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Perspectives On Integrating Health Into The Low-Income Housing Tax Credit: A Qualitative Study

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ABSTRACT While there is increasing attention to the ways in which safe and affordable housing may promote improved health, less work has focused on the role of the Low-Income Housing Tax Credit (LIHTC) program—the largest source of affordable housing in the United States. Through qualitative interviews, we examined the perspectives of diverse stakeholders in the housing sector on the opportunities and obstacles involved in including health-related criteria in LIHTC funding decisions. Our interviews revealed a growing desire within the housing sector to address health needs but, with the exception of green building criteria, a lack of clear standards on best practices. Stakeholders noted the challenges of effectively partnering with local health institutions, the need to develop sustainable payment mechanisms for health-related services, and the importance of locating developments near health-promoting resources. By describing mechanisms for integrating health services into the affordable housing infrastructure, this study helps lay the groundwork for the development of cross-sector partnerships.

Safe and affordable housing is increasingly recognized as a critical determinant of health. Forty-nine percent of low-income households spend the majority of their income on housing, which places them at increased risk of housing instability.[1] High housing costs may lead households to cut back on health care spending and force people to live in high-poverty neighborhoods that may increase the risk of poor health.[2–6] As advocates push for an overall increase in resources dedicated to affordable housing,[7] policy makers and public health advocates—recognizing the link between housing and health—have begun to consider ways to align the health care and housing sectors. Notable examples include health systems' investing in housing construction and neighborhood stabilization, the co-location of health services in housing developments, and screening for housing and other social needs in clinical settings.[8–12]

However, there is still relatively little discussion of how the government's largest initiative for developing affordable housing—the Low-Income Housing Tax Credit (LIHTC) program—may be used to improve health.[13–15] This tax credit program operated by the Internal Revenue Service in partnership with state housing finance agencies has, since its inception in 1986, created or rehabilitated more than three million affordable housing units.[16] The tax credits are designed to make rents affordable to households with incomes of 40–60 percent of an area's median income. However, a credit can be used with vouchers or additional federal or state subsidies, which makes it possible to allocate units to people with special needs and extremely low-income renters.

Given its scope and structure, the LIHTC program offers multiple potential points of collaboration between the health and housing sectors. Each state housing finance agency publishes documents called Qualified Allocation Plans

(QAPs) that outline specific criteria and eligibility requirements for developers competing for funds and that establish a scoring system to evaluate projects and priorities.[17] The creation of these plans and the allocation of tax credits offer important opportunities to consider health promotion in housing. To date, there has not been a thorough examination of how people responsible for the development of such plans or for the allocation or use of LIHTC funds consider ways to incorporate health into the LIHTC development process. With limited prior research, we used a qualitative approach with key stakeholders in the affordable housing field to generate themes related to the ways in which different states are considering health-related factors and to understand best practices moving forward.

Study Data And Methods

SAMPLE The study focused on key stakeholders in the affordable housing field who had expertise in using or studying LIHTC policy and funding. The stakeholders included representatives of state housing agencies who decide on the criteria for the allocation of tax credits, public health and public policy researchers who have investigated the LIHTC program, private and nonprofit housing developers, and members of advocacy groups that represent specific populations of affordable housing residents. The sample was selected through an initial list of stakeholders who worked in this space and was supplemented using the snowball method. Specific people were selected to ensure geographic and sector diversity.

INTERVIEW QUESTIONS The interview guide was generated after a review of the literature and iteratively revised during the interview process (for details on the final interview guide, see the online appendix).[18] We focused a series of questions on how each state developed its QAP—specifically, what health-related criteria might have been proposed or integrated into the QAP. QAPs are unique to each state and are reviewed and revised every one to three years. The number of specific requirements beyond the federal standards and the manner in which the QAP is used as a policy tool to shape the affordable housing landscape are discussed during the revision period, with input from stakeholder groups and the public. We asked questions that aimed to clarify this process, including how new QAP criteria are developed and finalized and how feedback is incorporated. QAP criteria can be designed as threshold requirements for all projects, point incentives, or set-asides for specific types of units, and we were interested in learning how these different mechanisms were used to prioritize different health policy objectives.

We were also interested in learning how interviewees dealt with factors regarding the location of LIHTC-funded projects. The existing literature points to potentially competing priorities: developing in high-poverty neighborhoods as a form of neighborhood revitalization, and developing in low-poverty neighborhoods to provide access to their resources and opportunities. We focused some of our questions on how public agencies and developers in different states managed to balance these priorities.

ANALYSIS The interviews were recorded, transcribed verbatim, and entered into NVivo, a qualitative data management and analysis software package. Using a grounded theory approach, we created a coding book based on the research questions.[19] Two of the authors (Marc Shi and Abigail Baum) independently coded four transcripts and achieved a 95 percent agreement on each transcript. For all transcripts, they summarized key themes using NVivo.

The Johns Hopkins Medicine Institutional Review Board approved the study.

LIMITATIONS This study had several limitations. First, while we sought to include a diverse range of perspectives to generate broad themes, the interventions, barriers, and opportunities identified in this study might not capture the full range of what all states currently practice. Notably, residents of affordable housing were not represented in our sample, and additional research is needed to understand their perspectives. Accordingly, we avoid presenting prescriptive policy recommendations so as not to overgeneralize our results.

Second, given our respondents' emphasis on forming productive partnerships with the health care sector and the increasing investment of that sector (including insurers and hospital systems) in developing affordable housing, investigating the attitudes of health institutions, practitioners, and payers toward such partnerships is a critical next step.

Third, while this study focused on the LIHTC program and the QAP, the QAP is not the only tool used in the allocation of funding for affordable housing. Indeed, many interviewees discussed the need to rely on sources of funding outside of the LIHTC program to support developments. Thus, further research is needed to explore non-QAP mechanisms for incorporating health in the development and implementation of affordable housing.

Finally, LIHTC funding is used not only to develop new affordable housing but also to preserve and maintain existing housing stock. Indeed, the physical rehabilitation of older,

poorer-quality housing stock may be particularly salient to the health benefits of the LIHTC program and deserves particular attention. Thus, future research may seek to delve into case studies of LIHTC properties to better understand the potential challenges as well as the benefits of particular types of housing-health partnerships that leverage LIHTC funding.[20,21] Such case studies of LIHTC properties may seek to incorporate factors that may be unique to new construction financed with the aid of the LIHTC program—in contrast to the rehabilitation or preservation of existing units—recognizing that there may be unique aspects that are differently related to health that we were unable to uncover in this study.

Study Results

We included information from twenty-two respondents across sectors in our data analysis. Interviewees were drawn from all four census regions, including representatives from fourteen different states, as well as representatives of national organizations (exhibit 1).

Exhibit 2 outlines the topics and themes addressed in our interviews, along with representative quotations. Interviewees generally recognized that health and housing were linked. As one developer in the Northeast noted, "We are aware that we are really part of the health care continuum of services." Some noted the benefits of addressing residents' health concerns for the benefit of the residents. A nonprofit developer in the Northeast commented, "Just providing somebody with a safe, decent, affordable place where they don't stress out every month about whether they're going to be able to pay the rent, where they can come home to and feel like it's stable…that is just essential for health,") as well as for the stability of their housing tenure. Furthermore, respondents mostly agreed that the QAP point system was effective as an incentive mechanism for developers.

HEALTH IN BUILDING OR REHABILITATION CRITERIA When asked to discuss the potential connection between the LIHTC program and health, many stakeholders identified the ways in which guidelines for environmental sustainability and housing quality were included in QAPs. Specifically, many states and developers used either standards established by local or state governments or widely adopted standards set by development agencies. One developer in the West stated, "One of the primary ways that we've been able to show success in that kind of approach has been through Enterprise Green Communities Criteria…[which have] been adopted, I believe, by pretty much every state in the country in their QAP prioritization." Developers in particular cited criteria that pertained to elements of housing construction, including prioritizing energy efficiency in construction, avoiding toxic materials, and using innovative construction techniques to reduce energy expenditure. These criteria also applied to projects that involved the rehabilitation of existing properties.

CHALLENGES TO INCORPORATING HEALTH-RELATED SERVICES In addition to standards applied to building construction, some stakeholders also described attempts to incorporate the provision of direct health-related services into QAP criteria. There was considerable variability in the types of services provided, including onsite health screenings, pharmacy services, nutrition and activity counseling, and telemedicine capabilities. The majority of stakeholders who reported on these attempts emphasized the importance of developing partnerships with service providers. One representative of a health finance agency in the West who had prior experience in the housing sector stated, "I think there should be some value placed on not just that they're within proximity to, say, an FQHC [federally qualified health center] or a community health center, but if a developer has the capacity to take one step further and actually partner with an organization that's able to visit the property." The challenges and opportunities inherent in that process are exemplified by one case in which telemedicine rooms were incorporated into LIHTC developments in a northeastern state. Developed through a state-led effort to increase access to health services, the initiative ultimately

EXHIBIT 1

Descriptive characteristics of interviewees in the study of the Low-Income Housing Tax Credit program, 2019

	Interviewees	
Characteristics	**Number**	**Percent**
Total	22	100.0
ROLE		
Housing finance agency member	8	36.4
Developer	5	22.7
Advocacy group member	2	9.1
Public health or public policy researcher	5	22.7
Health finance agency member	1	4.5
Service organization member	1	4.5
CENSUS REGION		
Northeast	5	22.7
Midwest	1	4.5
West	3	13.6
South	10	45.5
National organization	3	13.6

SOURCE Authors' analysis of study data. **NOTE** The percentages do not sum to 100 because of rounding.

EXHIBIT 2

Topics, themes, and representative quotations from interviews in the study of the Low-Income Housing Tax Credit (LIHTC) program, 2019

Topics and themes	Representative quotations
PERCEPTIONS ON INTEGRATING HEALTH AND HOUSING	
Housing developers are eager to support residents' health needs	"If it can help enhance the health of our residents, we will absolutely embrace it" (nonprofit developer, Northeast)
Housing developers identify benefits of supportive services for maintaining resident stability	"Most LIHTC developers…are very open to working with anyone who's going to help them bring programs onto the property, because by and large they see that their residents do better and are more stable and are more able to meet their rent demands when they have support programs" (health finance agency organization member, West)
BUILDING CONSTRUCTION	
Many states implement existing environmental standards for constructing LIHTC units	"We've required probably for the better part of a decade a minimum green building standard…[and] in the last couple years of the QAP[, they are incorporating]…LEED certifications, Enterprise Green Communities, National Green Building Standard, Energy Star" (housing finance agency member, Midwest)
Many QAPs include incentives for avoiding environmental toxins or hazardous materials	"We require every project that we finance to do full environmental assessments to remediate any toxins on the site to make sure we're not placing a project on a site that's going to expose people to toxins" (for-profit developer, South)
HEALTH SERVICES	
Difficulty developing and maintaining partnerships that are sustainable for a health care partner	"If we're only offering forty units here…is that enough apartments to catch the interest of a provider?" (nonprofit developer, Northeast)
Lack of clear reimbursement structure for health services	"We would need to have the health care provider go through the rigmarole of licensing our telemedicine room as a branch office now" (nonprofit developer, Northeast)
Examples of partnerships with local health institutions	"Our local hospital was a partner and provided a capital grant to that project, and we have an MOU with them where of those fourteen units, two units serve long-term care residents of the hospital" (nonprofit developer, Northeast)
OTHER SUPPORTIVE SERVICES	
Development of on-site care coordination services	"So the service coordination is coordination of services, not provision of services[;] …the service coordinator can try to help [residents] find the resources" (nonprofit developer, Northeast)
Supportive services often targeted to specific resident populations	"We have a whole series of threshold requirements to make sure that residents who are disabled in our properties are living in units that are accommodating to their specific disability" (housing finance agency member, South)
DEVELOPER FEEDBACK	
Concerns regarding cost of additional supportive services	"From the developer side, …they want to be able to keep the cost of production down, and they want to be able to create opportunities [so] that they can pretty much break even and make a profit on that development" (nonprofit developer, South)
Concerns about acting outside of expertise	"You can't ask a LIHTC developer to also be a service provider" (housing finance agency member, South)
HOUSING LOCATION	
Incentives to locate in proximity to health-related resources	"[We] try to locate our developments in communities that have…access to services, whether it's medical or grocery stores or employment centers or…access to transportation" (researcher, South)
Trade-offs in health and social benefits of proximity to resources	"We had some interesting debate over not locating next to busy highways because that's—I mean, that's a really well proven health hazard. But developers feel like they have to be visible from a busy road or they're not going to lease up, and they're going to have vacancies" (researcher, South)
Housing location as a lever to draw high-poverty residents into high-resource areas	"So if you really want to get those health benefits through LIHTC, you need to make it quite clear that for this aspect of health improvement…there has to be direct outreach to get families from the highest-poverty neighborhoods in the metro area into your LIHTC development" (researcher, national organization)
Drawbacks of emphasizing areas of opportunity in development	"For place-based, neighborhood-based, nonprofit developers who…utilize the tax credit program to do their neighborhood transformation work—you know, in some cases [those developers] are excluded [because of the tenants they serve], because those are areas of higher poverty rates and [have] less opportunities per se" (housing finance agency member, Midwest)

SOURCE Authors' analysis of study data. **NOTES** QAP is Qualified Allocation Plan. LEED is Leadership in Energy and Environmental Design. MOU is Memorandum of Understanding.

was halted—according to participating developers, because of the difficulty in identifying provider partners and lack of regular use by residents.

The obstacles experienced in that state's attempt to develop telemedicine rooms reflect many of the broader concerns with health integration into LIHTC requirements. Developing partnerships with health care providers or institutions was often mentioned as a challenge, because of the lack of either existing partners in development areas or, more commonly, an ex-

isting reimbursement structure that would incentivize such a partnership. There were isolated examples of productive partnerships between housing developers and health care institutions, as well as statements that illustrated the potential of increased integration to achieve Medicaid savings. However, such statements were less common than those expressing the difficulty in forming such partnerships.

Furthermore, when services were provided, residents sometimes failed to show interest in them. One nonprofit developer in the Northeast stated: "What we are finding is that residents are not taking advantage of it.... A lot of it is they just want to see their own doctor. They don't trust or want to use a random doctor who they don't know or a random nurse who they don't know." This comment reflects the additional challenges of preserving health care continuity while trying to offer on-site services for residents.

More common than the direct provision of clinical services were models of supportive housing in which additional services were provided for particular populations of residents—which representatives of many state housing agencies mentioned. Most of these populations were targeted either because state or federal resources for their support already existed (such as supportive services for people with disabilities or older residents) or because they were new priorities identified by the state legislature (for example, interviewees in the Midwest and West identified a new priority for families affected by the opioid crisis). While these services were less likely to be direct clinical services, many of them involved auxiliary services such as care coordination and case management or health-promoting resources such as nutrition and wellness classes. Some states specifically incentivized developments that included such services in their QAPs. However, few if any standards or best practices defined the types or scope of services to be provided, and some respondents noted that developers were uncomfortable about being responsible for identifying or providing additional services, as they felt they were acting outside their area of expertise.

In addition to the difficulty in partnering with health care institutions and the lack of clear best practices, another commonly cited obstacle to addressing health needs in LIHTC housing was the issue of cost. Developers often raised concerns about the cost of providing additional services, as reducing capital costs was often a central priority for both developers and the state. One nonprofit developer in the Northeast commented that "the QAP in [the state] for the last four years or so has put the most emphasis on the lowest cost." Thus, the aims of reducing costs and providing additional services at times came into direct conflict, as noted by a northeastern developer: "We care about building in a way that is good for tenants' health even if it is not required by code, and the way [the state's] QAP is currently written...[hurts] our ability to build with tenant health in mind because they're so focused on first up-front cost."

The goals of locating near specific services and locating in an opportunity neighborhood are sometimes in tension.

LOCATION OF DEVELOPMENTS NEAR HEALTH-PROMOTING RESOURCES Numerous interviewees also mentioned QAP criteria that incentivized the location of LIHTC developments in a manner that would increase access to health-promoting resources and services. While these criteria occasionally referred specifically to access to clinical sites, more often they promoted close proximity to resources that addressed the social determinants of health—such as healthy food options, recreational areas, high-quality education, and employment opportunities. A housing finance agency member from the Midwest referred to "incentives to locate [in] non–food deserts or in proximity to a grocery store offering fresh produce."

As with service provision criteria, there were few established standards or best practices regarding incentivizing location, and some interviewees noted tensions in how resources might be prioritized. For instance, one noted the trade-off between the transportation benefits of locating close to high-traffic thoroughfares and the potential exposure to harmful air pollutants. Another tension some interviewees identified was between developing standard criteria in the QAP and being responsive to local contexts. Some developers identified the lack of applicability of new criteria in the QAP to their target resident population, such as school performance incentives for developments intended for senior residents. Similarly, others pointed to local limitations regarding the availability of resources, specifically clinical resources. A health finance agency member in the West said: "There wasn't

There was general recognition that increasing the quantity of affordable housing units provided an important health benefit.

a mandate that you have to be next to an FQHC, but you did get points for it. The challenge is that when you don't have a lot of FQHCs and those FQHCs are not located close to light rail or employment, then you're starting to create these circles of designated areas where developers are most going to want to have a piece of property."

TAX CREDITS AND ACCESS TO OPPORTUNITY NEIGHBORHOODS Notably, some interviewees discussed efforts in their states to develop standardized criteria for "areas of opportunity" and to incentivize development in these areas. A nonprofit developer in the South stated, "There's a whole list of 'proximity to…' in the opportunity index, where you can get points." The development of standardized opportunity metrics was also sometimes discussed within the context of economic desegregation, with the development of housing in low-poverty, high-opportunity areas seen as a way to prevent the concentration of affordable housing in high-poverty neighborhoods. Notably, while health outcomes themselves were not cited as measures in opportunity indices to our participants' knowledge, and the health benefits of locating in high-opportunity areas were not specifically discussed, areas of opportunity were often defined by their proximity to health-related resources such as grocery stores, recreational areas, and even clinical sites. Furthermore, while many respondents identified an increasing emphasis on locating new developments in these high-opportunity areas. This goal was at times described as being in tension with the aim of revitalizing high-poverty neighborhoods and the common practice of developing LIHTC properties in such neighborhoods.

Discussion

The desire to integrate health-related interventions or criteria into state QAPs and the recognition of the importance of housing to health reflect the expansion of the definition of *health* to include social determinants such as housing.[22] Many stakeholders fundamentally agreed with the premise that the development and preservation of affordable housing stock was beneficial for health. However, beyond increasing the overall quantity of affordable housing, there was less consensus on how health-promoting factors could be integrated into housing units.

In particular, three main areas emerged as potential points of connection between health and housing. There appeared to be concerted, well-defined efforts to incorporate health into the construction and rehabilitation process, including using green building and energy efficiency standards. There was also consistent attention to several health-promoting factors in the location of LIHTC development. Finally, while there was interest in incorporating direct service provision into housing developments, there were several persistent questions about the best way to accomplish this and barriers to doing so.

The inclusion of standards related to construction and building materials was common. The widespread uptake of green standards[23] likely results from the existence of a model that can easily be applied to QAPs, with both clear alignment between the content of the standards and existing language in the QAP and a well-understood relationship between the physical condition of housing and an occupant's health. Notably, many of our stakeholders spoke about the application of these criteria specifically to new developments, ensuring that new housing met standards of quality that would safeguard occupants' health. There were fewer comments on how these criteria were applied to rehabilitation projects, where they might be used to improve the health conditions of poorer-quality housing. The standards—and the QAPs as a whole—are focused on the development (or redevelopment) and construction process, an area in which developers felt that they had a voice and even control.

Issues around the location of LIHTC housing—both new construction and rehabilitation—also fall squarely within the developers' purview and align with QAP criteria.[17,24,25] Several stakeholders described incentives in state QAPs to build in close proximity to public transportation, healthy food options, recreational areas, and health clinics—all of which are resources thought to promote health. Some participants and fair housing advocates described the LIHTC program as a potential tool to deconcentrate poverty by

encouraging development in higher cost, low-poverty neighborhoods (so-called areas of opportunity), which has also been found to improve health.[26–28] Notably, however, the goals of locating near specific services and locating in an opportunity neighborhood are sometimes in tension. For example, the majority of federally qualified health centers are concentrated in high-poverty, majority-nonwhite neighborhoods, and thus incentives for locating near the centers would not align well with those designed to promote location in opportunity neighborhoods.[29] This contributes to an ongoing conversation regarding the role that the LIHTC program has in reinforcing or undoing segregation: While stakeholders have pointed to the program's potential to promote community development and neighborhood revitalization, it has also been recognized that the program may contribute to the spatial concentration of subsidized developments.[30,31] It will be important to consider these and other potential factors when incentivizing locations near health-promoting resources and designing policies that seek to mitigate unintended consequences. Having different scoring criteria or set-asides for tax credits designed to be used in low-poverty neighborhoods has been one such approach.

In contrast to criteria related to material choices, energy efficiency, and project location, efforts to develop cross-sector partnerships in conjunction with the LIHTC program and directly provide health-related services were less well established. Existing partnerships and on-site service provision typically occurred in more isolated pilots, to varying degrees of success. And they often involved drawing on funding sources outside the LIHTC program, such as grant funding or partnerships with health care institutions or local nonprofits. This reflects the fact that service and partnership efforts likely occur over an extended period of time after construction has finished, and they are not typically the focus of the developer that submits the project proposal. Stakeholders also suggested some degree of discomfort with potential "mission creep," as they were often reluctant to see housing developers as the providers of health services and had concerns about the possibility of developing a feasible financial model for these services. Space that is built for service provision but goes unused may represent lost revenue for the developer and investors.

Across these discussions of how the quality of affordable housing could be improved, there was general recognition that increasing the quantity of affordable housing units provided an important health benefit. Indeed, some stakeholders voiced a tension between meeting a high level of quality (which may increase the per unit cost) and the total number of units that could be constructed. This tension could be seen in multiple areas of intervention, including building construction, the location of units (since it may cost more to build in opportunity neighborhoods), and providing space and funding for service provision. It further applies to the range of household incomes for people who have access to this housing, since a larger subsidy may be needed for lower-income households—which in turn may receive a relatively greater health benefit from the provision of affordable housing. In the setting of fixed budgets and making decisions about QAPs, it will be important for policy makers and practitioners to consider these and other trade-offs. At the same time, emphasizing the health benefits of affordable housing and explicitly integrating health initiatives into the QAP criteria may help policy makers advocate for more funding for the LIHTC program or draw more funding for affordable housing from other sources—for example, through public health financing or health care institutions.

Our interviews demonstrate the increasing recognition of housing as a foundation for health.

A growing interest in finding creative ways to increase resources for affordable housing is evidenced by emerging payment models that leverage health care financing to pay for housing-related services. For example, as part of a Centers for Medicare and Medicaid Services waiver, Maryland Medicaid is paying for housing-related tenancy services for formerly homeless people.[32] Various large health care institutions across the country are also developing initiatives to support the construction of housing for populations of patients who are high users of health care resources.[24,33,34] Initiatives designed to focus on high-need and high-cost patients may have the most immediate return on investment for the health care sector and may be one place to promote cross-sectoral collaboration. New learning communities are also being deployed to promote health system engagement, and approaches such as the Enterprise Community Partners' Health

Action Plan are designed to get developers to consider health needs.[21] These and other efforts may hold promise, although it is too early to know their impact. Further support for cross-sector partnerships—specifically, the application of health financing to housing and housing-related services—may help overcome some of the barriers identified by stakeholders.

Our interviews demonstrate the increasing recognition of housing as a foundation for health and the potential for the LIHTC program to foster this connection. In particular, in regard to the physical construction of housing units, there are clear examples of healthy standards—green building and energy efficiency—being incorporated into the decisions about allocating tax credits. The location of LIHTC developments near health-promoting resources is also viewed as an important opportunity, though careful consideration needs to be paid to potential trade-offs. Using the LIHTC program to promote direct service provision is still in its infancy and marked by challenges related to creating a sustainable funding model and defining and developing successful partnerships. Finally, we recognize that continuing to build upon these initiatives, while studying what works in these cross-sectoral partnerships, is critical for generating best practices at the intersection of the LIHTC program, affordable housing, and health. ■

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18 To access the appendix, click on the Details tab of the article online.

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