Spring 2015

LeadingAge California

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inspire...serve...advocate

Founded in 1961, LeadingAge California is the state's leading advocate for quality, not-for-profit senior living and care. The association's advocacy, educational programs and public relations help its members best serve the needs of more than 100,000 of the state's older adults. LeadingAge California represents more than 600 nonprofit providers of senior living and care – including affordable housing, continuing care retirement communities, assisted living, skilled-nursing, and home and community- based care.

Mission

It is the mission of LeadingAge California to advance housing and services for older adults and to support and inspire its members through advocacy, education, research and services enabling them to meet changing needs of their clients and communities.

Vision

LeadingAge California is a catalyst for members to advocate, enrich and advance aging services.

Shared Values

The values shared by LeadingAge California members include:

- Long term commitment to the security of older adults
- Mission driven
- Mutual support and assistance among members
- Respect of all peoples
- Commitment to socioeconomic and multicultural diversity
- Advocate for not-for-profit status
- Consumer focused
- Dignity and quality of life for older adults
- Community-based

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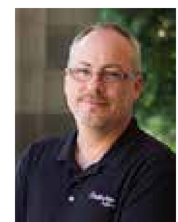
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A Note From The Editor

Spurring Strategic Innovation in a Shifting Environment

Welcome to our Spring 2015 issue of *Engage Magazine*! In this issue, we explore opportunities for innovation in the shifting policy environment; whether it's working under the relatively new framework of the Affordable Care Act or pushing for further change in the way long-term services and supports are paid for and managed.

Bill Pomeranz of Cain Brothers and Tara McGuinness of American Baptist Homes of the West (ABHOW) explore the options that are available for continuing care retirement communities and positioning as partners for accountable care organizations (ACOs). Our authors provide insights on what opportunities exist now and what lies ahead in the future. LeadingAge California's President and CEO, Joanne Handy provides an update on the progress being made in California and the association's effort to start the conversation on long-term services and supports financing for the middle class in our state.

In our People in Focus interview, we talk with Kari Olson, the Chief Innovation and Technology Officer at Front Porch. They have embarked on a project that is designed to spark transformative innovation at all levels, known as "Humanly Possible." Kari explains how the program works and the tangible ways it is put to use in maintaining a forward-thinking organization. LeadingAge California's own Meghan Rose, Esq. pens this issue's Legal Corner on an issue that has vexed housing providers for years. She will provide clarity around the use of medical marijuana in affordable senior housing communities despite the federal rules that seemingly contradict state law.

Be sure to check out our brand new website and *Engage* Communities! The website has been completely redesigned with you in mind. The member-centered site will allow you to better access important information and connect with fellow members in ways you never could. You will also find previous issues of *Engage Magazine* available for download.

As always, we welcome your feedback and editorial suggestions. Please send them directly to me at edowdy@aging.org.

Eric Dowdy
Editor-in-Chief
edowdy@aging.org

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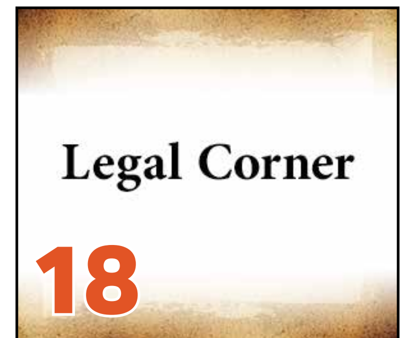

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From The CEO

LTSS Financing – A "BHAG"

A 73-year old man with a fairly active lifestyle suddenly has a stroke, leaving him with partial right side paralysis. His Medicare coverage takes care of the hospital, skilled nursing facility, and outpatient rehab bills over the first two months. He lives alone and his children are not nearby, so he hires in-home caregivers to assist him with both IADLs and ADLs. He pays privately for the caregivers for six months, depleting his small savings by 50 percent. Unable to afford assisted living, he contemplates his options as he anticipates the day when his savings runs out. This is an all-too familiar scenario for millions of Californians and a situation that may become a crisis in our state as the aging population explodes.

"California, as home to 10 percent of the country's population over 65, must get serious about this issue."

You have undoubtedly heard the statistic that 70 percent of people over 65 will require some type of long-term services and supports (LTSS) in their lifetime. For many, this may be a short period with full recovery; for others, it will be years. Yet, only 30 percent of people over 65 think they will need assistance. The majority still believe that Medicare covers long-term care. The lack of awareness and preparation for LTSS needs is widespread among consumers who do not have long-term care insurance and are not eligible for MediCal.

For this reason, LeadingAge California together with LeadingAge national has launched Pathways, a major initiative to foster state and federal LTSS reform that helps our country and its people prepare and pay for LTSS. While LeadingAge national has commissioned robust economic analysis of several financing plans, LeadingAge California has convened, along with co-conveners AARP and the Alzheimer's Association, a statewide stakeholder group in a series of Community Conversations. This group's goal is to adopt state LTSS reforms that foster preparing for and financing LTSS. The group met for its inaugural meeting in April, the same week that LeadingAge California with the Assembly Committee on Aging and Long Term Care, organized a legislative hearing on LTSS financing.

Yes, this is a "BHAG" (Big Hairy Audacious Goal"). California, as home to 10 percent of the country's population over 65, must get serious about this issue. Our association and our members can play leadership roles developing solutions to a looming crisis.

Have you Heard?

Filmmaker George Lucas will partner with PEP Housing on building a 224-unit complex at Grady Ranch in Marin County to provide affordable housing for local workforce and seniors.

PEP Housing board member Sid Lipton was honored with the 2015 Petaluma Community Awards of Excellence Service to Seniors for over 15 years of volunteer work.

ABHOW celebrated 66 years at their Annual Meeting in March.

A groundbreaking LGBT Bill of Rights for senior care facilities was unanimously approved by the San Francisco Board of Supervisors on March 31.

Pilgrim Place President and CEO Bill Cunitz recently announced his retirement at the end of 2015.

Front Porch announced on April 1 the appointment of John Woodward as their new CEO starting on May 6.

Molly Forrest, president and CEO of the Los Angeles Jewish Home, was recently honored with the "Pioneer Women Award" by the Los Angeles Commission on the Status of Women.

The Terraces at Los Altos won the Architectural Design and Enhancement Award from the Los Altos Chamber of Commerce for its three-phase redevelopment project.

Westlake Christian Homes, a Christian Church Homes (CCH) community, will host a grand re-opening on May 12.

Atterdag Village of Solvang celebrated a new building project in April. Construction is underway for a new state-of-the-art Assisted Living complex and nine new cottages.

ACC Senior Services in Sacramento was featured in a *Pocket News* article about local nonprofits participating in a "Day of Giving" on May 5.

Northern California Presbyterian Homes and Services (NCPHS) is in the early planning stages of developing a new CCRC, The Orchards at Walnut Creek.

Eskaton's Dr. Teri Tift, executive director of Quality and Compliance, was interviewed on Sacramento News 10's show, Sacramento & Company.

Episcopal Communities and Services recently announced the appointment of James Rothrock to the position of President-Elect, to succeed Martha Tamburrano upon her retirement at the end of 2015.

SCENE

1 Beth Southorn of LifeSTEPS shares a laugh with residents of the Vintage Woods Senior Apartments in Fair Oaks while judging the spring hat competition.

2 Christian Church Homes (CCH) celebrated the grand re-opening of the Lorenz Senior Apartments in Redding. Pictured: Don Stump, President and CEO of CCH at the ribbon cutting ceremony. He is surrounded by CCH's development partners, residents and local elected officials, including Mayor of Redding, Francie Sullivan. Built during 1901, The Lorenz is listed on the National Register of Historic Places and is located in the heart of downtown.

3 Gloria Bolin (left), Housing Manager of Mountain Vistas Senior Apartments poses with resident Gloria Stevens in Ms. Stevens's apartment. Mountain Vistas is a be.group community located in Redding, Calif.

4 The 2015 Policy and Leadership Summit, February 9-11 in Sacramento, included (L-R): Senator Carol Liu, Senator Mike McGuire.)

5 Assemblymember Cheryl Brown at the 2015 Policy and Leadership Summit, February 9-11 in Sacramento.

6 Secretary Diana Dooley, California Health and Human Services Agency, speaking at the Policy and Leadership Summit, February 9-11, 2015.

7 LeadingAge California members visiting the Capitol at the PEAK Leadership Summit in Washington DC.

8 Eskaton's Kid's Connection 8th graders visit Adult Day Health Center for service learning. Activities Director Lee Amir led the group in exercise.

9 LeadingAge California members visiting Senator Barbara Boxer's office during the PEAK Leadership Summit in Washington DC.

10 Bethany Home in Ripon unveiled their own "As I Age" wall during the Almond Blossom Festival in February.

11 April 10 Inland Empire Region Meeting: pictured (L-R): Keith Kasin, Plymouth Village Retirement Community; Tuan Nguyen, Ascension Benefits & Insurance Solutions; and Reginald Ingram, Hillcrest

12 Joanne Noppert and Mary Wolff with Inland Christian Home at the April 10 Inland Empire Region Meeting

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As I age...
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More than 7.2 million people receive care through accountable care organizations (ACOs), according to the Centers for Medicare and Medicaid Services. ACOs, which are groups of health care providers who work together to coordinate care and deliver service more efficiently to Medicare beneficiaries, are building partnerships with small groups of preferred health care organizations.

Perhaps more than any other tier of care, skilled nursing centers are key to these partnerships. Continuing care retirement communities (CCRCs) can demonstrate acute care expertise and join ACOs, but they must lay the groundwork now or risk becoming irrelevant to the health care system. While ACOs, encouraged by CMS are leading the nation's health care reform efforts, Medicare Advantage HMOs with over 33 percent of the nation's seniors are beginning to adapt and mimic these ACO advances.

The Changing Landscape

CCRCs have always been one of the most progressive vehicles for caring for older adults. Residents can move through various levels of care – assisted living, memory care, and skilled nursing – unburdened by the fear of running out of money or having to relocate for additional support. If residents need hospitalization, they can return to their community's skilled nursing center, where Medicare would pay for their services.

Almost always, CCRCs benefit financially from Medicare payments because they provide significant positive cash and profit margins, which help maintain a community's overall bottom line. In fact, a number of communities depended on Medicare during the recent recession as they suffered deep cuts in their residential living revenues because of low occupancy rates tied to the depressed housing market. Communities that didn't have spare skilled nursing beds to offer for short-stay Medicare-reimbursed care were more likely to file for debt relief or violate

A Serious Challenge or Opportunity for CCRCs?

By Bill Pomeranz, Managing Director of Cain Brothers and
Tara McGuinness, Vice President and Regional Operations Manager,
American Baptist Homes of the West

loan covenants than those with active Medicare patient volumes.

Today, Kindred, Brookdale, Sunrise and other senior living providers are using Medicare reform to create competing, and often more comprehensive, continuums of care than many CCRCs offer.

Medicare reform seeks to better connect hospitals and doctors to the supervision of their patients' post-acute care by creating an integrated continuum of service. In response, Kindred, Brookdale and Sunrise are linking physician and hospital payers and referral sources through information technology (IT) connections and on-site medical clinics. As a result, they provide highly supervised care for patients from acute to post-acute care. By adding more medically oriented assisted living, skilled nursing, and on-site clinics to their campuses, these large proprietary firms provide excellent health care oversight and a rental aging in-place alternative to CCRCs while gaining more Medicare referrals.

Brookdale, for instance, has seen its total Medicare/skilled care revenues grow from less than five percent of total revenues in 2008 to almost 40 percent in 2014. In addition to the extra cash flow, these organizations market their communities as places where residents can still gain access to various levels of care with priority access to skilled nursing, all under the close supervision of a medical care provider, on-site mid-level practitioner and without paying expensive entrance fees.

By courting newly emerging ACOs and hospital systems eager to share in the savings of a rationalized, bundled payment delivery system, these senior living providers can offer a full post-acute continuum of care. As a result, hospitals and other organizations are creating narrow network referral relationships that allow them to deal with a handful of post-acute care destinations instead of dozens of communities.

The Road Ahead for CCRCs

In response, CCRCs must get into the post-acute care game. Most CCRCs have the best reputations in their market areas for hands-on, personal care and skilled rehabilitation services. But many lack connections to the skilled post-acute marketplace. As ACOs form, Medicare Advantage enrollment grows and Medicare post-acute reforms take place, hospitals will begin working only with skilled nursing centers that accept a significant volume of their acute referrals, employ their system doctors as the CCRC medical director and have invested in the IT infrastructure needed for all parties to communicate about patient conditions and treatment plans.

How should CCRCs respond? The best organizations will bridge the gap between their strengths and weaknesses. Most communities grappling with health care reform already realize the importance of ACOs, but they might not understand how to become post-acute care providers.

CCRCs that are struggling to regain strong profitability after four or five years of stagnant entrance fee appreciation should understand the bottom line benefits of adding Medicare patients to their skilled nursing revenue mix. Most CCRCs treat skilled nursing as a cost center – a necessary component to attract residential living admissions. But increased Medicare exposure can turbo-charge a CCRC's bottom line.

As one of the largest nonprofit providers of senior housing and health care on the West Coast, ABHOW began evaluating ACO options as these partnerships started forming across Northern California in the spring of 2013. Here are some of the lessons we learned:

- Decide on your strategic direction and develop a strategy for getting there. Can you survive without Medicare? This is a time-limited offer, and first movers have the advantage.
- Identify areas of service that differentiate you from the competition, such as the ability to enhance quality and reduce re-hospitalizations.
- Develop your compelling messages and decide who is best to convey them. Make sure you pitch your value proposition, including benefits of care continuum post episodic payments.
- Adopt more evidence-based protocols, such as Interact Tools which help report and measure clinical outcomes. These metrics should enhance your image as a quality, value-based provider.

A Serious Challenge or Opportunity for CCRCs?

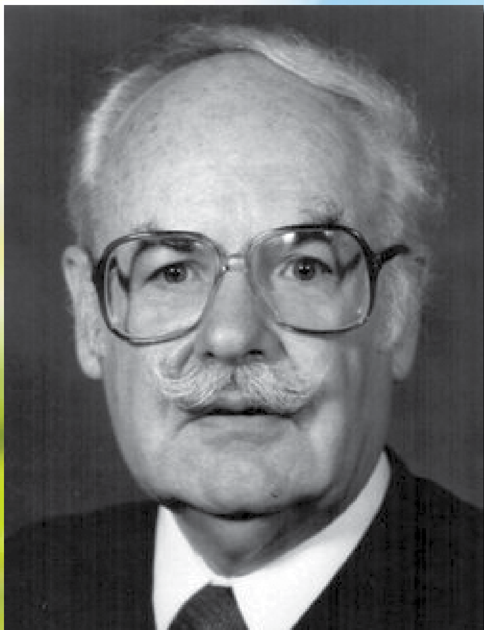
- Determine whether you have the infrastructure and technical expertise it takes to deliver top-quality, post-acute care. You do not need to wait for a signed contract to make changes. Successful CCRCs can self-identify their shortcomings.
- Hire the right team members with post-acute or acute care expertise. Add care navigators, registered nurses with medical surgery experience, and expand physician and therapy coverage to seven days a week.
- Streamline your admissions process and expand coverage 24/7.
- When possible, create a welcoming environment with private rooms and suites.
- Ensure that medical directors are actively engaged in clinical education and pathways development in alignment with local ACOs. They should also serve as active liaisons to other physicians and consulting surgeons.
- Reach out to others. Hiring a connected medical director, strategically recruiting board members with ACO affiliations, and joining hospital committees are just a few ways to position your organization as a reliable partner. For example, one of our communities added an associate medical director with ties to a local ACO.
- Develop your IT infrastructure and electronic health record systems. Relationships are valuable, but they won't replace inefficient, unreliable IT systems.

The Bottom Line

Continuing care communities usually have one chance to join an ACO or to become part of a Medicare Advantage capitated risk-taker, and long-term care providers will struggle to integrate into tight networks of partners after these relationships have already formed. When organizations take proactive steps, they become part of the solution to improve health through quality, efficient partnerships.

For decades, CCRCs have been robust providers of housing and health care. We believe this legacy will continue as these communities build partnerships and deliver exceptional services to older adults through accountable care organizations.

Congratulations Class of 2015!



Thomas Jenkins - 1921-2015

The Honorable Thomas M. Jenkins, 94, died peacefully at his home on March 16, 2015. Judge Jenkins was a founder of both LeadingAge and LeadingAge California. He served as a Judge with the San Mateo County Superior Court from 1976 to 1990 and Presiding Judge in 1980. He served on the Board of Directors for several organizations throughout his career and was a partner at the firm of Schofield, Hanson, Bridgett, Marcus and Jenkins (now Hanson Bridgett, LLP). He will be deeply missed.

Dear BRENDA

Dear Brenda: ***We would like to offer new and innovative services to residents, or use more current operational approaches in our community, but are worried about running afoul of the outdated state Title-22 licensing regulations. What are our options to help with these situations?***

Answer: ***You've raised some very important questions!***

Only a few of the Title 22 state licensing regulations for skilled nursing communities have been updated over the past few decades. Nevertheless, the department expects communities to comply with regulatory requirements at all times, regardless of the currency of regulations.

The good news is that state law certainly envisioned circumstances under which the regulations would not keep pace with community standards of care. Health and Safety Code §1276(c) states that:

While it is the intent of the Legislature that health facilities shall maintain continuous, ongoing compliance with the licensing rules and regulations …. The Legislature recognizes that health care technology, practice, pharmaceutical procurement systems, and personnel qualifications and availability are changing rapidly. Therefore, requests for program flexibility require expeditious consideration.

Fortunately, there is a mechanism to seek more flexibility in the way your community provides care. State law goes on to state that the department shall issue regulations that permit:

"(b)…program flexibility by the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use has the prior written approval of the department or the office, as applicable.

It is noteworthy that this does not include flexibility from meeting statutory requirements, only regulatory requirements. In addition, this does not give the department the authority to waive regulatory requirements altogether, but only to approve alternative means of meeting the intent of the requirement. Title 22, §72213 provides the regulatory authority to grant program flexibility. Not only does the statute and regulations permit program flexibility, but it gives the department the authority to approve pilot projects.

Communities that seek *prior approval* for program flexibility or pilot projects should submit the request in writing, cite the specific regulatory requirement for which flexibility is requested; and provide substantiating evidence (not a waiver of the requirement, but an alternative means of meeting the intent). Pilot projects will require more information than program flexibility requests, and may also be required to provide data or other information about the outcome of the pilots.

The department has developed a one-page form to use when submitting a request for program flexibility, the CDPH 5000. If approved, the department will provide you with the written terms and conditions under which the flexibility will be granted. If your community would like to discuss whether program flexibility is the right solution for your community, please feel free to contact me.

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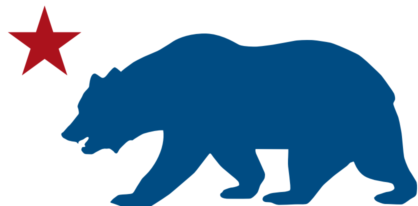

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Vito Genna, Sierra View Homes
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Lea Pipes, Motion Picture Television Fund
Frank Rockwood, Rockwood Pacific
Bill Scharbach, Palm Village Retirement Community
Justin Weber, St. Paul's Senior Services
Jay Zimmer, The Reutlinger Community for Jewish Living

**Organization names shown for identification purposes only.*

People In Focus

Kari Olson

Chief Innovation and Technology Officer, Front Porch

We sat down with Kari Olson with Front Porch to talk about Humanly Possible, the organization's new strategic approach to "caused-based innovation" and greater collaboration, now in its second year. *Click above to watch the full interview.*

Tell us how you became a part of Front Porch.
I became a part of Front Porch by making a jump from the legal technology sector into the not-for-profit sector. It had been my dream to marry my interests of creativity and technology and helping people, and I felt like the not-for-profit sector offered a great challenge in that regard.

How was Humanly Possible born?
Front Porch has a long history of being a very creative, innovative organization, and we were looking at the crossroads we've all come to with changing marketplaces, changing regulations, changing competition, and wanted to create something new that would take us to higher levels of achievement.

Can you explain the eight actions at the core of Humanly Possible?
This was something that we conceived of to help our workforce live, lead and teach the actions and values that we think will help us to transform, both in our individual thought and as an organization overall. Observe. Look at the world around you. Inquire. Be courageous. These are just some of the eight actions that we're trying to drive through our organization.

How has this approach changed the culture at Front Porch?
We've had a great reaction from the team and the world in general. Last year alone we executed 65 Humanly Possible projects. In our wildest dreams we didn't think that was going to be possible so quickly. We also embraced the opportunity to create a culture change in the office. We went from a more traditional environment to a really open setting, intentionally trying to spark collaboration and creativity. We created a wall called "What Inspires You?" to help everyone understand that we all have something unique to contribute. Which is really a key to Humanly Possible.

Can you share a success story with us?
At Villa Gardens (in Pasadena) the staff decided for their Humanly Possible project last year that they'd like to do a pilot with the Music and Memory Program. *Watch the video to hear the full story.*

What are some of your plans for the future?
We're really excited to build on what we started last year, and we want to continue to support the collaborations that have now started. Because once those relationships get going, they bring in a whole new vein of ideas and energy. We want to harness that and see where it will take us.

Inspiring Senior Documentaries

Throwing Curves – Eva Zeisel
Eva Zeisel became one of the most famous industrial designers of the modern era. This documentary chronicles her story from her birth in Hungary in 1906, through her career working in Berlin in the 1920s, the Soviet Union in the 1930s and New York from the 1940s on. She was a witness to all the major art and political movements of the 20th century, which she thought of as "her" century. She continued to design until her death at the age of 105. *(summary courtesy of canobiefilms.us)* Click Here to watch

Fabulous Fashionistas (2013)
This documentary explores the art of ageing in the company of six extraordinary women with the average age of 80. What they all have in common is a determination to squeeze the most they can out of life. To keep going. To look fabulous. To have fun. Click Here to watch

Four Seasons Lodge (2008)
From the darkness of Hitler's Europe to the mountains of the Catskills, Four Seasons Lodge follows a community of Holocaust survivors who come together each summer to dance, cook, fight and flirt - and celebrate their survival. Click Here to watch

Cyber Seniors (2014)
A film about senior citizens learning about computers from teenage mentors and the connections made both on and offline. Click Here to watch

Age of Champions (2011)
Age of Champions is the award-winning PBS documentary following five competitors who sprint, leap, and swim for gold at the National Senior Olympics. You'll meet a 100-year-old tennis champion, 86-year-old pole vaulter, and rough-and-tumble basketball grandmothers as they triumph over the limitations of age. *(summary courtesy of ageofchampions.org)* Click Here to watch

Over 90 and Loving It (2011)
A documentary about people in their 90s and 100s living extraordinary and passionate lives in every way. These are people who aren't aware of chronological age at all, but live as though the future and youth spring eternal, writing, marrying, getting a degree, putting on concerts, working full-time, as starters. Putting it succinctly, one says, 'You can drive yourself nuts worrying about something you can't do anything about, getting older, but you sure can be exhilarated about living.' Click Here to watch

Film summaries courtesy of IMDB
For more documentaries on aging visit programsforelderly.com

Legal Corner *with* LeadingAge™ CA

Clarifying HUD's Medical Marijuana Policy

By Meghan Rose, Esq.,
Director of Policy – Housing and HCBS

While medical marijuana use is legal in California, the federal government classifies marijuana as an illegal controlled substance and has criminalized its use for any purpose. This conflict has raised questions regarding the use of medical marijuana in federally assisted affordable housing. The U.S. Department of Housing and Urban Development (HUD) has published policy guidance on this issue. However, many housing providers remain unclear on how to administer HUD's guidance within their communities.

This article aims to clarify HUD's position on the use of marijuana for medical purposes by current and prospective tenants in federally assisted housing.

Medical Marijuana Policy in California

In 1996, voters passed Proposition 215, making California the first state in the nation to legalize marijuana for medical use. Proposition 215, also known as The Compassionate Use Act, gave Californians the ability to obtain and use marijuana for medical purposes in the treatment of chronic conditions or any other illness for which marijuana provides relief.

Since the passage of Proposition 215, the use of medical marijuana in California has been widespread. The Marijuana Policy Project estimates that there are over 500,000 medical marijuana users in California. In addition, Proposition 215 helped pave the road for other states to pass similar laws. Since its passage, a total of 23 states and the District of Columbia have enacted comprehensive public medical marijuana and cannabis programs.

Federal and State Law Conflicts

Under federal law, the manufacture, distribution or possession of marijuana for any reason, medical or otherwise, is a criminal offense. Federal laws pertaining to illegal drugs are codified in the Controlled Substances Act (CSA) (21 U.S.C. § 811). Under the CSA, every controlled substance is scheduled according to its medicinal value and potential for abuse. Like cocaine and LSD, marijuana is classified as a Schedule I drug. Schedule I is reserved for drugs believed to be highly addictive with no medical value.

The U.S. Drug Enforcement Agency (DEA) is tasked with enforcing the CSA. The DEA is able to set its enforcement priorities. Prior to 2014, the DEA was able to target medical marijuana patients and caregivers in general, and large cultivation and distribution operations more specifically, in federal drug investigations.

In 2005, the U.S. Supreme Court upheld this targeted enforcement practice by the DEA in *Gonzales v. Raich*, (2005) (545 U.S. 1, 352 F.3d 1222). In *Raich*, the Court ruled that the federal government has the authority to prohibit marijuana for all purposes, and as a result, it is within the federal government's power under the Constitution to arrest patients whose medical marijuana use is permitted under state law. The *Raich* decision did not overturn state laws legalizing medical marijuana use.

In late 2014, Congress passed and the President signed the 2015 federal spending bill that changed the federal government's position on the enforcement of marijuana criminal statutes. The measure forbids the federal government from spending any money to prevent states from implementing medical marijuana laws. In short, this new policy will preclude DEA agents from targeting patients, caregivers and retail operations in investigations occurring in states where medical marijuana use is legal.

While the DEA is shifting its focus away from enforcing the CSA in regard to medical marijuana, the CSA has not been changed and still classifies marijuana as a Schedule I substance. As recently as April 15, 2015, a federal judge in Sacramento declined to remove marijuana from the Schedule I list in the CSA. Until the CSA is amended, there will continue to be conflict between state and federal laws.

Marijuana in Federally Assisted Housing

Congress and HUD have consistently expressed that one of the primary concerns of public housing and assisted housing programs is to provide "decent, safe and sanitary dwellings for families of low income," and providing drug-free housing is integral to the government's responsibility in this regard. (U.S. Housing Act of 1937, Pub. L. No. 75-412; 42 U.S.C. § 1437a(a)(5)(C)(1)).

Since the upsurge of states passing medical marijuana laws in the late 1990s, HUD has issued a series of policy memoranda on the issue of marijuana use in federally assisted housing. HUD maintains that any state law purporting to legalize the use of medical marijuana in assisted housing would conflict with the assisted housing admission and termination standards found in the federal Quality Housing and Work and Responsibility Act of 1998 (QHWRA) (Title V of Pub. L. No. 105-276), and would be subject to federal preemption.

Under the QHWRA's admissions standards, owners must deny admission to any household with a member who the owner determines is, at the time of consideration for admission, illegally using a "controlled substance," as that term is defined by the CSA. (42 U.S.C. § 13661(b)(1)).

In contrast, under the QHWRA's termination standards, owners have the discretion to evict, or refrain from evicting, a current tenant who the owner determines is using a controlled substance. (42 U.S.C. § 13662(a)). Thus, while owners may elect to terminate occupancy based on drug use, they are not required to evict current tenants for such use.

HUD's policy guidance states that owners may not establish lease provisions or policies that are contrary to the intent of the QHWRA. This means that owners cannot permit the use of medical marijuana in a lease because doing so would deprive owners of the very discretion which Congress intended for them to exercise through the QHWRA.

Let's Break It Down: What This Means for Owners and Administrators

1. **Rule:** Owners *must* deny admission to any prospective tenant/household if the owner determines that any member of the household is using an illegal substance, including medical marijuana.

Best Practice: Create a policy for admission based on current and prior medical marijuana use of each household member. HUD requires a denial of admission to any household which has a member who currently uses marijuana. Determining if a household member is currently using marijuana requires a highly individualized, fact-specific examination of all relevant circumstances. Federal law does not specify a minimum length of time that must have transpired since the last use of medical marijuana for an applicant to be eligible for federally assisted housing. When creating a policy for admission, create two criteria that must be met for a former medical marijuana user to be eligible for tenancy, including: length of time since the last use of a controlled substance; and whether the household member has been rehabilitated. In this two part test, set a reasonable amount of time for sobriety as the first criteria. If the applicant meets the first criteria, move to the second criterion, which takes into consideration whether the former medical marijuana user has been rehabilitated. For example:

1) Has it been at least six months since any member of the household has used medical marijuana? If so,

2) Has that household member completed a supervised drug rehabilitation program and is no longer engaging in the use of medical marijuana, or has the household member otherwise been rehabilitated and is no longer engaging in the use of medical marijuana, or finally, is that household member currently participating in a supervised drug rehabilitation program and is no longer engaging in the use of medical marijuana?

If both conditions are met, a person is not considered to be 'currently' using medical marijuana and may be admitted to federally assisted housing. If a member of the household is believed to be currently using medical marijuana, the owner can admit the other members of the household as long as the member who is believed to be using medical marijuana *does not reside with the household on the premises.*

2) **Rule:** Owners may not establish lease provisions or policies that affirmatively permit occupancy by any member of a household who uses marijuana.

Best Practice: Make sure your admission policy clearly states that any prospective household will be denied occupancy if the owner determines that any member of the household is using an illegal substance, including medical marijuana.

3) **Rule:** Owners have *discretion* to evict or not evict current tenants for their use of medical marijuana. If an owner wants to allow a resident who is currently using medical marijuana to remain in occupancy, the owner may do so as an exercise of that discretion, but not as a reasonable accommodation.

Requirement: Owners *must* establish policies which allow for the termination of tenancy of any household with a member who is using marijuana or whose use interferes with the health, safety or right to peaceful enjoyment of the premises by other residents.

For any questions relating to this article, please contact Meghan Rose at mrose@aging.org.

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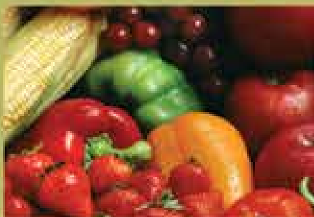

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