



POLICY OPTIONS FOR INTEGRATING HEALTH AND HOUSING FOR LOW-INCOME OLDER ADULTS

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EXECUTIVE SUMMARY

Affordable housing communities that provide supportive services are an important platform for meeting the health and social needs of low-income older adults. Almost three million older adults live in thousands of publicly subsidized senior housing communities across the country.¹ By virtue of their low incomes, age, and disability status, approximately three-fifths of these older adults are dually eligible for Medicare and Medicaid.

Affordable housing communities that provide on-site supports can help better address the medical and social care needs of their residents, supporting them to age successfully in community. Several affordable housing communities have introduced services to better meet their residents' social, health and functional needs, but more could be done to support residents' health, including more intentional collaborations with health care plans and providers.

While health care entities, including health providers and managed care plans, are making an array of investments in housing and housing-related services, these investments are neither uniform nor widespread. In addition, many older adults need subsidized housing, but are unable to access it, facing years-long waiting lists while living in inadequate, inaccessible or unaffordable housing. Older adults of color face added barriers of experiencing systemic racism in accessing affordable housing. They disproportionately experience higher costs burden compared to white older adults.²

In this paper, we examine the barriers that have hindered more widespread collaboration between affordable housing and health care entities and explored opportunities for increasing these partnerships. To help understand the barriers and opportunities, we conducted focus groups with low-income older adults and interviewed health care leaders, experts in health policy and housing policy, and housing operators. This research surfaced five key building blocks for success, namely an emphasis on systematically building **collaboration**; ensuring consumer **control** over which services and providers they use, being cognizant of the aspects of **community** that would be attractive to consumers; making it easier to secure **capital** and finance projects; and **convening** stakeholders to grow connectivity within the field.

In light of these considerations, we propose a three-pronged strategy to advance the role of affordable housing as hubs for addressing the health and social needs of low-income older adults: (1) **scale a model of on-site service coordination and wellness programming in affordable senior housing communities**; (2) **increase investment in developing new affordable senior housing in a way that supports partnerships with health care entities and builds services into the infrastructure**; and (3) **foster intentional partnerships between affordable senior housing communities and health care entities in order to break down the silos between the two stakeholder groups**.

At this time of recovery from the COVID-19 pandemic, renewed interest in government investment in infrastructure, including in affordable housing and home and community-based services, provides an opportunity to realize the potential of affordable housing communities as platforms for older adults to successfully age in supportive and flourishing communities.

¹ Public and Affordable Housing Research Corporation. 2021 Housing Impact Report: Feature on Older Adults. April 2021. Available at: http://www.pahrc.org/wp-content/uploads/2021/04/2021-Housing-Impact-Report_Feature-on-Older-Adults.pdf

² Patti Prunhuber and Vivian Kwok. Low-Income Older Adults Face Unaffordable Rents, Driving Housing Instability and Homelessness. Justice in Aging. February 2021. Available at: <https://justiceinaging.org/wp-content/uploads/2021/02/Older-Adults-Rental-Housing-Burdens.pdf?eType=EmailBlastContent&eId=b5e4fc11-e79b-4ec9-b0d0-de9783fb26cd>

INTRODUCTION

There is increasing recognition of the impact of stable and quality housing on health outcomes, particularly for older adults with complex health and social needs. Unfortunately, millions of older adult adults, including older adults of color who already face systemic racism in both the housing and health care sectors, are living in unaffordable and inadequate housing. The COVID-19 pandemic, which disproportionately affected older adults and older adults of color both in terms of infection rates and deaths, has forced a rethinking of our systems for providing long-term services and supports (LTSS) in this country.^{3,4} As we re-envision care for older adults with medical and functional support needs, we have a unique window of opportunity to improve our current system of care. This includes addressing the need for accessible and affordable housing, assuring coordinated health care and attention to social determinants of health, augmenting medical and support services in the home, and supporting the desire of many older adults to avoid institutional care, particularly nursing homes.

Affordable housing communities that provide supportive services are an important platform for meeting these needs. Nearly three million older adults live in thousands of publicly subsidized senior housing communities across the country.⁵ By virtue of their low incomes, age and disability status, approximately three-fifths of these older adults are dually eligible for Medicare and Medicaid.⁶ Many older adults need subsidized housing, but are unable to access it, facing years-long waiting lists while living in inadequate, inaccessible or unaffordable housing. Furthermore, older adults of color disproportionately experience higher cost burdens compared to white older adults.⁷

Affordable housing communities that provide on-site supports can help address the medical and social care needs of their residents, supporting them to age successfully in community. Several affordable housing communities have introduced services to better meet their residents' social, health and functional needs, but more could be done to support these needs, including more intentional collaborations with health care entities and providers.

Furthermore, efforts to augment the role of affordable housing communities in improving the health of older adults should recognize that the demand for units presented by older adults in need far exceeds the supply of units. Health care entities are making an array of investments in housing and housing-related services, but these investments are neither uniform nor widespread. At this time of recovery from the COVID-19 pandemic, renewed interest in government investment in infrastructure, including in affordable housing and home and community-based services, creates an opening to rethink how affordable senior housing communities could serve as a hub for supporting the needs of low-income older adults.

To help inform an equitable path forward, we reviewed the current policy and practice landscape as it pertains to housing and health collaborations, conducted focus groups with low-income older adults and interviewed health care leaders, experts in health policy and housing policy, and housing operators. Throughout this data gathering, we explored a wide range of ways in which health care entities and

3 Meredith Freed, Juliette Cubanski, Tricia Neuman, Jennifer Kates, and Josh Michaud. What Share of People Who Have Died of COVID-19 Are 65 and Older – and How Does It Vary By State? Kaiser Family Foundation. July 2020. Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/what-share-of-people-who-have-died-of-covid-19-are-65-and-older-and-how-does-it-vary-by-state/>

4 Judith Graham. Elderly, ill and Black in a pandemic: 'I'm doing everything I can not to get this virus.' Kaiser Health News. September 2020. Available at: <https://www.cnn.com/2020/09/01/health/older-black-americans-covid-19-disparities/index.html>

5 See footnote 1.

6 The Lewin Group. Picture of Housing and Health: Medicare and Medicaid Use Among Older Adults in HUD-Assisted Housing. March 2014. Available at: <https://aspe.hhs.gov/basic-report/picture-housing-and-health-medicare-and-medicaid-use-among-older-adults-hud-assisted-housing>

7 See footnote 2.

affordable housing communities could collaborate. This included options focused on targeting housing and services for the highest-need older adults (such those who are nursing home eligible), including dedicating affordable housing units to high-risk individuals served by a particular health program or plan. We also discussed approaches that emphasized making services available to a community of low-income older adults with a wide range of needs while preserving health care provider and plan choice. What we learned from our data collection drives the majority of the recommendations we put forward, which is on expanding services and partnerships serving a population with heterogeneous health care needs in a way that is payer-agnostic.

BACKGROUND

The importance of focusing on older adults

For older adults, housing that is affordable and accessible, enabling them to age in place, is a primary concern. One third of adults over the age of 65, or roughly 16 million people, spend over 30 percent of their income on housing, which by definition makes them “housing burdened.”⁸ Older adults of color are more likely to be housing burdened – 57% of Latinx and 58% of Black older adult households are cost burdened by housing.⁹

While health and housing partnerships have often focused on permanent supportive housing for those who are experiencing homelessness and those with mental health and substance use disorders, older adults with low incomes are an often under-recognized population with unique characteristics that would make building health and housing partnerships particularly favorable. This has become even more pronounced in the context of the COVID-19 pandemic, which affected older adults and older adults of color disproportionately.

Older adults tend to have high and increasing medical needs and costs over the lifespan. Compared to younger populations, older adults see greater persistence of high medical costs from year to year. This creates the potential to recoup the cost of upfront investments in services through managing care in a way that decreases health care costs over time. There is also an opportunity to avoid institutional care by implementing services and supports that enable older adults to age in community, creating a strong financial incentive for investment.

The role of affordable senior housing communities in supporting the health of older adults

For stakeholders interested in developing interventions to address the intertwined housing and health needs of older adults, we believe that affordable senior housing communities,¹⁰ with their large concentration of low-income older adults (including a majority who are dually eligible), hold tremendous potential.

Almost three million seniors lived in publicly supported housing in 2019. An additional 3.75 million seniors likely qualify for rental assistance but do not receive it, and that number continues to increase.¹¹ Black, Latinx, Asian, and Native American older adults are about three times as likely to be extremely housing burdened compared to their white counterparts.¹²

⁸ Joint Center for Housing Studies of Harvard University. The State of the Nation’s Housing 2020. December 2020. Available at: https://www.jchs.harvard.edu/sites/default/files/reports/files/Harvard_JCHS_The_State_of_the_Nations_Housing_2020_Report_Revised_120720.pdf

⁹ See footnote 2.

¹⁰ We use the terms “affordable senior housing communities” and “affordable housing communities” interchangeably.

¹¹ See footnote 1.

¹² See footnote 2.

Many of these assisted seniors live in housing properties that are designated for older adults.¹³ These properties may be funded through a range of sources, including programs offered by the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture (USDA) or the Low-Income Housing Tax Credit (LIHTC) program. Eligibility for senior housing communities is based on two criteria: age and income. The specifics vary by funding source. Generally, individuals must be at least 62 years old in HUD and USDA properties designated for older adults and 55 years old and above in LIHTC properties. In practice, new residents often move in at advanced ages and the average age in senior communities can range from the high 70s to early 80s. Income limits are generally set below a designated level of the area median income. The limit can vary according to the property's funding source. Frequently, income eligibility is limited to 50 or 60 percent of the area median income. For example, in 2021, 50 percent of the area median income for a household of one in Denver is \$36,700. In reality, resident incomes are often far below these limits. For example, the average annual income of a household living in a property funded by HUD's Section 202 Supportive Housing for the Elderly program is \$14,000.¹⁴

Rents in these affordable housing properties are subsidized in some manner that allows residents to pay a reasonable portion of their monthly income for rent. In HUD and USDA-assisted properties, residents generally receive a rental subsidy that requires them to pay only 30 percent of their monthly income. In LIHTC properties, rents are set at levels that would make the rent affordable to individuals earning a certain percentage of the area median income. For example, rent at a property in Denver could be set to \$983, which is a level affordable to an individual earning 50 percent of the area median income of \$36,700.

A large proportion of residents in affordable senior housing communities receive Medicare. Among individuals age 65 and older receiving HUD assistance, approximately 85 percent are Medicare beneficiaries, including 58 percent who are dually enrolled in Medicare and Medicaid.¹⁵ Many affordable senior housing residents are coping with multiple chronic illnesses and/or functional impairments.¹⁶ These conditions put residents at risk for poor health outcomes and make it more likely that they will use costly health and long-term care services.

Linking affordable senior housing communities with health and supportive services offers a number of potential benefits. Community-based health and service providers partnering with housing communities receive access to a concentrated population of vulnerable older adults, including many who are dually eligible for Medicare and Medicaid. Many reform efforts are attempting to better address the needs of this dually eligible population, which has complex health and functional needs and a high rate of care utilization. This concentration of vulnerable individuals in a common location offers a number of operating efficiencies, including more cost-effective delivery; improved client follow-through due to easier access to services and more regular contact; more complete knowledge about individuals' needs including social determinants of health needs due to regular contact with and better understanding of individuals' living situation; and the opportunity for a holistic approach that can encompass interventions

¹³ Some senior designated buildings may also be open to younger persons with disabilities.

¹⁴ Department of Housing and Urban Development. Office of Housing for the Elderly (Section 202) Summary of Resources. Available at: https://www.hud.gov/sites/dfiles/CFO/documents/26_FY22CJ-HousingfortheElderlySection202.pdf

¹⁵ See footnote 6.

¹⁶ Donald L. Redfoot and Andrew Kochera. Targeting Services to Those Most at Risk. January 2004. Available at: https://www.researchgate.net/publication/232964092_Targeting_Services_to_Those_Most_at_Risk; Karen M. Gibler. Aging Subsidized Housing Residents: A Growing Problem in U.S. Cities. October 2003. Available at: https://www.researchgate.net/publication/5142201_Aging_Subsidized_Housing_Residents_A_Growing_Problem_in_US_Cities; Andrew Kochera. Falls Among Older Persons and the Role of the Home: an Analysis of Cost, Incidence, and Potential Savings from Home Modification. March 2002. Available at: <https://pubmed.ncbi.nlm.nih.gov/12026938/>; Gray et al. Section 202 Supportive Housing for the Elderly: Program Status and Performance Measurement. June 2008. Available at: https://www.huduser.gov/portal/publications/hsgspec/sec_202.html; Lewin Group 2014 (see footnote 6)

for social isolation and disease self-management. From the perspective of the government payer, this concentration of Medicare-Medicaid enrollees also potentially provides a large number of beneficiaries and stability in insurance coverage that supports the long time horizon necessary to incentivize up-front investments in service-enriched housing initiatives.

Progress toward supporting the needs of older adults in affordable senior housing communities

Programs linking affordable senior housing properties with health and supportive services have developed on an ad hoc basis across the country. In many cases, housing providers have driven these linkages in an attempt to help address the growing needs of their aging residents. In some cases, health plans and health care providers have sought partnerships to address the housing needs of a high-need, high-cost population they serve. This includes efforts to support individuals in institutional settings – or those at risk for institutionalization – to live successfully in the community.

Service-enriched housing involves situating on-site services in a congregate housing setting. At a minimum, these services provide service coordination, but partnerships have also developed that offer a broad range of clinical services, such as on-site primary care clinics and co-located Program of All-Inclusive Care for the Elderly (PACE) sites.

Research on the impact of housing-plus-services strategies has focused primarily on the impacts of on-site service coordination strategies. Early evaluations suggested that residents and staff perceive that housing-plus-services programs are improving access to services, enhancing health status and quality of life and supporting residents' ability to age in place.¹⁷ A few studies have found that

¹⁷ Janet Griffith, Angela Greene, Leslie Stewart and Merry Wood. Evaluation of the New Congregate Housing Services Program. May 1996. Available at: <http://www.huduser.org/portal/publications/suppsvcs/interim.html>; Robert C. Fitz and Susan Berkowitz. Evaluation of the HOPE for Elderly Independence Demonstration: Final Report. December 1999. Available at: <https://www.huduser.gov/portal/publications/suppsvcs/hopeval.html>; Cheryl A. Levine and Ashkai Robinson Johns. Multifamily Property Managers' Satisfaction with Service Coordination. Washington, DC: U.S. Department of Housing and Urban Development. December 2008. Available at: http://www.huduser.org/portal/publications/hsgspec/serv_coord.html; Michelle Washko, Alisha Sanders, Mary Harahan, Robyn I. Stone, and Enid Cox. Connecting Affordable Senior Housing with Services: A Descriptive Study of Three Colorado Models. January 2007. Available at: https://www.leadingage.org/sites/default/files/Connecting_Affordable_Senior_Housing_and_Services.pdf; Alisha Sanders and Robyn Stone. Supporting Aging in Place in Subsidized Housing: An Evaluation of the WellElder Program. LeadingAge Center for Applied Research. Available at: [http://www.leadingageny.org/home/assets/File/Housing%20With%20Services_An%20Evaluation%20of%20the%20WellElder%20Program%20\(2\).pdf](http://www.leadingageny.org/home/assets/File/Housing%20With%20Services_An%20Evaluation%20of%20the%20WellElder%20Program%20(2).pdf)

Examples of Health and Housing Partnerships

Health Plan of San Mateo (HPSM) Community Care Settings Program

The Community Care Settings Program is an initiative to help individuals move back to the community from long-term care settings. As part of the initiative, HPSM partnered with two senior housing organizations in San Mateo County to secure affordable housing units for its transitioning members. The housing organizations set aside a small number of units in two of their properties for HPSM members, and HPSM pays the properties a small amount to help cover on-site supports the properties may provide the members, which generally take the form of a services coordinator. In addition, HPSM partners with an aging services organization to arrange and manage services that members need to live successfully in the community.

Christopher Community, Inc. and PACE CNY.

PACE CNY located one of its PACE centers next to two affordable senior housing properties operated by Christopher Community. Over time, an increasing number of residents in the Christopher Community properties have begun needing the level of support offered by the PACE program. Today, about 75% of residents are enrolled in the program. Residents are able to get to the PACE center next door easily during the day where they receive health care and other supports. The PACE program staffs aides on-site at the housing property in the evenings and weekends, allowing the program to provide an extra layer of assistance and monitoring.

participants in service-enriched housing experience improvements in some health behaviors and indicators.¹⁸

More recent and rigorous studies are showing that housing-plus-services strategies have an effect on health care utilization and costs. For example, residents in affordable housing properties offering the Staying-at-Home program were less likely to use the emergency department (ED) and hospital or move to a nursing home compared to residents in buildings not offering the program.¹⁹ Staying-at-Home participants were also more likely to see a physician and to report health improvements. Preliminary results from an evaluation of the Support and Services at Home (SASH) program in Vermont found that participants had lower growth in annual total Medicare expenditures relative to comparable individuals not participating in the program.^{20,21}

POLICY AND PRACTICE LANDSCAPE

Despite the growing evidence base for service-enriched housing, partnerships between senior affordable housing properties and health plans and providers are not widespread. There are important philosophical, operational, regulatory and financing considerations, which constrain the development of models for housing and health partnerships and the ability to scale and spread current models of service-enriched housing.

Philosophical

Housing Providers

Some housing providers believe that housing and services provision should be entirely separate and that housing providers should not be involved in or privy to information about residents' health needs or services. They view their primary responsibility being the operation and upkeep of the physical plant and not the health and social service needs of residents. Many do not believe that they have the training or capacity to address such needs. Some housing providers are also worried about possible liability and licensing implications of coordinating or co-locating health services on-site.

Older Adults and Consumer Advocates

Some existing or prospective residents have concerns about living in or moving to a housing community that emphasize health care. A building that appears overly "medicalized," especially when it is serving a more targeted medically ill and/or frail population with intensive medical services, is unattractive for many. In the extreme, some believe the housing property feels more like a nursing home, which many older adults are reluctant to consider.²²

¹⁸ Marek et al. Clinical Outcomes of Aging in Place. May 2005. Available at: <https://pubmed.ncbi.nlm.nih.gov/15897796/>; Yaggy et al. Just for Us: An Academic Medical Center-Community Partnership to Maintain the Health of a Frail Low-Income Senior Population. April 2006. Available at: <https://pubmed.ncbi.nlm.nih.gov/16581892/>; Nicholas G. Castle. Service Enriched Housing and the Senior Living Enhancement Program. October 2008. Available at: <https://doi.org/10.1080/02763890802232089>

¹⁹ Nicholas Castle and Neil Resnick. Service-Enriched Housing: The Staying at Home Program. July 2014. Available at: <https://doi.org/10.1177/0733464814540049>

²⁰ RTI International and LeadingAge. Support and Services at Home (SASH) Evaluation: First Annual Report. September 2014. Available at: <https://aspe.hhs.gov/pdf-report/support-and-services-home-sash-evaluation-first-annual-report>

²¹ The Department of Housing and Urban Development is testing the Integrated Wellness in Supportive Housing (IWISH) model, which funds a full-time Resident Wellness Director and part-time Wellness Nurse to work in HUD-assisted housing developments that either predominantly or exclusively serve households headed by people age 62 or over. More information available at: https://www.huduser.gov/portal/sites/default/files/pdf/IWISH_FirstInterimReport.pdf

²² Surveys of older adults have consistently shown that they have a strong preference to stay in their homes and communities as they age. See Leading Age. How Do Older Baby Boomers Envision Their Quality Of Life If They Need Long-Term Care Services? March 2019. Available at: <https://www.leadingage.org/press-release/leadingage-norc-poll-older-baby-boomers-preferences-aging>

Many older adults also are reluctant to sever relationships with existing health care providers, especially primary care physicians. Current residents of a housing property may be reluctant to switch to new health care provider that begins providing on-site services, or prospective residents may not be interested in moving in if they are required to see a collaborating provider that is not their current physician. In prior examples, health clinics operating in housing properties have struggled to attract residents and have been unable to maintain operations due to low volume.²³

Some consumer advocates also believe that housing and services provision should be entirely separate and that housing providers should not be involved in or privy to information about residents' health needs or services. These advocates are concerned that housing providers may use such information to try to evict residents from the building or to keep them from moving in.

Service Providers

Some health entities, particularly those with care coordination responsibilities like Medicare Advantage Plans or those assuming risk in value-based compensation arrangements, may be reluctant to share care coordination or other responsibilities with housing property staff. This could result from their desire to maintain quality control, a need to deliver a specific scope of services, the desire to employ their own care coordination tools, a concern about duplication of services or the perception that the health entity is required to deliver the service directly. There is also a question regarding who has ultimate responsibility for the health care needs of residents when there is shared accountability for certain overlapping functions.

Operational

Eligibility and Volume

The eligibility criteria for an individual to live in an affordable senior housing community and the way in which older adults receive their health insurance are separate and distinct processes with different standards. This difference can lead to challenges for health entities trying to collaborate with housing communities. Specifically, eligibility for affordable senior housing programs is based on age and income. There are no criteria based on health or function. In fact, housing operators are generally not allowed to inquire about an applicant's health or functional limitations. As a result, residents often vary in terms of their physical and mental health and functional status, and, accordingly, in their service needs. This heterogeneity may make it more difficult to overlay models that target services or housing solely to high-need individuals.

While Medicare insures almost all older adults, how they receive their Medicare coverage and where they receive their care varies. Residents in affordable senior housing communities may receive Medicare coverage through different mechanisms, including Original Medicare, Medicare Advantage (MA) plans, Special Needs Plans and Medicare-Medicaid plans. Within any of the managed care plan types, residents could be enrolled with different companies.

Medicaid is the main source of coverage for home and community-based services, with similar challenges in terms of fragmentation across health plans, and between fee-for-service and managed care programs. In recent years, Medicaid has demonstrated an increased focus on addressing social determinants of health, most recently through guidance on the American Rescue Plan delineating opportunities for using enhanced matching funds to support housing-related activities.²⁴

²³ Joe Strupp. Not Just Partners, But Neighbors: Health Care in Affordable Housing Developments. Shelterforce. February 2018. Available at: <https://shelterforce.org/2018/02/13/19958/>

²⁴ Centers for Medicare and Medicaid Services. State Medicaid Director Letter: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency. May 13, 2021. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>. See Appendix D specifically for "developing cross-system partnerships" as an example of housing related activities

A significant challenge relates to the concentration or volume of individuals who have the same health care coverage. If a health care entity does not have a sufficient number of beneficiaries residing at a property, then paying for the service infrastructure at a building may not be viewed as worth the investment. For example, if a health plan only has 10 members in a given property, the plan will understandably be reluctant to support hiring a care coordinator for such a small number of members.

On the care delivery side, there is a similar challenge of fragmentation. Residents may receive services from many different primary care practices, specialists, hospitals and long-term services and supports providers, making it more difficult to create efficiencies in care delivery and to develop provider partnerships.

There may be greater interest among health care entities in supporting services for senior housing communities that have a greater number of high-need, high-cost individuals, because there would be more opportunities to offset initial investments in service infrastructure by improving health and containing costs. However, as noted above, this resident mix may make it difficult for housing providers to market their property or maintain high satisfaction among current residents.

Communications

Communication, information and data sharing between housing and health providers has also proven to be challenging. The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has strict requirements related to protected health information and privacy which have led to real and perceived roadblocks to collaboration. Service coordinators might assist residents with accessing, navigating and understanding health care services and issues, and this could require communication with in-patient and outpatient health care providers. The large number of providers and entities involved, including medical providers, care coordinators and insurers make it difficult to communicate readily about residents' needs.

Regulatory and Statutory Issues

Targeting Populations in Housing

As noted earlier, health care payers might be interested in ensuring a sufficient membership in a particular building to justify their investment in supporting services or development of housing. However, targeting populations in a federally assisted housing community, particularly around health-related criteria, may be constrained by housing program statutes and regulations as well as several civil rights-related laws designed to protect against discrimination in housing. For instance, partners will need to demonstrate that their eligibility criteria do not violate the Fair Housing Act, which prohibits discrimination based on race, color, national origin, religion, sex, familial status, or disability.²⁵

While federally assisted properties generally cannot establish eligibility requirements to target certain types of individuals, they are allowed to establish selection preferences. These preferences establish priorities for selection though they cannot limit who may live in a property. While the specifics of what is allowable can vary under different programs of the Department of Housing and Urban Development (HUD), generally allowable categories of preferences established in statute include: residency in a geographic area; working families; people with disabilities (but not for a specific type of disability); victims of domestic violence, and; single persons who are elderly, displaced or experiencing homelessness.²⁶

²⁵ Fair Housing Act, 42 U.S.C. § 3604

²⁶ 24 CFR § 5.655

The Housing Choice Voucher program, also sometimes referred to as the Section 8 Voucher Program, allows for additional selection preferences.²⁷ Under this program, some tenant-based vouchers can be converted to project-based vouchers. A property that receives project-based vouchers can establish a preference for individuals who need services that are available at the property.

Although no data is available on the number of existing senior housing properties with any sort of established resident selection preferences, it is believed to be relatively uncommon. The most common preference employed is likely for persons experiencing homelessness. This is partially because HUD has encouraged housing communities to adopt this preference and has provided specific guidance on how to do so.²⁸

Residential Care Licensing

Each state establishes its own licensing requirements for residential care settings, although there are often commonalities across states. Requirements are often based on features such as eligibility requirements around service need, the type of services being provided, the provider of services and the provider's connection to the residential component. Licensing regulations, such as those for assisted living, do not necessarily preclude collaborations between housing and service providers; they just may put limitations on the manner in which certain types of services can be provided and the degree to which the funding and responsibility for providing the services can be integrated.

Resident Choice

Medicare and Medicaid guarantee beneficiaries the right to choose their providers. This means that residents of an affordable housing community generally could not be required to use a specific health care provider or be required to enroll in a specific managed care plan. Thus, if a property does not have a naturally occurring and sufficient volume of residents belonging to a single managed care plan or other health care entity, it may be challenging to attract interest in investing in collaborative health and housing models.

APPROACH

With these barriers in mind, we sought to better understand where there might be opportunities to better serve the needs of low-income older adults through affordable senior housing communities. To this end, we conducted focus groups with older adults to understand their views on affordable senior housing and its potential role as a setting for health care and supportive services. To gain a better understanding of barriers to and opportunities for expanded collaboration in the current environment we supplemented our data collection with key informant interviews. We interviewed an array of stakeholders with experience in designing and overseeing housing and health partnerships.

²⁷ Department of Housing and Urban Development. The Housing Choice Voucher Program Guidebook, Chapter 5: Eligibility Determination and Denial of Assistance. November 2019. Available at: https://www.hud.gov/sites/documents/DOC_35615.PDF

²⁸ Department of Housing and Urban Development. Implementation and Approval of Owner-Adopted Admissions Preferences for Individuals or Families Experiencing Homelessness. July 2013. Available at: <https://www.hud.gov/sites/documents/13-21HSGN.PDF>

FOCUS GROUPS

We held focus groups in October and November 2020 with two populations – older adults currently living in affordable senior housing communities and older adults living in the general community (i.e. own their own home or rent in a non-age-segregated community), who would be income-eligible for subsidized housing. We conducted focus groups in Massachusetts, Pennsylvania and Michigan with each population for a total of six groups. The purpose of the focus groups was to understand what participants thought about having different types of services potentially available in an affordable senior housing community and about living in a community that was targeted to residents with higher health and/or functional needs. Services explored included service coordination, wellness, medical, home care and personal care services. We asked participants living in the general community what reasons, if any, they might have for considering a move from their current home and if they would consider moving to an affordable senior housing community.

A total of 42 individuals participated in the six groups. While we did not collect information on participant characteristics, the majority were female (82 percent), the group appeared to be racially diverse, and participants' health and functional status appeared to range from active to frail. Some participants were independently mobile and active in their communities, while some were receiving home care assistance or participating in PACE programs. Participants were recruited and screened through partnerships with community-based organizations and given a gift card for their participation. Focus groups were conducted in English, led by a trained facilitator and held virtually via videoconference due to the COVID-19 pandemic. Participants without internet or technology access were able to call in to the Zoom platform by phone. Focus groups lasted for 90 minutes each.

Within the population currently living in the general community, four participants indicated they would not move from their current home, eight participants would move, and seven said they would move “only if” certain circumstances arose. Those who would not move said they like where they currently live (housing environment, neighborhood amenities, neighbors) and that they feel they have an appropriate environment or systems that would allow them to age in place (one floor, chairlift, medical alert, doctor will line up needed services). Among those who would move “only if,” the near-universal reason was if their physical or mental health declined to a point where they could not care for themselves, and for several it was if their rent became unaffordable. Similarly, those who would move said they would move for health or mobility reasons (e.g., would like to live on one floor), for something more affordable (e.g., lower rent or fewer expenses associated with homeownership), or for better quality housing.

About one-third of the group living in the general community said they would not move to a senior housing community. For about half, this was because they did not want to move from their current home for any reason. In addition, they and other participants who said they would not move to senior housing did not want to live in an age-segregated setting; were concerned about living in communities that also housed younger persons with disabilities, who they perceived as causing disruptions; or they disliked “high-rises,” which they perceived as being unsafe and having too-small apartments.

“I know a lot of friends and family that have lived in 55+ or just senior [housing]. They’ve lost so many people. They say that that’s very difficult. I think mixed keeps you young.”

— Focus group participant

“My apartment is one floor...and I’ve been so involved in this community for 43 years. I wouldn’t move. Maybe a pine box would take me, but that’s it as far as I’m concerned.”

— Focus group participant

“Yes, I definitely want to move because of arthritis, and it would be easier being on a one floor location and less expenses as well.”

— Focus group participant

About half of the group living in the general community said they would be willing to move to senior housing. However, they also expressed a dislike for “high rises” and had concerns about living with younger persons with disabilities.

Across both population groups, participants were generally amenable to having services available in their housing community. Most were amenable to having a service coordinator available in the property. A few of the participants living in the general community qualified their response by pointing out that they would only want a service coordinator to serve as a resource they could go to for questions and not to serve in a monitoring capacity. Participants were also largely in favor of having health and wellness programming, like education sessions or fitness activities, available. Similarly, they were comfortable with having a wellness nurse available to answer health-related questions, monitor vitals and help navigate the health system.

Participants living in the general community were mixed on their support for having health care services, such as a doctor, available on-site. While slightly more than half were in favor, some believed this type of service would make the community feel like a nursing home and/or they did not want to see doctors other than their current doctors. A few also expressed some concerns about the potential quality of doctors, drawing from experiences volunteering or having relatives in nursing homes where they perceived the doctors did not care about patients and did not provide patient-centric care. Several participants who currently lived in senior housing communities were open to having health care services on-site. However, when discussing what they would like, they often described health-related supports rather than primary care (e.g., help with exercises for scoliosis/back pain, breathing exercises for COPD, remembering to take medicine).

Participants from both groups expressed a broad unwillingness to switch primary care providers. Several said they would be willing to see an on-site health care provider as a “bridge” to their current primary care physician or in an emergency circumstance. However, they would not give up their current doctor if that were a condition of access to housing. The primary reasons participants gave were that they had a long history with and trusted their current provider and that their doctor knew their health situation well and they did not want to start all over with a new provider. Some participants also expressed that they would like to leave the property to see their doctors as long as they are physically able.

With regards to home care and personal care services, participants in both groups were generally open to the idea of having the services available on-site at a housing property. In discussing these types of services, participants living in the general community often reflected on wanting to do as much on their own for as long as they can. With the group currently living in senior housing, some participants were receiving home care assistance independently arranged through outside providers or they were aware of other residents receiving those services. While they were amenable to having these types of services on-site, it was not always clear that they understood the distinction of having the service delivered through a purposeful arrangement between their housing property and a service provider (i.e., staff stationed on-site serving multiple residents versus residents arranging their services with a provider independently).

"The reason why I said no, because my doctor, my primary doctor knows me, knows my illness, knows what I'm going to agree to or what I'm not going to agree to and just knows my health issues. Someone else doesn't know. Good to have them on-site, yes, I agree to that, but I prefer to keep my own doctor who knows."

— Focus group participant

"I said I'd like to be independent. Do it for myself. When I can't, maybe a little assistance, but not to just have someone to come in and clean for me."

— Focus group participant

Across both population groups, several participants expressed they were fine with the various services being available on-site, but they did not want use of the services to be mandatory. Participants also stated that although they might not need the services for themselves, it would be nice for other residents who might need such assistance.

Some participants also raised questions about the costs of the services and the impact on rent and affordability. The participants understood that they could not currently afford assisted living, so the notion of having health and supportive services delivered in a housing property seemed to draw a parallel for them. It should be noted that while we asked participants to ignore how the services would be paid for and focus on their comfort with the types of services in and of themselves, cost is a very real factor and would likely impact the potential structure of and demand for a specific model.

There was a split among participants from both groups on their willingness to live in a property that was targeted only to frail and complex individuals. Those who were opposed expressed that it would feel like a nursing home. They would prefer to be in a place with mixed abilities where residents might be able to help and support each other and they could socialize. Some said it might depend on their circumstances (e.g., if their cognitive ability declined), but they would prefer a setting with mixed abilities. Those who were open to the possibility expressed that it might allow more support and a higher degree of comfort if everyone needed a higher level of support. Some seemed comfortable with the idea of being in a nursing home (seeming to equate this model with that), if that is where they needed to be.

In answering the question of whether they would be willing to live in a community that was targeted to a higher-need population, participants were asked to picture themselves in the future when their needs may change and they need more supportive services. It appeared difficult for some participants to picture themselves as being frailer and more ill and then consider what kind of environment they might be willing to live in when in those circumstances. Additionally, it is not clear that all participants could understand how the housing community we described would differ from a nursing home. Even when we clarified that they would still have their own apartment, participants still perceived it to be like a nursing home and wanted to be in a mixed-ability environment. Several of the participants currently living in a housing community who said they would be fine living in a targeted community mentioned that they were currently receiving some type of supports. For these individuals, it may have been easier to envision themselves living in a community targeted to individuals with more complex needs.

"Well, my concern, the key word is available. If they have [home care] available and I don't have to commit to it, fine."

— Focus group participant

"[Personal care] is not something that I need right now, but I know that there are people in our building who could definitely use that."

— Focus group participant

"It looks like a nursing home. No."

— Focus group participant

"I think for me being able to be in a building where there are people who have different levels of health issues, I can rely on somebody who doesn't have those issues to help me mentally combat those. If everybody in the facility had those, for me mentally, it would be difficult."

— Focus group participant

"Well, because I've worked in nursing homes and my mother was in an assisted living, if you need the help, if I need the help, and if that's where I need to be, then fine."

— Focus group participant

"Yes, I think I would like that because everybody would be on the same level."

— Focus group participant

Overall, the focus groups revealed a mix of opinions among low-income older adults about the willingness to move to an affordable senior housing community and the level of support for having different types of services in housing communities. Among those currently living in the general community, there was mixed sentiment about leaving their current home and interest in moving into an affordable senior housing community. Some had concerns over the perceived safety of senior “high rises” and the physical features of senior apartments or did not want to live in an age-segregated community. Alternatively, some were willing to move in exchange for greater affordability and accessibility and/or to avoid the burdens of homeownership.

Participants were generally amenable to having services available on-site in a senior housing community, although there was broadly shared sentiment that services not be mandatory as a condition of living in the community, including requiring residents to change doctors. The perspective was mixed on interest in living in an affordable housing community that is targeted towards individuals with more complex needs. These combined sentiments seem to suggest that many older adults would not be interested in a housing model structured to serve only frailer individuals and where services are likely delivered through selected providers. However, it should be considered that participants were not necessarily placing themselves in the future when they needed greater services, and they had difficulty envisioning how the model we described might actually be an alternative to a nursing home setting.

KEY INFORMANT INTERVIEWS

Our research included 22 key informant interviews with housing providers, health care providers, health plans, policymakers and national organizations focused on health and housing policy issues. We conducted the interviews via videoconference from June through December 2020. Through our interviews, we sought to understand current activity and interest in various forms of housing and health care collaborations, as well as the barriers or incentives to implementation. We recorded and transcribed interviews and coded and analyzed the information using a qualitative analysis program to identify common themes and patterns across interviews.

A consistent message across interviews is that there is tremendous innovation and interest in health and housing partnerships, but these partnerships take a wide variety of forms. While there are successful health and housing collaborations happening across the country, many are focused on populations experiencing homelessness, individuals with substance use disorders and/or those with behavioral health needs. That said, interviewees showed great interest in and support for integrated health and housing models for low-income older adults, citing a growing need given demographic and economic changes. However, the structural limitations described above have thus far prevented the broader adoption of these innovative models.

“I guess the more we provide here and the more we observe our residents, to me, this is the future for serving low-income and middle-income seniors, that your congregate health-housing setting becomes the center of health care.”

— *Housing provider*

Interviewees who had developed housing and health partnerships often described unique circumstances under which their collaborations were created. Several were borne of relationships – friendships, alumni networks, health system contacts and previous coworkers – where a common personal connection encouraged the partners to take a chance or work through the heavy lift to create a program. Other collaborations emerged in unique environments such as where a health plan dominated market share in an area and there were sufficient numbers of current or potential residents in a housing property. The current nature of “one-off” or “unique situations” that have led to innovative models point to challenges for widespread scaling in the current environment. Unless a deliberative and systematic set of policies are developed and put in place to support and enable collaboration, they are not likely to proliferate.

Consistent with opinions expressed in the low-income older adult focus groups, some key informants felt that older adults might be hesitant to switch health care providers, as many have long-standing relationships with their existing doctors. Some interviewees believed, however, that on-site providers could eventually overcome this hesitation by investing in building trust with the older adults they sought to serve. Furthermore, the aesthetics of a site offering health services as well as user experience were noted as important elements in attracting older adults to use the services offered.

Some interviewees raised expectations for return on investment as a barrier to collaborations. Some felt health care entities may not view investments in on-site services as financially attractive because they expect to see decreases in health care utilization and savings in a short time frame, and what little evidence exists suggests that savings may occur over a much longer period of time. Senior housing-based interventions that take a population health approach may not produce the same level of savings as interventions that focus on frequent utilizers, that is, high-need, high-cost individuals. These models may take more time to show savings as they prevent participants from moving into higher risk and use categories. Some interviewees opined that mitigating the trajectory toward nursing home use could be a specific and compelling argument for a financial benefit, acknowledging that there are inherent challenges in demonstrating that something did not happen.

Interviewees described their involvement in a variety of initiatives supported through various financial mechanisms. As discussed above, many were developed through unique circumstances and interviewees emphasized that mechanisms that are more reliable are needed for scaling and sustainability.

Interviewees cited several considerations in constructing financial mechanisms. First, a sufficient volume of participants is key. In many cases, payers do not have a large enough number of members in a specific site to justify an investment in on-site services. Second, while current collaborations have been creative in tapping many different sources of dollars (including philanthropic grants, community benefit investments and strategic reserves), interviewees pointed to the necessity of identifying more sustainable health system funding. In the absence of that sustainable funding, interviewees shared a variety of approaches such as arrangements in which a health plan placed their own clinical staff on-site at an independent living facility, as well as examples where health plans invested in housing properties that would set aside dedicated units for members of that specific health plan. Interviewees were hopeful about opportunities created by value-based care, though cautioned about the challenge of cost shifting between Medicare and Medicaid, whereby investments made by Medicaid-funded programs might generate savings that accrue to Medicare. Finally, some interviewees stressed the importance of pursuing sustainable financing mechanisms that build on programs with a successful track record, such as CMS and/or HUD demonstrations, and for which there is at least some level of existing support among various stakeholders.

An additional operational consideration that emerged is around the legal liability for any accidents or instances of medical malpractice occurring where on-site health services are delivered. Some

“One thing we ran up against really quickly is that housing providers don't think of themselves as health care providers and health care providers don't think of themselves as housing providers and they don't want to. I'm not saying that's right. I just think that's a challenge in creating these more integrated models that the sponsors of the services are not generally integrated themselves, which to me, it leads to why we're reliant on these sort of rare and special relationships just to find models that work.”

— *National organization/policy expert*

“I think in almost all the models, it's either the cost savings or the cost avoidance, and so I think there needs to be some type of tool showing like, ‘By putting this investment in early on and upstream, we are saving the system this much down the line.’”

— *Health plan representative*

interviewees intentionally split their sites between general use of the building by its residents and health-related services. Providers were restricted to the specifically identified space, and residents were encouraged to visit the co-located space to access services. In some cases, these spaces were attached to housing, while in other cases they were in the immediate geographic area. Some interviewees found that having the health provider lease the dedicated space (this could be in-kind or heavily subsidized) helped navigate liability issues.

DEFINING THE PATH FORWARD

The focus groups and key informant interviews surfaced several building blocks for success on how affordable senior housing communities could serve as a platform for better-coordinated, more person-centered care. In formulating next steps, we believe that policymakers should pay attention to the following areas:

Collaboration: Through our key informant interviews, we learned how many innovative health and housing partnerships were built through personal connections and driven by dedicated individuals who had the relationships, skills and persistence to navigate financial and policy barriers. To get to scale, more systematic connections need to be built between the health and housing sectors at the federal, state and local levels, and financial pathways need to be defined that would enable and incentivize building these initiatives at scale.

Control: Consumers welcomed the availability of certain on-site services, but wished to retain control over which providers they see and which services they utilize. Many expressed reluctance about leaving their primary care providers in particular, and some had reservations about the potential quality of on-site care. We suspect that there would be similar reservations about limiting residents to specific health plans as well. This finding favors the development and expansion of models that preserve consumer choice and do not limit residents in a particular affordable senior housing community to a specific provider.

Community: When thinking about reasons for moving out of their current home or features they might want to see in a senior housing community, several focus group participants highlighted factors such as location/neighborhood and the physical features and appearance of the building and apartments, and affordability, rather than the availability of health care or other services. There were nuanced views around the mix of residents in the housing properties, with some expressing concern about buildings that included younger people with disabilities, and some noting that they would not like to live in a building where everyone was frail. While services were viewed positively, they were not seen to be the most important factor in the decision about whether one would want to move to a senior housing community. These views appear to favor models, such as service coordination programs, that do not require a high concentration of frail individuals. It may be possible that individuals who already have more significant impairments or their caregivers would have different perspectives and more targeted research may be helpful in further exploring these nuances.

Capitalization: Key informants emphasized the importance of sustainable sources of funding, primarily for the health care-related services offered on-site at affordable senior housing communities, though many noted the need for more funding for affordable housing in general. While some entities have managed to creatively finance health and housing collaborations, this required significant expertise and effort to put together. Establishing funding streams that would support on-site services is essential to reaching scale. Additionally, interviewees highlighted the lack of affordable housing, which is the foundation for housing and health collaborations.

Convening: It is clear from the interviews that we conducted that the nexus of health and housing is one that is full of possibility, energy and excitement. At the same time, the “thousand flowers blooming” approach has made it difficult to coalesce around specific models of care. There is a need to actively coalesce the field, in order to move toward policy that can bring housing and health partnerships to scale. When it comes to recommendations, some interviewees advised us to build on existing programs, rather than creating entirely new models, and to try to move forward ideas where there is already support coalescing.

With these considerations in mind, we identify opportunities to advance the role of affordable senior housing communities as hubs for addressing the health and social needs of low-income older adults. We focus on a three-pronged strategy:

1. Scale a model of on-site service coordination and wellness nursing in affordable senior housing

With a growing evidence base that supports the benefit of service-enriched housing, we think that models of on-site service coordination and wellness services are ready for scaling. This service model allows for optional use of services and serves older adults with a range of needs, not just the highest-need individuals, which makes it compatible with the consumer preferences elicited through the focus groups.

Financing remains the biggest barrier to scale. We conducted preliminary financial modeling to determine a rough order of magnitude for the program size needed to generate a return on investment.²⁹ These results are highly sensitive to the assumptions used, but baseline assumptions suggest a minimum program size around 150, which is likely greater than the membership of any single health plan at any given senior housing property. If this finding holds, a centralized financing mechanism through Medicare, which is the dominant payer for individuals residing in affordable senior housing properties, will be important.

Because service coordination or wellness nursing is not typically provided on a “per incident” basis, financing through a strictly fee-for-service model will be challenging. The shift of many payers, including Medicare and Medicaid, away from fee-for-service payments may open up financing opportunities for health service providers to work with housing communities in a more flexible and collaborative way. Medicaid, for example, allow states to now include wellness service coordinators in their waivers for home and community based services. Furthermore, value-based initiatives have created pathways, such as care management fees, capitated payments or shared savings incentives, for health entities to pay greater attention to care coordination needs, chronic condition management and wellness and prevention supports in an attempt to keep people healthier and reduce unnecessary use of high-cost services.

We recommend the following:

a) Engage CMS in a demonstration of service-enriched housing

HUD’s Supportive Services Demonstration is a large, randomized-controlled trial that leverages HUD-assisted properties as a platform for the coordination and delivery of services to better address the interdependent health and supportive service needs of its older residents. The demonstration tests the IWISH (Integrated Wellness in Supportive Housing) model, which funds a full-time Resident Wellness Director and part-time Wellness Nurse to work in HUD-assisted housing developments that either predominantly or exclusively serve older adult households. This is an ongoing demonstration with a planned evaluation.³⁰ While results from the

²⁹ Modeling assumed an on-site nurse and service coordinator (staffed at 1 FTE per 250 residents and 1 FTE per 175 residents, respectively), and a resident population with heterogeneous service needs (half who are able to live independently and half who require some assistance with activities of daily living). Savings come from projected reductions in hospitalizations, emergency department visits, ambulance use, and skilled nursing facility utilization.

³⁰ Abt Associates. Supporting Aging in Place Through IWISH: First Interim Report from the Supportive Services Demonstration. November 2019. Available at: https://www.huduser.gov/portal/sites/default/files/pdf/IWISH_FirstInterimReport.pdf

evaluation are forthcoming, we recommend that CMS use its authority through CMMI to test a financing mechanism for supporting housing-based wellness and coordination services. The focus of this test would be to define an effective financing mechanism for housing-based services, such as a bundled payment or a capitated per member per month payment, which could be scaled in Medicare. The demonstration should also collect data on beneficiary utilization and experience of service coordination and wellness services, medical utilization, and health and cost outcomes as well as quality of life measures. We note that CMMI has previously drawn from evidence developed from other agencies in expanding demonstration programs, such as the Medicare Diabetes Prevention Program, which was studied in a clinical trial conducted by the Centers for Disease Control and Prevention.³¹

b) Create a housing-based wellness/coordination benefit under Medicare

An alternative strategy for advancing on-site service coordination at affordable housing properties would be to establish a wellness/coordination benefit for on-site service coordination programs through Medicare. This would create a uniform basis for Original Medicare and Medicare Advantage plans to pay for housing-based wellness and coordination services. This approach does create some challenges for the entities who are providing these services, who will need to become Medicare providers and bill for services. The hope is that establishing a Medicare benefit would solve the volume issue currently faced by service providers. Of note, residents who have Medicare-only coverage may be subject to a 20 percent copay for services, which represents approximately 27-30 percent of HUD assisted individuals who are Medicare only.³² It would be valuable to examine whether there are initiatives that might provide opportunities to waive copays for wellness and coordination services.

2. Increase investment in developing new affordable senior housing in a way that supports partnerships with health care providers

Our research, including our key informant interviews, confirmed that the lack of affordable housing is a key barrier for low-income older adults to be able to live with dignity and independence as they age. The key obstacle is the lack of funding for new construction or new rental subsidies. Federal funding to build new housing is limited, and, where available, competition is high. Funding for new rental subsidies is also limited, particularly to cover a larger number of units in a property. From an older adult perspective, this translates to years-long waiting lists for units at affordable senior housing properties.

President Biden's infrastructure proposal calls for an additional \$213 billion in affordable housing investments as well as an investment in home and community-based services.³³ With this renewed focus on the need for affordable housing and LTSS, we believe there is an important opportunity to refocus attention on serving older adults and on facilitating partnerships with health care entities, particularly within proposed new funding for affordable housing.

Affordable housing developers often need to piece together funding from multiple sources, including funding for capital investment and rental subsidies. Additionally, if developers are proposing a physical space for use by a health care entity, they must also establish capital and revenue sources for that space as well. Streamlining the process for securing financing, and making a health and housing partnership a positive factor in applying for funds, would create an additional incentive for developers to do the extra work needed to plan for on-site health services.

³¹ RTI International. Evaluation of the Medicare Diabetes Prevention Program. March 2021. Available at: <https://innovation.cms.gov/data-and-reports/2021/mdpp-firstannevalrpt>

³² See footnote 6.

³³ The White House Briefing Room. Fact Sheet: The American Jobs Plan. March 2021. Available at: <https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/31/fact-sheet-the-american-jobs-plan/>

We recommend the following:

a) Foster interagency collaboration to ensure that affordable housing initiatives support health and housing partnerships.

We recommend that the Internal Revenue Service (IRS), the US Department of Housing and Urban Development (HUD) and US Department of Health and Human Services (HHS) work together to review processes and regulations that should be modified to facilitate health and housing collaboration. This should include reconciling any contradictory processes that complicate health and housing partnerships, and creating guidance for states on ways to foster collaborations with the health services sector within the Low-Income Housing Tax Credit (LIHTC) scoring criteria that places value on proposals that co-locate health-related services that meet the needs of low-income older adults and older adults of color.³⁴

More broadly, we support efforts to highlight interagency collaboration on addressing the health and housing needs of low-income older adults, including convening meetings at the national and regional levels, and creating materials such as toolkits on how to develop collaborations between affordable senior housing communities and health care entities.³⁵

b) Create a health and housing tax credit program

The primary capital source for constructing new affordable housing is the Low-Income Housing Tax Credit (LIHTC) program. As part of increased investment in affordable housing, Congress should establish a “Housing and Health” tax credit incentive within LIHTC. Within this new tax credit, applicants would need to demonstrate that they have established partnerships with a health care entity or entities to provide on-site and are developing a more person-centered outcomes based model in order to meet the needs of the intended resident population.

3. Foster partnerships between affordable senior housing properties and health care providers

Our research uncovered a highly active and rapidly evolving space of collaboration and innovation among health care entities and housing providers. This innovation spans a range of models and approaches, including efforts focused on the highest need populations (such as PACE-eligible populations); working to either avoid or end long-term institutional care; employing case management and tenancy supports; improving environmental features in the home to address mobility and functional impairments; and bringing health plan and provider dollars together for capital investments and rent subsidization. Echoing prior calls for innovative demonstration models,³⁶ we recommend supporting and coalescing this burgeoning field in the following ways:

a) Launch a health and housing innovation grant opportunity

We recommend that CMS work with HUD to develop a health and housing innovation grant opportunity to support and evaluate cohorts of emerging models of health and housing collaboration, including:

- Models with expanded on-site services, including, but not limited to, co-located primary care, PACE programs and clustered in-home long-term services and supports;
- Models focused on case management and housing placement for populations with complex medical needs, potentially premised on the Department of Housing and Urban Development and Department of Veterans Affairs Support Housing Program (HUD-VASH); and

³⁴ Marc Shi, Abigail Baum and Craig E. Pollack. Perspectives on Integrating Health into The Low-Income Housing Tax Credit: A Qualitative Study. Health Affairs. April 2020. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00853>

³⁵ LeadingAge. Housing Plus Services Toolkits. Available at: <https://www.ltsscenter.org/hps-toolkit/#Housing>

³⁶ See Bipartisan Policy Center. Healthy Aging Begins at Home. May 2016, pp. 52-54. Available at: <https://bipartisanpolicy.org/report/recommendations-for-healthy-aging/>

- Models that assess the return on investing directly in housing (i.e., rental assistance) for a medically complex population.

CMS is particularly well situated to advance health and housing collaborations, given its flexibility through CMMI to test payment models and its authority to expand the scope and duration of successful demonstrations. In designing this innovation grant, it will be important to emphasize study of sustainable and scalable financing mechanisms, and a long enough intervention period (potentially 7 to 10 years) to allow the model's impact to be properly assessed and scaled if promising results are shown.

b) Create an action network

We propose a learning and action network, focused on serving low-income older adults through either co-locating of services or highly coordinated partnership with affordable housing, similar to the Complex Care Innovation Lab.³⁷ This initiative would build on learnings from previous efforts, such as the Medicaid Innovation Accelerator Program State Medicaid Agency-Housing Partnerships Cohorts.³⁸ This network could serve as a learning community through seminars and workshops that could continuously add to the evidence base, build the skill set of health and housing providers by providing technical assistance, identify approaches to overcome barriers to expanded collaboration, and forge strong relationships between affordable housing developers and operators and health care providers.

c) Support research

There remain large gaps in the evidence base that need to be addressed in order to refine a model or set of models that draw on the potential of affordable housing as a platform for service delivery to improve the health of low-income older adults. Furthermore, there remains a critical need for more comprehensive data that looks at race, ethnicity, language, age, gender and gender identity and the intersectionality of these data points for older adults living in affordable housing or those who are housing insecure. Filling these gaps and getting better estimates of model costs and impacts on health outcomes and spending will be important for being able to define a clear return on investment, whether that is in the form of improved health, lower costs or both. We recommend that philanthropy and research entities (such as the Office of the Assistant Secretary for Planning and Evaluation) support large-scale trials to advance the evidence base for interventions that support low-income older adults, particularly older adults of color, living in affordable housing properties.

RESEARCH LIMITATIONS

In conducting this research, we faced a number of challenges. The goal of the focus groups was to tease out older adults' preferences around services and housing, but this idealized preference setting was difficult for many focus group participants, perhaps because it is so different from the current reality for those who need affordable housing. Given shortages of affordable housing and years-long waiting lists, the reality is that low-income older adults in need of affordable housing are not typically in a position to choose where they would like to go or what services they would like access to. Participants at times struggled to picture what positive features of affordable housing would be attractive to them. As new options for housing with services are developed, we recommend that older adults' preferences continue to be assessed and prioritized, as they may be better able to offer input as these models become more real and specific.

³⁷ Center for Health Care Strategies. Complex Care Innovation Lab. Available at: <https://www.chcs.org/project/complex-care-innovation-lab/>

³⁸ Centers for Medicare and Medicaid Services. Medicaid Housing-Related Services and Partnerships. Available at: <https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/program-areas/promoting-community-integration-through-long-term-services-and-supports/medicaid-housing-related-services-and-partnerships/index.html>

CONCLUSION

Affordable senior housing properties are a powerful platform for the place-based service integration and coordination needed to enable holistic, person-centered care. The older adult population has specific features that favor investing in on-site services at housing properties, particularly if these investments can help older adults successfully age in the community and avoid institutional care. Given the current focus on investing in both housing and in home and community-based services, there is an immediate opportunity to shape these investments so they are aligned to better support the needs of low-income older adults.

In our focus groups and key informant interviews, we identified the role that on-site services, particularly service coordination, could play for older adults living in affordable housing communities. We also identified potential interest in more comprehensive on-site services that did not restrict residents' choice in seeking services nor create communities that serve only the frailest older adults. We also heard about many of the barriers faced by housing and health care providers in forging the kinds of communities with on-site services that would support older adults as they age.

Our recommendations focus on scaling a service coordination and wellness-nursing model specifically, while supporting a broader approach to encouraging innovation and partnerships across the board, in a way that will allow for coalescing of the field toward the next emerging models to be scaled.

As significant investments are being contemplated in the nation's infrastructure and social safety net, we see an opportunity to invest in and provide incentives for increasing affordable housing that provides services to enable older adults to successfully age in a supportive and flourishing community. We look forward to working to achieve the full potential of affordable housing communities as platforms for better health.

APPENDIX A

Integrated Health and Housing Project Focus Group Guide

For older adults currently living in an affordable senior housing community that has a service coordinator

Introduction

Thank you for agreeing to talk with us today. [*Introduce ourselves and our organization(s).*]

We are interested in hearing your opinions on ways to connect affordable senior housing, like the kind of community where you live right now, to health related services that older adults might need as they age.

We are going to ask you a few questions about the housing community you currently live in. Then we will ask about how interested you would be in having some different types of services available to you. We want to be clear that we are just asking your opinions about these services and are not saying that these services are going to become available in your community.

We are really excited to learn from you all today and hope that you will all be willing to share your opinions with us. We will be recording our conversation, but that is just for our note taking purposes. The recordings and anything you say will be kept confidential. We will not identify you by name in any reports or other documents. Did everyone sign the release to allow us to record this conversation?

Can we answer any questions for you all before we get started?

Questions – Approach A (*asking more broadly about interest in health and supportive services*)

1. Please tell us your name and how long you have lived in this property.
2. We understand that your housing community has a service coordinator, [insert name]. Raise your hand if you interact with them at all. For those who raised their hands, what kind of things do you go to them for or what kind of things do they help you with? (Are there some things that you wish they would do that they are not currently doing?)
3. Do you currently have any type of health-related services at this property? For example, do you have blood pressure clinics, a nurse who visits, wellness classes or anything like that?
4. Would you be interested in your property offering more of these types of services onsite? Raise your hand if you would be interested.
5. For those of you who said “yes,” I would like to find out what kind of services you might be interested in. I am going to start off by reading a list of possible service options. Please raise your hand after I read each option if you would be interested in having it available here at your housing property.
 - Group wellness programs like flu shot clinics, blood pressure clinics, education programs on managing your health conditions, fall prevention, or fitness classes.

- A wellness nurse who can help you with monitoring your health conditions, answer any health questions you may have, coach you on taking care of your health, and coordinate with your doctor or other health providers you may be seeing.
 - Primary care services where a medical care provider like a doctor or a nurse practitioner could diagnose and treat your illnesses.
 - Help with needs like cleaning your home, preparing meals or grocery shopping.
 - Help with personal assistance needs like bathing, transferring in and out of bed, or using the toilet.
6. Are there any types of health related services I did not mention that you would be interested in having here at your property?
 7. If you were able to see a primary care provider (for example, a nurse, a doctor) onsite who is not your current doctor or nurse practitioner, would you be willing to see that person?
 8. In order to be able to have a doctor onsite here at your housing community that you could see when you needed to, you would likely need to switch from your current doctor to the one that would be onsite here? Is this something that you would be willing to do?
 9. Would you have any concerns about having health services available onsite at your property?
[Give residents opportunity to answer the broad question. If there are no responses or residents do not address specifically, ask if they have concerns such as the property or other residents knowing about their medical issues or the property feeling “medicalized.”]
 10. Now, imagine a situation where you started to have health problems that made walking, doing laundry, or making meals more difficult. As you think about this, does it change your interest in having onsite health related services available?

Questions – Approach B (*focused more on primary care and the delivery location and requirements to switch... although this is also in Approach A*)

1. Please tell us your name and how long you have lived in this property.
2. We understand that your housing community has a service coordinator, [insert name]. Raise your hand if you interact with them at all. For those who raised their hands, what kind of things do you go to them for or what kind of things do they help you with? (Are there some things that you wish they would do that they are not currently doing?)
3. Do you currently have any type of health-related services at this property? For example, do you have blood pressure clinics, or a nurse who visits, wellness classes or anything like that?
4. Would you be interested in your property having more of these types of services onsite? Raise your hand if you would be interested. For those who raised their hands, what kinds of services would you be interested in? [Let answer broad question and based on responses prompt types of services, if needed.]
5. Would you be interested if your housing property had a partnership with a primary care provider whereby you could see that doctor when you needed to? [May have to adapt this question based on responses to previous question.]

6. Would it matter to you if you saw that primary care provider at an office in the community or if they had a clinic or exam space onsite at the property? Would you prefer one or the other? Would you have any concerns about switch from your current doctor or nurse practitioner to be seen by one who was partnering in some way with your housing property, would you be willing to do so?
7. Would you have any concerns about having your primary care services being connected to your housing property in some way? *[Give residents opportunity to answer broad question. If there are no responses or residents do not address specifically, ask if they have concerns such as the property or other residents knowing about their medical issues or the property feeling “medicalized.”]*
8. Now, imagine a situation where you started to have health problems that made walking, doing laundry, or making meals more difficult. As you think about this, does it change your interest in having onsite health related services available?

For older adults who do not currently live in a senior housing community

Introduction:

Thank you for agreeing to talk with us today. *[Introduce ourselves and our organization(s).]* We are interested in hearing your opinions on ways to connect affordable senior housing to health related services that older adults might need as they age.

By affordable senior housing properties, we mean apartment communities that are dedicated to older adults, where each resident has their own apartment unit and the rents are made affordable to older adults with incomes below certain levels.

We are really excited to learn from you all today and hope that you will all be willing to share your opinions with us. We will be recording our conversation, but that is just for our note taking purposes. The recordings and anything you say will be kept confidential. We will not identify you by name in any reports or other documents. Did everyone sign the release to allow us to record this conversation?

Can we answer any questions for you all before we get started?

Questions:

1. Please introduce yourself and tell us about your current living arrangement. Do you rent an apartment or own your own home? *[If someone says they rent, ask them if it is a building for all ages or a senior community.]*
2. Are there any reasons that you would consider moving out of your current home to another place in the near or distant future? If so, what are they? *[Allow people to answer broad question. Depending on answers, probe on affordability or health functional issues.]*
3. Would you consider moving to a housing property where most or all of the residents are older adults with affordable rent and if so, what features would you want to be present at that property? *[Allow people to answer broad question. If need to prompt discussion, suggest examples, such as different location, ability to have more social interaction, access to services, access to meals and transportation, pets, etc.]*

4. Would you be interested in moving to a senior housing community that offers health-related services? *[provide examples]*
5. For those of you who said “yes,” I would like to find out what kind of services you might be interested in. I am going to start off by reading a list of possible options. Please raise your hand after I read each option if you would be interested in living in a senior housing property that has this kind of service available.
 - Group wellness programs like flu shot clinics, blood pressure clinics, education programs on managing health conditions, fall prevention or fitness classes.
 - A wellness nurse who can help you with monitoring your health conditions, answer any health questions you may have, coach you on taking care of your health, and coordinate with your doctor or other health providers you may be seeing.
 - Primary care services where a medical care provider like a doctor or a nurse practitioner could diagnose and treat your illnesses.
 - Help with needs like cleaning your home, preparing meals or grocery shopping.
 - Help with personal assistance needs like bathing or transferring in and out of bed. Are there any types of health-related services I did not mention that you would be interested in?
7. For those of you who said “no,” you would not be interested in moving to a senior housing community that offered health related services in some way. Can you tell us why not?
8. If a housing community had an onsite primary care provider, like a doctor or a nurse practitioner, would you be willing to give up your current primary care provider to be able to see the onsite provider?
9. If a housing community was designed to serve only older adults with more health problems, and you could benefit from these services, would you be interested in living there? Why or why not? *[For people who say no, depending on how answer, probe on if there are concerns about feeling like a nursing home, landlord being involved in their health, etc.]*

APPENDIX B

Integrated Health and Housing Project Key Informant Interview Guide

Template Introduction:

Hi,

Thank you for taking the time to speak with me today. *[provide name, role, and some background if interviewee is new to you and/or the Center/LTSS Center].*

I would like to share some background about the project with you and then go into some of the questions that I have for you today. Does that sound okay? *[wait for any response, clarifying questions]*

As you probably know, low-income older adults are experiencing an affordable housing crisis that will only intensify in upcoming years. Quality, affordable housing is increasingly sparse, even for populations eligible for housing supports. In addition to deep housing insecurity, older adults with complex health care needs experience fragmented health care that lacks adequate care coordination and social supports. This disjointed model of care puts them at risk for worse health outcomes, such as unnecessary hospitalizations and nursing home admissions. We believe that stronger integration of health care and housing would greatly improve the dignity, quality of life and health outcomes of low-income older adults across the country and, to that end, we are examining opportunities to expand the availability of these types of options. This will require identifying opportunities to achieve some economies of scale and carefully examining the needs and preferences of low-income older adults, their caregivers, health care providers, housing providers, health care plans and payers.

In addition to key informant interviews like this, we are also conducting consumer focus groups in three states: Massachusetts, Michigan and Pennsylvania, as well as examining policy and market considerations.

The final product of this project will be a report and accompanying toolkit, which sketches out features of a potential model for integrating housing and health care, including advantages, disadvantages and challenges.

We expect to complete this project in the spring of 2021.

Do you have any questions about the project?

This interview should last no more than one hour. We are asking a common set of questions to participants and certain sector-specific questions. Nothing you say during the interview will be attributable to you in the final report. We may use quotes from interviews, but will not to attribute comments to specific individuals unless we seek permission. The final report will only list your name as a participant. You will have a chance to see the final report before it is released.

I would also like to record this interview for notetaking purposes. We would like to record and then transcribe our discussion so that we can appropriately analyze it in the context of other interviews. This recording would be also confidential and non-attributable. Do I have your permission to record this interview?

Do you have any questions for me before we begin?

General Questions:

1. What is your role within the organization? How long have you been working in this field?
2. Tell me about your experience with bridging housing and health care services for low-income older adults.
3. What models for integrating housing and health care services do you think have been successful? What has contributed to their success?
4. Aside from the models you just described, what are you hearing about other approaches for integrating health care with housing? What approaches seem popular? Which approaches seem to have resistance or disinterest? Do you think this model would be acceptable to consumers? Do you think housing would serve as a sufficient incentive for consumers to agree to participate in a program that combines health care services and housing?

In our initial policy analysis, we identified some key barriers: financing barriers such as upfront investments, on-going operational costs, and costs of service delivery, as well as regulatory and service provision barriers. From your standpoint, what are the key challenges to improving or expanding integrated housing and health care models?

We are currently exploring two conceptual approaches to integration and I want to talk with you about both of them. The first approach is to focus on the highest-cost, highest needs older adults. With that perspective, the goal would be to understand how a housing-based intervention could reduce health care costs. This perspective leads naturally to a focus on populations with the highest health care utilization and with the greatest potential for health care savings.

The second approach is to focus on the health of the population or the community as a whole. This community or public health-oriented approach might look at the population of low-income older adults in a given community or state who are in affordable housing and think about how to meet their needs as a whole. This perspective leads to solutions focused on affordable housing status that serve a population with varying levels of health care needs.

Given your experience, I would like to ask you a set of questions on both sets of approaches to better understand the pros and cons of each. We would also like your perspective on these approaches in the context of COVID-19. *[pause and check for any clarifying questions and move on to ask the appropriate set of questions below]*

Stakeholder Type	Questions
Health Service Providers (and/or providers with expertise on program development and implementation)	<p><i>The following set of questions are for organizations that already have some sort of collaboration. Start with understanding their motivations through these questions before asking about our two approaches.</i></p> <p>However, before we go to those two approaches, I want to ask you a few more questions about your existing collaboration(s).</p> <ol style="list-style-type: none"> 1. Why were you interested in collaborating with housing? What were the underlying motivations for you to partner with a housing provider to deliver services to residents? <i>[Prompt if needed: Did you initiate this relationship or did the housing provider approach you?]</i> 2. What did you think would be the advantages for your organization or your patients/clients/ members? (or what was the incentive to work with housing). Have your expectations been met? 3. How are you working with the housing community (i.e. what is the actual collaboration/ interaction between the two groups)? What services are you currently providing and at what frequency? Is it for everyone in the building or a sub-set of individuals?

<p>Health Service Providers (and/or providers with expertise on program development and implementation) <i>continued</i></p>	<p>4. What challenges or barriers did you encounter as you established the collaboration? Was there anything you wanted to do in your collaboration, but were unable to?</p> <p>5. What, if any, are the challenges you are encountering in ongoing operations?</p> <p>6. Are there particular limitations or challenges to working with housing communities that make it hard for your organization to establish more purposeful collaborations with housing properties?</p> <p>7. What kind of outcomes or return on investment do you need to see to justify collaborating with a housing property?</p> <p>8. Are you considering making additional investments in the service model? (e.g. place their staff/ operations on site, building out service delivery space on housing site, pay for housing)</p> <p>9. Are you covering costs or are they shared for any of the services?</p> <p>Now, reflecting on your experiences, I want to ask you a few questions that will help us evaluate the two approaches I mentioned earlier.</p> <p><i>Questions about the two approaches:</i></p> <p>1. In your view, what are the critical factors that are needed to make collaborations between housing and service providers actually work for each of the parties and most importantly, for consumers?</p> <p>2. Earlier, we talked in more general terms about barriers to integrating health and housing (financial, regulatory and service provisions). From your perspective, what do you see as the most critical barriers to the successful integration of housing and health care services? For models like this to work, what is the most important barrier to overcome? What would be the most important barrier to overcome from the housing, payer and consumer perspective?</p> <p>3. What kind of service package would be attractive and sustainable from an operational perspective as well as a consumer perspective? Is there something regarding the services that you are currently providing that you would like to change to make more operationally sustainable or attractive to consumers?</p>
<p>Housing Experts</p>	<p><i>The following set of questions are for organizations that already have some sort of collaboration.</i></p> <p>However, before we go to those two approaches, I want to ask you a few more questions about your existing collaboration(s).</p> <p>1. Based on your experience, what do you see as the opportunities and barriers to working with health care providers? How did you financially support this collaboration?</p> <p>2. What is the value of adding services to your program?</p> <p>3. How did you financially support this collaboration? Who pays for the services? Was there an attempt made to share costs?</p> <p>4. What are the financial opportunities and barriers at the local, state and federal level that currently exist in the housing market that would help or limit this model? Do you think there are viable solutions?</p> <p>Now, reflecting on your experiences, I want to ask you a few questions that will help us evaluate the two approaches I mentioned earlier.</p> <p><i>Questions about the two approaches:</i></p> <p>1. Which of the two approaches seem more attractive and/or feasible to you? Why? [<i>probe about the issue of scale if it doesn't come up</i>]</p> <p>2. Earlier, we talked in more general terms about barriers to integrating health and housing (financial, regulatory and service provisions). From your perspective, what do you see as the most critical barriers to the successful integration of housing and health care services? For models like this to work, what is the most important barrier to overcome? What would be the most important barrier to overcome from the housing, payer and consumer perspective?</p> <p>3. What are the benefits to integration for housing providers?</p> <p>4. In your view, what are the critical factors that are needed to make collaborations between housing and service providers actually work for each of the parties and most importantly, for consumers?</p> <p>5. What kind of service package would be attractive and sustainable from an operational perspective as well as a consumer perspective?</p>

<p>Policymakers</p>	<ol style="list-style-type: none"> 1. Earlier, we talked in more general terms about barriers to integrating health and housing (financial, regulatory and service provisions). From your perspective, what do you see as the most critical barriers to the successful integration of housing and health care services? For models like this to work, what is the most important barrier to overcome? What would be the most important barrier to overcome from the housing, payer and consumer perspective? 2. From your perspective, what are the key considerations when developing a model like this? 3. Are there particular models that you think would be important to test? 4. What regulatory constraints or waivers would have to be granted in order to proceed with such a test or demonstration? How might such a model be funded? What would be the possible sources of financing? 5. What do you think is missing from current research and literature that is necessary to inform policy in this area? What have other efforts missed? Where should we be focusing our efforts regarding knowledge generation? 6. Are there issues with health care and housing integration that you think no one is really paying attention to that should be addressed?
<p>Consumer Advocacy Organizations/National Experts</p>	<ol style="list-style-type: none"> 1. Earlier, we talked in more general terms about barriers to integrating health and housing (financial, regulatory and service provisions). From your perspective, what do you see as the most critical barriers to the successful integration of housing and health care services? For models like this to work, what is the most important barrier to overcome? What would be the most important barrier to overcome from the housing, payer and consumer perspective? 2. Do you think these models would be acceptable to consumers? Do you think housing would serve as a sufficient incentive for consumers to agree to participate in an integrated program? Which aspects would be most attractive to consumers? Which aspects would worry them the most? 3. What factors would you say are most important in making a model like this work? 4. From your perspective, what kind of service package would be attractive and sustainable? Looking at the two potential models we described at the beginning [<i>recap both the health payer and community-based models</i>], how would you message this to consumers? 5. What do you think is missing from current research and literature? What have other efforts missed? 6. What is not being talked about and should be talked about? 7. In your role, what are you hearing and saying about merging health care with housing? What approaches seem popular? Which approaches seem to have resistance or disinterest?

Thank you for taking the time to answer our questions. We appreciate your perspective. As I said in the beginning, we do not intend to attribute comments to specific individuals. We may quote you, but if we wish to use your name or give information that could be used to identify you (your role, for example), we will check back with you first. If there is any information you would not like attributed to you, please let us know, and we will respect your wishes. And again, you will have a chance to see the final report before it is released.

If you have any follow up questions or comments, please feel free to reach out me.



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