

Making Subsidized Rental Housing a Platform for Improved Health for Vulnerable Populations

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It is widely recognized that the supply of affordable housing is insufficient to meet demand, with only one in four eligible households receiving a subsidized unit under one of the U.S. Department of Housing and Urban Development's programs. There is also evidence that access to housing subsidies can contribute to positive health outcomes.¹ The purpose of this paper is to present several policy proposals to increase the use of rental housing subsidies and coordinated health care for people for whom housing is most likely to be a platform for health improvement or stabilization of health conditions. Such an increase will help the federal government make the most of its considerable investment in rental housing subsidies and also recognize that the resources currently devoted to federal subsidies for rental housing — and likely to be for the foreseeable future — are not sufficient to serve everyone who cannot afford housing without help. Therefore, better targeting of current resources makes sense.

¹ Sanbonmatsu, Lisa, et al, *Moving to Opportunity for Fair Housing Demonstration Program — Final Impacts Evaluation*, US Department of Housing and Urban Development, October 2011.

At the same time, to make this targeting work, residents of subsidized housing with health challenges and functional impairments will need access to coordinated health care and associated case management and other supports so that they can live in a community-based setting. The combination — and coordination — of housing, health care, and supportive services, if effectively delivered and well-targeted, can help to achieve savings in health care expenditures, which are major drivers in federal deficit projections.

Subsidized rental housing makes it possible for low-income people to live in housing that they would not be able to afford without a subsidy. Subsidized rental housing includes public housing owned and operated by public agencies, Housing Choice Vouchers, or similar rental subsidies used by low-income people to afford private market rental housing, housing produced by the Low Income Housing Tax Credit, and housing subsidized by rental assistance contracts between the federal government and private owners, including Section 202 housing for the elderly. The exhibit summarizes some salient features of these programs.

Housing Subsidy Programs That May Serve People with Special Needs

	PROGRAM SIZE AND TARGET POPULATION	SERVICES AND RENT RULES
HUD Programs		
Public Housing	Owned and operated by local public housing agencies (PHAs). Serves families and individuals, mainly with incomes below the poverty level. About 330,000 seniors, half in developments designed for seniors.	May have service coordinator. Tenant pays 30 percent of income.
Section 202 Supportive Housing for the Elderly	263,000 units owned by nonprofit owners. Serves seniors, mainly with incomes below the poverty level.	Services must be available on-site or in the community. May have service coordinator. Tenant pays 30 percent of income.
Section 8 projects (HUD multifamily assisted housing stock)	947,000 units owned by for-profit and non-profit owners with whom HUD contracts to provide housing to individuals and families, mainly with incomes below the poverty level.	May have service coordinator. Tenant pays 30 percent of income.
Housing Choice Vouchers	Rental assistance administered by PHAs for families and individuals, mainly with incomes below the poverty level.	Very low income individual or family uses voucher to rent apartment from private landlord.
Tenant-based vouchers	About 334,000 voucher-holders are seniors. About 70,000 vouchers are in special programs for non-elderly people with disabilities.	Tenant pays 30 percent of income for unit below a payment standard; may rent above payment standard and pay up to 40 percent of income. Tenants may take voucher if they move.
Project-based vouchers	Rental assistance administered by PHAs that may choose to use a portion of the Housing Choice Voucher program in this way.	Rental assistance is tied to unit, not to tenant. Tenant pays 30 percent of income. Tenants may not take subsidy if they move.
Section 811 Supportive Housing for Persons with Disabilities	Historically, Sect. 811 provided grants to nonprofit sponsors to develop and operate housing specifically for non-elderly people with disabilities, mainly with incomes below the poverty level. New demonstration for project-based rental assistance in mixed occupancy buildings.	Serves people with physical or developmental disabilities or mental illness. Services provided on or off-site. Tenant pays 30 percent of income.
HOME Block Grant Program	Eligible uses include rental housing developments and tenant-based subsidies	Rental developments must be affordable for people with incomes below 65 percent of area median income, but rents do not vary with income. Tenant-based subsidies are very similar to Housing Choice Vouchers.
Homeless Assistance Grants	Various programs providing tenant or project-based assistance to people who experience homelessness. Administered by agencies associated with local homeless assistance networks. May be PHAs, public or nonprofit organizations. Some programs target homeless people with disabilities (e.g., Shelter Plus Care)	Services generally offered. Types, intensity, location of services vary. Rent rules vary--e.g., no rent, 30 percent of income, rent that goes into escrow for program graduates. Shelter Plus Care is similar to a Housing Choice Voucher.
Department of the Treasury		
Low Income Housing Tax Credit Program	State agencies allocate tax credits to investors in affordable rental developments. Housing may be owned by for-profit or non-profit owners. 27 percent of properties targeted to elderly, 12 percent to people with disabilities, 5 percent to homeless people.	Generally targeted to people with incomes up to 60 percent of AMI, but many state allocation plans have incentives to target lower incomes. Rents must be affordable for households below income target, but do not vary with income. Additional tenant- or project-based subsidies often needed to make rents affordable to renters with poverty-level incomes. May be linked to services.

People for whom subsidized rental housing is most likely to be a platform for health improvement or stabilization are individuals and members of families who have incomes below the poverty level and also have major health challenges and functional status issues. They include both seniors with frail health and younger people with physical or mental disabilities or major medical problems. The recent focus on providing supportive (or supported) housing to people with chronic patterns of homelessness has highlighted the importance of better coordination and integration across the health and housing sectors for people with complex health needs.

Access to health care raises two sets of issues: access to insurance (or coverage) and access to appropriate services. Medical care is available to many residents of subsidized rental housing through the Medicaid and Medicare programs. Others who are currently uninsured access care through the health care “safety net” that includes public hospitals and clinics, Community Health Centers, and “charity care.” However, not all vulnerable people in assisted housing have access to health care, the availability of community-based behavioral health services is often extremely limited, and funding for the health care coordination, case management, and supportive services needed to enable people with vulnerable health to live in a community setting can be difficult to access. Through its oversight of the Medicaid program and implementation of the Affordable Care Act, HHS may be able to provide states with the additional flexibility needed to make cost-effective use of health-care dollars for services in connection with assisted housing. However, it is the state administrators of the federal/state Medicaid program who will make the key decisions on how to use Medicaid’s flexibility for expanded coverage and community-based health care services.²

² The June 2012 Supreme Court decision on the ACA says states cannot be required to adopt the expanded eligibility provisions of the ACA, and some states have indicated they may opt out of the expansion. The Medicaid program

The following policy options do not represent official positions of Abt Associates or of any of the speakers at the Forum on the Intersection of Housing Policy and Health. The goal is to stimulate discussion on various options to target affordable housing effectively to vulnerable populations and to broaden and enhance access to community-based services and supports that promote health and stable housing.

We begin with a discussion of proposals for how affordable housing can be targeted more effectively to people with vulnerable health. The second half of the paper presents proposals for providing more complete and better coordinated health care to residents of subsidized housing in a way that is fiscally responsible.

Targeting Rental Housing Subsidies to People with Vulnerable Health

Proposal 1: The Section 202 program could be better used to serve elderly people with severe health conditions.

More than one-third (37 percent) of the approximately 5 million households receiving housing assistance from HUD are headed by an elderly person (defined by HUD as at least age 62). The Section 202 program is HUD’s primary program for producing affordable rental housing with supportive services for seniors in privately owned, HUD-assisted properties. More than 250,000 households are served in more than 5,000 Section 202 properties across the country.

HUD is committed to promoting aging in place for the low-income seniors served in its properties. One of HUD’s main aims in promoting aging in place is to help elderly households defer admission to nursing homes or other long-term care if their housing and

is a partnership between the federal government and states, and states have significant flexibility in defining covered services, payment mechanisms, and other program rules. Many of the services most likely to be connected to assisted housing can be covered through benefits that are available as “State Options.”

service needs can be met in HUD-assisted housing. A number of research studies have found that at least some residents of nursing homes and other long-term care facilities have relatively limited levels of impairment. These seniors could live independently if they had access to some services in the community.

A recent HUD-sponsored study found that housing occupied primarily by the elderly is successful in retaining residents until advanced average ages.³ These findings imply that resources to encourage and support aging in place may be best targeted to HUD-assisted households.

HUD has several mechanisms for supporting aging in place in Section 202 properties. The subsidies for the housing, or a related special grant program, can be used to cover the costs of service coordinators to link the housing to services the residents need. Service coordinators help residents access services in the community and may also work with property management to help outside organizations bring services such as Meals on Wheels, elder transportation programs, recreational activities, or personal care assistance to the property. Only about half of Section 202 properties have service coordinators, however. Furthermore, service coordinators are not generally qualified to address more severe or chronic health care needs.

Through the Assisted Living Conversion Program (ALCP), HUD provides grants to Section 202 owners to convert some or all of the units in elderly housing developments to assisted living or service-enriched housing. While this program does produce some additional units offering support for tenants with more complex or chronic health care needs, the ALCP is small, funding only between five and seven grants in the past several funding rounds

³ Locke, Gretchen, et al. *End of Participation in Assisted Housing: What Can We Learn About Aging in Place?* US Department of Housing and Urban Development, February 2011.

(FY2006 to FY2011). A 2005 HUD-sponsored study of the early implementation of the ALCP identified a number of reasons for the limited participation in the program. Many Section 202 units are occupied by people who meet the age qualification (age 62 or older) but who do not need the services linked to the property. Additional policy priorities that could increase the extent to which HUD's Section 202 program serves people with severe health conditions would more closely link housing and services:

- **Through information and referral** for seniors and their families and caregivers who are looking for service-enriched housing. Many states have used grants from the Aging and Disability Resource Center (ADRC) program or other sources to develop housing registries to serve as centralized information sources for housing available to the elderly and people with disabilities. ADRCs also serve as “one-stop shops” for community-based services and supports that seniors and people with disabilities may need. HUD and HHS should require PHAs and subsidized multifamily property owners and managers to contribute information on their housing options to these registries, including information on their units' accessibility features as well as services and amenities available on site or through community partnerships.
- **Through tenant selection preferences** for applicants who need the services available through Section 202 properties. Congress has given HUD the authority to approve tenant selection policies that must be related to the purpose of the Section 202 program to provide supportive housing to the elderly.⁴ The regulations that apply to Section 202 tenant selection policies specify only that preferences for people with particular disabilities are prohibited. Better targeting to seniors with disabilities would result

⁴ Section 202(i) of the National Housing Act, 12 U.S.C.1701q(i).

in more effective use of Section 202 and could potentially also support HHS's Money Follows the Person (MFP) initiative. MFP helps seniors living in nursing homes move to community-based settings linked to the services and supports they need.

- **Through preservation efforts.** About 19,000 Section 202 units are in properties built between 1959 and 1974 and currently do not have rental assistance tied to the units. In December 2010, Congress adopted new authority for HUD to provide “senior preservation rental assistance contracts” under Section 8 to preserve affordable units when these older properties take out new loans for rehabilitation. Funds should be made available for this purpose, and HUD should ensure that the properties will make available services needed to support aging in place and will serve people who are in need of supportive housing.

Proposal 2: HUD and USDA could take steps to ensure that all assisted housing units with special adaptations are used to house families or individuals who need those adaptations.

As many as 300,000 of the housing units with HUD-funded and USDA-funded project-based rental subsidies have been specially adapted for households that have a member with physical disabilities.⁵ The need for affordable, specially-adapted units is likely to grow as the population ages and the number of war veterans with permanent physical disabilities increases.

Anecdotal reports indicate that units with special adaptations frequently do not house individuals who need them. Current HUD rules require public housing agencies and private assisted owners to

⁵ We are not aware of any study that has counted the number of specially adapted units, but it probably is between 5 and 10 percent of the project-based assisted housing stock of almost 3 million units. This estimate does not include specially-adapted units in properties receiving Low Income Housing Tax Credits that do not have project-based rental assistance.

provide such units to households that need them if those households live in non-adapted units owned or managed by the PHA or a private owner or are on the waiting list. If there are no appropriate households among existing tenants or applicants, providers are permitted to rent the units to other applicants.⁶ HUD does not require its grantees to contact other HUD grantees in the area, including the PHAs that administer the Housing Choice Voucher program⁷ or to agencies that provide services to people with disabilities for referrals of people who need specially adapted units. Nor does HUD require local or state government grantees of CDBG or HOME funds to work with housing providers to establish city-wide, regional, or state-wide lists of specially-adapted assisted units. HUD should use its statutory authority to implement such requirements and should put in place reporting systems to monitor the results. The housing registries mentioned above may be one mechanism for accomplishing this aim, in collaboration with other community partners.

Proposal 3: Increased use of Housing Choice Vouchers, public housing, and Section 8 projects for supportive housing for people with vulnerable health would make more effective use of scarce housing assistance resources.

Supportive housing – sometimes called “supported housing” in the health care world – provides housing units that are independent but closely linked to services that residents need to remain stably housed and enhance their quality of life. Supportive housing

⁶ See 24 C.F.R. §8.27.

⁷ HUD's regulations require PHAs that administer Housing Choice Voucher programs to provide “an individual with handicaps” with a “current listing of available accessible units known to the PHA,” but it is doubtful PHAs commit the resources to developing and maintaining such lists. Recent HUD guidance urges PHAs also to compile and distribute lists of state and local agencies that may assist individuals with various types of disabilities to find an appropriate unit and maintain their housing stability (see PIH Notice 2011-32, June 14, 2011). While this is a well-intentioned step, it is unlikely that many PHAs will undertake such networking roles.

has been demonstrated to increase housing stability and to reduce the use of in-patient and emergency health care and long-term care services for people with histories of unstable housing, including individuals who have been chronically homeless. Although it is not proven that the reductions in health care costs are sufficient to offset *all* of the cost of producing and operating the housing itself and reductions in health care costs depend in part upon how (to whom) supportive housing opportunities are targeted,⁸ this recommendation is to devote a larger share of *existing* housing resources to supportive housing.

With the number of HUD-assisted housing units capped under current budget constraints at about 5 million, and with the numbers of both seniors and younger people in need of supportive housing continuing to rise, it makes sense to use a larger portion of assisted housing for supportive housing. In addition to supportive housing provided by “mainstream” HUD programs such as Section 202 and Section 811, a special category of supportive housing called Permanent Supportive Housing has been developed for homeless people with disabilities that make it difficult for them to get and keep housing. About 240,000 units of Permanent Supportive Housing have been identified by local communities, about half of which may be funded by HUD’s Homeless Assistance Grants programs.⁹ Other supportive housing units receive Housing Choice Voucher assistance. But the supply of such units is insufficient to meet demand. Several approaches could support expanded use of housing assistance for people who need supportive housing:

⁸ Culhane et al demonstrated that, for people with severe mental illness, reductions in health care costs covered most of the cost of the housing subsidy. See: Dennis P. Culhane, Stephen Metraux, and Trevor R. Hadley. “The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative” Housing Policy Debate 13.1 (2002): 107-163.

⁹ *The 2010 Annual Homeless Assessment Report to Congress*. US Department of Housing and Urban Development, 2011.

- ***HUD could encourage owners of public and assisted housing developments and administrators of the Housing Choice Voucher program to prefer applicants who need supportive housing for admission to appropriate units.*** PHAs already have the authority to use set-asides of Housing Choice Vouchers to benefit people with disabilities. This can be done through set-asides (technically “limited preferences”) of tenant-based vouchers to be used by the clients of agencies that provide health care and related services to populations with special needs, by assigning project-based voucher subsidies to supportive housing developments. PHAs and owners of subsidized housing developments may create set-asides of supportive housing units within larger public housing or subsidized housing developments. Set-asides of vouchers for the clients of an agency that serves people with a particular type of need also can help coordinate the delivery of health care and other services with housing assistance. However, PHAs and owners of Section 8 housing projects may be reluctant to provide set-asides for people with specific types of needs unless the next proposal is adopted.
- ***Through NOFA processes applicable to Section 8 projects and the Section 811 program,*** HUD could provide incentives for owners and PHAs to create additional supportive housing by tapping available Medicaid funding streams, forming service partnerships, and networking with agencies to get referrals of applicants in need of service-enriched housing. The recently announced Section 811 Project Rental Assistance Demonstration is one example of this approach.¹⁰ The demonstration will provide rental assistance subsidies for units in affordable, mixed occupancy, multi-family housing developments.

¹⁰ http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/grants/section811ptl/demoNOFA

The units must be leased to very low income people with disabilities. Eligible applicants for demonstration funding are state housing finance agencies (or similar state housing entities) in partnership with state Medicaid agencies. The NOFA requires that the housing and Medicaid agencies have a written partnership agreement as a condition for demonstration funding. HUD and CMS should carefully assess the implementation and results of this demonstration and apply promising approaches to other NOFAs.

Proposal 4: HUD could issue clarifying guidance on admissions policies that are permitted by the Fair Housing Act and consistent with the purposes and spirit of the law.

Strategies involving set-asides of voucher subsidy slots or of other HUD-assisted housing units such as public housing or units in Section 8 projects will require the admissions preferences that are permitted by the U.S. Housing Act. However, this may not happen to the extent that it could unless HUD provides clear guidance for what is permissible under the Fair Housing Act.

Based on its interpretation of the Fair Housing Act and other civil rights laws, HUD has had long-standing policies prohibiting admissions preferences based on *type* of disability. Such policies were designed to serve important anti-discrimination goals during an era when people with disabilities were frequently segregated in large institutions. However, in an era when federal and state programs that fund services have prioritized use of service dollars in community-based, integrated settings, HUD policies have created barriers to combining the funding streams for services with affordable housing.

Federal and state funding streams that pay for health care and other supportive services often have categorical restrictions based on the type of disability. Public and non-profit agencies that

specialize in serving individuals with particular kinds of disabilities may want assurance that “their” families will be housed before they commit to provide services to residents of a housing development or program. However, it can be difficult to provide them with that assurance because residents with *particular* kinds of disabilities cannot be given preference for housing, even if the particular units are integrated within larger developments that are not limited to people with disabilities. In practice, HUD’s policies and their sometimes inconsistent application have conflicted with efforts of PHAs, owners, and managers to obtain the services that residents need.

Moreover, “need” for services is often broader than the eligibility rules that govern the funding used to provide services. It is important that the rules permit a narrower preference for people who “need and qualify for” such services to avoid situations where residents of assisted housing cannot receive the services from other agencies that might benefit them, because of the rules that govern the other agencies’ service provisions.¹¹ In the past, HUD’s rules governing project-based vouchers did not permit such a preference but recent proposed rule changes suggest this may change, allowing preferences for people who qualify for available services.¹² HUD should move forward with this proposed change to the project-based voucher rules and add similar language to the rules for other HUD housing subsidy programs.

¹¹ 24 C.F.R. §983.251(d). It also is important to revise the project-based voucher statutory requirements to make it easier for properties to maintain site-specific waiting lists, without diminishing the ease of application by individuals seeking assistance. The Administration has supported this change, which has been included in versions of the Section 8 Voucher Reform Act filed in previous Congresses.

¹² Docket No. FR-5242-P-01, Changes to the Section 8 Tenant-based and Project-based Voucher Programs, published May 15, 2012.

Proposal 5: State and federal administrators of the Low Income Housing Tax Credit could take steps to increase the use of housing produced by that program for supportive housing.

The Low Income Housing Tax Credit (LIHTC) program is an important source of capital funding for affordable housing, including housing for elderly, disabled, and formerly homeless people. Among projects' allocated tax credits between 2003 and 2007, more than one-quarter (27 percent) were targeted to elderly households, 12 percent were targeted to persons with disabilities, and 5 percent were targeted to formerly homeless people.¹³

The income limit for LIHTC units is usually 60 percent of AMI. Federal law mandates that states' Qualified Allocation Plans (QAPs) assign priority to projects that serve people with lower incomes than the LIHTC income limit. At least 10 percent of each state's annual LIHTC allocation must be reserved for non-profit organizations, and in recent years more than a quarter of LIHTC projects have been developed by non-profits. But the rents charged for LIHTC units based on the program rules are often too high for the neediest households such as those relying solely on SSI income. While developers may opt to develop units with rents affordable to poorer households, that usually requires deeper subsidies for both development and operating costs). HUD's Housing Choice Voucher and Shelter Plus Care programs have been used effectively to help close the gap between the cost of operating the projects and rental income, but other incentives are needed to address unmet need.

Many states have set targets for producing housing for people with special needs through scoring preferences, set-asides for specific types of projects, or threshold requirements for LIHTC eligibility. Some states have created incentives for larger LIHTC developments to set aside some units for special needs populations.

¹³ <http://www.huduser.org/Datasets/lihtc/tables9507.pdf>, accessed on July 25, 2012.

- State allocators of LIHTC authority should assign more Qualified Allocation Plan (QAP) points to projects that provide supportive housing. State Medicaid agencies should persuade and support their sister state housing finance agencies in doing so.
- At the federal level, a “bonus pool” of additional LIHTC authority should be allocated to states that use their authority for supportive housing.
- HUD's encouragement of PHAs to create admissions preferences and set-asides for people with special needs, already discussed, can make rental subsidies available to LIHTC developments that provide supportive housing.

Providing More Complete and Better-Coordinated Health Care to Residents of Subsidized Housing

Proposal 6: HHS and the states could implement changes to Medicaid that would increase the availability of Medicaid and targeted health care programs for coordinated health care, case management, and related supports for residents of subsidized housing.

For vulnerable populations such as the elderly, people with disabilities or complex health needs, and people with long histories of homelessness, maintaining housing and maintaining health are intricately intertwined. People who experience chronic illnesses or frequent hospitalizations may have difficulty paying their rent on time and keeping up their homes, potentially jeopardizing their housing. Those in unstable housing may have more difficulty accessing medical care, managing chronic health conditions, maintaining good nutrition, and reducing risks of illness or injury. By improving coordination between services to keep vulnerable people stably housed and meeting their health care and supportive service needs, health outcomes can be improved, resulting in lower costs to the health care system.

Clinical health services are clearly important for people with complex health issues, but case management and care coordination can be just as important in helping people retain housing and maintain connections to health care and other supports, and motivating positive changes in habits and behaviors to improve well-being and produce significant savings in health care costs. Medicaid is — or can be — a key resource for providing many of these services and supports. Medicaid often covers case management and recovery or rehabilitation supports through which some people may receive referrals to services, develop (or re-develop) skills to locate and maintain housing, receive support during crises that might jeopardize housing, obtain support for development of employment skills, and receive assistance managing illness or addiction symptoms that could put housing at risk.

In the past, the ability to use Medicaid has been limited by categorical eligibility restrictions that screened out many low income people needing these services. While Medicaid will never be a panacea — as Medicaid eligibility is expanded under the Affordable Care Act to include low-income single individuals who do not qualify for SSI with the costs largely covered by the Federal government in the early years — states have new opportunities to assist these vulnerable populations and significant flexibility in defining covered services and the policies that will shape health care delivery systems.¹⁴ State budget limitations are not inconsequential, however, given that some of the services that could be financed by Medicaid and connected to assisted housing are covered as optional state plan benefits.¹⁵

¹⁴ As noted above, in response to the June 2012 Supreme Court decision on the expanded eligibility provisions of the ACA, some states have indicated they may opt out of the expansion.

¹⁵ The Medicaid benefit package consists of two federally-defined groups of services: mandatory services and optional services. States must provide mandatory services as a condition of participation in the Medicaid

The supportive housing model offers a promising platform for linking stable, affordable housing and access to community-based clinical and supportive services. A number of states have already begun to expand Medicaid eligibility and explore ways to use Medicaid to secure services for people living in supportive housing. These include services and supports to help people retain their housing such as making sure they pay rent on time and get along with their landlords and neighbors. Supports such as helping people monitor their medications, reducing alcohol use, and keeping a clean apartment have health benefits as well as supporting stable housing. The major challenge is that services flow through many different agencies and organizations, both public and private non-profits. The puzzle of matching eligible clients, eligible providers, and eligible services is exceedingly complex; the added challenge of state fiscal constraints further complicates the picture.

CMS should work with and support state efforts to use the flexibility of state plans to make sure flexible services and supports are available for people with significant health-related vulnerabilities and covered by Medicaid. States have considerable latitude to define covered services and supports, but may be reluctant to take a flexible approach if they are concerned the costs may not be covered with matching federal funds (or Federal Financial Participation – FFP). Some of the services and supports mentioned above can be covered under various Medicaid mechanisms such as targeted case management or the Medicaid rehabilitation option (MRO), but these tend to be piecemeal approaches and eligibility may be limited to persons with specific types or levels of disability such as serious mental illness.

program, but they may offer optional services at their discretion. Each state's State Medicaid Plan describes the groups eligible for Medicaid, services, reimbursement procedures and other program requirements.

Proposal 7: Increased access to Federally Qualified Health Centers for vulnerable residents of public and assisted housing developments and encouragement of partnerships that connect FQHCs with assisted housing would help people with vulnerable health needs achieve and maintain housing.

Federally Qualified Health Centers (FQHCs) are community health centers that serve medically under-served communities or populations. There are more than 1,100 FQHCs nationwide. FQHCs serve all patients, regardless of ability to pay. To cover the costs of care and operations, FQHCs receive federal grants from HHS and cost-based reimbursement for their Medicaid patients. The payment mechanism used for FQHCs results in payment rates that are higher than rates paid to other health care providers for similar services. Funding for FQHCs is expected to increase substantially as ACA takes effect and more very low income Americans gain access to health care.

Some FQHCs operate within or near HUD-funded housing. Some 63 FQHCs in 25 states provide care specifically targeted to public and assisted housing residents under the Public Housing Primary Care (PHPC) program, also funded by HHS.¹⁶ More than 95 percent of the PHPC clients are uninsured or have Medicare, Medicaid, or are dual participants in both Medicare and Medicaid. PHPC centers provide primary and dental care, health education and outreach, laboratory services, and case management. The centers may provide other services such as behavioral health, nutrition, podiatry, or optometry. The treatment and management of chronic diseases such as diabetes, hypertension, and asthma have been a focus for a number of centers, as summarized

in a recent report.¹⁷ Some centers have specialized programs targeted to sub-populations such as seniors, adolescents, or mothers of infants.

Policy priorities to enhance and expand the connections between affordable housing and FQHCs include:

- **Expanding and supporting replication of best practices in the PHPC model.** While PHPC seems to provide valuable services to public and assisted housing residents, the program is small, serving only about 175,000 residents through its 63 FQHCs. Public and assisted housing residents in many other communities are presumably currently served through FQHCs that are not funded by PHPC. Disseminating information about effective partnership models and outreach and engagement strategies used by PHPCs could increase contact at the organization level between FQHCs and the PHAs serving the same communities, as well as at the client level between residents of HUD-assisted housing and the community health centers. HUD and HHS should identify successful PHPC models, with a particular focus on programs that serve vulnerable people with complex health needs in public and assisted housing, and offer technical assistance and programmatic funding to replicate promising approaches through FQHCs.
- **Permitting Medicaid reimbursement for non-licensed providers, under proper supervision.** One challenge for FQHCs serving vulnerable populations in public and assisted housing, as well as those that work with homeless people, is that clinical staff are stretched thin, while many of the people they serve have complex needs that cannot be addressed adequately in a standard office visit. Team-based models that use other

¹⁶ <http://www.nchph.org/public-housing-primary-care-program/> accessed on July 25, 2012

¹⁷ Victoria Howard-Robinson, *Health and Wellness Programs for Public Housing Primary Care*. Institute for Community Strategies under subcontract with the National Center for Health Care for Public Housing Residents, North American Management. June 2008.

kinds of providers, including unlicensed staff with appropriate training and supervision, are a promising way to meet this challenge. While non-licensed social workers, case managers, and other staff may be less likely to have medical credentials, these “care extenders” often play important roles in establishing contact, engaging, and coordinating and integrating care for vulnerable people with complex needs.¹⁸ As an added benefit, these emerging roles may create job opportunities for people who come from and have strong ties to low-income communities, offering opportunities to connect efforts and achieve goals related to health, housing, and employment.

Proposal 8: If HHS were to ensure that Medicaid Managed Care plans have appropriate incentives to serve members with severe and chronic health care needs, more people with vulnerable health could achieve and maintain housing.

Nearly two-thirds of Medicaid members are enrolled in Medicaid Managed Care plans, and the proportion continues to grow. Under these plans, people get most or all of their services from an organization or health plan under contract to the state. The flexibility of managed care financing (with per member per month rates instead of fee for service) and payment mechanisms that pay for outcomes instead of procedures offer real promise. But this will not meet the needs of the most vulnerable people without the right incentives and adequate funding. Costs for the most vulnerable people living in or in need of assisted housing will be higher than average, so health plans and providers who receive capitated funding will need to have incentives to enroll and serve them. Better, more

¹⁸ The costs of these staff also should be considered for rate-setting purposes, when provided under the supervision of licensed professionals, as recommended in Wilkins, Carol, Martha Burt, Danna Mauch, *Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities*. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, February 2012.

integrated care linked to housing can produce significant savings and better outcomes if providers and plans face the right incentives. The next couple of years provide real opportunities but also risks to some of the most innovative providers who have been engaged in partnerships that link housing and services for the most vulnerable residents of public and assisted housing.

Proposal 9: HHS and the states could take steps to increase the availability of services to address substance abuse problems for people who have housing assistance and improve the integration of substance abuse services with other health services.

Substance use, addiction, and illegal drugs have been a difficult area across the spectrum of HUD-supported housing, from public housing to HUD-subsidized, privately owned apartments to housing assisted through HUD’s homeless assistance programs. PHA staff, property managers, and homeless assistance providers must balance meeting the needs of people who use and abuse alcohol and other drugs with the practical challenges of landlord and community relationships, housing management issues, safety, and potential for criminal activity. Ensuring access to services and supports to address substance use issues benefits the health care system by reducing the use of costly emergency rooms and other crisis care and improving health outcomes for people with chronic health conditions, but it is important that these services be provided in ways that respect people’s privacy and do not put them at greater risk of eviction.

Resources for services to address substance use problems can be difficult to find, and the funding requirements are often restrictive. Under current Medicaid rules in most states, people with substance use issues are eligible for Medicaid only if they qualify based on categorical eligibility such as being pregnant, or having a physical disability, disabling medical condition, or serious mental illness.

This will change in most states in 2014, as Medicaid eligibility is expanded based on income, and a significant number of people who will become newly eligible for Medicaid are likely to have health conditions or health risks that are complicated by substance use.

Medicaid reimbursement for substance abuse treatment is usually covered as an optional service under state plans. Reimbursement is often limited compared to other types of services, and services may be covered only if provided in a licensed or certified treatment facility. These rules and funding limitations are often inconsistent with team-based approaches to working with people to address substance use in the context of primary care, home visits, or services delivered by inter-disciplinary community support teams for people with mental illnesses or other complex health conditions.

ACA provides opportunities to test revised benefit packages for newly eligible people in ways that could improve outcomes and control costs. For example,

- ***Use ACA's flexibility to develop tailored Benchmark plans to expand services to people with serious substance abuse issues that have impacts on health, health care costs, housing stability, and communities.*** Under ACA, states will have to offer a "Benchmark" Medicaid package consisting of essential medical services, as well as mental health and substance use treatment, for those people who will become newly eligible for coverage based on incomes below 133 percent of the Federal Poverty Level.

For people with behavioral health needs, these Benchmark benefits may differ from the traditional Medicaid State Plan available to those categorically eligible. Given that the costs for the expansion population will be borne by the federal government in the early years, states have an incentive to offer robust plans. Subject to approval by CMS, states can develop tailored benefit plans for specified special populations — in this case, such as chronic inebriates or chronically homeless people with substance abuse problems — as long as essential health benefits are included. This limitation may help allay potential state concerns about having to offer the same extended benefits to everyone.



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