Consortium for Citizens with Disabilities Housing Task Force
Briefing Paper

HUD Permanent Supportive Housing Tenant Selection Preferences
October 12, 2015

Introduction

Since the beginning of the Obama Administration in 2009, there has been a federal policy emphasis on assisting people with significant disabilities to obtain decent, safe, and affordable housing in the community linked with appropriate and voluntary services and supports to ensure successful community living. This Permanent Supportive Housing (PSH) approach to organizing and delivering affordable housing and community-based supportive services is a best practice approach for vulnerable very low income people with the most significant and long term disabilities. PSH is also a central element of Obama Administration policies to end chronic homelessness, assist states to comply with Title II of the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's 1999 *Olmstead* decision, and reduce reliance on high cost Medicaid financed institutional settings.

Because of budgetary constraints, obtaining increased appropriations for U.S. Department of Housing and Urban Development (HUD) PSH programs (i.e. Homeless Assistance Programs, Section 811, etc.) has become extremely difficult. In response to this challenging fiscal environment, many state and local housing agencies have targeted HUD's so-called mainstream programs to expand PSH, particularly the Housing Choice Voucher (HVC) program. A modest percentage of "turnover" resources from the HCV program could create 20,000 or more new PSH units annually. New National Housing Trust Fund (NHTF) resources, expected to be available in 2016, could also provide a critical source of future PSH funding.

However, HUD tenant selection preference policies related to PSH in the HCV and NHTF programs are confusing at best and are in conflict with key U.S. Department of Justice (DOJ) and U.S. Department of Health and Human Services (HHS) policies, particularly policies related to Medicaid services that are critically important to most PSH tenants. HUD's tenant selection preference policies also have had a chilling effect on the willingness of some state and local housing agencies to create new PSH opportunities. Other housing agencies have proceeded to "do the right thing" by creating PSH opportunities – primarily using HCV. Some of these PSH initiatives appear to violate current HUD policies. Neither of these situations is helpful to HUD. HUD tenant selection preference policies do not make an explicit reference to the PSH model. Instead, they are based on HUD's Section 504 policies, which focus on the prohibition of housing discrimination, including on the basis of disability. As a vestigial product of early HUD

efforts to address housing discrimination, HUD PSH tenant selection preferences prohibit tenant selection based on: (1) specific disability subpopulations; (2) disability-specific services; and (3) referrals from disability-specific providers. The Consortium for Citizens with Disabilities (CCD) Housing Task Force strongly believes that PSH tenant selection preferences which have the affect of targeting certain disability subpopulations – and that synchronize with other federal programs, particularly Medicaid, as a means to address chronic homelessness and *Olmstead* compliance – should not be considered by HUD to constitute discrimination on the basis of disabilities

HUD PSH Policy Barriers

Unfortunately, HUD's policies related to PSH vary to some extent across all of HUD's mainstream programs, which is one cause of confusion. However, the most explicit policies, and the most troubling, are in the HCV and NHTF programs and summarized below:

1. HUD HCV and NHTF policies do not make it clear that prospective PSH tenants must qualify (e.g. meet all eligibility criteria) for the services that will be offered in conjunction with the PSH opportunity. As a result, some housing agencies are understandably concerned that they will be required to offer a PSH opportunity to a prospective tenant that cannot participate in the services being made available. CCD has proposed improved regulatory language – often in collaboration with HUD program staff – on numerous occasions over the past five years.

2. HUD prohibits disability-specific PSH initiatives, despite the fact that most of the services made available for PSH initiatives (increasingly through Medicaid) are disability specific. For example, the services funding for chronic homeless PSH initiatives is frequently provided Medicaid financing for Assertive Community Treatment (ACT) services, which are an evidence-based intervention for people with the <u>most</u> severe mental illnesses. As we understand current HUD policy, an Office of General Council (OGC) waiver would be needed to implement a PSH project for this specific subpopulation. OGC waivers are time-consuming and cumbersome for housing agencies struggling with reduced administrative fees, and should be unnecessary if appropriate HUD guidance is made available.

3. HUD PSH policies for the HCV and NHTF programs permit and incentivize the creation of single-site PSH units but appear to prohibit more integrated models in conjunction with state efforts to comply with Title II of the Americans with Disabilities Act (ADA), the U.S. Supreme Court's 1999 *Olmstead* decision, and recent Medicaid waiver regulations published by the HHS Centers for Medicare and Medicaid (CMS). HUD acknowledged this problem to CCD in a meeting with FHEO and OGC senior staff in February of 2015, but has yet to propose a solution.

These confusing and conflicting policies are best illustrated through the actual regulatory language of the Project-Based Voucher (PBV) program and the recently published Interim Rule

for the NHTF. The relevant language in the two rules is virtually identical but the citation below appears in the NHTF rule.

Section 93.303(d)(3)(ii) National Housing Trust Fund Interim Rule

If a project does not receive funding from a Federal program that limits eligibility to a particular segment of the population, the project may have a limitation or preference for persons with disabilities who need services offered at a project only if:

(A) The limitation or preference is limited to the population of families (including individuals) with disabilities that significantly interfere with their ability to obtain and maintain housing:

(B) Such families will not be able to obtain or maintain themselves in housing without appropriate supportive services; and

(C) *Such services cannot be provided in a non-segregated setting. The families must not be required to accept the services offered at the project. In advertising the project, the owner may advertise the project as offering services for a particular type of disability; however the project must be open to all otherwise eligible persons with disabilities who may benefit from the services provided in the project.*

[Emphasis added.]

Analysis

(A) and (B) above are very clear and are supported in full by the CCD Housing Task Force. However several confusing issues emerge from a reading of the language in (C).
The first issue is the underlying assumption that the services that will be offered can only be provided in a segregated setting. The language is awkward but strongly implies that PSH can only be created in a segregated setting. Certainly, we know from experience (i.e. the new Section 811 Project Rental Assistance (PRA) program, PSH initiatives funded with tenant based HCV etc.) that PSH can be provided in highly integrated settings. We also know that community based Medicaid financing models incentivized by HHS are the typical source of services financing for many of these initiatives. HUD guidance is essential to clarify that integrated models of PSH – which create scattered-site PSH units and/or PSH tenant-based opportunities – can also be funded through the NHTF and HCV programs. Such guidance is essential to provide clarity to state and local housing agencies.

Other issues arise from the lack of clarity in the language underlined in (C) above, including disability specific preferences. As noted above, the PSH approach targets the most vulnerable disability sub-populations. The Medicaid funding streams essential to provide them with community-based services are often disability specific, as explained below. This type of disability specific PSH preference should not be equated with the discrimination practiced in the 1980s and 1990s by some PHAs that "steered" applicants with mental Illness to crumbling public housing buildings in unsafe neighborhoods (which happened in the 1980s and early 1990s). Instead, HUD guidance should clarify that PSH tenant selection preferences which

target very specific subpopulations of people with disabilities (i.e. people with mental illness who are chronically homeless, people with intellectual and developmental disabilities leaving state facilities under an *Olmstead* Plan, etc.) are, in fact, consistent with affirmatively furthering fair housing opportunities for people with disabilities. With appropriate guidance, HUD Office of General Counsel (OGC) waivers to implement such preferences should not be required.

Finally, HUD policy also stipulates that the project must be open to all otherwise eligible persons with disabilities who may benefit from the services provided in the project. However, HUD is silent with respect to how this determination should be made. As a result, some housing agencies believe that if an otherwise eligible applicant asserts that he/she could benefit from the services to be offered, HUD regulations require that he/she be admitted. Guidance which clarifies that the housing agency is permitted to screen the prospective PSH tenant to ensure eligibility for the PSH services to be offered would be extremely helpful to housing agencies struggling with this issue.

Synchronization with Medicaid Policy

The federal/state Medicaid program has become the largest and most reliable source of supports and services funding for people living in PSH. Since HUD and HHS created their partnership during the early years of the Obama Administration, HUD has repeatedly emphasized the importance of Medicaid financed services as a critical component of housing strategies for vulnerable PSH populations. For example:

- CPD has issued guidance to Continuums of Care on the importance of leveraging Medicaid services funding in conjunction with efforts to end chronic homelessness;

- HUD's 2013 *Olmstead* guidance states that "states have been rebalancing their systems away from institutions and steadily increasing the array of services that can be provided with Medicaid funding in home-and community-based settings. The integration mandate of the ADA and *Olmstead* compels states to offer community-based health care services and long-term services and supports for individuals with disabilities who can live successfully in housing with access to those services and supports."

- PIH Notice 2011-51 and CPD Notice 2011-09 state that "To assist persons with disabilities transitioning out of institutional settings, for example, PHAs and grantees are encouraged to contact their State Medicaid agencies or the local office of these agencies to determine the availability of Medicaid home and community based services (HCBS) waivers and other resources under the Medicaid Program."

Given HUD's emphasis on supportive housing using Medicaid financed services, it is critical that HUD improve the synchronization of its PSH tenant selection preference policies with critical Medicaid optional and waiver services options, as suggested above. Specific Medicaid waivers are created to encourage states to reduce reliance on high cost disability specific institutional settings, such as state institutions for people with intellectual and developmental disabilities (I/DD). Similarly, states are using Medicaid optional services to help reduce reliance on public

mental health hospitals and provide more comprehensive services in community-based settings such as PSH. Categorical, disability-specific state appropriated services are often created as a result of closing mental health and/or I/DD institutional beds to improve compliance with *Olmstead* and ADA requirements.

Under these disability-specific Medicaid policies, some people receive services 24 hours a day, 7 days a week, while others have services provided every day or multiple times a week. These services are typically delivered by licensed and credentialed professionals who have the skills and training to deliver particular services to people with specific type(s) of disabilities. For example, it would be very unusual for a clinician qualified to deliver waiver services to people with I/DD to also be qualified to provide ACT services for people with mental illness.

For the development of HUD guidance, it is also important to note that while these services may be disability specific, only a small sub-set of people with that particularly disability – specifically those with the most significant level of disability – will be eligible to receive them. Thus, a housing agency should be able to rely on the service provider's determination of this need, which is also clearly spelled out in each state's Medicaid Plan approved by CMS. Similar level of care criteria also apply to virtually all state appropriations for disability specific services.

Because these programs provide comprehensive long-term supports and services, states also have policies that rigorously control access to these services in order to control costs. States have generally established rigorous service eligibility criteria designed to ensure that people do not receive access to these services unless they absolutely need them.

Conclusion and Recommendation

Given that efforts to end chronic homelessness among people with disabilities and state efforts to reduce reliance on institutional settings and comply with the ADA are increasingly being driven by Medicaid services, it is critically important to HUD's stated policy goals that HUD PSH tenant selection preference policies be synchronized and aligned with federal/state Medicaid policies and any comparable state-financed long-term care services.

One method to achieve this goal would be the publication of new HUD cross-cutting PSH guidance which clarifies the intent behind the regulations noted in this paper and possibly others. This approach would not require rule-making, it would strengthen HUD's partnership with HHS during the last year of this Administration, and most importantly, provide housing agencies with the clarity they need to participate successfully in efforts to end chronic homelessness and *Olmstead*-related PSH initiatives. The CCD Housing Task Force believes that such guidance would be extremely well received, and would stimulate a much greater level of PSH activity across the nation.