

HUD SECTION 811 PRA

Project Rental Assistance Program



Phase II Evaluation Final Report

Implementation and
Short-Term Outcomes

Executive Summary



Executive Summary

The U.S. Department of Housing and Urban Development (HUD)'s Section 811 Project Rental Assistance (PRA) Program provides rental housing assistance to non-elderly people with disabilities. In this second phase of its evaluation of the PRA program, HUD sought to determine the impact of the program on residents' housing tenancy and use of home and community-based services, characteristics of properties and neighborhoods where assisted residents live, and residents' healthcare diagnoses and utilization. In order to assess the program's effectiveness, the study compared short-term outcomes of the PRA program against outcomes for residents in the Section 811 Capital Advance/Project Rental Assistance Contract program (referred to as PRAC in this report), outcomes for people with disabilities in other HUD rental assistance programs, and outcomes for a group of similar people who receive Medicaid but are not assisted by HUD programs.

The evaluation found that the PRA program assists people who are different from people with disabilities in HUD's other housing assistance programs in their demographic characteristics, the types and sizes of properties they live in, and the characteristics of the neighborhoods where they live. PRA residents have lower incomes, have more chronic and disabling conditions, and are more likely to have had long-term stays in inpatient settings. Looking at early outcomes for a sample of units in just six states, both housing unit and neighborhood quality are lower for PRA units than for PRAC units. PRA units have greater access to public transportation and are in neighborhoods with greater walkability, but PRA residents do not feel as safe in their neighborhoods.

PRA residents receive tenancy supports similar to PRAC residents, and healthcare utilization rates are similar for residents of the two programs. Utilization rates for long-term inpatient care are lower for PRA residents than for the comparison group that does not receive HUD assistance, and utilization rates for case management services are higher. Rates of healthcare utilization for PRA residents do not differ significantly from rates for residents of other HUD housing assistance programs.

Our assessment of the cost-effectiveness of PRA in relation to other HUD programs that assist people with disabilities found that rental subsidy costs are similar

or lower than for other HUD programs but that program administrative costs are higher.

The Section 811 Project Rental Assistance Program

Authorized by the **Frank Melville Supportive Housing Investment Act of 2010**,¹ the PRA program provides project-based rental assistance to extremely low income, non-elderly people with disabilities. The program responds to the goals of the Supreme Court's 1999 decision in *Olmstead v. L.C.*² to allow people with disabilities to live in the least restrictive settings possible that meet their needs and preferences. The PRA program is a joint initiative between HUD and the U.S. Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS). **The goal of the PRA program is to expand access to high-quality, affordable housing and voluntary, community-based services to allow eligible people to live successfully in the community.** To assess the implementation and outcomes of the PRA approach, the Melville Act required an independent evaluation.

The PRA program was designed to respond to a number of policy priorities:

- To increase the supply of affordable housing for people with disabilities in a cost-effective way while continuing to serve households with extremely low incomes.
- To provide affordable, community-based housing options for people who might otherwise be, or be at risk of becoming, homeless or unnecessarily institutionalized. PRA residents must meet HUD eligibility requirements for age, income, and disability, and be eligible for Medicaid-funded or other home and community-based services (HCBS).
- To offer integrated housing settings where people with disabilities live in multifamily housing for people both with and without disabilities.
- To encourage collaborations between state housing and health agencies that result in long-term strategies for providing permanent, affordable housing options for people with disabilities and coordinated access to services.

To date, 27 state housing agencies are administering PRA grant programs and expect to provide rental assistance for an estimated 6,000 households. The housing agencies established interagency partnership agreements with state health agencies that administer community-based services funded through Medicaid.

Evaluating the PRA Program

The PRA program differs from PRAC and other HUD programs that assist similar populations in a number of ways—in the way in which the housing is identified and brought into the program, in the type of rental assistance, in the program’s cost structure, and in whether and how coordinated access to services is provided. These differences affect the experience of PRA residents, their housing location, access to services, and program costs.

An initial, Phase I Evaluation³ (2014–2016) examined the early implementation of the PRA program in 12 states, as state housing agency grantees established agreements with property owners to lease units to PRA residents, determined outreach and eligibility procedures to identify eligible applicants, and began moving people into housing. Given the complexities of launching the new program and that many grantees identified most or all of their PRA units in properties under development, few applicants had been housed by the end of the Phase I evaluation.

This Phase II Evaluation (2016–2019) assessed the ongoing PRA implementation experience as programs matured and the PRA program’s outcomes and effectiveness in six states. The selected states—California, Delaware, Louisiana, Maryland, Minnesota, and Washington—were chosen because they had housed the largest number of PRA residents by 2017 when the evaluation’s research design was finalized.

The Phase II evaluation was designed to answer these questions:

- How do short-term impacts of the Section 811 PRA program compare to outcomes for comparison groups made up of similar people living in other settings?
- What is the relationship between PRA features and strategies and program results?
- What are the costs of the PRA program, and how do they compare to costs for other HUD programs serving similar populations?

To estimate PRA program impacts, the study team constructed four statistically matched comparison groups comprising people similar to PRA residents based on their demographic characteristics, chronic and disabling conditions, and healthcare utilization patterns prior to PRA program implementation. The comparison groups are drawn from non-elderly people with disabilities from the six study states in the following categories:

- Receiving assistance through HUD’s Section 811 Capital Advance/Project Rental Assistance Contract

(**PRAC**) program, which provides capital grants to develop housing exclusively for people with disabilities and project rental assistance for operational costs. Like PRA, PRAC owners must ensure resident access to services.

- Receiving assistance through HUD’s Non-Elderly Disabled (**NED**) voucher program, which provides tenant-based rental assistance to non-elderly people with disabilities who may lease units of their choice that meet HUD’s requirements.
- Receiving assistance through (**other HUD**) programs available to eligible low-income people with and without disabilities; this category includes Housing Choice Vouchers, public housing, and multifamily assisted housing.
- Receiving Medicaid but not living in HUD-assisted housing (**non-HUD**).

The Phase II evaluation uses administrative data on individuals’ demographic characteristics and healthcare utilization patterns, neighborhood characteristics, property characteristics for the PRA and PRAC programs, and costs associated with the PRA and other HUD programs. The study team also compares healthcare utilization for people in the non-HUD comparison group. Evaluators also reviewed program documents, interviewed PRA program administrators and other program partners, and surveyed a sample of approximately 400 residents living in PRA and PRAC properties.

Key Findings from the Phase II Evaluation

How PRA Residents Differ from Similar Residents Assisted by Other HUD Programs

In order to estimate short-term impacts, and to place our findings in context, we assessed the characteristics of PRA residents relative to people served in other HUD programs. This analysis uses 2015 Medicaid data within the six selected states.

- On average, PRA residents are younger and have lower incomes than non-elderly people with disabilities in other HUD programs.
- PRA residents are less likely to live in single-person households than PRAC residents, but more likely than residents in NED and the other HUD programs.
- A larger share of PRA residents is African-American, and a smaller share is non-Hispanic white or Hispanic than residents in the comparison groups.

³ <https://www.huduser.gov/portal/section-811-process-evaluation.html>

- Based on 2015 Medicaid data, the prevalence of chronic and disabling conditions tended to be higher for PRA residents than for those in the comparison groups.
- Likewise, before being assisted by PRA, PRA residents tended to utilize healthcare services such as inpatient hospital services, emergency department services, and medical transportation *more often* than people in the comparison groups. They were also more likely to have a long-term stay in an institutional setting, such as a nursing facility, acute care hospital, or inpatient rehabilitation facility, than all comparison groups prior to receiving PRA assistance. This was expected, given that states often target PRA units to people leaving institutions.⁴

How Short-Term Outcomes of the PRA Program Differ from Outcomes of the Study's Comparison Groups

These descriptive findings informed the statistical construction of the four comparison groups comprising people living in other settings who are similar in demographics and health characteristics to those assisted in the PRA program in the six study states. Constructing such comparison groups allows us to attribute outcomes for PRA residents to the PRA program, rather than to differences in the populations served.

Quality of Properties and Neighborhoods

PRA units must be located in affordable housing developments built with other sources of capital funding, with no more than 25 percent of total units set aside for people with disabilities. The PRA program also has incentives for grantees to assist more households by subsidizing rents lower than HUD's Fair Market Rent (FMR) that is the basis for determining subsidy payments in the Housing Choice Voucher (HCV) and some other HUD programs. These requirements underscore the program's goals of housing people in mixed population properties, where both those with and without disabilities live, in a cost-effective, person-centered way.

We analyzed administrative data on PRA and PRAC properties and our survey of a sample of PRA and PRAC residents to determine if PRA units meet program goals and residents' needs and preferences. We found that PRA residents live in neighborhoods with higher poverty rates and lower levels of education and higher residential densities than similar people in other HUD programs (PRAC, NED, and other HUD). On average, PRA residents reported liking their buildings and neighborhoods and

feeling safe where they live, but not to the same extent as PRAC residents do.

Key findings are:

- Units under contract for PRA (but not necessarily occupied by PRA residents yet) are heavily concentrated in larger, newer properties with more than 50 units, in either walk-up or elevator buildings. Most properties with PRA units under contract (85 percent) were built or rehabilitated since 2000. By comparison (and as limited by statute), nearly all PRAC residents live in smaller properties, generally with fewer than 25 units, and with a smaller share of newer properties (60 percent built since 2000).
- On average, PRA units make up 10 percent of total units in properties with units under contract, well below the 25 percent cap. While units set aside under other state or local programs count towards the cap, information on these units was not available to the study team. Units occupied by, but not set aside for, people with disabilities are not included in the cap. Anecdotally, we heard that some properties would exceed the cap if all of these units are included.
- Significantly more PRAC residents reported feeling safe in their buildings, 92 percent, compared to 77 percent of PRA residents. Slightly higher shares of PRAC residents (80 percent) report they like where they live than PRA residents (76 percent), but this difference is not statistically significant.
- Significantly fewer PRA residents (70 percent) reported their units are in excellent or good condition compared to PRAC residents (83 percent).
- We measured whether residents feel integrated in their community by asking whether they know other people in their buildings and in the neighborhood. PRA residents were significantly less likely than PRAC residents to report knowing people in their buildings (81 percent vs 93 percent) or in their neighborhoods (38 percent vs 65 percent).

We found a number of statistically significant differences between the neighborhoods where properties with PRA units are located and those where comparison group members live. On average, PRA residents live in neighborhoods with higher residential density (that is, buildings with 50 or more units) and lower rates of single-family owner-occupancy than the comparison groups. PRA residents live in neighborhoods with greater access to public transit and higher rates of "walkability" than the comparison groups, factors that could contribute to their quality of life and potentially to improved health.

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- Relative to the comparison groups, census data indicate PRA residents also live in neighborhoods where a significantly higher share of non-elderly adults (age 35 to 64) self-report a disability, lower shares of all adults have an Associate degree or higher, and more households have incomes below the poverty line. Further, PRA residents live in neighborhoods with statistically significant higher exposure to harmful environmental toxins, according to federal data from the Environmental Protection Agency (EPA).
- PRA residents are significantly less likely to report feeling safe in their neighborhoods (68 percent) compared to PRAC residents (87 percent). However, despite some potential challenges to their neighborhood environments, the majority (73 percent) of PRA residents report they like their neighborhoods. This percentage is less than the share of PRAC residents (84 percent) who express satisfaction with their neighborhoods, but this difference is not statistically significant. (The study did not conduct surveys of residents in other HUD programs, so their perception of their neighborhood is unknown.)

The analyses of property administrative data and of resident survey responses are not representative of all properties and neighborhoods where PRA residents will eventually live. The analyses represent only a subset of the units and households that will eventually be assisted by PRA. The properties represent less than half of the estimated PRA units the six study states plan to assist with their PRA programs.⁵ Likewise, the resident survey responses represent the experience of a subset of PRA residents at an early point of their tenancy, and do not reflect the experience of all residents being assisted by PRA at the time or who will be assisted by PRA in the future.⁶

In addition, the evaluation's results only apply to the six states participating in the study and are not representative of the PRA program in all of the states that have PRA programs. The states were selected based on the implementation status of their programs after two years of grant funding, based on the number of PRA units leased in FY17. In many cases, the states that were able to implement their programs more quickly than others had prior experience with supportive housing programs or had previous state-level agency partnerships.

Access and Use of Community-Based Services and Tenancy Supports

The PRA program requires residents be eligible for Medicaid-funded HCBS or similar state plan services to ensure that residents will have the supports they need to live successfully in the community. Medicaid can fund certain tenancy support services to help Medicaid beneficiaries find, apply for, move to, and remain stably housed in community-based housing, although the exact mix of services varies by state. It can also pay for other community-based services that ensure beneficiaries' health and well-being, such as personal care assistance, home healthcare, or transportation assistance. These services are intended to support residents' health status and successful community living experience. Community-based services are available under Medicaid waiver programs, state plan services, and community-funded providers. Not all PRA residents are necessarily eligible to receive all services available in their communities.

We surveyed PRA residents in the six study states about their use of and experience with the services they receive in their homes and their perceived quality of life and health status. We also surveyed similar residents in PRAC properties to see whether their experiences differed from PRA residents. In PRAC, the nonprofit sponsors that developed and operate PRAC housing are responsible for ensuring residents have the services and community supports they need to remain in their homes. Services in both programs are voluntary for residents. Results showed:

- The majority of PRA and PRAC residents report that the tenancy supports and other services they receive meet their needs. Significantly more PRA residents reported receiving help with their lease application to move into their apartment.
- Overall, both PRA and PRAC residents rated the quality of their services well, but some residents in both groups report gaps in services. Notably, among the one-quarter of each group who reported needing help with medications, 65 percent of PRA residents reported they had gone without medication because there was no one to help them, compared to 15 percent of PRAC residents, a statistically significant difference.
- PRA and PRAC residents report no statistically significant differences in healthcare services received, amount of care provided by friends and family, or quality of care received from caregivers.

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- Most PRA and PRAC residents rate their quality of life and overall health as at least okay, but significantly more PRAC residents rate their quality of life and overall health as good or excellent than PRA residents.
- PRA and PRAC residents have similar rates of exits (about 20 percent a year), but PRA residents are more likely to leave for non-payment of rent than PRAC residents do.

Healthcare Utilization of PRA Residents

We found that, in less than one year after PRA residents moved into PRA units,

- PRA residents tended to use inpatient hospital, emergency department, medical transportation, and long-term inpatient services at lower rates than similar individuals in the comparison groups, but few of the differences were statistically significant.
- We did find statistically significant differences in healthcare utilization after receiving housing assistance between PRA residents and people not receiving HUD assistance: lower use of long-term inpatient care services and greater use of case management services. The absence of statistically significant differences among the HUD programs in utilization of health care services suggests that housing subsidies to help people with disabilities remain in community-based housing may matter more than the type of housing assistance. Because of small sample sizes and the short follow-up period, this inference should be viewed with caution, however.
- PRA residents were more likely to use personal care assistance or case management services, the study's proxies for Medicaid-funded HCBS. These differences may reflect greater access to or coordination of services, or a history of unmet needs prior to PRA tenancy.

This analysis provides early evidence that the PRA program might have a substantive long-term impact on healthcare utilization in a population with many unmet healthcare needs. There are caveats to drawing definitive conclusions, however. The PRA tenancy period in this evaluation was one year or less, and it is likely too short a period to detect or attribute significant changes in patterns of healthcare utilization to the PRA program, particularly in rare outcomes like transitions to long-term care institutions.

Additionally, while we estimate that between 20 and 40 percent of PRA residents and members of our comparison group are dual-enrolled in Medicaid and Medicare, we had access only to Medicaid data. Medicare is the primary payer for hospitalizations, physician services,

post-acute care services, hospice care, and prescription drugs among dual-enrolled individuals. Medicaid only pays for specific services not covered by Medicare and sometimes covers the cost of premiums, deductibles, co-pays, or co-insurance (benefits vary across states). We cannot be certain that we captured services that were entirely paid by Medicare. Thus, it is likely we have underestimated healthcare utilization by PRA residents and the comparison groups. Moreover, PRA residents were less likely than the PRAC, NED, and other-HUD groups to be dual-enrolled, so we may have overestimated the impact of PRA on healthcare utilization during tenancy to some degree.

Costs of PRA and Comparison to Other HUD Programs Serving Similar Populations

The PRA program leverages rental assistance in multifamily developments built with other capital funding sources such as the Low-Income Housing Tax Credit (LIHTC) program. To promote cost-effectiveness, the program seeks to maximize the number of units assisted at the lowest feasible per unit subsidy cost, while maintaining the long-term affordability requirements of the units. Additionally, PRA residents must have access to Medicaid-funded or state plan services that help them transition to and remain stably housed in community-based housing and ideally reduce use of costly long-term care and emergency department services.

To assess the PRA program's cost-effectiveness relative to other programs, we collected program documents and analyzed available administrative data on program costs for the PRA program and the comparison group programs that are assisted by HUD (PRAC, NED, other HUD programs). Specifically, we analyzed capital costs, rental subsidy costs, healthcare and disability-related services (paid or unpaid), and program administrative costs. The cost structures across programs are very different, the PRA program is still in the relatively early stages of implementation, and the cost data available to the study team are not complete across all the comparison groups, for all cost categories. The study also found that PRA residents in the study states had higher prevalence of chronic and disabling conditions and tended to use healthcare services at higher rates than individuals in the comparison groups.

Given these caveats, our preliminary findings are:

- Rental subsidy costs for PRA residents are higher than for PRAC residents, but lower than for NED and the other HUD-assisted housing programs. Per unit annual rental subsidies range from \$6,841 for PRA units to \$7,872 for NED vouchers.

- Estimated total housing costs (capital and rental subsidies) are \$11,800 per unit, per year for PRA units, compared to between \$12,000 and \$13,000 per unit per year for PRAC units. The estimated annual cost of rental assistance in the PRA program is \$6,941 while capital subsidy costs are estimated at \$4,969 annually. (Capital subsidies are either unknown or not applicable for the other comparison groups.) In the PRA program, many capital costs are incurred by non-HUD programs such as the Low-Income Housing Tax Credit.
- Program administrative costs are much higher for the PRA program (\$5,780 per unit, annually) compared to the comparison group costs of less than \$1,000 per unit annually. Grantee costs represent just less than half (43 percent) of the administrative costs, state agency partner costs represent about 50 percent, and the cost to HUD represents about 7 percent. PRA costs may go down as the program matures and more residents are housed, potentially driving down per-unit costs.
- In all, total annual program costs are \$17,577 per PRA unit compared to almost \$14,000 for PRAC units.
- The annual estimated cost of healthcare and disability services for PRA residents is \$51,179, slightly higher than for PRAC (\$50,321), and substantially lower than for NED (\$56,025). For residents of other HUD programs, the annual estimated healthcare and disability costs were much lower, \$34,204.

Strategies to Address Implementation Challenges

Identifying the Right Unit for the Right Person, at the Right Time, Continues to be the Central Challenge of the PRA Approach

As documented by Phase I of the evaluation, the PRA program is challenging to implement. The program's administration and cost structure differ in a number of ways from HUD's other rental subsidy programs. In addition, grantees primarily target populations with extensive needs—those who have been living in or are at risk of admission to institutions, and those experiencing or at risk of homelessness. Finding and engaging eligible PRA applicants and matching them to available, appropriate units that meet their needs and preferences—where and when they are ready to move—is very challenging. States are working to meet these challenges in multiple ways.

Securing PRA Units under Contract

As of September 2018, nationally PRA grantees and their partners have secured contracts for approximately 2,200 of the 6,000 units the program is expected to assist. The PRA program has successfully attracted owners willing to enter long-term rental assistance contracts, generally at rents below the program's limit set at HUD's Fair Market Rents. Roughly one-third of units committed to the program are under lease, although most residents had been housed less than one year at the time of this evaluation.

The majority of PRA residents report that they like where they live and feel safe in their neighborhoods, but a quarter of residents report concerns with property quality and safety. A fifth of PRA residents report unresolved maintenance issues. PRA residents are less likely to report that they feel safe in their building or neighborhood compared to PRAC residents. While PRA units are located in neighborhoods with higher rates of walkability and access to public transportation than most of the comparison groups, PRA units are located in census tracts with higher concentrations of poverty, lower levels of education, and lower levels of owner-occupied housing. PRA residents also live in neighborhoods with higher exposure to harmful environmental toxins. Several grantees have sought waivers to increase targeted rents, given the challenges of attracting units with modest rents. If granted, higher rents may attract more owner interest and give PRA residents more choices of units and neighborhoods.

Identifying and Selecting the PRA Target Populations

PRA grantees and their partners are successfully housing the vulnerable groups that grantees target. In the six study states, about half of the 1,459 planned units are occupied. Almost half of PRA residents were previously living in institutions (27 percent) or experiencing homelessness (20 percent) before moving to a PRA unit. PRA residents to date have histories of high rates of chronic and disabling conditions and higher rates of healthcare utilization than people in HUD's other assistance programs that serve non-elderly people with disabilities.

While the PRA program is reaching and engaging applicants, ineligibility continues to be an issue. Many applicants do not meet PRA program requirements for income or Medicaid eligibility. Even those who do may not meet the leasing requirements (for example, credit and criminal records checks) at the property where they wish to live. Grantees have greater success reaching these populations and clarifying eligibility when outreach strategies are tailored to the needs and current

(pre-PRA) living situations of each group. Finding effective, efficient ways to manage eligibility determination and waiting lists also facilitates timelier housing placement, as do strategies to work with property owners to mitigate concerns about poor credit or criminal histories.

Achieving Stable Housing and Access to Community-based Services

PRA residents should have access to the community-based services they need to ensure they can remain in their homes as long as they like and to promote positive health outcomes. Given the short tenure of most PRA residents, we cannot say definitively that these goals are being reached, but early evidence indicates that PRA residents use fewer high-cost healthcare services after they are housed than they did in the pre-occupancy period or relative to similar populations living in other housing settings. This provides early evidence that positive outcomes may be observed in the future.

Sustaining PRA Partnerships to Ensure Effective Ongoing Implementation of the PRA Program

The ultimate goal of the PRA program is to create institutional knowledge and capacity within states to further expand the availability of supportive housing for people with disabilities. At the core of this effort are sustainable partnerships between health and housing agencies that can bring together their respective resources and expertise. These partnerships grow over time, and many have their antecedents in previous state or CMS initiatives.

The grantees we evaluated see their partnerships as successful and offer insight into strategies to forming and deepening them. These include regular meetings and communication, recognizing and valuing the expertise of each partner, and automating or documenting key knowledge and functions so they are not lost when individual staff move on. As documented in the cost analysis for this study, however, the intensity of this effort contributes to relatively high PRA program administrative costs compared to other HUD programs.

Policy Implications for State and Federal Stakeholders

Based on the results of this study, we see early evidence that the PRA program is achieving its aims. Grantees are moving eligible households to community-based housing, and early outcomes appear promising. The research raises several policy implications and suggestions for further inquiry.

Going forward, HUD should **continue to monitor tenancy outcomes in program tenure, unmet support**

needs, and reasons for program exits. Grantees and their state partners may also want to monitor differences in tenancy outcomes by target population to see if some populations are more successfully maintaining community-based housing than others. Results after less than one year in housing appear promising but may not be definitive. The ongoing study is challenging, given how complicated and costly it is to acquire and match HUD and Medicaid data. We encourage HUD and CMS to **pursue opportunities to streamline data sharing** in ways that protect individual privacy and support rigorous research. In addition to pursuing opportunities to share data among federal agencies, HUD and CMS should explore similar opportunities to share data with state housing or Medicaid agencies. Such partnerships could include technical assistance for state agencies in linking and interpreting data.

It is not clear that PRA grantees will be able to continue securing high-quality units at rents below FMR, especially in high-cost areas. Overall PRA residents report a positive experience with their housing and neighborhoods but not to the same degree as PRAC residents. HUD should **exercise flexibility in working with grantees who seek waivers to increase rents to FMR.** This strategy potentially has dual benefits. It should help attract owners with high-quality housing and provide more housing choices to PRA applicants. It will have cost implications however, as average per-unit costs may increase. Incentives in future PRA grant Notices of Funding Availability (NOFAs) that promote locating units in higher quality neighborhoods, rather than incentives for setting contract rents lower than the maximum allowed, could be another tool to attract PRA units in neighborhoods PRA residents perceive as safe. As could strengthening inspections requirements for units placed under contract for PRA.

PRA partnerships between state housing and health agencies have the potential to help break down silos across systems that have traditionally not been well-coordinated, but program administrators report that they are time-consuming and costly. Costs may go down in the longer term, but HUD and CMS should continue to **support technical assistance** to grantees and their partners to build capacity, share information and tools across grantees, and institutionalize knowledge so that staff turnover is less disruptive.

HUD should **explore how the PRA cap of 25 percent units set aside for people with disabilities interacts with state incentives and property owner experience.** PRA grantee reporting indicates that PRA units total just 10 percent of all units in developments with units

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under contract, well below the 25-percent limit. However, some state affordable housing strategies (notably through states' Low-Income Housing Tax Credit program allocation processes) provide incentives for higher set-asides of housing for people with disabilities that may conflict with the PRA cap. Further, anecdotally we heard that some developments have additional people with disabilities living in their properties who are not in set-aside units.

What the "right" set-aside level should be to ensure community-integrated housing is difficult to assess. If states reduce incentives in other programs to set aside units for people with disabilities to align with the PRA program's caps, it may reduce the overall expansion of the supply of units for this population. HUD should work with states to explore how their incentive structures affect the shared federal-state goals of expanding housing opportunities for people with disabilities while permitting them to live in integrated settings.

While the short observation period for PRA-supported residency limits our ability to draw definitive policy implications regarding healthcare impacts, we did observe some differences in service utilization over the short term that could translate into long-term trends. People with disabilities in our study groups who were receiving housing assistance through HUD had lower rates of institutional care than those not supported by HUD programs. Community-based supports such as use of personal care attendants, are on average less costly than institutional care and can contribute to improved health status and reduction in unplanned and emergency care. CMS should continue to **work with states to support provision of HCBS, through Medicaid or other state funding sources, coupled with housing supports, to assist people with disabilities to live independently and promote more cost-effective utilization of healthcare services.**

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