Charity's Neighborhoods

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Abstract: This tribute compares Charity Scott to Fred Rogers, highlighting how Charity nurtured health law colleagues' unique gifts and built community. Continuing the neighborhood theme, it highlights encouraging developments relating to health, housing, and place: Medicaid housing supports and potential reparations for redlining-related health inequities.

I live in Pittsburgh, where one of our patron saints is Fred Rogers, popularly known as Mister Rogers. From creating and hosting a public television show meant to help children develop emotional and social skills, Fred Rogers, an ordained Presbyterian minister who studied child development, evolved into something of a cultural icon.[1] Decades after he stopped producing Mister Rogers' Neighborhood, Fred Rogers remained part of the public consciousness. The documentary film about Fred Rogers and his show, "Won't You Be My Neighbor?" was released to critical acclaim in 2018 and became the top-grossing biographical documentary.[2] And just a year later, the feature film "A Beautiful Day in the Neighborhood" starring Tom Hanks enjoyed box office success.[3]

Fred Rogers offered children, parents, and the world many messages, both on and off his show. One of his core themes, and the one that most closely reminds me of the message that I and many others in the health law community received from Charity Scott, is that each person is worthy, with unique gifts that can find their fullest expression when nurtured in relationship with others. According to Fred Rogers, "As human beings, our job in life is to help people realize how rare and valuable each one of us really is, that each of us has something that no one else has — or ever will have — something inside that is unique to all time. It's our job to encourage each other to discover that uniqueness and to provide ways of developing its expression."[4]

In the part of Charity's world that I knew, she helped her health law professor colleagues imagine how they might use their gifts to better nurture the development of their students, as well as the profession and the communities it serves. Like Mister Rogers, Charity relied on the power of human connection to nudge

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people forward. And, like Mister Rogers, Charity had an uncanny ability to see and name the gifts that her colleagues harbored and then to encourage them to activate that potential.

Charity did that for me personally multiple times. The time I'll share briefly in this tribute is Charity's inviting me in 2014 to serve as a faculty mentor for the Future of Public Health Law Education Fellowship Program. This program, sponsored by Georgia State University and funded by the Robert Wood Johnson Foundation (RWJF), was Charity's brainchild. RWJF's central goal in funding the program was to "promote the innovative teaching of public health law nationally" by supporting the development of innovative curricular offerings in law schools, public health schools, and other health-related professional schools. As project director for the program, Charity added a goal that echoes Mister Rogers' approach: "to create a dynamic and supportive 'community of practice' in public health law that would foster the fellows' personal growth and professional development."[5]

In the part of Charity's world that I knew, she helped her health law professor colleagues imagine how they might use their gifts to better nurture the development of their students, as well as the profession and the communities it serves. Like Mister Rogers, Charity relied on the power of human connection to nudge people forward. And, like Mister Rogers, Charity had an uncanny ability to see and name the gifts that her colleagues harbored and then to encourage them to activate that potential.

The commitment to developing a community of practice was at the core of the faculty fellowship program. Bringing together ten faculty fellows, four faculty mentors, along with Charity and a handful of other key program participants created a cohort of participants who learned from each other, supported each other, and grew to value one another. As Charity put it: "'it's all about the relationship' became a watchword of the fellowship program."[6] I believe that this was Charity's version of asking each participant "Won't you be my neighbor?" And for ten days in Park City, Utah, during the summer of 2014, we accepted her invitation and became our own neighborhood.

Participating in the RWJF Faculty Fellowship Program, and especially the time spent in Park City, proved to be the most personally and professionally meaningful professional experience I've had in a career that now exceeds three decades. It changed how I thought about health law and public health law, provided me with enduring connections to other participants, and shaped the direction that my scholarship has taken. Among the many inspiring curricular innovations that the Faculty Fellows developed, I was particularly taken by Professor Amy Campbell's project. Then at the University of Memphis's law school, Professor Campbell was developing and implementing a progressive, cross-disciplinary public health law curriculum. A central component of her planned curriculum was a practicum permitting law students to work within a "Healthy Homes Partnership" in the city of Memphis.[7] The practicum gave students hands-on experience working across sectors and disciplines to address how policy decisions and housing code issues adversely affected the health of low-income Memphians.

Talking with Professor Campbell about her work intensified my own nascent interest in housing and health, an area that simultaneously poses thorny challenges and holds immense promise for improving health and advancing health equity. In honor of Charity's vision of the ways that public health law — broadly understood — can serve as a tool to improve people's lives, this tribute briefly highlights two distinctive areas where encouraging and intriguing developments relating to health, housing, and place are unfolding.

Housing Stability as a Health Issue

Today, housing stability's role as an important determinant of health is uncontroversial. Housing insecurity is associated with numerous adverse physical and mental health outcomes.[8] As a result, devastating health consequences are among the threats posed by the worsening crisis of a lack of affordable housing in many metropolitan areas. Moreover, the harms of housing insecurity are not evenly distributed across the U.S. population. People in racially minoritized communities, people with disabilities, and low-

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income women with children face heightened challenges in achieving and maintaining affordable and accessible housing, and thus are more likely to suffer the ill health effects of housing insecurity.[9]

Recognizing these connections has led advocates and policymakers to suggest that providing secure housing might be framed as a health intervention.[10] Following that logic, some suggested tapping into health care funding streams to support the housing needs of some groups. A June 2022 headline in the *New York Times* provocatively asked: "If Housing is a Health Care Issue, Should Medicaid Pay the Rent?"[11]

The idea was not new in 2022. For some time, scholars, advocates, and providers had explored how Medicaid funds might be used to supplement other public funding streams explicitly dedicated to helping low-income persons find and maintain housing (through mechanisms like housing vouchers and public housing). Proponents of "Housing First" approaches have sought to tap into Medicaid funds to support their efforts to get homeless persons with substance use disorders into stable housing, with social and medical services available. The rationale was that providing permanent supportive housing might produce overall savings on health spending for participants.[12] In 2018, I made a justice-based argument that, since Medicaid pays for "room and board" for low-income persons whose frailty or disability requires them to reside in a nursing home to receive effective health care, it should also pay for housing-related needs for persons whose chronic mental illness or substance use disorder requires them to have stable housing to receive effective health care.[13]

But, beyond any (likely considerable) political barriers to using Medicaid to fund housing for persons with chronic mental illness or substance use disorders, a legal barrier also existed. That barrier has often been framed in broad terms as a prohibition on using federal Medicaid funds to pay for housing. Over the past decade, however, the Centers for Medicare & Medicaid Services (CMS) has issued several guidance documents setting out a more refined understanding of the limits on using Medicaid funds to address housing as a social need that affects health.[14] These guidance documents instructed states that, while Medicaid would not pay for rent, states might use federal Medicaid funds to help Medicaid enrollees achieve stable housing by paying for things like move-in expenses or services that help renters meet their obligations as tenants. In a sense, over time CMS has nibbled away around the edges of the core prohibition that Medicaid cannot pay for rent, by expanding the universe of housing-related items that states *can* use Medicaid funds to pay for. The past few years have witnessed a couple of notable developments along these lines.

In 2021, CMS described to state Medicaid officials how they might use section 1115 demonstration waivers to incorporate services that address Medicaid beneficiaries' health-related social needs (HRSN), including housing instability.[15] At the top of a list of types of housing supports that could be considered under section 1115 demonstrations, CMS included temporary rental assistance for up to six months for specific populations (including persons transitioning out of institutional care; youth transitioning out of the child welfare system, and persons who are homeless or at risk of homelessness). This enhanced flexibility permits interested states to employ Medicaid funds to provide a bridge or stopgap that might address the timing and coordination issues that often plague persons' entry into housing-focused programs.

In 2023, CMS offered additional guidance to state Medicaid directors on how states might structure contracts with Medicaid managed care providers to authorize coverage of services or settings that are substitutes for services or settings covered under a state plan.[16] These substitute services/settings are commonly referred to in Medicaid circles as ILOS (for "in lieu of" services). The 2023 guidance clarified that states and their managed care contractors can use ILOSs to address Medicaid enrollees' HRSNs as a way of "improv[ing] population health, reduc[ing] health inequities, and lower[ing] overall health care costs in Medicaid."[17] The 2023 guidance notes that flexibility does not extend to an ILOS that violates applicable federal requirements, explicitly including Medicaid's general prohibition on payment for room and board cost. But it "paves the way for interested states to allow Medicaid managed care plans to offer services, like housing … supports, as substitutes for standard Medicaid benefits,"[18] as long as they conform to parameters articulated in the guidance.

These developments demonstrate that, under the Biden Administration, CMS has been willing to push the envelope on Medicaid's role in supporting housing for its recipients. And a number of states are already pursuing these options.[19] Analogous interventions to create or protect housing stability occurred during the COVID-19 pandemic. For example, many communities relied on CARES Act funding to pay for unhoused persons to stay in hotels, typically in an attempt either to isolate persons who had tested positive for COVID-19 or to move people out of densely packed shelters, where the risk of transmission was high.[20] The Biden Administration similarly justified its September 2020 eviction moratorium as a means of preventing the

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spread of COVID-19.[21] Although these interventions turned out to be temporary, they offer further examples of policies that advanced both individuals' health and the public's health by protecting housing.

Redlining's Health Legacy and Reparations

A second area that holds great potential for promoting health equity is addressing the centrality of neighborhood context for individual and community flourishing and health. Research supports the idea that, beyond an individual's or family's housing stability, the neighborhood where a person resides influences their health. This knowledge has fed the growth of what are sometimes referred to as place-based health interventions.[22] These interventions are wide ranging and include initiatives to improve the social, physical, and economic environments of neighborhoods.[23] They typically target neighborhoods for interventions based on low income, poor health outcomes, or other factors indicating that neighborhood residents experience health disparities.

I am particularly interested in the potential that communities that were historically redlined might be targeted for interventions as a form of reparations. "Redlining" refers to a federal agency's use, starting in the 1930s, of color-coded maps to designate the relative risk of issuing mortgages in different neighborhoods. The neighborhoods deemed riskiest — often because they had Black residents — were marked in red; residents of these neighborhoods could not obtain home loans backed by government insurance.[24] Over time, the term came to be applied to a range of discriminatory practices in the housing market. Although the Fair Housing Act of 1968 made racial discrimination in the housing sector illegal, the practice's negative impacts on redlined communities live on in many forms, including in community residents' health.[25] For example, research highlights the congruence between government redlining maps from the 1930s and contemporary food desert maps in cities across the U.S.[26] To the extent that redlining's legacy encompasses adverse impacts on social determinants of health like employment opportunities, access to public transit, or availability of fresh foods, an adverse impact on residents' health is also predictable.

Recent studies suggest an association between historical redlining and contemporary health-related outcomes.[27] For example, one recent study of veterans with cardiovascular disease found that veterans living in neighborhoods that had been redlined historically had higher risks of experiencing a major adverse cardiovascular event and of dying from any cause than did veterans living in areas that were historically white and wealthy.[28] This body of research is nascent, with much work remaining to flesh out connections between historical redlining of neighborhoods and present-day residents' health. But this emerging line of research suggests the importance of viewing health disparities in historically redlined neighborhoods as connected to a specific government-sponsored mechanism of structural racism and the potential value of using a reparations lens to support prioritizing place-based interventions in those neighborhoods.

Proposals to make reparations specifically for health-related injustices have been advanced before,[29] but have not to date gained traction on a broad scale. However, reparations have been approved for discrete groups of persons subjected to health-related abuses sponsored or mandated by the government. In 1974, a class-action lawsuit produced a $10 million settlement for survivors of the Tuskegee Syphilis Study to make repair for their exploitation in a U.S. Public Health Service-sponsored experiment that stretched four decades.[30] In addition to monetary compensation, survivors of the study, along with their wives, widows, and offspring, were provided with free medical care for life. In another reparative model, some states have paid compensation to persons who suffered eugenic sterilizations compelled by state laws enacted and enforced during the early to mid-twentieth century.[31]

In recent years, just as research has been illuminating a connection between the historical practice of government-sponsored residential redlining and specific health harms, a handful of cities have adopted programs that offer some form of reparations for historical injustices. Evanston, Illinois, for example, adopted a program to distribute housing grants to Black households that had been injured by the city's racist housing policies.[32] In July 2020, Asheville, North Carolina's City Council passed a resolution endorsing community reparations for Black Asheville. Pursuant to the resolution, Asheville appointed a Reparations Commission to make recommendations for actions that will meaningfully repair the damage caused by systemic racism.[33] Asheville's resolution contemplates investments to address racial disparities in Asheville, including health care disparities.[34]

The coincidence of a movement towards reparations initiatives at the local level and emergence of research connecting historical residential redlining practices to contemporary health disparities suggests an opportunity for applying a reparative lens to the development of place-based initiatives meant to address health disparities. Directly addressing these connections could support targeting community investments in health

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care or the social determinants of health to neighborhoods that suffered redlining. It might also influence the measures adopted to repair the damages of redlining.[35]

One thing central to my memory of Charity Scott is her vision of the law as a generative tool for advancing human flourishing. Law's impact can be consequential, even when it is not dramatic. Policies expanding states' flexibility within Medicaid to address housing instability as a health issue and reparations arguments supporting place-based initiatives targeted to historically redlined neighborhoods both suggest realms where further work may yet achieve Charity's vision.

Note

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