Affordable Housing and Resident Health

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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,[1] all of which impact individual and communal health outcomes. Particularly within the context of chronic homelessness, research has demonstrated that providing hous-

1. *Social Determinants of Health, Key Concepts*, WORLD HEALTH ORGANIZATION, *available at* http://www.who.int/social_determinants/final_report/key_concepts_en.pdf?ua=1.

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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[2] 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.[3] 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.

2. *See* Olmstead v. L.C., 527 U.S. 581 (1999); *see also* Dep't of Justice, Civil Rights Div., *Statement of the Department of Justice on Enforcing the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*, *available at* https://www.ada.gov/olmstead/q&a_olmstead.htm (last accessed May 13, 2018).

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-

4. Harvard Joint Center on Housing Studies of Harvard University, *America's Rental Housing 2017* at 26–27, *available at* http://www.jchs.harvard.edu/americas-rental-housing.

5. *Id.*

6. *Id.* at 5.

7. *Id.*

8. U.S. Department of Housing and Urban Development, *Worst Case Housing Needs: Report to Congress 2017* 17, *available at* https://www.huduser.gov/portal/publications/Worst-Case-Housing-Needs.html.

9. *Id.*

10. Elizabeth L. March et al., *Rx for Hunger: Affordable Housing*, Children's HealthWatch and Medical-Legal Partnership of Boston (Dec. 2009), *available at* http://www.issuelab.org/resources/5379/5379.pdf.

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

11. Bipartisan Policy Commission, *Building the Case: Low Income Housing Tax Credits and Health*, *available at* https://bipartisanpolicy.org/wp-content/uploads/2017/11/BPC-Health-Building-the-Case-Low-Income-Housing-Tax-Credits-and-Health.pdf.

12. Megan Sandel et al., *Unstable Housing and Caregiver and Child Health in Renter Families*, Pediatrics (Jan. 2018), *available at* http://pediatrics.aappublications.org/content/early/2018/01/18/peds.2017-2199.

13. Child Health Impact Working Group, *Affordable Housing and Child Health: A Child Health Impact Assessment of the Massachusetts Rental Voucher Program Executive Summary* (2005), *available at* http://www.pewtrusts.org/~/media/assets/external-sites/health-impact-project/massachusettsrentalvoucherprogram.pdf?la=en.

14. *Id.*

15. Diana Becker Cutts et al., *US Housing Insecurity and the Health of Very Young Children*, 101(8) Am. J. Pub. Health 1508–14 (2011), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3134514/.

16. March et al., *supra* note 10.

17. *Picture of Subsidized Households 2017*, U.S. Dep't of Housing and Urban Development, *available at* https://www.huduser.gov/portal/datasets/assthsg.html.

18. *Understanding Whom the LIHTC Serves: Data on Tenants in LIHTC Units as of December 31, 2015*, U.S. Dep't of Housing and Urban Development (Mar. 2018), *available at* https://www.huduser.gov/portal/sites/default/files/pdf/LIHTC-TenantReport-2015.pdf.

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.[19] Over the next 20 years, nearly 40% of individuals 62 or older will have assets of $25,000 or less.[20] The number of senior renter households will more than double from 2010 to 2030—from 5.8 million to 12.2 million.[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.[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.[23] Among LIHTC units, approximately 26% are already occupied by households headed by someone 62 and over.[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.[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

19. *Baby Boomers Retire*, Pew Research Center (Dec. 29, 2010), *available at* http://www.pewresearch.org/fact-tank/2010/12/29/baby-boomers-retire/.

20. Bipartisan Policy Commission, *Healthy Aging Begins at Home* at 38, *available at* https://bipartisanpolicy.org/wp-content/uploads/2016/05/BPC-Healthy-Aging.pdf.

21. Laurie Goodman, Rolf Pendall & Jun Zhu, *Explosion in Senior Households by 2030 Demands Housing and Community, Adaptations*, Urban Institute (June 15, 2015), https://www.urban.org/urban-wire/explosion-senior-households-2030-demands-housing-and-community-adaptations.

22. National Low Income Housing Coalition, *The Gap: A Shortage of Affordable Homes*, (Mar. 2017), *available at* http://nlihc.org/sites/default/files/gap/Gap-Report_2018.pdf.

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.

24. *Understanding Whom the LIHTC Serves*, *supra* note 18.

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.[26] HUD calculates AMI for metropolitan areas and on a national non-metropolitan basis and publishes AMI and the derived income limits annually.[27] 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.[28] In states that have expanded Medicaid eligibility, households with MAGI below 133% of FPL may be eligible for Medicaid.[29] 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

26. 24 C.F.R. § 5.603; 24 C.F.R. § 92.2.

27. *See Income Limits*, U.S. Dep't of Housing and Urban Development, *available at* https://www.huduser.gov/portal/datasets/il.html.

28. 42 C.F.R. Part 435, Subpart B.

29. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14). The ACA provides for expansion of coverage to those with MAGI below 133% of the FPL, but also allows a 5% deduction from the FPL, effectively making the limit 138% of FPL. *See ACA Note: When 133 Equals 138–FPL Calculations in the Affordable Care Act*, State Health Access Data Assistance Center, (Jan. 27, 2012), *available at* http://www.shadac.org/news/aca-note-when-133-equals-138-fpl-calculations-affordable-care-act. For a general overview of Medicaid eligibility, see Medicaid.gov, https://www.medicaid.gov/medicaid/eligibility/.

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).[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.[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.[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.

An Evolving Landscape: Changes in Policy and Practice Prior to the Affordable Care Act

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[33] and later expanded to serve non-elderly persons with disabilities, initially under the Section 202/162 program[34] and subsequently its successor, the Section 811 program designed to provide supportive housing for non-elderly persons with disabilities.[35] Much of the housing developed under the Section 202/162 and Section 811 pro-

30. *Dual Eligibles*, Centers for Medicare & Medicaid Services, https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html.

31. *Update on Demonstrations for Dual-Eligible Medicare-Medicaid Beneficiaries*, Bipartisan Policy Center (Aug. 2017), *available at* https://bipartisanpolicy.org/wp-content/uploads/2017/08/BPC-Health-Update-on-Demonstrations-for-Dual-Eligible-Medicare-Medicaid-Beneficiaries.pdf.

32. *Id.*

33. *See* Section 202 of the Housing Act of 1959, Pub. L. No. 86-372, Title II, 73 Stat. 667, enacted Sept. 23, 1959 (codified at 12 U.S.C. § 1701).

34. *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.

35. *See* Cranston-Gonzales National Affordable Housing Act of 1990 (1990 Act), Pub. L. No. 101-625, § 811, 104 Stat. 4085, enacted Nov. 28, 1990 (codified at 42 U.S.C. § 8013). Among other changes, Section 811 limited building size maximums to 24 persons in independent living facilities for persons with disabilities and to 20 persons per building in projects serving persons with chronic mental illness; the maximum size for group homes was reduced from 15 to 8 persons. *See* Applied Real Estate Analysis, Inc., Evaluation of Supportive Housing Program for Persons with Disabilities,

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[39] 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-

Vol. 1: *Findings* (July 1995) (report prepared for HUD), *available at* https://www.huduser.gov/Publications/pdf/suphous1.pdf (last accessed May 21, 2018).

36. *Id.*

37. *See* Congregate Housing Services Act of 1978, Pub. L. No. 95-557, Title IV, § 402, 92 Stat. 2104, enacted Oct. 31, 1978 (codified as 42 U.S.C. § 8001 *et seq.*).

38. *See* 1990 Act § 802 (codified at 42 U.S.C. § 8011) (Appendix 1); Housing and Community Development Act of 1992, Pub. L. No. 102-550, 106 Stat. 3672, enacted Oct. 28, 1992.

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.

41. *See* Jewish Community Housing for the Elderly, HUD.GOV, https://www.hud.gov/program_offices/housing/mfh/progdesc/chsp/jche; Caring Choices, JEWISH COMMUNITY HOUSING FOR THE ELDERLY, http://www.jche.org/caringchoices-306.shtml (last accessed May 15, 2018).

42. CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.medicaid.gov/medicaid/index.html.

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

43. *FY2017 Federal Medical Assistance Percentages*, U.S. Dep't of Health and Human Services, https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages. *See* 42 U.S.C. § 1396d (b) for relationship of income.

44. Congress introduced mandatory coverage of pregnant women, infants, and children through several legislative actions beginning in 1984. *See* Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health & Human Services, *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook* (Jan. 24, 2005), *available at* https://aspe.hhs.gov/report/using-medicaid-support-working-age-adults-serious-mental-illnesses-community-handbook#note2-13 (last accessed May 21, 2018).

45. *See* Gary Smith et al., Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health & Human Services, *Understanding Medicaid Home and Community Services: A Primer* (Oct. 1, 2000), *available at* https://aspe.hhs.gov/basic-report/understanding-medicaid-home-and-community-services-primer#Chap2 (last accessed May 21, 2018). As of 2000, nearly 3.6 million people were served through Medicaid medically needy programs, constituting 8% of all Medicaid beneficiaries, but 14% of Medicaid spending; by 2009, the number served had dropped somewhat, to 2.8 million. *See* Kaiser Commission on Medicaid and the Uninsured, *Medicaid Medically Need Programs: An Important Source of Medicaid Coverage* (Jan. 2003), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2014/07/medicallyneedy2003.pdf (last accessed May 21, 2018); Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Medically Need Programs: Spending and Enrollment Update* (Dec. 2012), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/4096.pdf (last accessed May 21, 2018).

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[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.[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.[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.[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.[50] Under a Section 1115 waiver, a state may use a new delivery system or way in

46. *See* 42 U.S.C. § 1386n (i).

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).

48. *Id.*

49. 42 U.S.C. § 1315.

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 eligibility 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 institutionalization, such as elderly or disabled individuals, rather than the population as a whole. Section 1915(c) waivers are limited, in that waiver programs 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 individuals 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 *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, HENRY J. KAISER FAMILY FOUNDATION, *available at* https://www.kff.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 & MEDICAID SERVICES, https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/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, *Summary of the Improved 1915i Medicaid Home and Community Based State Plan Amendment Options* (2010), *available at* http://www.csh.org/wp-content/uploads/2011/12/Report_HCBSfactsheet2010.pdf)).

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-

55. Pub. L. No. 109-171, 120 Stat. 4, enacted Feb. 8, 2006, § 6071. The ACA appropriated additional funding for grants to be awarded through federal fiscal year 2016; unused grant funds awarded in 2016 may be used through federal FY 2020. *See Money Follows the Person*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html (last accessed June 20, 2018).

56. Eric D. Hargan, Acting Secretary of the Department of Health and Human Services, *Report to the President and Congress, The Money Follows the Person (MFP) Rebalancing Demonstration, as Required by the Deficit Reduction Act of 2005 (P.L. 109-171) and Amended by the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)* (June 2017), *available at* https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf (last accessed May 15, 2018).

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.[60] 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.[61] 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,[62] 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.[63]

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).

61. *See* Internal Revenue Serv., Dep't of the Treasury, *IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report 1* (2009), *available at* http://www.irs.gov/pub/irs/tege/frepthospproj.pdf (last accessed May 15, 2018).

62. For an overview of research and policy evolution, *see* Libby Perl & Erin Bagalman, *Chronic Homelessness: Background, Research and Outcomes*, Congressional Research Service 7-5700 (Dec. 8, 2015), *available at* https://fas.org/sgp/crs/misc/R44302.pdf (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.

services. *See* Thomas Byrne & George Smart, *Estimating Cost Reductions Associated with the Community Support Program for People Experiencing Chronic Homelessness*, Blue Cross Blue Shield of Massachusetts Foundation (Mar. 2017), *available at* https://bluecrossmafoundation.org/sites/default/files/download/publication/CSPECH_Report_Mar17_FINAL.pdf (last accessed May 15, 2018).

64. Donald M. Berwick, Thomas W. Nolan & John Whittington, *The Triple Aim: Care, Health, and Cost*, 27(3) Health Affairs 759 (2008).

65. *Id.*

66. *Affordable Care Act*, Healthcare.gov, *available at* https://www.healthcare.gov/glossary/affordable-care-act/ (last accessed June 11, 2018).

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.[67] 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.[68] Medicaid now covers approximately one in five people in the United States.[69]

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.[70]

(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.

67. *Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/affordable-care-act/eligibility/index.html; *see also* note 28 *supra* regarding income eligibility limits.

68. *Status of State Action on the Medicaid Expansion Decision*, HENRY J. KAISER FAMILY FOUNDATION, *available at* https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care act/?current Timeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

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%22colId%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

71. Mathematica Policy Research, *Medicaid Managed Care Enrollment and Program Characteristics, 2016*, Centers for Medicare & Medicaid Services (Spring 2018), *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf.

72. Accountable Care Organization, Centers for Medicare & Medicaid Services, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/ (last accessed June 11, 2018).

73. *Accountable Care Organizations, Explained*, Kaiser Health News, https://khn.org/news/aco-accountable-care-organization-faq/.

74. Viveiros, *supra* note 51, at 5.

was established to improve care and lower costs.[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.[76] The demonstrations included both a capitated model and a fee for services model. As of 2016, 13 states were participating.[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.[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.[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.[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

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/.

76. *Update on Demonstrations for Dual-Eligible Medicare-Medicaid Beneficiaries*, Bipartisan Policy Center (Aug. 2017), *available at* https://bipartisanpolicy.org/wp-content/uploads/2017/08/BPC-Health-Update-on-Demonstrations-for-Dual-Eligible-Medicare-Medicaid-Beneficiaries.pdf.

77. *Medicare-Medicaid Coordination Office Fiscal Year 2016 Report to Congress*, Centers for Medicare & Medicaid Services, *available at* https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2016_RTC.pdf.

78. *Update on Demonstrations for Dual-Eligible Medicare-Medicaid Beneficiaries*, *supra* note 76.

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.

80. Cindy Mann, *CMCS Informational Bulletin, Update on Preventative Services Initiative*, Centers for Medicare & Medicaid Services (Nov. 27, 2013), *available at* https://www.medicaid.gov/federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf.

through waivers and, while in place, the Money Follows Person program.[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.[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."[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-

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.

82. *Id.*

83. *Exempt Organizations Update Archive*, INTERNAL REVENUE SERVICE, https://www.irs.gov/charities-non-profits/exempt-organizations-update-archive (Dec. 18, 2015).

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.

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).

85. *Housing and Community Benefit: What Counts?*, Enterprise Community Partners & Catholic Health Association of the United States, *available at* https://www.enterprisecommunity.org/resources/housing-and-community-benefit-what-counts-6230.

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)[86] 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.[87] 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.[88]

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.[89] 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.[90]

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.

89. Pub. L. No. 113-76 Div. L, tit. II (Jan. 17, 2014).

90. Press Release, U.S. Dep't of Housing & Urban Development, HUD Announces $15M to Test a New Approach to Help Low-Income Seniors Age in Place (Jan. 13, 2017), *available at* https://www.hud.gov/press/press_releases_media_advisories/2017/HUDNo_17-007.

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.[91] 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.[92] UHC and CPLC have previously partnered to create an electronic referral system that provided comprehensive data to CPLC for United

91. *Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing*, FR-5900-N-22, U.S. Dep't of Housing and Urban Development (Sept. 18, 2015), *available at* https://www.hud.gov/sites/documents/2015SSDEMO-NOFA.PDF.

92. Mercy Housing, Low Income Investment Fund for the California Endowment, and Kresge Foundation, *Innovative Models in Health and Housing, Case Study 2: Managed Care Capital Investment to Improve Community Health* (Aug. 2017), *available at* http://www.liifund.org/wp-content/uploads/2017/08/Health-and-Housing-LIIF-Mercy-Report-2017.pdf.

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,[93] 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.[94] 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.[95]

93. Press Release, UnitedHealth Group, $22 Million UnitedHealth Group Investment Helps Fund Three New Affordable-Housing Communities in New Mexico (June 25, 2013), *available at* http://www.unitedhealthgroup.com/Newsroom/Articles/Feed/UnitedHealth%20Group/2013/0625AffordableHousingNewMexico.aspx.

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

95. Janet Vivieros, *Investing in Affordable Housing to Promote Community Health: A Profile on the United Healthcare Community & State Partnership with Chicanos Por La Causa*, National Housing Conference, *available at* https://www.nhc.org/wp-content/uploads/2017/03/Investing-in-Affordable-Housing-to-Promote-Community-Health.pdf.

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.

97. Kevin Boes, *Connecting Housing and Health Care through Community Development*, 25(1) COMMUNITY INVESTMENTS 19 (Spring 2013), *available at* https://www.frbsf.org/community-development/files/Boes_CISP13.pdf.

98. *Healthy Futures Fund*, LISC.ORG, http://www.lisc.org/our-initiatives/health/healthy-futures-fund/.

99. *Tax Credits at the Center of Health, Housing and Economic Mobility*, LISC.ORG, http://www.lisc.org/media/filer_public/1f/78/1f781b46-3c16-45f7-bae1f362c4cfceb9/04262018_conway_center_one_pg__final.pdf.

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)[101] 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).[102] 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.[103]

101. Pub. L. 104-191, 110 Stat. 1936, enacted Aug. 21, 1996. Provisions relevant to privacy are codified at 42 U.S.C. §§ 1320d *et seq.*

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.[104] 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.[105]

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 consitute a HIPAA violation *if* their employer is a HIPAA-covered entity, or a business associate of a HIPAA-covered entity.[106] 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.[107] 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.[108]

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-

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.

107. 42 U.S.C. § 1320d-1, 1320d-2.

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[109] and other federal statutes governing HUD programs[110] restrict disclosure of certain personal information about the people served in HUD programs. HUD regulations setting forth general HUD program requirements[111] require recipients of HUD assistance, including public housing authorities[112] 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[113] (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.[114] "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).[115] Many private entities and local public agencies in Massachusetts fall within the definition of "holder" with respect to per-

109. 5 U.S.C. § 552a; *see also* Freedom of Information Act, 5 U.S.C. § 552.

110. S*ee, e.g.*, Section 208 of the E-Government Act; Housing and Community Development Act of 1987, 42 U.S.C. § 1437d(q)(4), 42 U.S.C. § 1437d(t)(2), 42 U.S.C. § 3543; and the Stewart B. McKinney Homeless Assistance Act of 1988, 42 U.S.C. § 3544.

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.[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.[117] Indeed, a recent Superior Court decision found that FIPA would prohibit disclosure of information that would *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.[118] In addition, states may establish a private right of action for interference with an individual's privacy by statute[119] or case law.[120]

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.

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.

117. *See* Globe Newspaper Co. v. Boston Retirement Bd., 388 Mass. 427, 438 (1983).

118. *See* Hardiman v. Mass. Dep't of Developmental Servs. et al., C.A. No. 2014-01561-H (Mass. Super. Ct. Mar. 3, 2016).

119. *See, e.g.*, MASS. GEN. LAWS c. 214, § 1B.

120. *See, 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,[121] provides a credit[122] against federal income taxes for taxpayers that develop (through new construction or substantial rehabilitation of existing buildings) qualified rental housing[123] in which at least the statutorily required percentage of units[124] is both income-restricted and rent-restricted.[125] Although the amount of LIHTC allocated to a state to support projects in any given year is limited by statute,[126] HUD has recognized that the LIHTC program remains the "most important resource for creating affordable housing in the United States today."[127]

121. Pub. L. No. 99-614, 100 Stat. 2085, enacted Oct. 22, 1986. The LIHTC is codified as Section 42 of the Internal Revenue Code of 1986, as amended (IRC).

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).

127. *Low Income Housing Tax Credits*, U.S. DEP'T OF HOUSING AND URBAN DEVELOPMENT (rev. July 10, 2017), *available at* https://www.huduser.gov/portal/datasets/lihtc.html (last accessed May 9, 2018). According to HUD data, "an average of over 1,460 projects

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.[128] However, state housing credit agencies may also approve additional "4% credits" in projects financed with certain tax-exempt bonds[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.[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."[131] Treasury Regulation § 1.42-9(b)[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).[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-

and 110,000 units were placed in service annually between 1995–2015." *Id.* (citing HUD's National Low Income Housing Tax Credit (LIHTC) Database: Projects Placed in Service Through 2015).

128. *See* 26 U.S.C. § 42(m).

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.

130. 26 U.S.C. § 42(h)(4); 26 U.S.C. § 146.

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).

132. 26 C.F.R. § 1.142-9(b).

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.

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. For such properties, the amount of "qualified basis" on which the credit is calculated explicitly includes certain portions of the property used to provide supportive services to assist homeless residents in locating and retaining permanent housing. *See* 26 U.S.C. §§ 42(c)(1)(E); 42(i)(3)(B)(iii).

135. Rev. Rul. 98-47, 1998-2 C.B. 397, issued Sept. 28, 1998.

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.[137]

Subsequently, in Pvt. Ltr. Rul. 199949044,[138] 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.[139]

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.[140] In that ruling, the IRS found that an assisted living facility qualified as residential rental property notwithstanding the availability of health-related services[141] 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.

137. Pvt. Ltr. Rul. 9814006 (1997).

138. Pvt. Ltr. Rul. 199949044 (addressing LIHTC under IRC § 42).

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).

140. Pvt. Ltr. Rul. 200038001 (June 28, 2000) (addressing tax-exempt bonds under IRC § 142).

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.[142]

b. Federal HOME Program

The HOME Investment Partnerships Act of 1990[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.[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.[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.[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[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[148] expressly contemplates the use of HOME funds to support group homes with live-in supportive service providers. Similarly, HUD Notice CPD 01-01[149] clarifies that HOME funds may be combined with

142. I.R.C. § 42(g)(99), added by the Housing and Economic Recovery Act of 2008, Pub. L. No. 110–289, 122 Stat. 2654, enacted July 30, 2008.

143. Enacted as part of the Cranston-Gonzales National Affordable Housing Act of 1990, Pub. L. No. 101-625, 104 Stat. 4085 (codified at 42 U.S.C. § 12741 *et seq*.).

144. *See* 42 U.S.C. §§ 12746–12747.

145. *See* 42 U.S.C. §§ 12750–12752.

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 . . ."

147. Pub. L. No. 100-77, July 22, 1987, 101 Stat. 482, 42 U.S.C. § 11301 *et seq*.

148. HUD Notice 94-01, Using HOME Funds for Single-Room Occupancy (SRO) and Group Housing (Jan. 4, 1994), *available at* https://www.hudexchange.info/resources/documents/Notice-CPD-94-01-Using-HOME-Funds-Sro-Group-Housing.pdf (last accessed May 13, 2018).

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.[150]

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,[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.[152] Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability in programs and activities receiving federal financial assistance.[153]

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

2001), *available at* https://www.hudexchange.info/resources/documents/Notice-CPD-01-01-Combining-Mckinney-Act-Hopwa-HOME.pdf (last accessed May 13, 2018).

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.

151. Title VIII of the Civil Rights Act of 1968, Pub. L. No. 90-284, 82 Stat. 73, enacted April 11, 1968 (codified as 42 U.S.C. § 3601 *et seq.*).

152. Pub. L. No. 93-112, 87 Stat. 394 (codified at 29 U.S.C. § 701 *et seq.*)

153. *See* 29 U.S.C. § 701.

154. Pub. L. No. 100-430, 102 Stat. 1619, enacted Sept. 13, 1988.

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,[156] on the basis of disability.[157] 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.[158]

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.[159] HUD regulations extend this requirement to use and enjoyment of public and common areas.[160] 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.[161] Additional requirements relating to architectural access are imposed under the Architectural Barriers Act of 1968.[162] These laws impose a variety of requirements, including architec-

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of a handicap" of the buyer or renter, a member of his household, or any person associated with him. 42 U.S.C. § 3604; *see also* 24 C.F.R. Part 100, Subpart D.

156. Certain single-family homes sold or rented by an owner, as well as owner-occupied one-to-four family dwellings, are exempt. *See* 42 U.S.C. § 3603.

157. 42 U.S.C. § 3604(f). The term used in the Fair Housing Act is "handicap," defined to mean,

> with respect to a person—
>
> (1) A physical or mental impairment which substantially limits one or more of such person's major life activities,
> (2) A record of having such an impairment, or
> (3) Being regarded as having such an impairment,
>
> But such term does not include current, illegal use of or addiction to a controlled substance (as defined in section 802 of title 21).

42 U.S.C. § 3602(h). This wording is substantively identical to the wording in the Americans with Disabilities Act. This Article uses the term "disability" consistently notwithstanding the terminology used in the FHA.

For an excellent summary of the FHA design and construction requirements, with additional references to other sources of law, see HUD and DOJ, *Joint Statement of the Department of Housing and Urban Development and the Department of Justice, Accessibility (Design and Construction) Requirements Under the Fair Housing Act*, *available at* https://www.hud.gov/sites/documents/JOINTSTATEMENT.PDF (last accessed May 23, 2018).

158. *See* 24 C.F.R. § 8.22.

159. *See* 42 U.S.C. § 3604(f)(2).

160. *See* 24 C.F.R. § 100.204.

161. *See* 42 U.S.C. § 3604(f)(3).

162. Pub. L. No. 94-541.

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)[163] prohibits discrimination by any state or local "public entity"[164] against any qualified individual with a disability (Title II) as well as discrimination in any places of public accommodation, including social services programs.[165] HUD regulations implementing Title II prohibit discrimination by private entities receiving federal financial assistance under any HUD program or activity.[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.[167] Although only public entities themselves are liable in a private right of action for Title II violations,[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.[169] In addition, a housing owner providing social services programs may be directly liable for violations under Title III.[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-

163. Pub. L. No. 101-336, 104 Stat. 327, enacted July 26, 1990 (codified at 42 U.S.C. § 12101 *et seq.*).

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.

167. *See* Treas. Reg. 1.42-9, 26 C.F.R. § 1.42-9; Memorandum of Understanding Among the Department of the Treasury, the Department of Housing and Urban Development and the Department of Justice (Aug. 2000), *available at* https://www.novoco.com/sites/default/files/atoms/files/mou_081100.pdf (LIHTC MOU).

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.

170. *See* 42 U.S.C. § 12188; *see also* § 28 C.F.R. 36.501.

ified individuals with disabilities.[171] 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.[172]

a. *Olmstead* decision

In a landmark 1999 decision, *Olmstead v. L.C.*,[173] 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,"[174] finding that "[u]njustified isolation . . . is properly regarded as discrimination based on disability."[175] 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."[176] 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.[177]

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"[178]:

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).

173. 527 U.S. 581 (1999).

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.

178. *See* Dep't of Justice, Civil Rights Div., *Statement of the Department of Justice on Enforcing the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.* (June 22, 2011), *available at* https://www.ada.gov/olmstead/q&a_olmstead.htm (last accessed May 14, 2018).

> 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 nonelderly 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).

181. The Housing for Older Persons Act of 1995, Pub. L. No. 104-76, 109 Stat. 787, enacted Dec. 28, 1995, amended Title VIII of the FHA to expressly permit certain age-restricted housing, notwithstanding provisions of the FHA that would otherwise prohibit discrimination on the basis of familial status. *See* 42 U.S.C. § 3607.

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.

183. *See, e.g.*, National Association of State Mental Health Program Directors Research Institute, Inc., National Association of State Alcohol/Drug Abuse Directors & Truven Health Analytics, Inc., *Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2013*, *available at* https://www.nri-inc.org/media/1104/2013-funding-and-characteristics-of-single-

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]

state-agencies-for-substance-abuse-services-and-state-mental-health-agencies-lutterman.pdf (last accessed May 22, 2018).

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.*[186] 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."[187] 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.[188]

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.[189] 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.

Id.

186. *Id.* at 6.

187. *Id.*

188. *See Section 504 Frequently Asked Questions*, DEP'T OF HOUSING AND URBAN DEVELOPMENT, *available at* https://www.hud.gov/program_offices/fair_housing_equal_opp/disabilities/sect504faq#anchor261701 (last accessed May 22, 2018).

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 regulations[193] 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.*

193. *See* 24 C.F.R. § 5.655; *see also* 24 C.F.R. Parts 402, 880–881 (new construction and substantial rehabilitation programs), 883–884 (state-administered PBRA and new construction set-aside for Section 515 Rural Rental Housing Projects administered by the U.S. Department of Agriculture).

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.[195] HUD PBRA regulations mirror HUD's regulations governing tenant-based housing choice voucher assistance, allowing an owner to adopt 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.[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.[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.[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.[199]

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[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)."[201] Owners of rental

195. *See generally Rental Assistance Demonstration (RAD) Quick Reference Guide to Multifamily Housing Requirements* (Oct. 2015), DEP'T OF HOUSING AND URBAN DEVELOPMENT, *available a*t https://www.hud.gov/sites/documents/RAD_PBRAQUICKREF.PDF (last accessed May 22, 2018).

196. *See* 24 C.F.R. § 5.655(c)(3).

197. *See* 24 C.F.R. § 880.601(e).

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.

199. *See* 24 C.F.R. § 880.205.

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.

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 order[207]—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.

202. *See* 24 C.F.R. § 92.253(d)(3).

203. Pub. L. No. 111-22, enacted May 20, 2009.

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).

205. *See Coordinated Entry Policy Brief*, Dep't of Housing and Urban Development, *available at* https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf (last accessed May 14, 2018).

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).

210. Notice CPD-14-012, Notice on Prioritizing Persons Experiencing Chronic Homelessness in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status (July 28, 2014), *available at* https://www.hudexchange.info/resources/documents/Notice-CPD-14-012-Prioritizing-Persons-Experiencing-Chronic-Homelessness-in-PSH-and-Recordkeeping-Requirements.pdf (last accessed May 14, 2018).

211. *Frequently Asked Questions on Notice CPD-14-012*, at 10, Dep't of Housing and Urban Development, *available at* https://www.hudexchange.info/resources/documents/FAQs-Notice-CPD-14-012.pdf (last accessed May 14, 2018).

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[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.[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.[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.[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.[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.[219] Based on public comment, CMS elected not to utilize the term "disability-specific housing complex" included in an earlier draft

214. 42 C.F.R. 430, 431, 435, 436, 440, 441, and 447. *See* Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 Fed. Reg. 2947 *et seq.* (Jan. 16, 2014).

215. *Id.* at 2947.

216. *Id.*, 42 C.F.R. § 710(a).

217. *Id.*

218. *Id.*

219. See 79 Fed. Reg. at 2971–72.

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.

Olmstead v. L.C., 527 U.S. 581, 597 (1999)

- 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,[223] 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.[224] 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.[225] Units assisted through Section 811 PRA at a multifamily housing project cannot exceed 25% of the units at the project.[226]

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.[227]

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

223. Pub. L. No. 111-374, Jan. 4, 2011 (Melville Act), amending Section 811 of the 1990 Act. References below are to Section 811 as amended by the Melville Act.

224. Section 811(b)(3)(A).

225. Section 811(b)(3)(D).

226. Section 811(b)(3)(B)(2).

227. For a discussion of a variety of challenges in attracting owners to participate in the 811 PRA program, including rent levels, financial feasibility, and program administrative requirements, see Randal Pinkett et al., *HUD Section 811 PRA Project Rental Assistance Program: Project Evaluation*, HUD Office of Policy Development and Research (Jan. 2018), *available at* https://www.huduser.gov/portal/sites/default/files/pdf/section-811-processeval-report.pdf (last accessed June 12, 2018).

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

228. An Act Relative to Community Housing and Services, Chapter 58 of the Acts of 2012, *available at* https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter58.

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 HCBS[231] 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

wp-content/uploads/2017/06/Building-on-Success-Year-3-Final-Report-Interagency-Supportive-Housing-Initiative..pdf (last accessed May 14, 2018).

230. *See* ICHH Action Plan Meeting, June 30, 2017, Committee on Supportive Housing Production and Services, *available at* https://www.mass.gov/files/documents/2016/09/ws/interagency-council-supportive-housing.pdf (last accessed May 14, 2018).

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.[232] 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.[233]

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,[234] 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).

233. For a discussion of the challenges involved in preserving affordable housing, see generally Alexander von Hoffman, *To Preserve Affordable Housing in the United States: A Policy History* (Joint Center for Housing Studies Working Paper, Mar. 2016), *available at* http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/von_hoffman_to_preserve_affordable_housing_april16.pdf (last accessed June 10, 2018).

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-

challenges remain.[235] 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.[236]

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

ment, (4) primary health care, and (5) veteran health services. The CICH program was followed by a national evaluation, which showed positive trends in system integration and a "significant increase of 20% in the reported ability of CICH agencies to obtain information about clients served and services delivered to them by the CICH network." The evaluation did not address the issue of whether the increases in system integration and information-sharing were associated with improved client outcomes. Greg A. Greenberg & Robert A. Rosenheck, *HUD/HHS/VA Collaborative Initiative to Help End Chronic Homelessness: An Evaluation of an Initiative to Improve Coordination and Service Delivery of Homeless Services Networks*, Dep't of Health and Human Services (Feb. 13, 2007), *available at* https://aspe.hhs.gov/report/hudhhsva-collaborative-initiative-help-end-chronic-homelessness-evaluation-initiative-improve-coordination-and-service-delivery-homeless-services-networks (last accessed June 6, 2018). A subsequent study focusing on service use and two-year treatment outcomes found a 52% increase in days housed compared with chronically homeless individuals receiving more typical care in the same communities. The study also found that increased use of outpatient health and substance abuse services resulted in roughly 25% higher health care costs, while there were no significant differences in substance use, health status, or community adjustment outcomes. *See* Alvin S. Mares & Robert A. Rosenheck, *A Comparison of Treatment Outcomes Among Chronically Homeless Adults Receiving Comprehensive Housing and Health Care Services Versus Usual Local Care*, 38(6) Admin. & Pol'y Mental Health & Mental Health Servs. Research 459–75 (2011), *available at* https://doi.org/10.1007/s10488-011-0333-4 (last accessed June 10, 2018).

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).

236. *See generally Healthcare and Housing (H2) Systems Integration Initiative—State and Community Action Planning*, HUD Exchange, https://www.hudexchange.info/programs/housing-healthcare/action-planning/#connecticut (last accessed May 14, 2018).

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.