures, for example, as a mezzanine debt lender.

HNEF will only invest in projects with strong community and public sector support. Because HNEF relies to a large extent on neighborhood transformation for its returns, projects will typically be part of a larger neighborhood revitalization plan that has garnered substantial community input and support. HNEF capital is flexible in terms of project type (residential, commercial, industrial), though it is not designed to fund projects that are solely deed-restricted affordable housing. HNEF often invests in one phase of a multi-phase project that also includes a phase with low-income housing tax credit (LIHTC) financing. HNEF projects have total development costs of at least $5,000,000 and the Fund targets investments of $1,000,000 or more, though it has invested smaller amounts in two projects to date. HNEF equity can finance 5 percent to 25 percent of total development costs. This range reflects the differing ability of project sponsors to: (1) obtain public subsidies or philanthropic resources to fund the project; and/or (2) invest their own equity. It also reflects projects’ vary-
ing degrees of upside potential. HNEF expects project developers to provide at least 10 percent of the total equity required by the project. For non-profit sponsors that have projects with substantial public subsidy, the public funds secured by the project may be considered the sponsor’s equity contribution. Leverage is limited to no more than 75 percent.

Measuring Impact

In addition to financial underwriting, projects seeking an investment from HNEF are evaluated for impact using a weighted index of neighborhood and project-level metrics. This scoring system is managed by the Conservation Law Foundation and is intended to ensure a high level of consistency, transparency, and accountability to investors and other stakeholders.

Candidate projects for investment are evaluated based on a set of measures related to the project and its neighborhood context. The HealthScore for any individual project is a weighted average of the neighborhood score (representing 25 percent of the total) and the project score (representing 75 percent of the total). The neighborhood score measures the need and opportunity for healthy development, and the project score measures how well the project meets the need and captures the opportunity. The neighborhood
and project scores are both based on a weighted index of measures. The weighting of neighborhood criteria reflects the Fund’s commitment to investing in communities that have demonstrated both the potential and the desire for growth and where these investments will deliver the greatest benefits to health and well-being of the people who live there. The weighting of project criteria reflects the degree of impact on pathways that link TOD to health and health-related outcomes, such as obesity, stress, cardiovascular disease, respiratory disease, injuries, and premature mortality. The pathways, which were identified in a HNEF Health Impact Assessment commissioned by CLF, include walkability/active transport, safety from crime, economic opportunity, displacement/gentrification, affordable housing, green housing, social cohesion, green space, access to healthy food, safety from traffic, air quality, and environmental contamination. The project screening process will also generate a comprehensive set of baseline measures for projects that receive an HNEF investment. A subset of these measures will be monitored and reported at the midpoint and end of the investment period to provide a detailed view of project impact and neighborhood-scale change relative to the baseline.

HNEF Impact and Leverage

To date, six HNEF projects have closed with a total of $18.1 million of HNEF equity, with one additional project approved and in the closing process for an investment of $1.3 million in equity. This $19.4 million of HNEF equity has supported $150 million of total development costs. The projects are concentrated in Boston, with some projects in downtown areas and around commuter rail stops in smaller cities and towns in the metro area. The majority of projects are mixed-income, mixed-use development with retail and office uses on the lower floors and housing above. The first HNEF investment of $894,500 in the Chelsea Flats project was closed in December 2014. In 2016, two investments were closed: $5,000,000 in Braintree and $486,130 in Dorchester. Three additional projects in Roxbury, Dorchester, and Beverly totaling $11.7 million closed in 2017. In May 2018, a $1.3 million investment in the City of Haverhill was approved. Overall, the closed and approved projects are expected to create 552 new housing units, 25 percent of which are affordable to households at or below 80 percent Area Median Income (AMI). Starting market rate rents range from 74 percent to 120 percent of the 2017 AMI, affordable to working families. The projects will also create nearly 138,000 square feet of commercial space, including neighborhood serving retail, office, and social service space. In total, HNEF’s closed and approved projects are expected to create over 1,260 construction jobs and

150 permanent jobs in low- and moderate-income neighborhoods and catalyze significant additional public and private investment.

**Case Study: Bartlett Station**

For the past 30 years, the City of Boston, community-based organizations, and their partners have worked to revitalize Dudley Square. MHIC alone has invested $116 million from its various financing programs in 14 different projects. In 2007, the Dudley Square Vision Plan was unveiled to direct these efforts. The plan, a collaboration between the City and the Dudley Vision Advisory Task Force, charted a road map for the transformation of Dudley Square into a major commercial hub for the predominantly low-income neighborhoods of Roxbury, Dorchester, and Jamaica Plain. One of the plan’s linchpins, to create a “government services hub” in Dudley Square, was achieved after many years of delay with the opening of the 206,000 square foot Bolling Municipal Center to house 500 employees from the city’s school department and provide 20,000 square feet of retail space opposite the Dudley Square Station, a bus hub that includes access to the Silver Line, a regional Bus Rapid Transit service. Other important recent projects include the new Tropical Foods store a few blocks outside the square and the 135-room Melnea Marriot Residence Inn and the adjacent Melnea Residences, a 50-unit, mixed-income, mixed-use project also financed in part by HNEF.

Formerly an 8.76-acre Massachusetts Bay Transportation Authority (MBTA) bus yard, Bartlett Yard had been vacant since 1994. Nuestra Community, a local Community Development Corporation, has been working on its redevelopment since 2006. Nuestra participated in a years-long community process that shaped the multi-phase redevelopment plan. In particular, the community wanted market-rate and homeownership units, rather than solely LIHTC housing, in the first phases. When fully built out, the new Bartlett Station will be a transformative, mixed-use, mixed-income development bringing 323 homes and apartments to Dudley Square, 46,000 square feet of retail and commercial space, an estimated 100 new jobs, and a public plaza with a wide range of programming emphasizing the arts and fresh, local food. Nuestra acquired Bartlett Yard from the MBTA, remediated the site, cleared the site, and built the public infrastructure (sidewalks, lighting, street trees, benches, parking) with the help of MassDevelopment; the U.S. Environmental Protection Agency; a Massworks infrastructure grant from the Commonwealth; and grants and loans from Neighborworks, LISC, Boston Community Loan Fund, and others.

The first phase of the Bartlett Yards transformation, known as Bartlett Building B, involves the new construction of an 80,000 square foot 5-story, 60-unit building split into two condominiums:

- LIHTC condo: 32 units of affordable housing financed through the low-income housing tax credit program and a 15,500 square foot public plaza.
• NMTC condo: 28 units of market (22 units) and moderate (6 units) rate housing, 48 structured parking spaces, and 12,000 square feet of ground floor retail financed with new markets tax credits and HNEF equity.

HNEF provided $2.9 million of the total $17.05 million of project financing for the Bartlett Building B NMTC condo project, structured as: (1) a $2,040,000 leveraged loan to the NMTC investment fund; (2) a $495,000 loan to the Qualified Low-Income Community Business (QALICB, i.e., the single purpose entity formed to own the NMTC condo); and (3) $365,000
loan to Nuestra CDC, the sponsor and master tenant of the ground floor retail space. While the combination of NMTC, LIHTC, and HNEF certainly complicated the structure of the transaction, the flexibility of HNEF allowed MHIC to design a structure that could generate returns for the fund, while honoring the constraints on the project imposed by the federal tax credit programs. In the underwriting, MHIC acknowledged that this project was the most at risk of not delivering the target IRR of 10 percent to HNEF, however, given the “Very High Impact” rating the project received (see below) and the presence of stronger performing projects in the fund, MHIC was comfortable recommending the project for investment. The investment closed in March of 2017 and was 61.6 percent complete as of March 31, 2018, with substantial completion anticipated in November 2018.

As noted above, the Bartlett Station project received a Very High Impact rating with a HealthScore of 90.63—the highest scoring project in the portfolio to date. This high score is a result of many factors, including strong community support and growth potential; the opportunity to reduce health disparities and advance regional equity; and the provision of healthy, energy efficient, mixed-income housing, a full service grocery store, and a public plaza with arts and cultural programming on a formerly vacant and contaminated site close to public transit. All of these amenities and opportunities are important drivers of health and well-being for the people who live, work, and move through the neighborhood. Specific highlights from the HealthScore review and rating process include the following:

I. Neighborhood Criteria

Community Support and Growth Potential:

• The site went through an extensive design charrette process with community residents and leaders to develop a plan and a set of priorities for Bartlett Station. The project development process is being guided by the Roxbury Strategic Master Plan Oversight Committee and a sub-committee specifically formed for Bartlett Station called the Project Review Committee (PRC), also comprised of Roxbury residents and community leaders.

Opportunity to Reduce Health Disparities:

As documented in the HNEF Health Impact Assessment, many elements of TOD can positively influence health outcomes, including chronic disease, mental health, and safety from traffic. HNEF seeks to invest in communities with significant health disparities where impact will be the greatest.

• The 3-year age-adjusted rate for diabetes in-patient hospitalizations in 2010–2012 in zip code 02119 was 1466 per 100,000 population, 10.7 times the state rate.\textsuperscript{15}

• The 3-year age-adjusted rate for mental health Emergency Department visits in 2010–2012 in zip code 02119 was 40,235 per 100,000 population, 18.3 times the state rate.\textsuperscript{16}

**Transportation Access and Utilization:**

• Dudley Station (bus hub) is 0.3 miles from the site.

• Current mode share for local residents for transit is 40.3 percent, walking is 13.6 percent, and biking is 2.9 percent.\textsuperscript{17}

**Opportunity to Advance Regional Equity:**

• The poverty rate in Roxbury is 35.5 percent, 3.2 times the state rate.\textsuperscript{18}

• Unemployment in Roxbury is 13 percent, 3.6 times the state rate.\textsuperscript{19}

• Linguistic isolation in Roxbury is 12.3 percent, 2.9 times the state rate.\textsuperscript{20}

• Population of color in Roxbury is 90.8 percent, 3.5 times the statewide rate.\textsuperscript{21}

**II. Project Criteria**

**Walkability and Community Safety:**

• The project will produce an 8 percent increase in the State of Place index for the neighborhood and an 83 percent increase in the State of Place index for the project area.\textsuperscript{22} The greatest gains are in personal safety, aesthetics, density, pedestrian amenities, parks and public spaces, and proximity.

**Economic Opportunity and Transformative Impact:**

• The project is expected to create a total of 400 construction jobs across all phases. The general contractor will be required to meet the City of Boston Residents Jobs Policy of 25 percent minority, 10 percent female, and 50 percent Boston residents. At full build-out, the project is expected to create 100 new permanent jobs.

\textsuperscript{15} Center for Health Information Analysis (CHIA), Uniform Hospital Discharge Database System (UHDDS), Inpatient Hospitalization and Emergency Department Data, Calendar Year 2010–2012.

\textsuperscript{16} Id.

\textsuperscript{17} Metropolitan Area Planning Council, American Community Survey, 2009–2013.

\textsuperscript{18} Id.

\textsuperscript{19} Id.

\textsuperscript{20} Id.

\textsuperscript{21} Metropolitan Area Planning Council, 2010 U.S. Census.

\textsuperscript{22} For more information on the State of Place index and measurement tool, see www.stateofplace.com.
**Housing:**

- The project will provide a total of 323 residential units at full build-out. Phase 1 includes 32 LIHTC units, 6 units at 70 percent AMI and 22 market rate units. Starting rents for the market-rate units are 87 percent to 97 percent of 2016 AMI.

**Green Space:**

- The project will divide a large 8-acre superblock into several smaller blocks with new streets and buildings with a variety of scale, massing, and uses. The site also includes a new public plaza that is designed to create a focal point for the community with arts and cultural programming planned. These spaces will provide new opportunities for social interaction and physical activity and create a sense of place for both existing and new residents of the neighborhood.

**Healthy Food Access:**

- The new grocery store will create an 11 percent improvement in the Food Market Score for the 1-mile area around the project. This is the result of adding a new full-service grocery store in an area that currently has a high proportion of convenience stores and relatively fewer options for healthy, fresh, and affordable food.

**Transportation, Energy, and Environmental Performance:**

- Building energy models using ASHREA 90.1-2010 as the baseline show an energy use savings of greater than 40 percent and an energy cost savings of 22 percent.

**Conclusion**

Our journey to build and launch the Healthy Neighborhoods Equity Fund has yielded several important lessons. First, it is critically important to clearly define the problem you are trying to solve and the outcomes you are working to create at the beginning of the fund development process in order to attract impact investors and to build a strong project pipeline. Second, partnership is not only valuable but essential for data collection and analysis, as is research to support investment screening and impact measurement. Third, the use of a blended fund structure allows multiple investors with different risk/return requirements to co-invest, thereby creating a larger pool of capital and generating significant leverage on scarce public and philanthropic dollars. Finally, our most important lesson is that health is a critically important and compelling lens for strategic, community-driven, place-based investing. Aligning capital in support of healthy neighborhoods alongside supportive public policy and infrastructure investment is one of the most promising avenues for generating positive long-term economic, environmental, and community health impacts.
The Massachusetts PFS Story: Social Innovation Financing as a Catalyst for Change?

Joe Finn, Singumbe Muyeba, and Thomas Brigham

Introduction

If you ask Mike, Massachusetts’ Pay for Success (PFS) initiative was a complete success. For years Mike was living in shelters or on the street as he battled the twin disabilities of serious and persistent mental illness and substance use disorder. After years of bouncing around various homeless providers, one finally offered him something that would fix his homelessness: a place to live. Now, not only has Mike been able to maintain his sobriety, but he is also in a place to seek the regular treatment he requires to address those issues associated with his mental illness. “It’s definitely night and day in terms of having your own place,” Mike says.

Mike is in a good place because of PFS, but it is unlikely that he could understand how the convergence of resources came to be that were necessary to achieve his successful outcome. In fact, there were moments in the process of constructing the first PFS for the homeless in the country that we at the Massachusetts Housing and Shelter Alliance (MHSA), who won the right to negotiate a contract with the Commonwealth of Massachusetts, thought it might never come to be. Now, with over 700 persons housed to date, we have only just come to appreciate the utility of PFS, not only in providing private resources for innovative approaches for specific problems, but in its ability to realign and repurpose public resources to achieve public goals.

In this article, we examine our history and experience within the Massachusetts’ social innovation experiment, the PFS program for homeless persons. We will examine not only the programmatic results, demonstrating the successful reduction in utilization of emergency medical services, but we will also reflect on the systemic impact by the reshaping of the delivery of public services in the face of a seemingly intractable problem. Social finance was used not only to supplement scarce public resources but also to incentivize public private reform in addressing a specific problem. The “innovation” is not only a new financing model, but a new way of governmental agencies and nonprofit providers working together to

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provide outcome-based solutions consistent with public objectives. Finally, the article discusses lessons learned, briefly addresses arguments about the cost-benefit of PFS initiatives, and stresses that complex social problems demand collaborative outcome based initiatives founded on both fiscal and social metrics.

**Social Innovation Financing: Pay for Success**

What is PFS? It is a form of social innovation financing that refers to the concept of performance-based contracting between government and the organizations responsible for implementing a given intervention. Under this model, impact is measured rigorously and government makes “success payments” based on results, not activities. This focus on paying for positive social impact, rather than paying for services performed, helps ensure that incentives are properly aligned to achieve social impact and will provide a mechanism for government to ensure it pays only for what works.\(^1\) Social Impact Financing in Massachusetts is backed by the Commonwealth’s full faith and credit. It allows non-profit organizations to access the upfront working capital required to implement an intervention that is proven to save money over time but requires a significant start-up investment. This upfront capital investment can be provided by philanthropic sources as well as institutional investors, which typically receive a modest return on investment attained through success payments tied to the intervention’s performance. Others considering PFS have pointed to three main overall merits.\(^2\) First, PFS shifts the focus of government service provision from inputs to outputs. By focusing on payment for delivery of results, the focus of government funding becomes output-based. Secondly, PFS transfers risk for failure of programs from the government to private investors and providers. If the program does not produce results, government can refuse to pay the investors and service providers as agreed in the contract. Finally, PFS has potential to increase accountability and evidence-based decision-making in government.

**The Massachusetts Pay for Success program**

With our collaborative partners and investors, United Way of Massachusetts Bay and Merrimack Valley (UWMB), the Corporation for Supportive Housing, and our major investor, Santander Bank, N.A., we created the

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Massachusetts Alliance for Supportive Housing (MASH). With MASH, private capital was used to leverage the capacity of a robust network of housing and service providers to help people move from the streets and shelters into affordable housing with services to build stability and independence. The program aligned public resources to a proven solution in line with the Commonwealth’s plan to end homelessness. Supportive housing reduces inappropriate use of emergency rooms, inpatient hospitalization, and behavioral and correctional services. This saves public resources and creates a rare opportunity for return on investment tied to achieving the impact of transitioning the most vulnerable homeless into stable, supported housing.

However, the Massachusetts’ experiment would from the beginning present itself as a hybrid of the standard model of Pay for Success. Prior to the development of PFS in Massachusetts, when social investment financing and social impact bonds first hit Massachusetts, they did so with a wave of enthusiasm accompanied by little empirical evidence to indicate their effectiveness. Some nonprofits believed that their fundraising woes were over. From the beginning, MHSA had taken a “wait and see” approach that saw the possibility of engaging private capital in our work as an enticing possibility, but a complex one nonetheless, given the already entitled community we served within the framework of a host of public services.

Once we were aware of the Commonwealth’s intention to seek proposals for a PFS that focused on bringing to scale our model of low-threshold permanent housing for unaccompanied chronic/long-term homeless persons, we became more aggressively engaged in the new world of intermediaries, evaluators, and investment. Thanks to a great number of meetings, particularly with our consulting partner, Third Sector Capital,

3. In general, Social Innovation Financing (also known as SIF or “Pay for Success”) is a creative approach to program implementation that allows governments to pay for programs that demonstrate success. SIF contracts are targeted at innovative social service programs with financing arrangements where third party investors give service providers—typically non-profits—upfront funding to allow them to enter into pay for success contracts with the government. The government contracts with an intermediary that is responsible for operating the program. The intermediary then establishes partnerships with private sector investors. In these partnerships, investors provide a portion of the program funds up front to the intermediary. Then the Commonwealth will reimburse the intermediary if the program is successful, which in turn will repay the investors with a small return. See https://www.huduser.gov/portal/pdredge/pdr_edge_inpractice_030813.html for more details.

4. MHSA had been operating a program called Home & Healthy for Good (HHG) for a decade. See https://www.mhsa.net/HHG for more details on HHG.

5. Final Rule on Defining “Chronically Homeless,” Fed. Reg., Dec. 4, 2015, 75791–806. A chronically homeless individual is defined as an individual with a disability who lives in a place not meant for human habitation and has lived in such conditions continuously for at least 12 months, or has had four episodes in which he/she has spent at least seven nights living in such conditions in the last three years with a combined length of 12 months. PFS houses chronically homeless
what became apparent to us was that the network of service delivery that MHSA and its member agencies had formed was the entity best positioned and best qualified to amplify the scale of this innovative housing program. As PFS was first being presented, it was framed around the concept of “cost savings.” Metrics for success were determined by money saved. Although there was data to suggest housing chronic homeless persons saved money, particularly in Medicaid savings due to changes in utilization of care after housing, it was still a tough case to make that private investment could cover the full cost of housing and the requisite services and save money while providers would also continue to utilize a host of public resources available to this population. If a PFS was to be cost efficient, it had to be a leveraged model that took other sources into account. This being the case, collaboration of private and public resources was critical. Also, with great credit to the Commonwealth and Governor Deval Patrick, it was established that the primary metric for success would be a “social” one and not a “fiscal” one: the successful tenancies of homeless persons.6

The development of a PFS for unaccompanied homeless adults in Massachusetts fostered an opportunity for change. It brought various state departments and agencies around the same table to focus upon the problem of chronic homelessness and the best way to address it. Driven by the Secretariat of Administration and Finance, the immediate need for leveraging of resources also brought the Department of Housing and Community Development (DHCD), Mass Health, (Massachusetts Medicaid program), and Health and Human Services together to see how infusion of private dollars might best be utilized to effect an appropriate housing solution for a distinct population with a unique set of needs. The PFS dollars, inadequate in themselves to cover the cost of housing the homeless, resulted in the repurposing of public resources in order to leverage the necessary housing across the Commonwealth.7 The expansion of a Medicaid reimbursement program, Community Support Program for Persons Experiencing Chronic Homelessness (CSPECH) that MHSA had piloted with one managed care entity, the Massachusetts Behavioral Health Partnership (MBHP), was expanded to be covered by all of the managed care entities in Massachusetts. This alone leveraged $10 million dollars in supportive services.

or individuals who are the highest utilizers of emergency medical services, a most vulnerable sub-population among the homeless.


7. Repurposing took place in three ways. Medicaid dollars prior to the PFS were covered only by a single managed care entity. Under PFS, all the MCEs had to provide such a resource to tenants. DHCD shelter dollars were allowed to be converted into dollars to support permanent supportive housing. Massachusetts Rental Voucher Dollars were converted into a “Sponsor-based” type program in order to meet the unique needs of chronic homeless persons.
The infusion of Medicaid dollars to finance supportive services was the most significant infusion of public resources that drew housing providers to the PFS. It would not have happened without the opportunity the Pay for Success program provided.8 On top of this coveted service support, the Commonwealth, through DHCD, provided 145 rental vouchers that could be utilized to leverage other existing housing and service resources. Finally, participating agencies were also allowed to convert existing shelter resources toward permanent supportive housing. MASH worked closely with 20 supportive housing providers across the Commonwealth to implement the PFS. These providers brought some additional resources into the mix9 to accomplish our goal of housing some of the most challenging citizens. In the end, the overall deal resulted in $28.5 million dollars, targeting new permanent supportive housing opportunities for the poorest and most disabled homeless people in the Commonwealth. Most importantly, it created the structure necessary to administer a statewide housing program committed to the same objective outcomes of successful tenancy and funded the evaluative component to gauge the validity of the outcomes.

Additionally, MASH was required to engage with an independent evaluator, Root Cause, a specialist organization focused on planning, non-profit service delivery, and evaluation. The independent evaluator is tasked with assessing and reporting on the initiative’s performance outcomes. The evaluator’s role includes quarterly reviews of MASH’S Periodic Report, attendance as requested at quarterly oversight meetings, provider agency interviews, tenant unit visits, and the development of an annual report on performance outcomes.

**Program Performance**

The program performance model for the MASH PFS was rooted in the evidence-based practice of “Housing First.” The Commonwealth desired to develop a housing model, based on the low-threshold “Housing First” model first pioneered in Massachusetts by MHSA, which targeted those most likely to be “high utilizers” of costly emergency and acute medical services. Although the primary objective was to house homeless persons, the assumption was made that targeting a scarce resource to those most in need would result in greater savings and efficiencies. Such savings, if appropriately recaptured, could help to pay private investors.

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8. Our participation in PFS was conditioned upon the expansion of Medicaid. The PFS alone did not provide sufficient resources and services to house our population. The PFS became the structure to integrate CSPECH Medicaid dollars from a wider array of health plans, to a greater number of housing providers, and the resources to measure the implementation and the outcomes of such housing.

9. Additional resources included HUD McKinney lease up dollars, local vouchers from local housing authorities, converted DHCD resources, and other state based housing development resources.
To implement targeting, MHSA and Boston Health Care for the Homeless Program created a triage and assessment tool to assess participants’ health issues and current use of emergency services.\(^\text{10}\) The tool is used to compute a triage score, which ranks individuals based on their diagnoses to predict their frequency of utilization of emergency medical services. The score is made up of six domains: homelessness history, use of emergency services, physical health, mental health, substance use disorder (SUD), and dual diagnosis of mental health and SUD. The triage assessment assigns a score to each domain and a total score, that is, the sum of the component scores and dual diagnosis score. MHSA uses the total score to rank people based on their likelihood of being frequent users of emergency health services and returns the ranked list to providers. As housing units become available, providers use the list to determine to whom to provide housing. This ensures that housing has the greatest impact in terms of stabilization and use of services.

As an evidence-based practice, the “Housing First” model has a track record as a successful intervention. Studies examining the effects of “Housing First” on the cost of health and correctional services have been observed in recent years, although rudimentary forms of the intervention can be seen in scholarly studies on psychiatric health from as early as 1980.\(^\text{11}\) These early studies demonstrated that treating individuals with severe and persistent mental illnesses while they were based in their homes and communities had better health benefits. They reduced the number of hospitalizations and length of re-hospitalizations and had a modest cost benefit over inpatient services. Several studies that followed\(^\text{12}\)

\(^{10}\) See Mabli, James and Hande Inanc. 2017. *The Massachusetts Homeless Triage Assessment*. Cambridge, Massachusetts: Mathematica Policy Research; a report of a study by Mathematic Policy Research titled *The Massachusetts Homeless Triage Assessment*. MHSA contracted Mathematica to conduct a study as to whether the tool predicts those who will be high utilizers. The study found that the tool does indeed predict high utilizers.


were in agreement with the earlier findings. Burns and Santos\textsuperscript{13} further confirmed these positive findings. In 1992, Columbia University professor Sam Tsemberis consolidated these ideas in relation to homeless, mentally ill individuals and developed what is referred to as the “Housing First” model. After Tsemberis established his Pathways to Housing Inc., the term “Housing First” came into prominent use. At the turn of the century, evaluations of programs among non-profit organizations that address homelessness aimed to demonstrate effects of the model on retention and healthcare. From 1994 to 1998, Martinez and Burt\textsuperscript{14} evaluated the cost of supportive services for individuals with dual psychiatric and substance use disorders, demonstrating that support services led to a reduction in cost. Beginning in 1999, O’Connell and Swain\textsuperscript{15} followed up with a study of a group of 119 homeless people in Boston, whom they referred to as the “Rough Sleepers.” The study tracked the “Rough Sleepers” for five years and demonstrated a reduction in costs of healthcare after housing. From the start of the new millennium onwards, a plethora of program evaluation reports by nonprofits and research centers emerged\textsuperscript{16} (Culhane, 2002 in New York; Moore, 2006 in Portland, Oregon; Massachusetts Housing & Shelter Alliance, 2007 in Massachusetts; Mondello, 2007 in Maine; Linkins


et al., 2008 in California; Hirsch, 2008 in Rhode Island; Bamberger and Considine-Cortelyou, 2008 in San Francisco; and Nogaski et al., 2009 in Illinois). These evaluations all demonstrated reductions in the utilization of services and costs.

The Massachusetts Housing & Shelter Alliance (MHSA) was a leader in this movement in the Commonwealth of Massachusetts with its Home & Healthy for Good (HHG) program, which established the model foundation for PFS.

Like many of the studies discussed above, PFS uses program data. Data are collected during four types of assessments: Triage, Entry, Monthly follow-up, Quarterly follow-up and Exit. Outcome performance metrics include housing retention rate, hospitalization nights, medical respite, days in a detox facility, number of days in detention, emergency shelter, incarceration, and emergency room visits. The data are self-reported. At the triage assessment stage, providers administer the triage tool to assess potential clients for high utilization and housing. Providers then enter the data into Clienttrack, the PFS online database with real time updating capabilities. Once a client is housed, data is collected at housing entry. The data include demographics, homelessness history, income sources, health insurance, quality of life, disability, and health history and service usage six months before housing. Monthly follow up data is collected following housing. The data fields are the same ones collected at housing entry. Finally, after 12 monthly follow up interviews the quarterly follow up stage begins. Although the intervals between follow-up and quarterly follow-up interviews differ, the data fields are the same.

To analyze the data, we use survival analysis to compute housing retention17 and a pre-post study design—that is, compare utilization six months before and after program enrollment and the six months from the seventh to the twelfth month after enrollment—to measure impact. The pre-post part of our analysis consists of clients who have been in the program for at least six months—clients who have at least six follow up interviews. This is the main focus of the before and after analysis because it covers a significant portion of the total number of clients in the program. The Wilcoxon Signed-Rank test18 is employed to test for the significance of differences between use before and after housing entry.

17. Survival analysis is a statistical method also referred to as time to event analysis. It is used where the interest is in finding out how long it takes for an event to take place, and for predicting the likelihood that it will take place. See https://stats.idre.ucla.edu/stata/seminars/stata-survival/.

18. The Wilcoxon Signed-Rank test is a form of a dependent samples t-test used when data do not satisfy parametric assumptions (data are not normally distributed). In other words, it is a test employed when the data show concentration of a specific service-use among a few individuals while the majority use fewer services. We follow up this analysis with a robustness check by analyzing data only on clients who have been in the program for at least one year. See https://stats.idre.ucla.edu/
Since the commencement of the program in June 2015 through May 31, 2018, 710 clients were enrolled in the program. Of these, 571 had been in the program for at least six months and 409 for a year. The average age of all clients was 49 years, showing that the typical client is about to become an elder adult. Most clients were between the ages of 45 and 64 (466), indicating that most are older adults. Two thirds of the clients are male. Four-fifths identify as non-Hispanic. Two-thirds identify as white, a quarter as black or African American, and 5 percent as multi-racial.

**Retention**

At the two-year mark, the retention rate was 93 percent, above the 85 percent threshold. This means that 93 percent of the clients had each accumulated at least 365 days in the program, moved on to other permanent housing options, or died while living in program housing. There were altogether 181 exits, 117 of which were successful and 64 unsuccessful. Among the successful exits, 37 reunited with family, 31 moved on to other permanent housing, 34 died after housing, 11 were transferred to long term service and supports and 3 moved to a skilled nursing facility and 1 was hospitalized in a mental health institution. Among the unsuccessful exits, 19 were discharged due to criminal activities, 17 went to an unknown destinations, 14 returned to street or shelter homelessness, 10 were incarcerated. Three were dissatisfied with services and one was dissatisfied with housing.

**Utilization of Emergency Medical and Corrections Services**

Collectively, the 571 PFS clients who had been in the program for at least six months spent 44,244 nights in emergency shelters across the state in the six months before entry into PFS housing. In the six months after, the same individuals spent 300 nights. This translates to 43,944 fewer days than would have been spent in the shelter system. Accounting for the 300 nights are some clients who spend nights in shelter after being housed because they wish to move into a different unit from the unit that they have been allocated. They temporarily move into shelter before moving into their preferred apartment.

Clients spent a total of 2,667 hospitalization days prior to housing. This means that at the time they were chronically homeless, each client spent an average of six days. In the six months after entering permanent supportive housing, clients spent 937 days, or an average of two days each. Clients spent 1,730 fewer inpatient hospitalization days after housing entry. The fact that the evidence shows a reduction of this magnitude supports the theory that permanent supportive housing reduces utilization of inpa-
tient hospitalizations. This result is consistent with what other programs using the “Housing First” model find.

In the six months before housing entry, clients spent 744 days in substance use detox facilities. In the six months after, clients spent 247 days. The difference translates to 497 fewer days. This may mean that after housing entry, fewer chronically homeless individuals needed detox. We see that the number of days in detox does not reduce completely as expected, which we attribute to the fact that many clients are starting to access services and still dealing with the challenges of substance use and addiction.

Turning to medical respite days, clients utilized 1,053 days in the six months before housing entry. In the six months that they were in PFS housing, clients spent 80 days, a large difference of 973 fewer days. The National Health Care for the Homeless Council\(^\text{19}\) defines medical respite as “acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital.” This means that while under PFS, clients experienced fewer days requiring acute medical care. Clients had fewer days of exposure to the elements and health hazards that go with living on the streets and lacking shelter as a result of PFS housing.

An important and high cost service regularly utilized by chronically homeless individuals is the emergency department. While many clients visit emergency rooms for medical emergencies, many also use it as a place of shelter, especially when emergency shelters are full and during severe weather conditions. During the six months prior to entering PFS housing, clients made 983 visits to the emergency room. Six months after entering the program, the number of visits dropped to 461. In the time they were housed, clients made 522 fewer visits.

There were also reductions in the number of times that clients were transported to the hospital by ambulance. Clients used an ambulance 467 times in the six months prior to entry into PFS. In the six months after, they used the service 256 times, representing 211 fewer times. This means clients had fewer medical emergencies that required ambulance transportation in the six months they were in PFS.

Another public service that is over utilized by chronically homeless individuals is the corrections system. Altogether, clients spent 859 days incarcerated in the six months prior to entry into PFS. In the six months after, they spent 150 days. The difference was 709 days. Once clients were housed, they had fewer incidences and encounters with the corrections system as their primary need was met.

We tested the statistical significance of the differences in service usage before and after housing entry. There are statistically significant reduc-
tions in average utilization of health services but not in days incarcerated. All reductions are statistically significant at the one percent level, indicating that we can be 99 percent confident that the reduction is not by chance. The reduction in incarceration days is not statistically significant because the large number of days incarcerated is shared among a very small number of individuals (27). We cannot claim for sure that the significant differences are caused by entry into PFS because our analysis does not control for any factors. However, we are confident in advancing the hypothesis that entry into PFS housing plays an important role based on the theory and results of empirical studies that continue to provide evidence from across the nation.

As a robustness check, we tested for the significance of the difference in service usage between six months prior and seven to twelve months after housing for the 409 clients who have been in the program for at least twelve months. Results are consistent with the findings for the six-month analysis. The tests show that clients had significantly less utilization of medical services and shelter but no significant differences in incarceration. In addition, we examined whether there were improvements in satisfaction with average health scores reported by the clients. Individuals who had been in the program for at least six months reported that before entry into the program, they were dissatisfied with their health on average. Six months after, they reported being satisfied. Similarly, those who had been in the program for at least twelve months reported being dissatisfied on average prior to housing and reported being satisfied six to twelve months after.

Estimated Cost Savings to State Medicaid System

In terms of cost savings, comparison of collective service usage six months before and six months after housing indicates that savings were made on each service. Total use of services amounted to $11.8 million prior to housing entry and $3.7 million after, a difference of $8 million. Program costs over six months amounted to $4.8 million, bringing the savings to $3.2 million. This translates to about $6,000 per person for six months, a potential saving of $12,000 per person per year. In terms of the breakdown, emergency shelter use was reduced by about $1.4 million. The cost of hospitalization dropped by $5 million. The cost of detox use, medical respite, and emergency department visits was reduced by $300,000, $390,000, and $645,000, respectively. A saving of $230,000 was made based on reduced ambulance use.

Overall, the performance evaluation indicates that since the PFS program commenced, there have been significant reductions in the use of public services among clients after housing. The data shows prima facie evidence of an association between housing and utilization of services, allowing us to make the claim that PFS housing was a highly plausible determinant of the observed utilization outcomes. The design and evidence, however, is that of
an observational study using program data, which cannot provide the evidence that housing is the cause of these utilization outcomes.

There are some limitations with the overall design and data that the reader ought to be aware of. First, the evaluation uses an observational design and therefore does not control for any unobserved factors. Typical of program data, this data is self-reported, leaving it susceptible to recall bias. In the triage and assessment and housing entry stages, clients recollect events of the previous six months. During the monthly and quarterly follow up interviews, clients recall events of the previous month and three months respectively. Additionally, self-reported data can be susceptible to social desirability bias. For example, typically, homeless clients avoid the social stereotype that mental disability is socially undesirable, leading to underreporting. The results are interpreted and presented with these design and data limitations in mind.

Lessons Learned

PFS in Massachusetts has once again pointed to the value of permanent supportive housing based on a low-threshold model of service. However, we also believe that our experience of PFS has taught us some basic lessons about the relationship between nonprofit service providers and governmental funders:

PFS and Cost Savings

Are there greater cost savings to the public as a result of PFS? Long before MHSA was engaged in a PFS, we would argue that there is a tremendous cost associated with “doing nothing” in the face of any serious social problem. We think it has been well established that homelessness is costly to the state and federal government. Prolonged exposure to the elements is associated with ill health that is reflected in public expenditure on the “chronically homeless.” In a well-known article in *The New Yorker Magazine*, Malcolm Gladwell talked of “Million-Dollar Murray,” who had cost the state of Nevada up to a million dollars over the course of ten years in medical and corrections services because of his chronic homeless status. Study after study would demonstrate the incredible direct and indirect costs associated with chronic homelessness.

The question being posed as the PFS came into being has been: can housing impact those costs? PFS in Massachusetts provided the opportunity to bring a housing initiative to scale and a system in place to collect the necessary data to make answering such a question possible. Although fiscal savings is not the success metric, it is still one of the primary questions of concern to the governmental agencies as well as to providers of such housing. The data we are collecting can be later compared and ana-

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lyzed using other administrative data bases, such as actual Medicaid claims. Propensity scoring studies and other forms of alternative control could be constructed to test the effectiveness of such housing in reducing cost. The private investment of PFS dollars made such scale possible by incentivizing participation and supporting the necessary infrastructure to test outcomes. Although the initial investment of the Commonwealth of Massachusetts was so significant as to question the value of PFS investment as limiting the liability of risk, the Commonwealth felt it was leveraging private investment, in a time of scarcity, in order to build an experiment necessary to assess the value and importance of housing high utilizers of care.

An argument is made that a downside to PFS arrangements is that they have high transaction costs. This is a legitimate concern and if public entities are to adopt PFS as a financing service model, they will need to streamline the processes for procurement and contracting under such models. It should be noted that all public interactions with nonprofits have some type of “transaction” costs both on the procurement and particularly on the administrative side. There is, should be, some solace in the fact that at least with PFS there is far greater certainty that the public objectives are being met. If public entities were to shift suddenly toward more performance-based contracting apart from PFS as a financing tool, these too would likely come with significant transaction costs.

### Intermediaries Work

There are over 33,000 nonprofits in the Commonwealth of Massachusetts. Those responding to homelessness range from the small community-based organization that throws birthday parties for homeless children in shelters to mega-million dollar sophisticated human service agencies providing an extensive range of shelter, housing, and services. Many of these agencies are contracted by state government to address a wide array of homeless issues. Surprisingly, or maybe not, there is a deficit of structures in place to regulate, measure, or determine the effectiveness of any of these efforts. The intermediary represents a new tool for governmental agencies in effecting serious measurable social change as well as possible cost savings.

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21. With a grant from the Blue Cross Blue Shield of Massachusetts Foundation, MHSA is working with Commonwealth Medicine at the University of Massachusetts Medical School and Analysis Group to study the effect of “Housing First” on utilization and claims for emergency medical services. We will utilize propensity score analysis to show the linkage between “Housing First” and utilization and claims for emergency medical services.

PFS was a disruption to the status quo of public funding and nonprofit service delivery. One of its most positive outcomes was the creation of a mediating structure between the public agencies and community-based providers. This provided a framework where a public objective, “successful tenancies” could be accomplished, measured, and evaluated to assess if it indeed was achieving such an outcome. It moved private non-profits away from their past culture of describing “Outputs” to measuring “Outcomes” in a manner that could be independently evaluated and validated by a professional intermediary familiar with the challenges of its task.

While it seems apparent that intermediaries could be effectively utilized to address a wide array of social ills, we appreciate these could be threatening to existing groups of providers delivering critical resources and services. That is why it is critical that such agencies themselves consider the value of forming collaborative intermediaries and that governmental agencies make certain that those proposing such a role are able to demonstrate the experience, qualifications, and skills related to any issue before consecrating an organization for such a role. Simply the ability to raise money should not be the sole criteria for being an intermediary organization.

The Importance of Service Delivery Networks

Apart from housing over 700 people, our greatest satisfaction from PFS has been the formation, the operation, and the sustaining of a critical delivery of service system to both achieve and measure the impact of housing.

Homelessness is the result of total system failure. The mainstream systems of care have not been able to meet the needs of a significant number of persons. Those with serious and persistent mental illness, those with serious substance use disorder issues, and even those poor crippled for years by progressive and debilitating illness oftentimes find themselves shut out of more traditional care systems. As a result, they seek services in those areas that cost the most: emergency rooms, acute care settings, and mental health hospitals, all of which cost a great deal in Massachusetts.

PFS has demonstrated the incredible things that can happen when separate agencies are gathered together with a carefully defined mission and model. At MHSA, we have called this a fidelity-based model of contracting. All providers agree to an outcome-based model of service provision, a common set of outcomes to be measured, and a willingness to be open to evaluation and auditing to ensure the social objectives are being met.

These organizations, joined in a unified collaborative effort and coordinated venture, can together learn, improve, and modify approaches to the problem they address. One of the incredible experiences of the PFS in Massachusetts as noted by the providers has been the learning collaboratives that have been formed. Designed and operated with the assistance of CSH, these provide opportunities to gather to discuss experience, share best practices, and receive technical assistance related to “Housing First.” This is not limited to gatherings of providers but also includes webinars
and other on-line forms of assistance. This provides a sense of solidarity for those in the trenches. None of this would have happened without the resources of the PFS.

Public and Private Stakeholders Can Work Together

We have learned that complex social problems demand collaborative outcome-based initiatives founded on both fiscal and social metrics. It may seem a statement of the obvious, but the public and private sector should work together to solve the tough problems like homelessness, unemployment, or severe substance use disorder. Too often, however, we do not. The paradigm we too often choose on the private-sector side is institutional self-survival. We struggle to keep afloat in the midst of an ever declining availability of resources. And so, the allure of working together to come up with different solutions to perplexing problems is faint, if at all. Instead, single agencies advocate for funding existing services or systems as opposed to solutions.

Agencies need demonstration that this is a defeatist strategy. We are playing a dangerous zero-sum game to risk it all on self-preservation. This is particularly true as government is beginning to seek a return on investment to justify any increase in budgets. What made Massachusetts’ experience with PFS so unique was that it brought all the stakeholders around the same table to discuss how we could solve what to many seemed to be an intractable problem. This was not just the non-profit community, but public agencies as well that often approach the problem of homelessness from their very narrow and closed silo.

This spirit is alive and well with Oversight Meetings and Stakeholder sessions all negotiated within the contract. Both of these allow for intermediary, investors, and governing agencies to receive and study outcomes, understand the fiscal operation of the project, and raise any questions they may have. From MHSA’s view as advocates, it has become a great platform for us to promote better approaches to policy. Whether PFS is an effective financing tool or not, all participants have agreed that the operating structure in place could serve as a model for how publicly funded programs could better meet critical public needs.

Conclusion

The Commonwealth and MHSA’s Social Innovation Financing Pay for Success program has successfully met its targets for housing retention and demonstrated a reduction in utilization of medical services by clients as well as a cost-benefit. The program has reduced the number of nights spent in emergency shelters, inpatient hospitalizations, and days spent in detox during the first six months and one year of housing for chronically homeless and high utilizers of health services. It has also brought much needed services to clients who could not otherwise have accessed services. In terms of cost-benefit analysis, the program made cost savings after housing services were subtracted.
Aside from these incredible outcomes, it also foreshadows, if not a new way of financing, a new way for public entities to promote social change. The greatest achievement of our PFS is the new way it broke down siloes and brought multiple agencies together to work on what had previously been thought an intractable problem. Aside from adding additional financial resources, it became a way of re-directing existing resources to more effectively address the problem.

Our experiment in Massachusetts has represented a new way for public agencies and private non-profits to work in collaboration on a specific problem, utilize metrics to gauge our success, and engage private capital to leverage resources to scale for appropriate evaluation. For us at MHSA, all of this is great. But most important of all, over 700 people like Mike got a place to call home.

References


News outlets were full of reports of New York City Housing Authority’s (NYCHA) systemic failures at the end of 2017. When questioned whether people who live in public housing deserve the same standard of living as people in private housing, Mayor Bill de Blasio explained “[p]eople in public housing deserve the very best living standard we can give them with the money we have.”1 This statement both manages to acknowledge the dignity of the tenants and yet still excuses the city’s failure to provide healthy housing.

Dr. Ben Carson, who as Secretary of the U.S. Department of Housing and Urban Development (HUD) oversees public housing across the nation, has made public comments that fail to even recognize the dignity of public housing tenants. Dr. Carson states poverty is a “state of mind,”2 where his interest is to make sure tenants are not provided “a comfortable setting that would make somebody want to stay,”3 instead of instituting ambitious goals such as reducing child lead poisoning.4

Across the political spectrum our leaders and our funding demonstrate that the physical health of public housing tenants is not a priority. Every new initiative is a reaction to the latest crisis. NYCHA tenants are expected to be thankful and accept that the cost of lower rent is lower expectations for their safety. NYCHA’s lack of accountability is in stark contrast to the standard to which NYCHA residents are held. They “face life

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changing consequences for *de minimis* defaults” in following the agency’s regulations, but are forced to wait months or even years for basic repairs of questionable quality.

This essay will briefly examine the history of housing as instrumental to public health in New York City. Part II will describe the different regulatory arrangements that partition the rights and remedies of private and public housing tenants regarding the health and safety conditions of their housing. The separate and unequal protection of NYCHA tenants will be demonstrated in Part III, using lead, lack of heat and hot water, and mold as recent examples of regulatory failure. From these failures Part IV will articulate general principles of what has worked for private housing tenants and apply those lessons to improving the conditions of public housing.

**I. Brief History of Health and Housing in New York City**

Poor housing has long been understood to be a public health problem. Many of New York’s earliest and most important housing laws and judicial doctrines were publicly connected to promoting public health. These include constructive evictions, Tenement House Laws, criminal prosecution as an enforcement tool for repairs, the first zoning law in the

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7. Dyett v. Pendleton, 8 Cow. 727 (N.Y. 1826). See generally Max P. Rapacz, *Origin and Evolution of Constructive Eviction in the United States*, 1 DEPAUL L. REV. 69 (1951). “[C]onstructive eviction exists where, although there has been no physical expulsion or exclusion of the tenant, the landlord’s wrongful acts substantially and materially deprive the tenant of the beneficial use and enjoyment of the premises.” Barash v. Pennsylvania Terminal Real Estate Corp., 256 N.E.2d 707 (N.Y. 1970). This includes conditions that affect the health and safety of the tenant.

8. 1867 N.Y. Law 908. The first Tenement House Law was passed in response to a report by physicians who after examining the city’s tenements found that, “New York, by permitting such evils to continue, not only puts in jeopardy the prosperity of trade and the welfare of citizens, but also becomes guilty of a high crime against society at large.” CITIZENS’ ASSOCIATION OF NEW YORK, REPORT OF THE COUNCIL OF HYGIENE AND PUBLIC HEALTH OF THE CITIZENS’ ASS’N OF NEW YORK UPON THE SANITARY CONDITION OF THE CITY Ixi (1865). It was later updated to better achieve its goals. See 1879 N.Y. Law 504 and 1901 N.Y. Law 334.

9. 1915 N.Y. Law 531 ¶ 43(g). This permitted the state to seek criminal sanctions for owners who put tenants at risk.
United State, the Multiple Dwelling Law, and the creation of Housing Court.

An often ignored but critical question to ask when considering the evolution of housing law and public health is not merely whether low-income communities benefited from these regulations, but whether concern for their welfare was what actually led to their creation. Professor Peter Marcuse argues these changes “were not the beginnings of a benevolent concern for the housing of the poor; they were a continuation of the use of state power to prevent any disturbance—physical, social, or political—of the private conduct of economic affairs.” It is hard to ignore that many important moments in the development of tenants’ rights were connected to social movements causing unrest or dangers that reached beyond the borders of so-called slums.

Professor Marcuse’s explanation is especially relevant in considering the history of public housing. During the Great Depression, substantial attention was paid to the old tenements that were considered the source of all social ills. One *New York Times* article expressed it well: “[i]t is to the slum that the criminologist traces the bulk of crime. To the slum the social worker looks for delinquency; health agencies for much rickets, cardiac trouble, pernicious anemia; and to the schools in the slums for great mental deficiency.” Consistent with this line of argument, then Mayor-Elect LaGuardia advocated that public housing was “in competition not with real estate, but with disease and poverty.”

NYCHA was founded in 1934 with the goal of creating jobs and providing a safe alternative to the slums. NYCHA’s purpose is to provide “decent, affordable housing for low- and moderate-income New Yorkers.” This matches the federal purpose of remedying “the unsafe hous-

10. 1916 N.Y. Law 497 (The purpose as defined by ¶ 18 was “for the promotion of the public health, safety, comfort, convenience and general welfare.”).
12. “[T]he court may recommend or employ any remedy, program, procedure or sanction authorized by law for the enforcement of housing standards, if it believes they will be more effective to accomplish compliance or to protect and promote the public interest . . .” Civil Court Act § 110(c).
ing conditions and the acute shortage of decent and safe dwellings for low-income families.\textsuperscript{18} When one tenement owner challenged the eminent domain that condemned and would soon clear his buildings for future public housing, the New York Court of Appeals supported the public use by finding the evils of slums are “unquestioned and unquestionable” and that slums were “the breeding places of disease which take toll not only from denizens, but, by spread, from the inhabitants of the entire city and state.”\textsuperscript{19} From the start public health and public housing have been intertwined.

NYCHA at its inception was not “low-quality housing for lower-class people, but middle-class housing for working people.”\textsuperscript{20} It was from this era that NYCHA became considered “one of the finest housing authorities in the nation.”\textsuperscript{21} The population shifted over time from the submerged middle-class who was unemployed during the Depression to tenants entrenched in poverty.\textsuperscript{22} This change was spurred by “three decades of federally financed ‘white flight’ to the suburbs, steady disinvestment in public housing infrastructure, and segregationist housing practices such as redlining” wherein public housing became home to primarily low-income minorities.\textsuperscript{23} Exacerbating the transition was that private housing in New York City became drastically unaffordable,\textsuperscript{24} with the result that for many tenants NYCHA is housing of last resort.\textsuperscript{25}

II. Separate and Unequal Protection of Tenant’s Health

Currently, public housing in New York City is a city within a city. NYCHA is by far the largest landlord in the city, officially housing over 400,000 people or a population roughly the size of Miami, Florida.\textsuperscript{26} As

\textsuperscript{19} N.Y.C. Housing Auth. v. Muller, 270 N.Y. 333, 339 (N.Y. 1936).
\textsuperscript{21} Phillip Thompson, Public Housing in New York City in Housing and Community Development in New York City 139 (Michael H. Schill ed., 1999).
\textsuperscript{22} See generally Lawrence M. Friedman, Public Housing and the Poor: An Overview, 54 Calif. L. Rev. 642 (1966).
\textsuperscript{26} NYCHA 2017 FACT SHEET 1, supra note 17. Research by the N.Y.C. Department of Sanitation estimates the actual population is over a half million people. Joe Anuta, How Many People Live in the City’s Public Housing? The Answer is in the Trash, Crain’s N.Y. Bus., Oct. 29, 2015, http://www.crcainsnewyork.com/article/
this section will detail, public housing tenants are segregated into a different regulatory system than their neighbors in private housing.

A private housing tenant can call 311 and request an independent government inspector to investigate the conditions and issue fines to the property owner. If corrections are not made by certain deadlines, more fines will be incurred. The complaints and violations are public records so anyone can find them online. The violations are also used by government officials to shame the worst landlords or to allow the New York City Department of Housing Preservation and Development (HPD) to repair the conditions at the owner’s expense.

In contrast, NYCHA tenants call the internal NYCHA Customer Contact Center to make a complaint and receive a work ticket number. The inspectors who investigate are NYCHA employees and provide no penalty to those responsible for failing to repair. The records of complaints and violations are not publicly available. This means tenants and their advocates “are in the dark about its code violations.” There is very little incentive for NYCHA to act because there is generally no external pressure, such as an active regulator, or financial consequences, such as cumulative fines. If NYCHA were subject to the same penalties as private landlords, it would be at risk of substantial fines.


34. Id.


36. This is beginning to change. The greater publicity has led new actors outside of the city’s control to intervene as discussed in Part III.

The separate and unequal treatment stems from not only the procedures but also the laws. NYCHA is exempted from regulations such as lead poisoning and prevention regulations, boiler inspections, and certification for mold removal. It is no accident that the failures NYCHA is experiencing with lead, loss of heat and hot water, and mold (as discussed in Part III) are often the same issues NYCHA is shielded from by city and state legislators.

This practice of exemption also nearly applied to legal representation for tenants. The funding legal services providers receive to represent public housing tenants has been traditionally limited compared to protecting private housing tenants. New York City was the first jurisdiction in the United States to guarantee legal representation for low-income tenants. The purpose of this access to counsel (also called right to counsel though no right was created) was to reduce the justice gap where property owners almost always had an attorney and tenants mostly did not, putting tenants at a disadvantage in court. After the landmark passage of access to counsel, it took months of advocacy from elected officials and tenant advocates to overcome the concerns of the Mayor’s office to ensure that NYCHA tenants also receive an attorney at administrative hearings. Access to counsel at the administrative hearing stage allows attorneys to use their legal knowledge to articulate NYCHA tenant’s arguments and build better records for appeals of adverse decisions.

Housing Court is a court of limited jurisdiction. It has authority to hear NYCHA tenant cases on the merits when tenants sue for repairs or when NYCHA seeks to evict tenants for the nonpayment of rent. All other types of termination cases are decided on the merits in an administrative hearing in which a NYCHA-employed attorney prosecutes the case in front of a NYCHA-employed hearing officer. If a tenant loses at the administrative hearing the case is then brought to Housing Court so NYCHA can obtain the warrant of eviction to dispossess the tenant. Housing Court lacks the authority to review the decision of the administrative hearing. Tenants who want to appeal the merits of an adverse administrative decision are

38. N.Y.C., N.Y., ADMIN. CODE § 27-2056.
40. N.Y. LABOR LAW § 933(4) (McKinney 2018).
41. This statement is based upon the author’s personal experience and observations.
42. N.Y.C., N.Y., ADMIN. CODE § 26-1301 et seq.
43. La Mort, supra note 24, at 371.
44. Erin Durkin, Tenants Facing Eviction Will Get Lawyers Paid For By the City, N.Y. DAILY NEWS, July 20, 2017; Steve Wishnia, Tenants Are Finally Getting the Right to an Attorney in Housing Court, VILLAGE VOICE, July 21, 2017.
required to file an Article 78 action (where there is no right to counsel) within four months of the final determination to either a New York State Supreme or an Appellate Division Court.46 These courts give great deference to NYCHA decisions; as a government agency, it only has to show “a rational basis for the action in question” and that the decision was not arbitrary and capricious to defeat most challenges.47

These differences in laws and protections put public housing tenants at a disadvantage. These distinctions create an underclass of tenants who are primarily low-income people of color. These unjust distinctions between public and private tenants do nothing to protect the tenants, but only ease the administrative burdens of NYCHA. The length of time it took to ensure public housing tenants would not continue to suffer from the justice gap exemplifies how hard it is to maintain equality.

III. Public Health Crisis for NYCHA Tenants

The fact public housing has become so dilapidated compared to private housing “is ironic considering the original mission of the New York City Housing Authority.”48 There has been no shortage of recent dangerous conditions in NYCHA developments, such as playground equipment,49 broken lights,50 elevators,51 and smoke alarms.52 It has reached such critical levels that Governor Andrew Cuomo believes he can intervene because “the conditions of habitability at NYCHA-managed residential properties constitute a public nuisance affecting the security of life and health in the City of New York . . .”53 While Cuomo’s actions may be seen as a way to score political points against Mayor de Blasio,54 he

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46. N.Y. C.P.L.R. § 7801 et seq.
49. Sharon Otterman, Perils on Housing Authority Playgrounds Went Unreported, an Audit Finds, N.Y. TIMES, Apr. 5, 2018, at A22.
54. See e.g., Jeffery C. Mays, The Latest Mayor-Governor Spat Is Over Fixing Public Housing Boilers, N.Y. TIMES, Feb. 17, 2018, at A21; Amir Khafagy, Cuomo, Now an Advocate for Saving NYCHA, Oversaw Public-Housing Demolition as HUD Chief, CITY LIM-
would not have the political leverage to justify such drastic action on a
city agency if the conditions were not so dire.

NYCHA has made some progress in recent years but the failures have
been too large and the proposed solutions too small. The problems
NYCHA faces are decades in the making—neglect by federal authorities,
past mismanagement, and buildings that are only getting older as more
maintenance and modernization is deferred. The following case studies high-
light the structural deficiencies in NYCHA’s buildings and bureaucracy.

A. Lead

Lead is particularly dangerous to children because it has been docu-
mented to cause adverse cognitive, cardiovascular, immunological, and
endocrine effects. NYCHA is required by federal law to perform visual
assessments of approximately 55,000 apartments a year where lead-based
paint is possible. However, starting in August 2012 through 2016,
NYCHA ceased performing these inspections, despite certifying it did so
to HUD in 2013–16.

The Citywide Council of Presidents, a group of tenant leaders chosen by
residents, brought a lawsuit against NYCHA claiming “a pattern and prac-
tice of failing to protect” tenants. The tenants are empowered to go to the
court because NYCHA failed to perform a clear legal duty. In this case,
the judge found “[i]n a startling display of sophistry, NYCHA posits it
can be trusted to expeditiously complete the requisite inspections and re-
mediations. This rings hollow in light of NYCHA’s record of making
false statements about its compliance with its lead paint inspection require-
ments.” The judge ordered NYCHA to identify and inspect thousands of

55. Jarrett Murphy, How Bill de Blasio Bought NYCHA, CITY LIMITS, Apr. 30, 2018,
https://citylimits.org/2018/04/30/how-bill-de-blasio-bought-nycha/.
56. NEW YORK CITY HOUSING AUTHORITY, CAPITAL PLAN CALENDAR YEARS 2016–2020
5 (Dec. 23, 2015).
57. STRINGER, supra note 48, at 7–10.
58. ADVISORY COMMITTEE ON CHILDHOOD LEAD POISONING PREVENTION, CENTERS FOR
DISEASE CONTROL AND PREVENTION, LOW LEVEL LEAD EXPOSURE HARMS CHILDREN: A REN-
EWED CALL FOR PRIMARY PREVENTION ix (Jan. 4, 2012).
59. 24 C.F.R. § 35.1115.
60. MARK G. PETERS, NEW YORK CITY DEPARTMENT OF INVESTIGATIONS, INVESTIGATION
INTO FALSE CERTIFICATIONS OF NYCHA LEAD PAINT INSPECTIONS 2 (Nov. 2017).
61. Id. at 3–6.
62. City-Wide Council of Presidents v. NYCHA, 100283/18 Sup. Ct. N.Y. Cty.,
Verified Article 78 Petition 1 (Feb. 26, 2018).
63. N.Y. C.P.L.R. § 7803(1).
64. City-Wide Council of Presidents v. NYCHA, 100283/18 Sup. Ct. N.Y. Cty.,
Decision and Order 14 (Apr. 23, 2018).
apartments. While this is occurring, federal prosecutors are investigating the false certifications to HUD with the outcome of their investigation remaining uncertain.

B. No Heat and Hot Water

New York City has strict rules on heat: from October 1–May 31, landlords must provide enough heat to maintain 68 degrees Fahrenheit during the day and 55 degrees Fahrenheit at night. Exposure to cold indoor temperatures is more than unpleasant. Lack of heat can have serious consequences, such as an increased risk of cardiovascular disease for seniors, hypothermia, and weakened immunity to respiratory illness.

More than 80 percent of NYCHA residents lost their heat and hot water during the winter of 2017–18. This failure was partly due to colder than average weather, but it was also directly the result of an agency ill-equipped for winter. NYCHA still keeps its boiler records as handwritten documents, making analysis of the heating systems difficult. NYCHA has suffered a 36 percent reduction in the number of boiler maintenance workers over the last five years. This loss of workforce is especially challenging since 39.5 percent of their inspections of NYCHA housing boilers found defects, compared to 7.9 percent in buildings citywide. This result is not surprising because of the combination of a recordkeeping system preventing a meaningful review of the overall status of the heating system, fewer employees to inspect and repair the heating system, and the fact that the records that do exist demonstrate a high rate of defective equipment. The city’s response is a proposal to spend $82 million to install replacement boilers for 104 buildings over the next four years. While a positive step, NYCHA has previously stated the cost to replace the most

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65. Luis Ferré-Sadurní, Public Housing Must Be Tested For Lead Paint, Judge Orders, N.Y. TIMES, Apr. 18, 2018, at A17.
67. N.Y. Multiple Dwelling Law § 79.
70. Neuman, supra note 1.
71. Id.
critical boilers would cost $2 billion.  

Legal Aid has brought a lawsuit requesting a rent abatement on behalf of the 323,098 tenants who lost heat or hot water. NYCHA argues that “[e]very dollar spent on a rent abatement would be one less dollar for staff and repairs. . . .” NYCHA is absolutely right that lost funding hurts its organization, but it is misguided if it thinks the harm inflicted on tenants by its failures is of no consequence. The litigation continues, and there is no public interim plan in place that will protect tenants in the forthcoming winters while the four-year plan is implemented.

C. Mold

In 2006, the State of New York assembled a task force to evaluate the risk of mold to the health and safety of people in indoor environments. The task force found the “strongest evidence exists for associations between indoor mold exposures and upper and lower respiratory health effects such as nasal symptoms and asthma exacerbations.” This is especially important in public housing as researchers have found that children residing in NYCHA buildings have asthma at prevalence rates that are double that of their classmates who live in private housing.

In 2013, the National Resources Defense Council and the National Center for Law and Economic Justice brought a suit against the city for its failure to remedy mold in public housing apartments. The suit was quickly settled. Under the settlement, NYCHA agreed to repair simple mold cases within seven days and complex cases within 15 days with the goal of 95 percent of work orders meeting this timeline.

After this consent agreement, legal advocates had tenants claiming mold would persist for years and that repairs would consist of superficial treatment. The reported data validates the anecdotal reports given to legal advocates. NYCHA never came close to 95 percent of repairs within the given deadlines, and 34 percent of the mold recurred, indicating that

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75. Jeffery C. Mays, Legal Aid Sues Housing Authority After a Freezing Winter, N.Y. TIMES, Apr. 13, 2018, at A21.
76. Id.
77. NEW YORK STATE TOXIC MOLD TASK FORCE, FINAL REPORT TO THE GOVERNOR AND LEGISLATURE 38 (Dec. 2010).
78. Jennifer Northridge et al., The Role of Housing Type and Housing Quality in Urban Children with Asthma, 87 J. URB. HEALTH 211, 218 (2010).
the work being done was cosmetic instead of comprehensive. A special master was appointed by a federal judge after finding “Nycha’s justifications for its failure to comply are inadequate, and the attitude of Nycha officials appears to be one of indifference.” The judge concluded that this inaction “jeopardizes the health and public welfare of hundreds of thousands of New Yorkers.”

The special master met with NYCHA for two years, which is now rolling out the “Mold Busters” program in an effort to comply with the 2013 agreement. In March 2018, the New York Senate Independent Democratic Conference released a report based on a survey of NYCHA tenants. While not necessarily methodologically sound, it echoed previous reports that the majority of tenants with mold believe NYCHA “did nothing” to correct the problem. It remains to be seen whether the Mold Buster program will be effective, but the special master is in place to hold the agency accountable if its efforts are inadequate.

IV. Proposals for Protecting Public Housing Tenants’ Health

The challenges facing NYCHA go beyond the current administration. There will be those who will call for neoliberal solutions claiming only market forces can solve public housing’s problems. I disagree. NYCHA is a public good, not a commodity. Neoliberalism has led to the slow strangulation through defunding that has put public housing in danger. Despite some recent improvements, the management of NYCHA has done a disservice to its tenants and the status quo is simply not acceptable. When people are put in danger, they need more than apologies. The following proposals articulate guiding principles that have worked for private housing and could address the weaknesses of the current practices in public housing.

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85. STRINGER, supra note 48, at 7–10.
A. Funding

NYCHA’s average unit is 58 years old and 84 percent of its housing was built before 1970.\(^{87}\) Every five years, HUD requires public housing authorities to assess their capital assets. NYCHA’s last assessment was made in 2015 when it estimated it needed $16.5 billion over five years to bring up its properties to a state of good repair.\(^{88}\) As the buildings grow older, the amount of federal assistance has declined. From 2001 to 2015, the federal capital grants have declined by 27 percent.\(^{89}\) During their administrations, former Mayor Michael Bloomberg and former New York Governor George Pataki also terminated funding for NYCHA that was never fully restored.\(^{90}\) The challenges facing NYCHA are immense. Any solution to undo the damage wrought from decades of disinvestment is going to be costly. Federal, state, and city financing must be made available in a way that does not cause displacement or permanently foreclose opportunities for future affordable housing. Better management can lead to greater savings but only a large infusion of funds now and stable financing in the future will resolve the public health crisis.

B. Transparency

Tenants should not be left in the dark about code violations. Complaints and violations should be publicly available. With greater transparency NYCHA would be able to improve itself by using the information to evaluate its performance. Greater exposure of violations would also create accountability because problems would be visible for the public to see and respond to. Tenant leaders would be able to recognize patterns and attorneys under access to counsel could substantiate anecdotal evidence to enforce tenants’ rights.

Under the existing HPD model, tenants in private housing can call 311 to report problems in their units. There is no reason why 311 cannot absorb the calls from NYCHA tenants and make the appropriate referrals. Mayor de Blasio even identified NYCHA’s Customer Call Center as a redundant service in NYCHA’s ten-year plan.\(^{91}\) This is not to say that the HPD model is perfect,\(^{92}\) but it is a much more transparent system. If NYCHA is convinced that its decentralized model will be more efficient, it should still use 311 as the gateway and publicize the results in exactly

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88. Capital Plan Calendar, supra note 56, at 5.
89. Id.
91. New York City Housing Authority, Next Generation NYCHA 59 (May 2015).
the same manner as HPD. If poor conditions continue to linger, then HPD should intervene with a commensurate funding increase. Advocates and tenants should not have to depend on litigation and City Council intervention to access such basic information.

C. Accountability

This is a strange time for NYCHA. Many of the problems it faces are in part due to the lack of accountability and foresight by its leadership. At the same time, it now has a pack of watchdogs: a special master for mold, the New York City Department of Investigations, state and federal judges, U.S. Attorney’s Office of the Southern District of New York, HUD, Governor Cuomo, and potentially an independent federal monitor may all soon oversee NYCHA.93 I think this is too many, but NYCHA has only itself to blame. In order for this congregation of regulators to work, there would need to be coordination, cooperation, and communication among the various parties. I do not believe such collaboration is possible with the full group above: it will more likely lead to inefficiency and become an arena of political infighting.94

Accountability means that there needs to be communication and consequences for failures. While the Baez case concerning mold has been excruciatingly slow, it can serve as a model of respecting the breadth of the challenges facing NYCHA without absolving it of protecting tenants’ health. An independent watchdog that could serve as a direct link between tenants and their advocates would be extremely useful for cases where NYCHA is not fulfilling its obligations. Either the judiciary or the executive branch could make such an appointment. To avoid regulatory capture, this monitor would need to be independent from those using public housing for political purposes and from NYCHA. Most importantly, the monitor must work with the tenants because no program will succeed without the cooperation and support of the tenant community.

The monitor must also be able to provide remedies and assess penalties in response to failures. Those harmed by the deteriorating conditions have the right to be heard and, where appropriate, compensated or provided voluntary alternative housing. These remedies should include both recognizing the right of tenants to safe housing and penalizing NYCHA when it puts people at risk.

The judiciary is already developing creative solutions to incentivize NYCHA to better protect its tenants. Recent cases provide a good example. Typically when the court orders HPD to inspect an apartment, any violation of the Housing Maintenance Code that results in a fine is payable to HPD. If this remedy were applied in the public housing context, it

94. Ferré-Sadurní & Mays, supra note 90.
would be ineffective because money would merely be transferred between city agencies. However, pursuant to Civil Court Act § 110(c), Housing Court can instead order the penalty be paid to the tenant in the form of a rent abatement\(^\text{95}\) or provide a \textit{de facto} abatement through contempt fines for NYCHA’s failure to make court-ordered repairs.\(^\text{96}\) NYCHA rightfully argues that every dollar paid as a penalty is a dollar the agency cannot spend on repairs but this truth should not undermine the tenant’s right to be recognized and compensated for substandard housing. Penalties are necessary; otherwise the authority can continue ignoring health and safety without repercussions.

D. Equality

A tenant is a tenant regardless of whether she lives in public or private housing. There are too many legal exceptions for NYCHA that do not benefit the public housing residents. Elected officials should examine all exceptions and eliminate the ones that do not protect the tenants or for which NYCHA does not have a legitimate justification. The desire to avoid administrative burdens or have greater control should not be considered a sufficient reason. Litigation has been one of the few successful tools tenants have to protect themselves and their families from dangerous conditions. While litigation can be inefficient, we should ensure it remains an option for public housing tenants to protect themselves. Therefore, in addition to repealing unjustified exemptions, funding restrictions on legal services that prevent attorneys from representing NYCHA tenants or bring lawsuits against the city in an effort to enforce their rights should be removed.

Conclusion

It is no accident that separate and unequal treatment under the law has led to separate and unequal outcomes. Public housing is too important to let the buildings crumble to dust. Our neighbors in NYCHA deserve to be treated with the same dignity and provided the same protections as any other New Yorker. This disparate treatment puts people’s lives in danger and has no justification beyond the acceptance that federal financial assistance for public housing will continue to be inadequate. We are legally and morally obligated to do better.

This essay’s proposals recognize and build on what works without abandoning public housing to profiteering or obsolescence. The amount of media attention paid to this issue is a source of hope, but we need more than tragic stories and outrage. If Professor Marcuse is correct that


benevolence is not enough, then what more must fail before action is taken? We need systemic change so NYCHA tenants will be empowered to advocate for themselves before systems collapse. This will allow for proactive investment into the infrastructure and personnel of NYCHA, which will surely be cheaper than reacting to cascading crises and certainly better than waiting for unrest or permanent harm to force the issue. These suggestions will not be easy to implement, but increasing funding, transparency, accountability, and equality will make it possible for New York City to uphold its duty of providing safe housing to the hundreds of thousands of New Yorkers who call NYCHA home.
Leveraging State and Local Antidiscrimination Laws to Prohibit Discrimination Against Recipients of Federal Rental Assistance

Derek Waller

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Derek Waller (walle218@umn.edu) expects to receive his J.D. from the University of Minnesota Law School in May 2019. Special thanks to Heidi Crees for sharing her insights about the Section 8 voucher process from the perspective of voucher holders and Professor Myron Orfield for his guidance as I developed this article. I would also like to thank the ABA Forum on Affordable Housing & Community Development Law for providing an opportunity to participate in this student writing competition and the staff of the ABA Journal of Affordable Housing & Community Development Law for their editing contributions. Finally, thanks to Benjamin Olsen for his support as I wrote this article and for his help editing an early draft.
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Introduction

When Lysette Johnson received her Section 8 housing voucher, she thought that she finally had an opportunity to turn her life around. Ms. Johnson had struggled with mental illness and spent several years in and out of treatment programs. After successfully completing a program, she was ready to live independently. Obtaining housing was her first priority because it was a prerequisite for her to find stable work and to spend time with her children. But she could not afford stable housing immediately, so she applied to the Section 8 voucher program through

1. Lysette Johnson is a pseudonym for a Section 8 voucher recipient in Minnesota. I learned about Ms. Johnson’s story from her case manager, Heidi Crees. Ms. Crees works with clients with mental health diagnoses in Hennepin County, Minnesota. She helps clients transition to stable housing and has assisted many clients with Section 8 voucher applications. Telephone Interview with Heidi Crees, MSW, LGSW, Targeted Case Manager, Touchstone Mental Health (Dec. 12, 2017).
her Housing and Redevelopment Authority (HRA). She had spent years on the waitlist but was finally lucky enough to receive a voucher. However, she soon found that few landlords would accept her voucher. Vouchers must be used soon after being awarded, so she needed to request time extensions from the HRA to keep her voucher during her housing search. While trying to find a landlord who would accept vouchers, she received temporary housing through a county social service program, lived with friends, and was homeless. During this time, she was also separated from her children because she could not provide them with a home. After over a year of searching, she finally found a landlord willing to accept her voucher in Anoka County, Minnesota. But her family, health care providers, and social services were located in Hennepin County, Minnesota. Faced with the choice of remaining homeless or losing her county-based services, she chose to lose the services and take the apartment in Anoka County. The services she received had been critical to her transition to independent living, but she decided that it was more important to have stable housing.

Of the lucky few who receive a Section 8 voucher, many have stories like Ms. Johnson’s. Section 8 vouchers are in high demand, but are of little use to renters when landlords refuse to accept them. In 2015, for example, Ms. Johnson competed with over 36,000 people for 2,000 available spots on her HRA’s waitlist. While some landlords prefer tenants with vouchers because it provides a steady revenue stream, many do not accept vouchers. Landlords often cite burdensome administrative requirements and bad tenants as reasons to refuse vouchers. These arguments often

2. HRAs administer federal Section 8 housing vouchers, see infra Part I.A. Ms. Johnson applied through Minnesota’s Metropolitan Council, which operates the HRA for Anoka, Carver, Hennepin, and Ramsey Counties, excluding the areas of Hennepin and Ramsey Counties controlled by another housing authority. See Metro HRA Rental Assistance, METROPOLITAN COUNCIL, https://metrocouncil.org/Housing/Services/Metro-HRA-Rental-Assistance.aspx (last visited Mar. 3, 2018).

3. Telephone Interview with Heidi Crees, MSW, LGSW, Targeted Case Manager, Touchstone Mental Health (Dec. 12, 2017).

4. Id.

5. Id.

6. Id.


9. See Armen H. Merjian, Attempted Nullification: The Administrative Burden Defense in Source of Income Discrimination Cases, 22 Geo. J. Poverty L. & Pol’y 211, 212 (2012) (noting that landlords almost invariably argue that accepting vouchers imposes burdens such as form-leases, inspection requirements, and payment delays);
have little or no basis in evidence. The Section 8 program offers extensive landlord protections so that “Section 8 tenants cost landlords no more money than unsubsidized tenants.” Further, Section 8 tenants provide landlords with a steady and guaranteed income.

Landlord policies that exclude Section 8 tenants are one reason that Ms. Johnson and other low-income people bear the brunt of the nation’s affordable housing crisis. A lack of affordable housing plagues every county in the United States, but is especially severe in urban counties. Minnesota is no exception. With a highly competitive market and a vacancy rate of two-and-a-half percent, property managers in the Twin Cities can discriminate against low-income renters and still rent every unit. Landlords commonly engage in practices that disadvantage low-income


10. Many states and cities have heard landlords argue that the Section 8 program is too administratively burdensome. Notably, however, all have rejected these arguments and chosen not to allow landlords to opt out of public housing programs strictly for administrative burden reasons. See Merijan, supra note 9, at 246.


12. See Kim Johnson-Spratt, Note, Housing Discrimination and Source of Income: A Tenant’s Losing Battle, 32 IND. L. REV. 457, 460 (1999) (“When a landlord enters a lease with a tenant that receives Section 8 assistance . . . the tenant has a reliable and steady source of income to fund rent payments. One would think that a landlord would want a steady flow of cash rather than an unpredictable one in which tenants might default on their rent, especially if no formal lease agreement exists.”).


people by imposing high minimum income requirements, dramatically increasing rent for current tenants, running strict credit checks, and refusing to accept housing vouchers. And those low-income people lucky enough to receive rental assistance through the Section 8 voucher program face discrimination when searching for housing.

Limiting discrimination by landlords against voucher holders will give renters more housing options without adding costs for taxpayers or landlords. Ending discrimination in the voucher system will improve voucher utilization rates and can help decrease segregation. States with antidiscrimination laws that prevent landlords from discriminating against voucher holders had voucher utilization rates around six percent higher than states without these laws. Additionally, these laws help voucher holders access higher opportunity neighborhoods. A study commissioned by HUD to assess the impact of antidiscrimination laws on voucher holders found that these laws correlate with accessing higher opportunity neighborhoods.

This Article argues that state and local housing antidiscrimination laws should be used to prohibit landlords from categorically excluding Section 8 recipients. Using Minnesota’s antidiscrimination law as an example, this Article explains why these laws prohibit landlords from turning away


21. See FREEMAN, supra note 8, at vii.

22. See id. at 22.

23. Although the study cautioned that this correlation is modest, any legal changes that could improve voucher holders’ access to opportunity areas in the Twin Cities are worth pursuing. See id.
Section 8 voucher recipients. For affordable housing advocates seeking to defend similar antidiscrimination laws in other states, Minnesota’s legal history on this issue provides a useful example. Part I describes the federal laws governing the housing choice voucher program and state law approaches to voucher-based discrimination. It catalogs state antidiscrimination laws in all states with source of income laws and explains their similarities and differences. Part II focuses on laws used to combat voucher-based discrimination in Minnesota. By considering the Minnesota Court of Appeals decision that permitted landlords to refuse voucher-recipients, this Part argues that permitting such discrimination contradicts the plain meaning of Minnesota’s source of income law. In response to the statewide decision that permits voucher-based discrimination, Minneapolis has adopted its own ordinance prohibiting discrimination against voucher holders. Part II concludes by arguing that Minneapolis’s ordinance is permissible. Part III explains how the lessons learned from these legal battles in Minnesota are applicable to other states.

I. Federal and State Voucher Laws

A. Federal Law and Housing Vouchers

Congress enacted the Section 8 program through the Housing and Community Redevelopment Act of 1974 to help low-income people obtain housing. The program funds both project-based housing, which subsidizes low-income housing in specific buildings, and voucher-based housing, which awards funds to low-income people who can then rent any unit that meets the program’s criteria. The Housing Choice Voucher (HCV) program subsidizes the cost of rent by paying money directly to the program participant’s landlord. To qualify for a voucher, the recipient’s income must not exceed fifty percent of the area median income. By law, a housing authority must provide seventy-five percent of its vouchers to applicants whose income is below thirty percent of the area median income. The voucher only covers a portion of the recipient’s rent. The rest is paid by the recipient. Local housing authorities admin-

28. Id.
29. Id.
30. Id.
31. The exact amount varies between housing authorities. Id. For example, in Minnesota, renters receiving HCVs must pay between thirty percent and forty per-
ister the Section 8 program as either a public housing authority (PHA) or a housing and redevelopment authority (HRA).\(^\text{32}\)

Federal law does not require landlords to participate in the Section 8 program. The statute, which provides that “the selection of tenants shall be the function of the [property] owner,” suggests that landlords may choose not to participate in the program.\(^\text{33}\) Every federal court that has considered the issue has found that federal law does not require universal participation in the HCV program.\(^\text{34}\) HUD regulations support this view.\(^\text{35}\) However, HUD regulations specifically note that they do not pre-empt “[s]tate and local laws that prohibit discrimination against a Section 8 voucher holder because of status as a Section 8 voucher holder.”\(^\text{36}\) Federal courts have generally supported this position, noting that federal law does not prohibit states from requiring participation in Section 8.\(^\text{37}\)

\(^{32}\) See Housing Choice Vouchers Fact Sheet, supra note 27.


\(^{34}\) See, e.g., Salute v. Stratford Greens Garden Apartments, 136 F.3d 293, 296 (2d Cir. 1998) (“Participation by landlords is voluntary; they lawfully may refuse to accept applications from Section 8 beneficiaries.”); Knapp v. Eagle Prop. Mgmt. Corp., 54 F.3d 1272, 1282 (7th Cir. 1995) (“Participation by landlords is voluntary; they lawfully may refuse to accept applications from Section 8 beneficiaries.”). But cf. Graoch Assocs. v. Louisville/Jefferson Cty. Metro Human Relations Comm’n, 508 F.3d 366, 376 (6th Cir. 2007) (finding that withdrawal from the Section program could, but would not necessarily, subject a landlord to disparate impact liability under the Fair Housing Act).

\(^{35}\) See 24 C.F.R. § 302(b) (2017) (noting that an owner must be willing to lease a unit under the Section 8 program for a voucher recipient to use the voucher there); see also id. § 482.452(b)(1) (granting landlords the discretion to determine whether a voucher holder is a suitable tenant).


\(^{37}\) See, e.g., Bourbeau v. Jonathan Woodner Co., 549 F. Supp. 2d 78, 88 (D.D.C. 2008) (holding that because a local law may offer greater protections than a federal law, federal law did not preempt Washington D.C.’s Human Rights Act, which requires landlords not to discriminate because of a tenant’s Section 8 voucher status); see also Montgomery Cty. v. Glenmont Hills Assocs. Privacy World at Glenmont Metro Centre, 936 A.2d 325, 336 (Md. 2007); Comm’n on Human Rights & Opportunities v. Sullivan Assocs., 739 A.2d 238, 243 (Conn. 1999) (holding that federal law does not preempt a state law requiring landlords to accept Section 8 vouchers). But see Knapp, 54 F.3d at 1282 (“It seems questionable, however, to allow a state to make a voluntary federal program mandatory.”); but cf. Mother Zion Tenant Ass’n v. Donovan, 865 N.Y.S.2d 64, 65–67 (N.Y. Sup. Ct. 2008) (holding that because Section 8 is voluntary, federal law preempted a New York City ordinance requiring owners who participated in Section 8 to provide a one-year notice before selling a building).
B. State Antidiscrimination Laws and Voucher-Based Discrimination

Although federal law does not prohibit discrimination against housing voucher recipients, several states have laws that prohibit discrimination on the basis of an individual’s source of income or status with regard to public assistance. Some states use these antidiscrimination statutes to prevent landlords from evicting tenants or turning away otherwise eligible renters because they receive Section 8 vouchers. However, courts in several states have created exceptions from these laws for housing vouchers, reasoning that because the program is voluntary, landlords should not be compelled to participate. In other states, legislatures have created express exemptions for housing vouchers in their antidiscrimination laws. This Section surveys these state-level approaches in all states that have source of income laws.

1. States with Judicially Created Housing Voucher Exemptions from Source of Income Laws

a. Minnesota

The Minnesota Human Rights Acts (MHRA) prohibits any person “having the right to sell, rent, or lease any real property” from refusing to “sell, rent, or lease” the property to any person because of that person’s “status with regard to public assistance.” The statute defines “status with regard to public assistance” as “the condition of being a recipient of federal, state, or local assistance, including medical assistance, or of being a tenant receiving federal, state, or local subsidies, including rental assistance or rent supplements.” The statute also contains a few exemptions related to housing, including an exemption from the statute for owners or occupiers of single-family residences. The legislature clarified the overall purpose of the statute, declaring that “[i]t is the public policy of this state to secure for persons in this state, freedom from discrimination . . . in housing and real property because of . . . status with regard to public assistance.”

38. For a recently updated and comprehensive list of state and local laws that bar source of income discrimination, see LaKeeshia Fox, Poverty & Race Research Action Council, Appendix B, Expanding Choice: Practical Strategies for Building a Successful Housing Mobility Program (2018), http://www.prrac.org/pdf/AppendixB.pdf; see also FREEMAN, supra note 8, at 29–30 (listing states and jurisdictions with source of income laws).

40. Id. § 363A.09, subdiv. 1.
41. Id. § 363A.03, subdiv. 47.
42. See id. § 363A.21, subdiv. 1(2). This exemption is analogous to the “Mrs. Murphy” exemption in the federal Fair Housing Act. See 42 U.S.C. § 2000a(b)(1) (2012); see also James D. Walsh, Note, Reaching Mrs. Murphy: A Call for Repeal of the Mrs. Murphy Exemption to the Fair Housing Act, 34 HARV. C.R. C.L. L. REV. 605, 605 n.3 (1999) (explaining the origins of the Mrs. Murphy exemption).
43. MINN. STAT. § 363A.02, subdiv. 1 (2017).
Further, “[t]he opportunity to obtain . . . housing . . . without such discrimination as is prohibited by this chapter is hereby recognized as and declared to be a civil right.” 44 To support this overall purpose, the statute must “be construed liberally.” 45

Despite the statutory language that suggests the MHRA prohibits discrimination against voucher recipients, the Minnesota Court of Appeals held that the MHRA does not require landlords to accept Section 8 vouchers. 46 In Edwards v. Hopkins Plaza Ltd. Partnership, the court held that because the Section 8 program is voluntary, landlords cannot be held liable under the MHRA for ending participation in the Section 8 housing program. 47 The plaintiff, Jimmie Edwards, rented an apartment from Hopkins Plaza for five years on a renewable annual lease. 48 During that time, the housing authority paid about a third of Edwards’s total rent cost to Hopkins Plaza. 49 Hopkins Plaza qualified for a lower property tax assessment because it participated in the Section 8 program. 50 However, in 2004, the state legislature repealed the property tax benefits. 51 As a result, Hopkins Plaza discontinued its participation in the Section 8 program and, in 2006, it refused to renew Edwards’s lease. 52

The Court of Appeals reached its holding in Edwards by focusing on the language of relevant Minnesota statutes, non-binding administrative decisions, and the purpose of the federal Section 8 program. The court found that the legislature did not require property owners to participate in Section 8 because another statutory provision required project-based rental housing owners to give a one-year notice of their intent to terminate a Section 8 contract. 53 Further, “[i]f participation in Section 8 programs were not voluntary, there would have been no reason for the state to provide incentives for property owner participation.” 54 Although the court recognized that it was not bound by state agency decisions when interpreting state statutes, it agreed with an administrative decision by the state’s Department of Human Rights (the agency charged with enforcing the

44. Id. § 363A.02, subdiv. 2.
45. Id. § 363A.04.
47. Id. at 177.
48. Id. at 174.
49. Id.
50. Id.
51. Id.
52. Id.
53. Id. at 176.
54. Id.
MHRA) and a statement on the Metropolitan Council’s website. According to the court, both determined that participation in the Section 8 program was not mandatory. Finally, the court cited federal regulations that suggest the program is voluntary, notwithstanding the provision that allows states to prohibit discrimination against voucher holders. By relying on non-binding authority, the Edwards court excluded voucher-based discrimination from the MHRA.

b. Wisconsin

Wisconsin’s Open Housing law prohibits landlord discrimination against tenants based on “lawful source of income.” State regulations define “lawful source of income” to include “public assistance” and “any negotiable draft, coupon or voucher representing monetary value such as food stamps.” Despite this clear statutory and regulatory language, the Seventh Circuit has carved out an exception from this statute for housing voucher-based discrimination. It reasoned that vouchers, unlike food stamps, “do not have a monetary value independent of the voucher holder and the apartment sought.” This analysis disregarded the regulatory definition that simply describes “public assistance” as a lawful source of income. It noted that “it seems questionable . . . to allow a state to make a voluntary federal program mandatory.” It further opined that even if it

55. See Report and Order of the Hearing Examiner, State by Wilson v. High View N. Apartments, State of Minn. Office of Hearing Exam’rs for Dep’t of Human Rights, File No. H0420 (May 2, 1979) (available in Minnesota Historical Society archives and on file with author). In State by Wilson, the hearing officer found that because the plaintiff was not yet receiving subsidies when she filed the lawsuit, she did not meet the definition of “status with regard to public assistance” in the MHRA. In this case, the plaintiff’s landlord increased the rent, which the plaintiff could not afford without housing subsidies. She requested that the landlord approve her voucher application so that she could continue living there and he refused. The hearing officer’s reading of the statute would protect only tenants who were already receiving housing subsidies.

56. Edwards, 783 N.W.2d at 176.

57. Id. at 177. When deciding that the Metropolitan Council’s HRA claimed the Section 8 program was voluntary, the court cited its website, which simply read “[y]our decision to join other rental property colleagues in the . . . HCV . . . Program will make a difference in providing affordable housing in the Twin Cities’ region.” Id. This statement appears not to establish a legal principle, but simply thanks landlords for participating in the program.

58. Id. at 176 (citing 24 C.F.R. § 982.302(b)).

59. Id. (citing 24 C.F.R. § 982.53(d)).


61. Wis. Admin. Code DWD § 220.02(8).


63. Id. at 1282.

64. Id.
determined that lawful source of income includes vouchers, landlords could still refuse to accept vouchers by citing a legitimate business reason, such as non-participation in the Section 8 program.65

c. California

California’s housing discrimination law prohibits discrimination on the basis of a tenant’s source of income,66 but the state’s Court of Appeal found that housing vouchers do not satisfy the statute’s definition of “source of income.”67 The California Government Code defines “source of income” as “lawful verifiable income paid directly to a tenant or paid to a representative of a tenant [and] a landlord is not considered a representative of a tenant.”68 Because Section 8 vouchers are paid to landlords by a local housing authority, the tenant never receives direct payment under the program.69 Therefore, Section 8 payments are not considered a “source of income” under California law.70 The court also noted that the state legislature never intended to make participation in Section 8 mandatory.71

2. States with Source of Income Laws That Exclude Housing Vouchers

a. Delaware

Delaware prohibits housing discrimination because of a tenant’s source of income,72 but allows landlords to choose not to accept housing vouchers.73 Landlords are “not required to participate in any government-sponsored rental assistance program, voucher, or certificate system.” Additionally, “[a] landlord’s nonparticipation . . . may not serve as a basis for any administrative or judicial proceeding” under the state’s antidiscrimination laws.74

b. Maine

Maine’s antidiscrimination law does not contain a clear exemption for landlords like the one contained in Delaware’s law. Instead, the Maine Human Rights Act allows landlords to raise a business necessity defense if they refuse to rent to voucher holders for legitimate business reasons.75 Maine’s statute includes a provision that prevents anything in it from being interpreted to prohibit landlords from renting according to practices

65. Id. at 1283.
69. Sabi, 107 Cal. Rptr. 3d at 818–19.
70. Id. at 819.
71. Id. at 826.
73. Id. § 4607(j).
74. Id.
“that are consistent with business necessity and are not based on . . . the receipt of public assistance payments.” A landlord in Maine can avoid liability by showing it made the decision not to rent to a voucher holder because of business necessity and not for discriminatory reasons.

3. States with Source of Income Laws That Include Housing Vouchers

a. Oregon

Oregon prohibits discrimination on the basis of a prospective tenant’s source of income when renting or leasing property. “Source of income” includes Section 8 voucher payments and “any other local, state, or federal housing assistance.” The legislature added this definition in 2014 to address discrimination against voucher holders in the state.

b. Connecticut

Connecticut prohibits rental discrimination because of a person’s “lawful source of income,” and the Connecticut Supreme Court applied this law to landlords that refused to accept Section 8. The defendant landlord argued that federal law preempted the state’s law, but the court disagreed. The court found that the legislature had the authority to make landlord participation in the Section 8 program mandatory. It noted that the Connecticut law furthers the objectives of the federal law.

76. Id.; Dussault v. RRE Coach Lantern Holdings, 86 A.3d 52, 59 (Me. 2014) (noting that the statute allows a landlord to refuse to rent to a recipient of public assistance if she can demonstrate a business necessity).

77. For example, in Dussault, the defendant argued that it was still willing to rent the apartment to the plaintiff, but that it simply was unwilling to accept vouchers. Dussault, 186 A.3d at 57. The court took this as evidence that the defendant was not discriminating. Id. at 59. The local housing authority required a lease addendum for Section 8 landlords and the landlord was not willing to agree to the terms of that addendum. Id. at 57. In responding to the plaintiff’s case worker, the defendant was careful to say that it “is not refusing to rent to [plaintiff] primarily because she is a recipient of public assistance.” Id. Therefore, the court reasoned, the landlord established the affirmative defense by pointing to legitimate business reasons for rejecting the tenant. Id.

78. OR. REV. STAT. § 659A.421 (2017)

79. Id. § 659A.421(d)(A).


81. CONN. GEN. STAT. § 46a-64c(a) (2017).


83. Id. at 245.

84. Id. at 246.

85. Id.
which was passed “for the purpose of aiding low-income families in obtaining a decent place to live and of promoting economically mixed housing.”

c. Massachusetts

Massachusetts prohibits discrimination in rental housing on the basis of a tenant’s receipt of public assistance or “local housing subsidies, including rental assistance or rental supplements.” Additionally, discrimination is prohibited “because of any requirement of such public assistance, rental assistance, or housing subsidy program.” In DiLiddo v. Oxford Street Realty, Inc., Massachusetts’s highest court held that this law prohibited landlords from rejecting applicants who received Section 8. It rejected the landlord’s argument that the statute should apply only to landlords who exhibit discriminatory animus, not to those who are simply making a “legitimate, non-discriminatory” decision. Because the statute contained no language adding this exception, the court refused to add an exception to the statute’s plain meaning.

d. New Jersey

New Jersey’s statute prohibits discrimination by landlords against tenants because of the “source of any lawful rent payment to be paid for the house or apartment.” In Franklin Tower One, LLC v. N.M., the New Jersey Supreme Court held that a landlord’s refusal to accept a Section 8 voucher violated this statute. The court found that the state’s statute was not preempted by federal law. Although federal law made the program voluntary, the voluntary nature of the program was “not at the heart of the federal scheme.” The court also dismissed the landlord defendant’s policy argument that the program imposed substantial burdens on landlords, finding nothing in the record that supported that assertion.

4. States with Source of Income Laws That Have Not Been Litigated

a. North Dakota

North Dakota prohibits housing discrimination because of a tenant’s status with regard to public assistance, which is defined as “the condition of

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88. Id.
89. 876 N.E.2d 421, 422 (Mass. 2007).
90. Id. at 429.
91. Id.
92. N.J. STAT. ANN. § 10:5-12g(4) (West 2017) (previously codified at § 2A:42-100).
94. Id. at 1113.
95. Id.
96. Id. at 1113–14.
97. N.D. CENT. CODE § 14-02.5-02 (2017).
being a recipient of federal, state, or local assistance . . . or of being a tenant receiving federal, state, or local subsidies, including rental assistance or rent supplements.” The statute resembles the Minnesota antidiscrimination law, but courts have not issued decisions interpreting how the language might apply to discrimination against Section 8 voucher holders.

b. Oklahoma

Oklahoma’s housing discrimination law makes it unlawful for a landlord “[t]o refuse to consider as a valid source of income any public assistance . . . when that source can be verified as to its amount, length of time received, regularity, or receipt because of race, color, religion, gender, national origin, age, familial status, or disability.” This provision seems to suggest that it is only discriminatory to refuse public assistance because of the recipient’s “race, color, religion, gender, national origin, age, familial status, or disability.” No court has interpreted this provision, so it is unclear whether this statute prohibits all voucher-based discrimination or only source of income discrimination in conjunction with discrimination because of race, religion, gender, national origin, age, familial status, or disability.

c. Utah

Utah’s Fair Housing Act prohibits refusing to rent to a tenant because of her “source of income.” The statute defines “source of income” as “the verifiable condition of being a recipient of federal, state, or local assistance . . . or of being a tenant receiving federal, state, or local subsidies, including rental assistance or rent supplements.” The act also prohibits landlords from publishing a notice that “directly or indirectly expresses any preference, limitation, or discrimination based on . . . source of income.” Although courts have not interpreted this provision, in 2016, some state legislators attempted to amend the statute to specify that a landlord’s refusal to accept Section 8 vouchers was not discrimination. However, the amendment failed so the current law remains in effect.

d. Vermont

Vermont’s fair housing law prohibits discrimination against a tenant because she is a recipient of public assistance. “Public assistance” is de-

98. Id. § 14-02.4-02(19).
101. Id.
102. Id. § 57-21-2(24).
103. Id. § 57-21-5(2).
fined in the statute as “any assistance provided by federal, state, or local
government, including medical and housing assistance.”\textsuperscript{106} The defini-
tion’s specific inclusion of housing suggests that the legislature intended
the law to prohibit voucher-based discrimination. However, the law
also contains an exemption for landlords: it does not apply to “limit a
landlord’s right to establish and enforce legitimate business practices nec-
essary to protect and manage the rental property, such as the use of refer-
ences.”\textsuperscript{107} The law has not yet been challenged in court, so it is unclear
how a court would interpret this language.

II. Voucher-Based Discrimination in Minnesota:
A Case Study

This Part examines Minnesota’s antidiscrimination law and assesses
two strategies for reducing discrimination against voucher holders in
the Twin Cities: challenging the wrongly decided \textit{Edwards} decision and
implementing local ordinances that prevent voucher discrimination. By
focusing on how a court wrongly undermined Minnesota’s antidiscrimi-
nation law, this Part provides an example of legal arguments that can
be used to defend source of income laws in other states. Because courts
have not considered this issue in many states with source of income
laws, fair housing advocates in those states should anticipate that their
laws will be challenged as Minnesota’s was.

A. State-Wide Protections for Voucher Holders: Overturning \textit{Edwards}

The Minnesota Court of Appeals wrongly decided the \textit{Edwards} deci-
sion. First, it relied on improper authority, using a state statute preempted
by federal law and a repealed state statute. Second, it failed to follow the
basic principles of statutory interpretation by disregarding the plain text
of the statute. Third, it gave deference to the landlord’s proffered reasons
for discrimination, an approach that should only be used when a plaintiff
relies on indirect evidence. Fourth, it inappropriately distinguished the
MHRA from nearly identical statutes in other states. Given these substan-
tial errors made by the court, future litigants have a strong case to recon-
sider the issue.

1. Improper Authority

The Court of Appeals relied on a state statute preempted by federal
law, claiming that it proves the legislature intended the Section 8 program
to be voluntary.\textsuperscript{108} The statute required landlords who operated federally
subsidized rental housing to give a one-year notice if they planned to stop
offering rental housing.\textsuperscript{109} As a preliminary matter, this statute only ap-

\textsuperscript{106} Id. § 4501(6).
\textsuperscript{107} Id. § 4504(4).
\textsuperscript{108} \textit{Edwards}, 783 N.W.2d at 176; \textit{see} \textsc{Minn. Stat.} § 504B.255 (2017).
\textsuperscript{109} \textit{See Minn Stat.} § 504B.255.
plies to landlords receiving project-based Section 8 subsidies, not Section 8 vouchers,\textsuperscript{110} a fact the Court of Appeals recognized in \textit{Edwards}.\textsuperscript{111} In 2003, the Eight Circuit held that federal law expressly and impliedly preempted this entire statute because it interfered with the Low-Income Housing Preservation and Resident Homeownership Act of 1990 (LIHPRA).\textsuperscript{112} LIHPRA contains an express preemption provision that prohibits states from interfering with federally backed mortgages.\textsuperscript{113} The state statute prevented owners of subsidized housing from terminating their contracts with the federal government unless tenants were notified one year before the termination.\textsuperscript{114} The Eight Circuit found that the state statute required landlords and the federal government to maintain a relationship even after the federal government had decided to terminate a contract.\textsuperscript{115} Therefore, federal law preempted the entire statute.\textsuperscript{116}

This preempted statute was central to the analysis in \textit{Edwards}. The court reasoned that because the statute assumed that Section 8 was a voluntary program, the MHRA must not require landlords to participate in it.\textsuperscript{117} If the court had recognized that this statute was no longer effective, it would have lost the linchpin of this legal argument. Surprisingly, neither the plaintiff nor any of the amici brought this point to the court’s attention in briefing.\textsuperscript{118}

The court cited only one other statute to support the proposition that the legislature intended the Section 8 program to be mandatory, and that statute was repealed at the time of the decision.\textsuperscript{119} This statute created a tax incentive for property owners that made a minimum portion of units in their buildings available to voucher holders.\textsuperscript{120} If participation in Section 8 were mandatory, reasoned the court, “there would have been no reason for the state to provide incentives for property owner participa-
tion.” Thus, the only two statutes cited to support the central premise of its decision were either preempted or repealed.

2. Statutory Interpretation

A central principle of statutory interpretation is adhering to the plain text of the statute unless there is an ambiguity. Instead of relying on two dead statutes to divine the legislature’s intent, the court should have adhered to the plain text of the MHRA, which prevents landlords from discriminating on the basis of a voucher holder’s status as a recipient of public assistance. The statute prohibits property owners from “refus[ing] to sell, rent, or lease, or otherwise deny to or withhold from any person or group of persons because of . . . status with regard to public assistance.” Receiving a housing choice voucher fits clearly within the statute’s definition of “status with regard to public assistance”: “the condition of being a recipient of federal, state, or local assistance, including medical assistance, or of being a tenant receiving federal, state, or local subsidies, including rental assistance or rent supplements.” Section 8 vouchers are indisputably rental assistance. The statute’s “because of” language also requires causation. In the Edwards case, the property manager stated that it refused to renew Edwards’s lease because he received Section 8 vouchers: “[d]ue to changes in the Section 8 program we are unable to renew your lease.” Refusing to rent to a voucher holder because of his status as a voucher holder unambiguously violates the MHRA’s plain meaning.

Although the plain text of the statute controls, the history of the MHRA suggests that the legislature contemplated Section 8 subsidies when drafting the amendment. The express inclusion of rental assistance or rent supplements in the definition of “status with regard to public assistance” demonstrates that the legislature intended the MHRA to protect recipients of federal rental assistance. The legislature amended the MHRA to include “status with regard to public assistance” as a ground protected from discrimination in real property in 1973. The legislature also drafted a definition of the phrase that included tenants receiving rental assistance. Although this amendment passed a year before the Section 8 voucher program, the federal government had already enacted a housing subsidy pro-

121. Edwards, 783 N.W.2d at 176.
122. See, e.g., Gilberson v. Williams Dingmann, LLC, 894 N.W.2d 148, 151 (Minn. 2017) (“If a statute is unambiguous, then we must apply the statute’s plain meaning.”).
125. Edwards, 783 N.W.2d at 174.
127. Id. at 2159.
gram in 1965. This program established PHAs that paid rents for low-income people directly to property managers. The tenants paid the PHA a minimum rent, and the federal government subsidized the rest of the cost. Therefore, the legislature was already aware of federal housing subsidies and would have considered that program when amending the MHRA in 1973.

3. The Wrong Standard for Direct Evidence

Although Edwards alleged direct evidence of discrimination under the MHRA, the Court of Appeals gave significant weight to the landlord’s “legitimate business reasons” for not renewing Edwards’s lease. However, this factor should enter the analysis of an MHRA claim only if the plaintiff relies on indirect evidence of discriminatory intent. Courts analyze MHRA claims without direct evidence under the three-stage McDonnell Douglas framework, which allows a plaintiff to allege a prima facie case that gives rise to an inference of discrimination. The defendant can then proffer a legitimate nondiscriminatory reason for its allegedly discriminatory conduct. At the final stage, the plaintiff must prove that the allegedly nondiscriminatory reason was false and was pretext for discrimination. In Edwards, the court notes numerous times that the defendant chose not to accept Section 8 vouchers for business reasons. In the analysis, the court seems to assume that business reasons and discrimination are mutually exclusive.

By deferring to the landlord’s business judgment, the court impliedly considers the case through a McDonnell Douglas framework. Although the court does not explicitly follow McDonnell Douglas, it emphasizes that the defendant made its decision for “legitimate business reasons.” For example, the court frames the question as whether “a property owner’s business decision to end participation in a Section 8” violates the MHRA. This analysis is appropriate in cases without direct evidence of discrimina-

129. Daniel, supra note 128, at 773.
130. Id.
131. See, e.g., Edwards, 783 N.W.2d at 177 (“[R]efusal to participate in a voluntary program for a legitimate business reason does not constitute discrimination.”).
134. Id. at 802.
135. Id. at 802–03.
136. See Edwards, 783 N.W.2d at 177–78, 182.
137. Id. at 177–78, 180.
138. Id. at 174.
tion. Here, however, the defendant admits that the only reason it denied Edwards’s lease was because he received Section 8 vouchers. Therefore, rather than considering the question in light of the landlord’s “legitimate business reasons,” the court should have only considered whether refusing to accept vouchers violated the MHRA.

Framing the question in light of the landlord’s explanation affects the legal analysis in Edwards by highlighting policy concerns irrelevant to the MHRA. The policy directive of the MHRA requires courts to construe the statute liberally to prevent discrimination in housing. Further, the statute creates a civil right for Minnesotans to rent, free from discrimination based on their receipt of public rental assistance. The statute does not contemplate the business decisions of landlords. By allowing the McDonnell Douglas framework to infect its analysis in Edwards, the court gives weight to policy concerns irrelevant to a MHRA claim with direct evidence.

The Edwards decision functionally amended the MHRA to include a business necessity defense for landlords facing claims of discrimination against voucher holders. Compare the court’s decision with the Maine Human Rights Act, which expressly includes a business necessity defense. The Maine Human Rights Act also prohibits rental discrimination because of a person’s status with regard to public assistance, but contains an exception for business necessity. Unlike Maine, however, Minnesota’s legislature did not include language that references “business necessity.” Instead, it required the MHRA to be interpreted liberally to protect the rights of Minnesotans.

4. Comparing the MHRA to Similar Statutes in Other States

The Edwards court distinguished Minnesota’s antidiscrimination law from statutes in New Jersey and Massachusetts, states that protect tenants from voucher-based discrimination. New Jersey’s statute prohibits discrimination by landlords against tenants because of the “source of any lawful rent payment to be paid for the house or apartment.”

139. See Goins, 635 N.W.2d at 722–24 (Minn. 2001) (describing direct and circumstantial evidence in MHRA cases and applying the McDonnell Douglas framework where the plaintiff relied on circumstantial evidence).
140. Edwards, 783 N.W.2d at 175.
142. See id. § 363A.02.
144. Id. § 4581–A (2017).
145. Compare id. § 4583 with Minn. Stat. § 363A.03, subdiv. 47. See supra Part I. B.2.0.
146. See Minn. Stat. § 363A.04.
147. Edwards, 783 N.W.2d at 177–78.
nesota Court of Appeals distinguished Minnesota’s statute “[b]ecause Minnesota’s statute is fundamentally different.” It similarly distinguished Massachusetts’s statute, which makes it illegal for a landlord “to discriminate against any individual . . . who is a tenant receiving federal, state, or local housing subsidies, including rental assistance or rental supplements, because the individual is such a recipient.” Unlike the Massachusetts law, reasoned the court, Minnesota’s law was not specific to a rental assistance program.

An interpretation of the MHRA that requires landlords to accept Section 8 vouchers would align with identical language in a Massachusetts statute. Both statutes prohibit discrimination by landlords against a tenant because that tenant is “receiving federal, state, or local housing subsidies, including rental assistance or rental supplements.” In fact, the Massachusetts legislature used this language in order to require landlords to accept Section 8 vouchers. Despite the identical language in the two statutes, the Minnesota Court of Appeals found that the language in the MHRA was similar to an earlier version of the Massachusetts statute, which prohibited discrimination “solely because” the tenant received rental assistance. However, the MHRA contained no “solely because” language. Additionally, the Court of Appeals inaccurately attributed a quote to the Massachusetts Supreme Court. It wrote that the old Massachusetts law allowed landlords to refuse Section 8 vouchers for a “legitimate business reason,” citing DiLiddo. However, that phrase appears nowhere in the DiLiddo opinion. The Court of Appeals invented a “legitimate business reason” exception and then misattributed the concept to a Massachusetts law nearly identical to the relevant provision of the MHRA.

5. Re-Evaluating Edwards

The Court of Appeals made several legal errors in the Edwards decision and failed to enforce the textual meaning of the MHRA. The court relied on a statute preempted by federal law and a statute repealed by the legislature. It improperly compared the MHRA to a similar Massachusetts

149. Edwards, 783 N.W.2d at 177–78.
151. Edwards, 783 N.W.2d at 178.
155. Id. (quoting DiLiddo, 786 N.E.2d at 428–29).
156. See DiLiddo, 876 N.E.2d at 421–31.
statute by misquoting the Massachusetts Supreme Court. It decided the case by giving weight to the landlord’s “business reasons.” This concept had no basis in the statutory text or in the judicial framework for analyzing a MHRA claim with direct evidence. The court overstepped its authority by functionally adding a business necessity defense to the MHRA without the consent of the legislature. For these reasons, there is a strong case to challenge the *Edwards* decision and ask the Minnesota Supreme Court to overrule it.

Overturning the *Edwards* case would provide the best solution to the problems created by the decision. The *Edwards* court noted that the problem of voucher-based discrimination could be solved by the legislature through an amendment to the statute.\(^\text{157}\) After going outside the text of the statute to reach its holding, the court found, ironically, that it could not solve that problem because it was “limited by the language in the statutes that the legislature has enacted.”\(^\text{158}\) Because the court made legal errors, not errors of policy judgment, the courts are suited to fix those mistakes. First, the plain text of the MHRA clearly prohibits voucher-based discrimination. Although the legislature has the power to clarify that the MHRA prohibits this discrimination, the courts are best suited to correct the error. Additionally, the court allowed a judicially created doctrine for discrimination cases with circumstantial evidence, *McDonnell Douglas*, to infect its analysis of a claim based on direct evidence of discrimination. By resolving this issue, the Minnesota Supreme Court could also clarify the proper role of *McDonnell Douglas* in housing discrimination litigation.

If the legislature amended the statute to include vouchers in the definition of public assistance, the amended statute could be interpreted more narrowly than the MHRA requires. By listing specific forms of public assistance that the MHRA includes, future litigants could argue that new forms of public assistance benefits should not be included in the definition. Under a traditional canon of statutory interpretation, the inclusion of specific terms impliedly excludes others.\(^\text{159}\) Although this canon would not override the legislature’s clear intent that the MHRA “be construed liberally,”\(^\text{160}\) the canon demonstrates how an amendment to the MHRA could actually create further confusion, not clarity, about the meaning of the statute. Instead of relying on a legislative amendment, the errors in *Edwards* should be corrected by the Minnesota Supreme Court.

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\(^{157}\) *Edwards*, 783 N.W.2d at 179.

\(^{158}\) *Id.*

\(^{159}\)*This canon is commonly known by its Latin name: *expressio unius est exclusio alterius*. See Norman Singer & Shambie Singer, *Sutherland Statutory Construction* § 47:23 (7th ed. 2017).

\(^{160}\)*Minn. Stat.* § 363A.04.
B. Minneapolis’s Local Ordinance Prohibiting Voucher Discrimination

Although only a handful of states have laws prohibiting Section 8 voucher discrimination, over seventy cities and counties have implemented these laws. The Poverty and Race Research Action Council (PRRAC) maintains a list of these laws and tracks pending legislation. In states where legislatures have not passed source of income laws or where courts have limited the application of those laws, local ordinances are a practical solution to voucher-based discrimination in cities and counties. This Section describes Minneapolis’s voucher antidiscrimination ordinance and the state district court order that blocked it from going into effect. It also analyzes the district court’s order and provides advice for cities considering implementing similar ordinances.

1. Minneapolis’s Amended Antidiscrimination Ordinance

In March 2017, Minneapolis’s City Council passed an ordinance prohibiting discrimination by landlords against Section 8 holders. Effective May 1, 2018, the ordinance updated the city’s antidiscrimination law, which closely resembled the MHRA, by including Section 8 vouchers in the definition of a public assistance program. The ordinance prohibits landlords from rejecting renters because they receive Section 8. It also declares that refusing to rent to someone when “any requirement of a public assistance program is a motivating factor” is “an unlawful discriminatory practice.” The ordinance includes an “undue hardship” provision that allows landlords to discriminate if they can show “significant difficulty or expense.” It defines three factors to be considered: the cost of complying with public assistance program requirements, the overall financial resources of the landlord, and the impact of complying with any public assistance program requirement.

City landlords challenged the legality of this ordinance, arguing that state law mandates Section 8 to be a voluntary program. The state dis-
district court granted summary judgment in favor of the landlord plaintiffs, but the city plans to appeal.

2. Fletcher v. City of Minneapolis

In *Fletcher v. City of Minneapolis*, the landlords alleged that the ordinance is preempted by state law, violates their substantive due process rights, denies them equal protection of the laws, constitutes a regulatory taking, and interferes with their right to contract. The district court addressed only the due process and equal protection claims. This Subsection evaluates the court’s analysis of these two claims. It also assesses the preemption argument because, if this issue is raised on appeal, it gives the state appellate courts an opportunity to reconsider the *Edwards* decision.

a. Preemption

The landlords argued that the ordinance is preempted by the MHRA because “[c]ase law interpreting Minnesota statutes has specifically held that refusal to participate in the voluntary HCV program for legitimate business reasons does not constitute discrimination.” This statement clearly refers to the *Edwards* case. The landlords claim the city ordinance is expressly preempted by the MHRA because the ordinance “forbids that which state statute expressly permits.” Although the district court decided *Fletcher* on other grounds and did not reach a preemption argument, this Subsection analyzes whether the ordinance is preempted by state law, as interpreted in *Edwards*.

Municipalities are generally considered “creatures of the state” and have no inherent powers. In “home rule” states like Minnesota, cities may operate with greater independence from state governments and op-

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170. *Id.* ¶¶ 100–42.
172. *Id.* ¶ 107.
173. See Order, Fletcher, 27-CV-17-9410, at 43.
175. See Bicking v. City of Minneapolis, 891 N.W.2d 304, 312–13 (Minn. 2017).
176. Minnesota’s Constitution allows municipalities to pass a home rule charter and many cities, including Minneapolis, have enacted a charter under the state’s constitution. MINN. CONST. art. XII, ¶ 4. See MINNEAPOLIS, MINN. CHARTER, art. 1, ¶ 1.2.
erate within “an area of autonomy immune from state control.”177 Cities in home rule states may operate autonomously in areas that are local in nature, but they cannot violate state law.178 For example, municipalities cannot enact ordinances that conflict with state law or enact ordinances when state law occupies a field of legislation.179 On the other hand, “a city’s ordinance or resolution does not conflict with state law if it is ‘merely additional and complementary to’ a statute.”180 An ordinance conflicts with state law where it permits what a statute forbids or where it forbids what the statute expressly permits.181 A statute may also impliedly preempt local ordinances when the legislature has declared it to be an “area solely of state concern.”182 If the legislature regulated the subject matter of the local ordinance, a court would consider whether the legislature intended it to be an area of state concern and what “unreasonably adverse effects” the ordinance would have on the state.183

The Minneapolis ordinance does not expressly conflict with state law because there is no statutory provision that requires the Section 8 program to be voluntary.184 The ordinance simply adds “housing choice vouchers” to the definition of “public assistance program.”185 The ordinance also prohibits landlords from refusing to rent to anyone because of that person’s “status with regard to a public assistance program” or because of “any requirement of a public assistance program.”186 This language mirrors the MHRA, with only three minor differences.187 First, the ordinance uses the language “public assistance program” instead of “public assistance.”188 Second, the definition of “public assistance program” includes

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179. Id. at 313.
180. Lilly v. City of Minneapolis, 527 N.W.2d 107, 114 (Minn. Ct. App. 1995) (Schumacher, J. dissenting) (quoting Mangold Midwest Co. v. Vill. of Richfield, 143 N.W.2d 813, 817 (Minn. 1966)).
182. City of Morris v. Sax Invs., Inc., 749 N.W.2d 1, 6 (Minn. 2008) (quoting Mangold, 143 N.W.2d at 820).
183. Id. at 6–7.
184. See supra Part II.A.
186. Id. at tit. 7, § 139.40 (e)(1).
187. Compare MINN. STAT. § 363A.09, subdiv. 1(1) (“It is an unfair discriminatory practice for an owner . . . to refuse to sell, rent, or lease . . . because of . . . status with regard to public assistance. . . .”) with MINNEAPOLIS, MINN. CODE OF ORDINANCES, tit. 7, § 139.40 (e)(1) (“[T]he following are declared to be unfair discriminatory acts . . . [t]o refuse to sell, rent, or lease . . . because of . . . status with regard to a public assistance program, or any requirement of a public assistance program.”).
188. Id.
housing choice vouchers. The ordinance contains language about any requirement of a public assistance program. The MHRA does not permit discrimination on the basis of housing choice vouchers, so the ordinance is not expressly preempted. Additionally, the ordinance is predicted to affect only six percent of landlords in Minneapolis. This hardly creates an “unreasonably adverse effect” on the entire state, so the ordinance is not impliedly preempted. Rather, the ordinance complements the MHRA by clarifying that Section 8 voucher holders are recipients of public assistance.

b. Due Process

The court in Fletcher reached its decision primarily on substantive due process grounds. The landlords argued that because the ordinance deprived them of the fundamental right to rent property, it should be subject to strict scrutiny. Rejecting this argument, the court found that there is no fundamental right to rent property and instead applied the rational relation test. This standard requires that the law “promote a public purpose, that it not be an unreasonable, arbitrary, or capricious interference with a private interest, and that the means chosen bear a rational relation to the purpose served.” This standard is highly deferential to the city because “[t]here is a presumption in favor of the constitutionality of the legislation and a party challenging constitutionality has the burden of demonstrating beyond a reasonable doubt a statute violates a provision of the constitution.” In spite of this demanding standard, the court found that the ordinance was arbitrary and unreasonable because it could find no evidence that landlords were refusing to accept vouchers as the result of an unfair and prejudicial dislike of voucher holders.

When considering the rationality of the ordinance, the court also weighed the alleged administrative burdens of the Section 8 program. Concluding that participation in the Section 8 program requires a landlord to give up significant control of the unit, the court found that the landlords had a legitimate business reason for choosing not to participate in

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189. MINNEAPOLIS, MINN. CODE OF ORDINANCES, tit. 7, § 139.20.
190. See MINN. STAT. § 363A.
191. City of Minneapolis, supra note 163.
192. City of Morris v. Sax Invs., Inc., 749 N.W.2d 1, 6 (Minn. 2008).
194. Id. at 9.
195. Id. at 12.
196. Id. (quoting State by Humphrey v. Ri-Mel, Inc., 417 N.W.2d 102, 106 (Minn. Ct. App. 1987)).
197. Specifically, the court found that the program requires a landlord to “give[] up varying degrees of control over the sale of the building, the amount and certainty of the income from the unit, the lease terms and the ability to terminate the lease for
the program. Because the ordinance declares that refusal to rent to a voucher holder is unlawful discrimination, the court weighed the purported evidence of an administrative burden against the evidence of discrimination against voucher holders.

In *Fletcher*, the court minimized evidence of discrimination because there was no evidence of animus. Despite acknowledging that over three-quarters of affordable rental properties categorically reject tenants with vouchers, the court determined that there must be evidence of animus, or “unfair prejudice,” against voucher holders to justify the ordinance. The city accumulated evidence to justify the law, including testimony from voucher holders, statements from members of the city council, testimony from nonprofits representing the interests of low-income renters, and testimony from city administrative officials. However, among all this evidence of landlords categorically refusing to accept vouchers, the court found no evidence of hateful prejudice against voucher holders. The court concluded that the ordinance makes an unreasonable factual presumption that all landlords who refuse to rent to Section 8 tenants are hateful discriminators. Thus, the ordinance “automatically tar[s] all of [the landlords] with the brush of discrimination.”

The court also found that the ordinance’s prohibition on rejecting a prospective tenant because of “any requirement of a public assistance program” is unlike “personal characteristics of person,” like race, religion, or gender. However, this conclusion misreads the ordinance: “It is an unlawful discriminatory practice . . . [to refuse to rent because of a renter’s] status with regard to public assistance, or any requirement of a public assistance program.” The ordinance should not be read to add “requirements of a public assistance program” as a separate protected class. Instead, the phrase “status with regard to” modifies both “public assistance” and “any requirement.” The ordinance prohibits refusing to rent to some because of their “status with regard to . . . any requirement of a public assistance program.” This reading of the ordinance makes sense in context because a person’s “status with regard to” a requirement is a personal characteristic, like the other characteristics in the ordinance.

violations, access to the unit and to its business records, and [the landlord] must comply with new reporting and inspection requirements.” *Id.* at 19.

198. *Id.* at 23.
199. *Id.* at 21–23.
200. *Id.* at 30.
201. *Id.* at 43–44.
202. *Id.* at 29.
204. The ordinance adds “any requirement of a public assistance program” to a list that includes race, sex, gender identity, sexual orientation, disability, religion, and other characteristics. *Id.*
This distinction is critical because it prevents discriminating against a specific person because of that person’s status with regard to the requirements of a public assistance program. Under the court’s reading, any landlord who does not like any requirement of a public assistance program is automatically discriminating. The proper reading of the ordinance reveals that it is only discrimination when there is a specific individual who must follow requirements of a public assistance program. Although a person’s status with regard to a program requirement is not as intuitive to understand as a person’s race, it is a legitimate personal characteristic. For example, if a person receives HIV-related medical assistance, a requirement to qualify for that type of assistance is that the beneficiary have a diagnosis of HIV. Under this provision of the ordinance, a landlord could not refuse to rent because the tenant has HIV.205 This reading of the ordinance also aligns with the practical realities of voucher-based discrimination because landlords cannot discriminate in the abstract if no voucher holder has attempted to rent from them. A landlord only discriminates once voucher holders apply to rent his property and he refuses to rent to them because they receive a public rental assistance.

In addition to misconstruing the ordinance, the court’s analysis fundamentally misunderstands how discrimination works and fails to acknowledge that recipients of public assistance are a protected class as legitimate as other protected classes. By requiring the city to show animus to justify its ordinance, the court creates a high barrier for cities attempting to prevent discrimination. Discrimination includes treating one class of persons differently than another class—it does not require animus. As the Supreme Court has acknowledged, “the absence of a malevolent motive does not convert a facially discriminatory policy into a neutral policy with a discriminatory effect.”206 If a plaintiff can successfully prove discrimination without evidence of animus but with evidence of a facially discriminatory policy, courts cannot require legislative bodies to produce evidence of animus to justify an antidiscrimination law. As the MHRA has established, recipients of public assistance are a protected class who cannot be excluded from housing on that basis alone and there does not need to be evidence of animus to prove a case based on this kind of discrimination. By misunderstanding antidiscrimination law, the court appears to

205. Note that in this particular example, refusing to rent to someone with HIV would also constitute disability discrimination under most state laws and the Fair Housing Act. See 42 U.S.C. § 3602 (h) (defining “handicap”); 24 C.F.R. § 100.201 (2017) (defining “handicap” to include any physiological condition that affects major bodily functions); see also Bragdon v. Abbott, 524 U.S. 624, 655 (2008) (acknowledging that the Fair Housing Act, which is interpreted consistently with the Americans with Disabilities Act, prohibits discrimination because of a person’s HIV status).

suggest that recipients of public assistance are not a legitimate protected class, contrary to the legislative directive of the MHRA.

In addition to denying the legitimacy of recipients of public assistance as a protected class, the court’s due process analysis disregards the experiences of Section 8 voucher holders. Although it acknowledges the “poignant accounts of what it feels like for Section 8 voucher holders to encounter blanket refusals to rent to them,” it finds these “feelings” to be an insufficient reason to pass the ordinance. Instead, the court takes the landlords at their word, sympathizing with their assertion that “their issue is not with the tenants, it is with the program.” When the city pointed out that one particular landlord refused to rent to Section 8 tenants because he thought they cause more damage than other renters, the court empathized with landlord. It found that he was simply speaking from personal experience and could not possibly have an unfair prejudice against voucher holders because he stated that he just did not want to deal with the administrative burdens of the program. By taking the landlords at their word and writing off the “feelings” of Section 8 voucher holders, who experience the indignity of being told they are not accepted because of the public assistance they receive, the court gave legal weight to the landlord’s testimony, but not to the testimony of Section 8 tenants.

By taking the landlords at their word, but requiring that the city prove some evidence of animus, the court also misapplied the rational relation standard. This standard is difficult for plaintiffs to meet because they must demonstrate that the facts that formed the basis of the city’s decision “could not reasonably be conceived to be true by the governmental decision-maker.” In Fletcher, the court’s analysis suggests that the only reasonable way the city could have determined that voucher-based discrimination occurred would be if it presented evidence that landlords who refuse to rent to voucher holder have irrational and hateful feelings toward voucher holders. Instead, the court simply needed to determine whether the city council’s factual findings could not reasonably be conceived to be true. Given the abundance of direct evidence that landlords treated recipients of public assistance differently than other tenants, the city clearly satisfied the rational relation test.

c. Equal Protection

The Fletcher court also found that the ordinance denies landlords equal protection of the laws because it contains exceptions for small renters, akin to the “Mrs. Murphy” exemptions in the Fair Housing Act and the MHRA. The court found that because the purpose of ordinance is to

207. See Order, Fletcher, 27-CV-17-9410, at 25 n.11.
208. Id. at 23–24.
210. See supra note 42 for an explanation of this exemption.
prevent discrimination and that there was no evidence that landlords who meet the exemption are less likely to discriminate than other landlords, the ordinance treated classes of landlords unequally. However, the court disregards the fact that the ordinance also provides landlords an opportunity to present an “undue hardship” defense. This defense allows landlords an opportunity to provide actual evidence that the Section 8 program is overly burdensome. This defense demonstrates that a purpose of the ordinance was to prohibit discrimination only in situations where a landlord cannot prove an undue burden.

The court’s cursory analysis of the equal protection claim also fails to acknowledge that many civil rights laws contain similar exemptions. In fact, the MHRA has an entire section of exemptions, including those that allow private schools to discriminate on the basis of sex, owners of single-family dwellings to discriminate against tenants, and religious organizations to discriminate in their hiring practices on the basis of religion and sexual orientation. Under the court’s reasoning, each of these distinctions would violate equal protection. Each of these exemptions permits discrimination even though there was no finding that the exempted organizations were less likely to discriminate. To the contrary, the entire purpose of these exemptions was to allow discrimination in specific areas where the legislature decided discrimination was socially permissible. Similarly, the Minneapolis ordinance establishes an exemption where discrimination will be tolerated in light of other interests.

3. Amending City Rental License Requirements

The Fletcher court suggests an alternate route for the city to solve the problems faced by voucher holders: amending the rental licensing requirements to require landlords to accept Section 8 tenants. It notes that the shortage of rental housing available for voucher holders would provide a rational basis to modify the city’s rental requirements. This approach may offer Minneapolis and other cities an alternative method of reaching the same result for voucher holders. However, by classifying the requirement as a provision of civil rights law, Minneapolis affirmed that recipients of public assistance have a right to rent, free from discrimination.

If the city is unsuccessful on appeal, amending the rental license requirements provides another way for the city to meet its goals. Regardless of whether the city wins or loses on appeal, other municipalities in the Twin Cities could also use either antidiscrimination or rental licensing,
whichever is deemed permissible, to prohibit voucher-based discrimination. However, if only Minneapolis implements this ordinance, it may further concentrate low-income voucher holders in Minneapolis. If many other municipalities implemented ordinances like Minneapolis’s, the ordinances would give voucher holders more rental options throughout the metropolitan area.

### III. Legal Strategies to Prohibit Voucher-Based Discrimination

The *Edwards* decision and Minneapolis’s ordinance provide useful lessons for other states seeking to protect the rights of voucher recipients. In states without source of income laws, state legislators considering passing these kinds of protections should craft statutes that avoid the problems created by the Minnesota law. In states with source of income laws, advocates should prepare to defend the application of their state’s law to voucher-based discrimination. This Part explains arguments that advocates should make to courts when defending source of income laws and to state legislatures considering passing these laws.

#### A. Plain Text

Source of income laws unambiguously prohibit discrimination against voucher holders. Although the language used by states and municipalities varies slightly, a purely textual reading of most of these statutes prohibits landlords from categorically rejecting all Section 8 recipients. Statutory interpretation begins with the plain text of the statute so courts only consider external evidence of legislative intent after a preliminary finding of ambiguity.217 By focusing on the text of these statutes, litigants can persuade the court to enforce the plain meaning without needing to consider legislative history or other extrinsic sources.

The first category of source of income laws prevents discrimination because of a tenant’s lawful source of income.218 Many state laws define “lawful source of income” to include public assistance,219 and some clarify that this includes rental assistance or housing subsidies.220 A second category of these laws prohibits a landlord from refusing to rent because of

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217. *See* United States v. Ron Pair Enters., 489 U.S. 235, 241 (1989) (internal quotations omitted) (explaining that if “the statute’s language is plain, the sole function of the courts is to enforce it according to its terms”).

218. The statutes in California, Connecticut, Delaware, New Jersey, Oregon, Oklahoma, Utah, and Wisconsin all contain some form of “source of income” language in their housing antidiscrimination laws. *See supra* Part I.B.


220. *See, e.g.*, MASS. GEN. LAWS ch. 151B, § 4(10) (2017); MINN. STAT. § 0363A.03, subdiv. 47 (2017); OR. REV. STAT. § 659A.421(d)(A); UTAH CODE ANN. § 57-21-5.
the applicant’s status with regard to public assistance. The language between these laws differs slightly, but refusing to rent to Section 8 voucher recipients because of their status as voucher holders falls squarely within the plain meaning of both types of laws.

Section 8 vouchers are unambiguously a form of public assistance and constitute a lawful source of income. Simply because the vouchers have procedural limitations—they may be used only for paying rent and the money is paid directly to the landlord—does not mean that vouchers do not constitute a source of income. Black’s Law Dictionary defines income as “[t]he money or other form of payment that one receives, usually periodically, from employment, investments, royalties, gifts, and the like.” The voucher is a monthly benefit that subsidizes a participant’s housing, which clearly fits in the ordinary meaning of “income.”

The Section 8 voucher process supports this plain meaning analysis. Landlords have argued that a voucher is not technically “income” because it is paid directly to the landlord instead of the tenant. However, a Section 8 voucher is not attached to the property—it belongs to the tenant. In contrast to project-based Section 8 subsidies, voucher-based subsidies travel with the tenant. Additionally, the tenant must apply for a voucher before searching for a rental unit. After receiving the voucher, tenants must find a unit whose owner is willing to lease to them under the Section 8 program. Then, the local housing authority must approve the arrangement. This process demonstrates how the voucher belongs to tenants because they are entitled to the benefit only after being approved by the local housing authority but before finding a landlord. Therefore, under a textual reading of source of income laws, a landlord who rejects a voucher recipient because he is entitled to a voucher is refusing to rent because of the prospective tenant’s lawful source of income.

B. Direct Evidence

When analyzing housing discrimination cases, courts often use the McDonnell Douglas framework to uncover a discriminatory intent. For

221. The laws in Minnesota, Maine, North Dakota, and Vermont all contain “public assistance” language. See supra Part I.B.
226. Id. § 982.302(b).
227. Although originally conceived in the employment discrimination context in McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973), the McDonnell Douglas framework is also applied to claims under the federal Fair Housing Act. See, e.g.,
example, the Minnesota Court of Appeals used the framework to determine that the property management company in Edwards had no discriminatory motive when it rejected Section 8 recipients. However, the McDonnell Douglas framework is only appropriate when analyzing indirect evidence of discrimination. The framework is inappropriate if the property manager affirmatively states that it is rejecting the applicant because it does not wish to participate in the Section 8 program. This constitutes direct evidence of discriminatory intent.

Some property manager litigants seem to confuse direct evidence of a discriminatory intent with animus. Animus or hostility is not a required element of a source of income discrimination claim. All that is necessary to prove discrimination is that a person’s status as a Section 8 voucher holder was the reason for rejecting an applicant. If that is the case, litigants should frame that evidence as dispositive. Landlords often admit that they reject applicants because they do not want to participate in the Section 8 program. Many argue that they should not be compelled to accept vouchers because they do not want to participate in the program.

When arguing a source of income discrimination case, litigants should gather direct evidence of discrimination and frame it as dispositive. Types of direct evidence include advertisements that state “no Section 8” or statements from landlords that they have rejected prospective tenants with a Section 8 voucher. This kind of direct evidence gives a court sufficient evidence to deny summary judgment.

Pinchback v. Armistead Homes Corp., 907 F.2d 1447, 1451 (4th Cir. 1990); Selden Apartments v. HUD, 785 F.2d 152, 159 (6th Cir. 1986); Ring v. First Interstate Mortg., Inc., 984 F.2d 927 (8th Cir. 1993); Phiffer v. Proud Parrot Motor Hotel, Inc., 648 F.2d 548, 551 (9th Cir. 1980); Asbury v. Broyham, 866 F.2d 1276, 1279 (10th Cir. 1989).


231. See supra Part I.B for a survey of state source of income laws. None requires animus.

232. Under Title VII in the employment discrimination context, direct evidence of an employer’s discriminatory motive has allowed courts to deny an employer’s motion for summary judgment. See Kearney, supra note 229, at 304.
C. The Myth of Making a Voluntary Program Mandatory

Landlords often argue successfully that the federal government made the Section 8 program voluntary so the state cannot make the program mandatory. To support this policy argument, landlords will cite federal statutes and regulations that explain how landlords may choose whether or not to participate in the program. They argue that if the court were to rule in favor of the voucher-recipient, the effect would be to mandate that all landlords must participate in a burdensome and optional federal program. For example, writing as an amicus in support of the landlord in Edwards v. Hopkins Plaza, the Minnesota Multi Housing Association described several outcomes it perceived as unfair and burdensome to landlords. It argued that a ruling for the tenants would force all landlords to contract with the federal government, add a lease addendum for Section 8 tenants, limit the security deposit to that of a “private market practice,” limit rent increases, and allow annual inspections.

These arguments do not comport with the realities of the Section 8 program because landlords may still reject tenants for non-discriminatory reasons. Landlords could discern these reasons through methods commonly used to screen rental applicants. For example, many landlords run credit checks on applicants and will reject applicants with an unreliable credit history. Additionally, if a unit’s fair market value rent exceeds the area median, the property is too expensive for a Section 8 recipient and the landlord may not participate in the program. Some of these practices could be subject to scrutiny by courts if they are pretext for discrimination and the landlord merely adopts these measures to avoid renting to Section 8 recipients. As long as a landlord documents a neutral practice and applies it fairly to all applicants, a landlord should be able to demonstrate that it is not discriminating against applicants.

Litigants should frame source of income laws as prohibiting categorical exclusions of Section 8 tenants. Landlords prefer to frame this issue as mandating participation in a government program, but a prohibition on categorical exclusions is a more accurate characterization. The laws do not require landlords to accept Section 8 tenants. Instead, they require landlords to consider Section 8 recipients’ applications and determine whether they meet neutral rental criteria. Comparing source of income laws to other civil rights laws highlights this distinction. For example, Title VII prohibits discrimination on the basis of race, sex, religion, and na-

233. See supra notes 33–35 and accompanying text for federal laws that suggest the Section 8 voucher program is voluntary.
235. Id.
tional origin by employers. Title VII does not require employers to hire racial minorities, but it prohibits a categorical exclusion of employees on the basis of race, sex, religion, or national origin. A racial exclusion policy would constitute a prima facie violation of Title VII. Source of income laws should work in exactly the same way. A policy that excludes all voucher holders constitutes a prima facie violation of the law, but that does not mean that landlords are required to accept every Section 8 applicant.

**Conclusion**

State source of income laws can prohibit discrimination against Section 8 voucher recipients and provide them with more affordable housing choices. Although these laws will not solve the affordable housing crisis, they can make the Section 8 system work more efficiently and fairly. Without source of income laws, Section 8 recipients must find alternative housing while searching for a landlord who will accept their voucher and may lose their voucher if they cannot find a landlord in time. In states with source of income laws, fair housing advocates should be prepared to defend the laws from attempts to weaken them. While the specific arguments needed to support these laws will vary from state to state, the general strategy remains the same: focus on the plain meaning of the statute and frame a landlord’s decision not to rent to voucher holders as direct evidence of discrimination.

At a time when affordable housing is scarce throughout the United States, fair housing advocates should use every tool available to make rental housing fair for low-income people. Although federal law does not prohibit discrimination against Section 8 voucher holders, the housing choice voucher program creates an opportunity for states to step in and protect the rights of their residents to rent, free from discrimination. Vouchers are a critical resource for very low-income renters, so states and municipalities should take steps to make the voucher system work efficiently and fairly. Rather than letting the federal dollars go to waste as recipients search for housing, states and municipalities can use source of income laws to ensure that voucher holders can quickly find a place to live and put their vouchers to use.

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237. Id. § 2000e-2(j); Ricci v. DeStefano, 557 U.S. 557, 582 (2009) (“Title VII is express in disclaiming any interpretation of its requirements as calling for outright racial balancing.”).
Why Does My Tax Lawyer Keep Saying We Need Nonrecourse Debt for My Low-Income Housing Tax Credit Project

Glenn A. Graff

As anyone who has worked on a transaction involving low-income housing tax credits (LIHTCs or Credits) knows, the financial structure of LIHTC transactions becomes very complicated due to the interaction of the LIHTC rules under Section 42 of the Internal Revenue Code of 1986, as amended, and the partnership taxation rules. This essay discusses the basic interaction of those rules using very simplified descriptions in an attempt to make the overall concepts accessible to a non-expert audience. It then addresses a key question that arises in LIHTC transactions: Why does permanent debt generally need to be nonrecourse in transactions involving LIHTC?

I. Interaction of LIHTC Rules and Partnership Taxation Rules: A Simplified Description

LIHTCs are earned when a building participates in the LIHTC program and the building is rented to low-income persons at affordable rents.1 A building generally earns LIHTCs over a 10-year period called the “credit period”2 (sometimes, this credit period can be 11 years).3 LIHTCs are earned by the owner of a low-income building—they cannot be sold. For tax reasons beyond the scope of this essay, the LIHTC project developer and its affiliates generally cannot use the LIHTC.4 In order to enable

1. I.R.C. § 42. All references to “Code” refer to the Internal Revenue Code of 1986, as amended.
4. Due to the at-risk rules under Section 49 and the passive activity loss rules under Section 469, the ability for individuals and non-widely held C-corporations

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a tax credit investor (Investor) to use LIHTC, the Investor needs to be a partner of a partnership that owns a building. Because Investors want to limit their potential liability to the amount that they agreed to invest for the LIHTC, the owner will generally be a limited partnership and the Investor will be the limited partner. In exchange for a limited partner interest, the Investor will make a substantial capital contribution that is proportionate to the LIHTC and tax losses expected to be received by the Investor. The general partner (GP) is usually an affiliate of the project developer. Note that the Investor can also be a member of an owner that has been formed as a limited liability company (LLC) that is treated as a partnership for tax purposes. This essay will use the word “Partnership” to refer to both limited partnerships and LLCs taxed as partnerships.

When LIHTCs are earned by the owner of a building and that owner is treated as a partnership for federal tax purposes, the LIHTCs are allocated among the partners in the same manner as depreciation is allocated among the partners of the owner. To maximize the Investor equity, projects are commonly structured so that the Investor will receive 99.99% of the LIHTC. Thus, if the Investor wants to receive 99.99% of the LIHTCs earned by the Partnership, it needs to be allocated 99.99% of the depreciation. Depreciation makes up the majority of tax losses for most LIHTC projects and thus 99.99% of the tax losses are generally allocated to the Investor.

The Investor receives a capital account equal to the amount that it agrees to invest in return for the Credits and tax losses expected to be generated by the Partnership. That capital account is reduced each year by any distributions from the Partnership to the Investor, as well as by the Investor’s share of the tax losses of the Partnership. However, once the Investor’s capital account reaches zero, the Investor generally cannot be allocated additional tax losses. Because LIHTC partnerships always gen-

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5. The ability to deduct tax losses such as depreciation is valuable to Investors because such tax losses allow them to reduce taxable income earned from other parts of their business. A $100 tax loss will save an Investor $21 in federal taxes with the current 2018 21% corporate tax rate imposed under Code Section 11(b).


8. Id.

9. Investors are generally limited partners and do not have an obligation to restore a deficit in their capital account. Thus, loss allocations to an Investor that would drive the Investor’s capital account negative would generally not be respected because they would not be considered to be “substantial” under Treas. Reg. § 1.704-1(b)(2)(ii)(b)(3). But see infra note 11 regarding the ability to have a negative capital account if a partner has minimum gain.
erate taxable losses, it is not uncommon for the losses to exceed the Investor’s capital account before the end of the 10-year credit period. If that happens, the Investor’s capital account will be run down to zero, and no more tax losses can be allocated to the Investor.

Once the Investor’s capital account reaches zero, any losses and any remaining LIHTCs would generally be allocated to the GP—this is referred to as a “reallocation.”\(^{10}\) If such a reallocation is expected to occur based on the financial projections for the transaction, the Investor will contribute less equity because it will receive less Credits. Since, as referenced above, the GP generally cannot use much LIHTCs, in years in which the Investor’s capital account is zero (preventing it from benefiting from the LIHTCs), LIHTCs earned by the Partnership will go unused (and will not generate the benefit of the Investor’s equity investment in the LIHTC project). This is a result to be avoided since it will typically result in a project that is not financially viable.

\[\text{II. Treatment of Nonrecourse Debt}\]

Nonrecourse debt often can be used to avoid such reallocations because a partner is allowed to go negative in its capital account up to its share of minimum gain.\(^{11}\) For purposes of partnership taxation regulations, nonrecourse debt is debt for which no partner bears the economic risk of loss.\(^{12}\) In other words, if the partnership defaults, no partner is required to repay the debt. The partnership tax rules generally allow an Investor’s capital account to go negative to the extent of the Investor’s share of “Partnership Minimum Gain.”\(^{13}\) Partnership Minimum Gain generally exists when a third party nonrecourse loan for which no partner (or related party) is liable exceeds the basis of the assets encumbered by the liability.\(^{14}\)

\[\text{A. Minimum Gain}\]

The definition of “Minimum Gain” is key to understanding the role of nonrecourse debt in LIHTC transactions. In technical terms, Minimum

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10. Because general partners often have an obligation to restore a deficit balance in their capital accounts, they could be allocated such losses and the resulting LIHTC. \textit{Id.}


12. Treas. Reg. § 1.752-1(a)(2). Note that the definition of “nonrecourse debt” for purposes of the partnership tax rules differs from the definition of “nonrecourse debt” used for purposes of determining the gain or loss recognized from the disposition of property under Section 1001. Under Section 1001, “nonrecourse debt” refers to debt secured by property where, in the event that the borrower defaults on the debt, the lender’s only recourse is against the property securing the debt. Thus, a loan where a borrower under state law has recourse to all assets of a Partnership but does not have recourse to any of the partners would be recourse for purposes of Section 1001, but nonrecourse for purposes of Treasury Regulation § 1.752-1(a)(2).


Gain is equal to the positive difference between the amount of non-recourse debt and the cost basis of the building less any tax depreciation.\textsuperscript{15} In non-technical terms, Minimum Gain is literally the minimum amount of gain a partnership could have even if it gave the property back to a lender for nothing. How tax law computes gain in transactions involving nonrecourse debt is critical to this conclusion. Under tax law, if a taxpayer disposes of property and is discharged from a nonrecourse obligation encumbering the property, the taxpayer is deemed to have received consideration from the disposition equal to the amount of the discharged nonrecourse liability.\textsuperscript{16} Thus, if a partnership gave the keys to the building back to a $1,000,000 nonrecourse lender and received no additional consideration, the partnership would be deemed to have an amount received of $1,000,000. If the Partnership’s basis in the building was $900,000, then the Minimum Gain would be equal to $100,000; the $1,000,000 amount received less the $900,000 of basis.\textsuperscript{17}

The generation of Minimum Gain can be shown by a simplified example.

\textit{Example 1.} Assume that a Partnership borrows $300,000 with a 5\% interest only loan and buys an apartment building for $300,000. Because residential rental property has a 30-year life, assuming an election under Code Section 163(j) is made,\textsuperscript{18} the Partnership would have $10,000 of depreciation for the year and the building’s adjusted basis at the end of the year would be $290,000. Five percent interest on the $300,000 loan would be $15,000. If the Partnership generated taxable income equal to the $15,000 at the end of the year, the Partnership would break even on a cash flow basis. However, the balance of the interest only debt at the end of the year would still be $300,000 while the building’s adjusted basis would be only $290,000. Thus, if the building were given back to the lender, the Partnership would have $10,000 of gain. This is the minimum amount of gain possible no matter whether the building is given back to the lender, burns down, or is sold. This $10,000 is the “Minimum Gain.”\textsuperscript{19}

\begin{itemize}
  \item \textsuperscript{15} Treas. Reg. § 1.704-2(d)(1).
  \item \textsuperscript{16} See I.R.C. § 7701(g) (“in determining the amount of gain or loss (or deemed gain or loss) with respect to any property, the fair market value of such property shall be treated as being not less than the amount of any nonrecourse indebtedness to which such property is subject’’); Treas. Reg. § 1.1001-2 (amount realized from disposition of property includes the amount of debt a taxpayer is discharged from); Commissioner v. Tufts, 461 U.S. 300, 317 (1983) (amount realized from disposition of property includes nonrecourse debt that exceeded the value of the property).
  \item \textsuperscript{17} See I.R.C. § 1001 (gain equals amount realized less adjusted basis).
  \item \textsuperscript{18} I.R.C. § 168(g)(2).
  \item \textsuperscript{19} One can ask, why does the IRS allow one’s capital account to go negative due to minimum gain. The partner is taking more tax benefits (usually depreciation) than the amount of capital it contributed. The reason this is allowed is that
\end{itemize}
Whether a Partnership will generate minimum gain depends on a number of factors. LIHTC projects that have slow debt amortization, especially interest only loans or loans where interest is accruing, are much more likely to have minimum gain. This is because depreciation will cause the adjusted basis to fall below the debt balance. Also, projects with more nonrecourse debt are more likely to have minimum gain because depreciation can cause the adjusted basis to fall below the debt balance more quickly. The likelihood that a Partnership will generate minimum gain is much higher for projects that receive their credits through the use of tax-exempt bonds. Such projects are generally eligible to receive less than half the LIHTC that projects that do not use tax-exempt bonds but instead receive allocated credits from the State Credit Agency authorized to issue the LIHTC. Because they are eligible for less LIHTC, the Investors in such transactions will contribute significantly less capital. Example 2 shows how tax-exempt bond financed projects receive much less equity and therefore need to borrow funds to make up for the lower equity amount.

Example 2. Assume the eligible basis of a newly constructed building is $10,000,000 and all of the units qualify for LIHTC. If the building uses tax-exempt bonds to receive its LIHTC, applying the July 2018 rate of 3.29% means that the maximum amount of LIHTC for the building would be $329,000 per year or $3,290,000 over 10 years. However, if the building did not use tax-exempt bonds and instead received an allocation of LIHTC from the State Credit Agency, the maximum amount of LIHTC

if a partner has such a negative capital account, the IRS knows that someday when the building is disposed of for any reason, e.g., default, fire, or sale, the Partnership will be deemed to have an amount received at least equal to the discharged debt. As a result, partners with a negative capital account will have taxable income allocated to them that reverses their negative capital account. In this way, the IRS is made whole by the partner paying tax on that income.


21. Tax-exempt bond financed projects compute the amount of LIHTCs to which they are entitled using a tax credit rate, i.e., “applicable percentage,” such that present value of the 10-year stream of credits is equal to 30% of the qualified basis of the building. I.R.C. § 42(b)(1)(B)(ii). The applicable percentage for June 2018 is 3.29%. Rev. Rul. 2018-19, I.R.B. 2018-27 (June 18, 2018). Projects financed without tax-exempt bonds that receive an allocation of credits from the state credit agency use an applicable percentage for new construction costs or rehabilitation costs that creates a present value of the 10-year stream of credits equal to 70% of the qualified basis of the building. I.R.C. § 42(b)(1)(B)(i). However, acquisition costs for projects with state allocations still use the 30% rate. I.R.C. § 42(b)(1)(B)(ii). The 70% rate for July 2018 is 7.68%. Rev. Rul. 2018-19. However, under a revision to Code Section 42, the applicable percentage for new construction or rehabilitation costs for projects that do not use tax-exempt bonds is 9%. I.R.C. § 42(b)(2).

22. See footnote 21.
would be $900,000 per year or $9,000,000.23 The tax-exempt bond-financed building has $5,710,000 less LIHTC than the building financed without bonds. That is 63.4% less LIHTC. As a result, the Partnership owning the tax-exempt bond financed building will need to find other sources of funds to make up the much lower equity the Investor will invest due to receiving $5,710,000 less LIHTC. This shortfall is commonly solved with additional debt.

In addition to having more debt and more minimum gain, tax-exempt bond transactions also have significantly less Investor equity. Thus the depreciation and losses on a $10,000,000 tax-exempt bond-financed building will consume the Investor’s small amount of capital much more quickly than the exact same amount of losses on a building financed without tax-exempt bonds.24 Therefore the need for good Partnership Minimum Gain (described further below) is much more common in tax-exempt bond transactions.

B. Allocations of Debt and Minimum Gain

Because of the possibility of negative capital accounts, whether or not an Investor is allocated minimum gain is very important for LIHTC transactions. This in turn depends on the type of debt.

1. Partnership Nonrecourse Debt

The general rule is that debt is allocated to the partner that bears the economic risk of loss.25 Minimum Gain generated from nonrecourse debt for which no partner bears the economic risk of loss is called “Partnership Minimum Gain.”26 The partners in a Partnership have significant flexibility in choosing how to allocate Partnership Minimum Gain among the partners.27 Generally they choose to allocate 99.99% of the Partnership Minimum Gain to the Investor. As a result the Investor can continue to receive tax losses and LIHTC even though it has exhausted its capital account and the capital account turns negative.28

23. The building financed without tax-exempt bonds would use an applicable percentage of 9%. I.R.C. § 42(b)(2); see also footnote 21.
24. The foregoing assumes that the State Credit Agency chooses to allocate LIHTC to the Project in an amount that is higher than what would be earned through the use of tax-exempt bonds. However, it is common that the amount of LIHTCs allocated by State Credit Agencies for a non-bond transaction is much higher than the amount of LIHTCs that would have been earned through the use of tax-exempt bonds.
27. See note 30.
28. The reason for this is that under the partnership tax rules, if the building is ever disposed of—even if it is turned over to the lender for nothing other than satisfaction of the debt—the owner (and thus the 99.99% investor) will have taxable
Any time Minimum Gain exists, “Nonrecourse Deductions” are created equal to the amount of Minimum Gain created. Under Treasury Regulations Sections 1.704-2(c) and 1.704-2(j), nonrecourse deductions first consist of depreciation to the extent there is sufficient depreciation. As long as there is no Partner Nonrecourse Debt, Partnerships can generally allocate 99.99% of nonrecourse deductions to the Investor and as a result the Investor gets 99.99% of the depreciation and 99.99% of LIHTCs.

In summary, Partnership Nonrecourse Debt allows Investors to go negative in their capital accounts and also allows depreciation and LIHTCs to be allocated to them. Thus it is the best type of debt for a LIHTC transaction.

2. Recourse Debt

If the debt is recourse, the above rules do not apply. This is because the GP usually bears the risk of loss on recourse debt. If the Partnership defaults on the loan, then the GP will have to pay off the lender. Because the Partnership would have paid the debt in full (via the GP’s funds), there is no gain and thus no Minimum Gain. As a result, an Investor cannot go negative in its capital account based on such a loan. Thus, when the Investor’s capital account reaches zero and there is only recourse debt, then the Investor will no longer be able to receive LIHTC, resulting in the problems discussed above.

An additional important difference between recourse debt and Partnership nonrecourse debt is that because recourse debt generally does not create minimum gain, it also does not create nonrecourse deductions. Thus while recourse debt does not allow an Investor to go negative in its capital account, at least it does not force an allocation of nonrecourse deduction to the GP that would then drag depreciation and LIHTCs over to the GP. Therefore, recourse debt is the second best type of debt.

3. Partner Nonrecourse Debt

Significant problems can occur where there is financing that is nonrecourse but guaranteed by the GP or someone related to the GP or if the gain equal to at least the amount of Minimum Gain. From the IRS perspective, that taxable gain makes up for the fact that prior tax losses exceeded the equity put in by the Investor. LIHTC investors can live with this tax result.


30. Under Treas. Reg. § 1.704-2(e)(3), partners can allocate nonrecourse deductions “in a manner that is reasonably consistent with allocations that have substantial economic effect of some other significant partnership item attributable to the property securing the nonrecourse liabilities.” Treas. Reg. § 1.704-2 then generally provides that minimum gain is allocated in the same manner as the nonrecourse deductions.

31. It is possible that recourse debt could cause a Partnership to create minimum gain sooner under the “stacking rules” of Treasury Regulation Section 1.704-2(d)(2). This would occur where the recourse debt’s mortgage lien is senior to the mortgage lien of nonrecourse debt. The scope of the stacking rules is beyond the scope of this essay.
loan is from the GP or someone related to the GP. In such a case any minimum gain that is generated is considered “Partner Minimum Gain.” Partner Minimum Gain is required to be allocated to the GP because the GP bears the risk of loss related to the loan.32 In addition, any time Partner Minimum Gain exists, Nonrecourse Deductions up to the increase in the amount of Partner Minimum Gain must be allocated to the GP and are called “Partner Nonrecourse Deductions.”33 Because the Nonrecourse Deductions will be primarily composed of depreciation, this will cause LIHTC to be reallocated over to the related party partner. If there is debt from a related party or an affiliate of a related party in an LIHTC transaction, such debt will almost always come from the GP or someone related to the GP. As a result, the presence of GP nonrecourse debt or GP affiliate nonrecourse debt will often cause LIHTC to be reallocated to the GP rather than the Investor. This is true even if the Investor has a positive capital account.

Partner Nonrecourse Debt is the least desirable form of debt. If Partner Minimum Gain is generated, that will force depreciation and LIHTCs to go to the GP. In addition, any Minimum Gain generated will be Partner Minimum Gain allocated to the GP and thus the Minimum Gain will not allow the Investor to go negative in its capital account.

III. Conclusion

This essay illustrated a few important points about how nonrecourse debt can be used to fully maximize LIHTC investment. As described above, third party nonrecourse debt gives a project the best chance to allow an Investor to fully utilize all the LIHTC by allowing the creation of Partnership Minimum Gain. Such Partnership Minimum Gain can be allocated to the Investor and can allow the Investor to go negative in its capital account and thus continue to be allocated LIHTC. In contrast, recourse debt does not create Minimum Gain and still reduces the ability of Investors to be allocated 99.99% of the LIHTC. When the Investor’s capital account reaches zero, it will no longer be allocated any tax losses or LIHTC. Nonrecourse debt from the GP or nonrecourse debt guaranteed by the GP is the least desirable kind of debt from a LIHTC perspective. It can create Partner Minimum Gain, which forces LIHTC to be reallocated to the GP even if the Investor has a positive capital account. As previously stated, the above explanation is a significant simplification of the actual rules. Thus, the discussion included here is not equally applicable to every LIHTC transaction. Financial projections for each LIHTC project must be carefully analyzed.