Housing Workgroup Assignment

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Please find attached a list of barriers to housing impacting those with HIV or most at risk. I have also attached the briefing paper we distributed at the first meeting along with a cost/savings chart. Finally, I have attached two proposals that I submitted to the Health Disparities Work Group that probably belong at this table. One is for respite care, mentioned in the SHNNY document, and the other is for Crisis Centers.

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DEMAND HOUSING
FOR HOMELESS PEOPLE
LIVING WITH AIDS & HIV

Barriers to Housing

Housing Works supports the SHNNY document outlining barriers and solutions. In addition to those named therein, we would add the following:

1. Barrier: HIV State Enhanced Rental Assistance Program does not have a cap on tenant contributions, so people with AIDS remain in supportive housing to avail themselves of the federal cap of 30% or pay in excess of 50% of their income in rent.

   Solution: Cap tenant rent under this program at 30% of income.

2. Barrier: HIV State Enhanced Rental Assistance Program is only accessible to people with a clinical diagnosis of AIDS. This keeps people with HIV from taking ARV's or Homeless

   Solution: Expand eligibility to all low-income persons with HIV.

3. Barrier: Most NYS counties do not participate in the HIV/AIDS rental assistance program to avoid the local match.

   Solution: Redraft legislation so that participation by counties is clearly required.

4. Barrier: Though youth, particularly LGBT youth, have the highest risk for HIV, and though some 50% of all homeless youth in NYC are LGBT, there are very few supportive housing programs for these youth.

   Solution: Expand supportive housing for this population.

5. Barrier: Many chronic drug users are precluded from housing due to their current drug use or history of relapse.

   Solution: Remove regulatory and programmatic barriers to housing for people who are still using drugs or who are likely to relapse.

   Solution: Enhance the rates of Crisis Care for Chemically Dependency Centers so that they can become a gateway to housing.

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Medicaid Redesign Taskforce – Affordable Housing Work Group
Housing and HIV/AIDS Prevention and Care
Briefing Paper – October 28, 2011[1]

New York's Medicaid Redesign offers an important opportunity to improve health outcomes for homeless and unstably housed New Yorkers living with HIV/AIDS and other chronic conditions. Rigorous study has shown that housing supports create stability and connection to care for people living with HIV/AIDS (PLWHA) regardless of co-occurring issues – improving health, reducing individual behaviors that can transmit HIV, and sharply reducing the individual and public costs of avoidable emergency room visits and inpatient care. Both the National HIV/AIDS Strategy and the Federal Strategic Plan to Prevent and End Homelessness recognize housing as an evidence-based HIV prevention and care intervention, and both plans call for policies and practices that incorporate housing assistance as a critical component of health care.

For homeless and unstably housing people living with HIV and other chronic health conditions, housing assistance is also a key cost containment strategy. In 2007, 9.4% of New York State's Medicaid recipients with HIV disease accounted for 44.9% of total HIV/AIDS-related Medicaid costs. Almost all (94%) high-cost Medicaid recipients (median annual expenditure = $157,209) had co-occurring health and mental health issues, and the most expensive service category for the high-cost group was hospital inpatient (50.2% of total costs) followed by institutional LTC (27.6%). (Chesnut, 2011). For many persons living with HIV and other chronic conditions, efforts to improve health outcomes will not succeed without attention to housing needs, and the evidence shows that housing interventions for this group generate HIV health care savings that offset the cost of housing supports. As recently observed in an Institutes of Medicine report on barriers to HIV care, "successful management of patients experiencing multiple, interacting conditions requires, in addition to appropriate medical care, the availability of comprehensive and flexible services, such as transportation, medication adherence programs, and dietary and housing assistance, which generally are not reimbursable by health care financing programs." (IOM, 2011).

As outlined below, Housing Works urges the MRT Affordable Housing Work Group to support concrete steps to address unmet housing needs among people living with HIV and other chronic conditions. Steps to insure access to HIV-specific housing resources include: an affordable housing protection for permanently disabled New Yorkers who rely on rental assistance; eligibility for HIV-specific housing supports for all persons living with HIV infection; and equal access to housing resources for New Yorkers with HIV outside New York City. Also important are housing resources for homeless/unstably-housed persons at high risk of acquiring HIV infection, such as street-involved youth and active substance users. Finally, we urge a public health approach that will ensure access to housing supports for those most vulnerable to poor health outcomes, including active drug users.

Finally, we note that the evidence base for housing as an HIV health care intervention has broader implications for persons managing other chronic conditions. While the "hard markers" of HIV disease status – laboratory measures of viral load and immune function – provide particularly clear evidence of the independent impact of housing on HIV health outcomes, we believe that the lessons learned from this research demonstrate the

[1] Prepared for Housing Works by Virginia Shubert of Shubert Botein Policy Associates.

importance of early intervention with safe and affordable housing to ensure effective and cost-efficient management of any chronic health condition.

Background – Housing is HIV Prevention and Care

Housing status and HIV health outcomes

Homelessness and unstable housing have been strongly associated with greater HIV risk, inadequate HIV health care, poor health outcomes, and early death. In New York City, the rate of new HIV diagnoses among homeless persons is sixteen times the rate in the general population, and death rates due to HIV/AIDS are five to seven times higher among homeless persons (Kerker, et al., 2005). Persons living with HIV who lack stable housing are: more likely to delay HIV care; have poorer access to regular care; are less likely to receive optimal antiretroviral therapy; and are less likely to adhere to therapy (Wolitski, et al., 2007; Aidala, et al., 2007; Leaver, et al., 2007). Compared to stably housed PLWHA, homeless PLWHA rate their mental, physical and overall health worse, and are more likely to be uninsured, use an emergency room, and be admitted to a hospital (Kidder, et al., 2007). Homeless PLWHA have lower CD4 counts and are less likely to report an undetectable viral load; a lower percentage of homeless PLWHA have ever taken HIV antiretroviral medications, and they are less likely to be on antiretroviral therapy (ART) currently; and among those on ART, self-reported adherence is significantly lower among homeless PLWHA (Kidder, et al., 2007). Significantly, housing status is a more significant predictor of health care access and outcomes than substance use, mental health status or other individual characteristics (Kidder, et al., 2007).

For homeless and unstably housed PLHWA housing assistance is an evidence-based HIV health care intervention. A long-term ongoing study of PLWHA in NYC shows that over a 12-year period, receipt of housing assistance was among the strongest predictors of accessing HIV primary care, maintaining continuous care, receiving care that meets clinical practice standards, and entry into HIV care among those outside or marginal to the health care system. (Aidala, et al., 2007). Receipt of housing assistance has an independent impact on improved medical care, regardless of demographics, drug use, health and mental health status, or receipt of other services (Aidala, et al., 2007). Injection drug users with stable housing were found to be 1.5 times as likely to access highly active antiretroviral therapy (HAART) than those who lacked stable housing, and among IDUs on treatment, those with stable housing were almost 3.7 times as likely to achieve viral suppression (Knowlton, 2008). Indeed, results of a systematic review of the literature reveal a significant positive association between increased housing stability and better health-related outcomes in all studies examining housing status and HIV risk behaviors, medication adherence and utilization of health and social services (Leaver, et al., 2007; Aidala, 2008).

Housing status and HIV risk

Numerous studies document the direct and independent relationship between housing status and behaviors that can transmit HIV, after controlling for other factors such as demographics, substance use, mental health issues and access to services (Wolitski, et al., 2008; Aidala, et al., 2005). Among extremely low-income HIV+ persons coping with multiple behavioral issues, those who are homeless or unstably housed are two to six times more likely to use hard drugs, share needles or exchange sex than stably housed persons with the same personal and service use characteristics (Aidala, et al., 2005). Data gathered from 8,075 PLWHA as part of the US CDC's Supplement to HIV/AIDS Surveillance (SHAS) project show that, compared to stably housed persons with HIV, PLWHA who lack stable housing

are: 2.9 times more likely to engage in sex exchange; 2 times more likely to have unprotected sex with an unknown status partner; 2.3 times more like to use drugs; and 2.75 times more likely to inject drugs. Housing instability is also a barrier to reducing HIV risk; counseling, needle exchange, and other proven HIV prevention interventions are less effective among people who are homeless or unstably housed (Des Jarlais, 2007; Elifson, 2007).

Among persons at greatest risk of HIV infection (e.g., men who have sex with men, persons of color, homeless youth, IV drug users, and impoverished women), those who lack stable housing are much more likely to acquire HIV over time. A large study of homeless men showed that HIV risk was directly related to the severity of housing need, with sexual risk behavior more frequent among those who had particularly poor-quality housing such as living on the street or in an abandoned building (Stein, 2009). Studies show consistent associations between housing status and sexual- and injecting-related HIV risk behaviors among IV drug users, and find higher rates of HIV infection and increased risk of HIV seroconversion among IDU who are homeless/unstably-housed (Marshall, 2011). An ongoing study of at-risk street-involved youth shows that homelessness plays an important role in the transmission of HIV and sexually transmitted diseases in this vulnerable group, as indicated by significantly lower levels of condom use and greater numbers of sexual partners among homeless youth as compared to those with more stable housing (Marshall, 2009). Homeless women were 2 to 5 times more likely than their housed counterparts to report multiple sex partners in the last 6 months, in part due to recent victimization by physical violence (Wenzel, 2007).

Indeed, there is increasing recognition that effective HIV prevention strategies must address contexts of risk – such as poverty and homelessness – in addition to individual behaviors. A CDC analysis of National HIV Behavioral Surveillance data among heterosexuals found that men and women in 23 major U.S. cities living below the poverty line were twice as likely to have HIV infection (2.4%) as those living above it (1.2%), and that the rate of new HIV diagnoses were almost twice as high (1.8%) among residents of poor communities who had a recent experience of homelessness. In NYC, annualized HIV incidence among heterosexuals in the 30 poorest neighborhoods was 3.31%. Significantly, more than half of the NYC respondents had a lifetime experience of homelessness and 39% were currently homeless at the time of the study. HIV testing revealed that 8.6% of all study participants were HIV positive (8% of men; 9.2% of women; 10.1% of blacks), and that 94% of those who tested HIV-positive were not previously aware of their status. As stated by the researchers, "individual risk behaviors do not appear to explain the high prevalence of HIV" found in this group (Jenness, 2011).

For homeless/unstably-housed people, housing assistance is an evidence-based HIV prevention intervention. Over time, persons who improve their housing status reduce risk behaviors by as much as half, while persons whose housing status worsens are as much as four times as likely to engage in behaviors that can transmit HIV (Aidala, 2005). Women who receive federal housing assistance are half as likely to engage in sexual risk behaviors as similar low-income women who are homeless (Wenzel, 2007). Access to housing also improves access and adherence to antiretroviral medications, which lower viral load and reduce the risk of transmission (NIAID, 2011).

Housing is a Cost-Effective Health Care Intervention

HIV housing interventions work to improve health outcomes and reduce costs.
Two recent random controlled trials have linked housing assistance to improved health outcomes for homeless and unstably housed persons living with HIV and other chronic health conditions, and indicate that investment in housing not only improves health outcomes but reduces overall public expense. These two studies were the first of their kind, designed specifically to examine the significance of housing as an independent determinant of health.

The Housing and Health (H&H) Study was conducted by the U.S. Centers for Disease Control and Prevention (CDC) and the HUD Housing Opportunities for People with AIDS (HOPWA) program, to assess the impact of immediate access to HOPWA housing vouchers on the physical health, mental health and HIV risk behaviors of homeless and unstably housed people living with HIV/AIDS (PLWHA). The study included 630 HIV-positive participants in three cities – Baltimore, Chicago and Los Angeles, between 2006-2008. At the end of the 18-month study period, only 18% of participants who got study vouchers remained homeless or unstably housed. Despite high levels of connection to care at baseline, health outcomes improved dramatically with housing stability – including a 35% reduction in emergency room visits, a 57% reduction in the number of hospitalizations, and significantly improved mental health status. Even stronger differences were found in analyses that compared study participants who experienced homelessness during the follow-up period with those who did not. After controlling for socio-demographic variables, substance use, and physical and mental health status, those who experienced homelessness were 2.5 times more likely to use an emergency room, 2.8 more likely to have a detectible viral load at follow up, reported significantly higher levels of perceived stress, and were more likely to report unprotected sex with a negative/unknown status partner. (Wolitski, et al., 2009).

H&H researchers are evaluating these statistically significant differences related to housing status to determine the "cost-utility" of the H&H housing intervention as an HIV risk reduction and health care intervention. The cost-utility of the H&H intervention is a function of the cost of the services provided, transmissions averted, medical costs saved, and quality-adjusted life years saved. Findings show that housing is a cost effective health care intervention for PLWHA, with a cost per quality-adjusted life year (QALY) of $35,000 to $62,000, in the same range as widely accepted health care interventions such as kidney dialysis ($52,000 to $129,000 per QALY) and screening mammography ($57,000 per QALY) – and far less expensive than HIV pre-exposure prophylaxis (PrEP) ($298,000 per QALY). (Holtgrave, 2009).

The Chicago Housing for Health Partnership (CHHP) is an integrated system of housing and supports for individuals with chronic medical illnesses who are homeless upon discharge from hospitalization. An 18-month randomized control trial compared hospitalizations, hospital days, and emergency department visits among housed participants and a comparison group of chronically ill homeless persons who continued to receive "usual care" – emergency shelters, family and recovery programs. CHHP participants were three times more likely to achieve stable housing at 18 months than the usual care group (66% vs. 21%), with significantly fewer housing changes (2 vs. 3). This stability translated into significantly improved health outcomes. Controlling for a range of individual and service variables, housed participants had 29% fewer hospitalizations, 29% fewer hospital days, and 24% fewer emergency department visits than their "usual care" counterparts

(Sadowski, et al., 2009). After twelve months, 55% of HIV-positive participants who received a CHHP housing placement were alive and had "intact immunity," compared to only 34% of the HIV-positive participants randomly assigned to "usual care," and members of the intervention group were almost twice as likely at 12 months to have an undetectable HIV viral load (40%) as those who did not receive housing (21%) (Buchanan, et al. 2009).

The San Francisco Department of Public Health has also examined the impact of housing assistance on the health of persons living with an AIDS diagnosis (PLWA). The SF DPH compared mortality over a 5-year period for homeless PLWA who received supportive housing through their Direct Access to Housing (DAH) program (n=70) and those that did not (n=606). There were two deaths among persons who received DAH supportive housing, 219 deaths among those who were not housed. After adjusting for potentially confounding variables, obtaining supportive housing was independently associated with an 80% reduction in mortality among these PLWA (Schwartz, et al., 2009).

Savings in avoidable health care costs offset the cost of housing.
The H&H and CHHP study findings add to a growing body of evidence that housing interventions produce public cost offsets that are equal to or greater than the cost of housing. An evaluation of the Seattle DESC 1811 Eastlake project for homeless people with chronic alcohol addiction showed that a "Housing First" supportive housing model for persons with severe alcohol challenges created stability, reduced alcohol consumption, and decreased health costs 53% relative to a comparison group in a wait-list condition. Among persons housed, there was also an 87% reduction in sobering center use and a 45% reduction in county jail bookings (Larimer, 2009).

A large-scale study commissioned by the Los Angeles Homeless Services Authority examined a wide range of public costs among 10,193 homeless persons in Los Angeles County, including 1,007 who were able to exit homelessness via supportive housing (Flaming, 2009). Public costs were found to go down for all homeless persons once they were housed. Savings were greater for more vulnerable persons with greater needs. The average public costs for impaired homeless adults decreased 79% when they were placed in supportive housing – from a monthly average of $2,897 for the group experiencing homelessness, to a monthly average of $605 for the group in supportive housing. Most savings in public costs came from reductions in outlays for avoidable crisis health services, with the greatest average cost savings realized among persons with HIV/AIDS who moved from homelessness into housing.

These cost-offset analyses support the provision of housing even before taking into account the costs of heightened HIV risk and treatment failure among homeless PLWHA. Each new HIV infection prevented through increased housing stability saves over $300,000 in lifetime medical costs (Schackman, 2006).

Important new cost findings were presented for the first time at the recent North American Housing and HIV/AIDS Research Summit held in New Orleans in September 21-23, 2011. The NYC Department of Health & Mental Hygiene presented findings from a study of HIV health care utilization among homeless and unstably housed PLWHA "living on the street, in a shelter, an emergency single room occupancy (SRO) hotel, or in jail and without a place to live upon release" in New York City. Interviews with participants revealed good connection to primary care and regular primary care visits. Yet despite connection to primary care,

77% of the homeless PLWHA interviewed had visited an emergency room in the last six months and 56% had an inpatient hospital stay. DOHMH researchers concluded, "lack of stable housing may underlie persistent HIV-related health problems" (Towe, 2011).

Findings from the ongoing study of PLWHA enrolled in housing with the San Francisco Department of Public Health "Direct Access to Housing" (DAH) program show that the housing intervention dramatically reduces avoidable healthcare spending among PLWHA. The study examined public healthcare utilization by HIV-positive residents (hospital, ER, inpatient, skilled nursing facility) two years before and two years after placement in the DAH low-threshold permanent supportive housing program. Analysis revealed that healthcare "high users" (>$50,000/year in healthcare costs) represented just 13% of the study group but accounted for 73% of total healthcare costs for the group. The median healthcare costs for these high users was $100K/year per person prior to housing, but after housing placement median annual healthcare costs dropped to just $1,819/year per person. Significantly, the study found no difference in housing stability between high users and other HIV+ residents, and the cost reductions among the high users of health care services generated savings that more than offset housing costs for the full group of HIV-positive residents. The study authors concluded, "housing costs provided locally (or by HUD) created savings in mainstream healthcare costs" (Bamberger, 2011).

Recommendation:
Improve Housing Stability for New Yorkers Living with HIV/AIDS

The NYS HIV/AIDS enhanced rental assistance program
The primary housing program for poor New Yorkers living with HIV/AIDS is tenant-based rental assistance funded jointly by New York State and localities. The enhanced rental assistance program for PLHWA was established by New York State regulation early in the AIDS epidemic. The program subsidizes clients' rents in private market apartments and is used by some supportive housing programs to cover a portion of operating costs. In NYC the Human Resources Administration's HIV/AIDS Services Administration (HASA) administers the program. Given the limited amount of supportive housing available to PLWHA, over 80% of HASA clients in need of housing supports rely on the rental assistance program. The ratio of total rent to income among program recipients is approximately 124%, meaning that on average unsubsidized rents are greater than income. This makes the program a vital source of housing support for households living with HIV. However, current administration of the program limits its availability and undermines its effectiveness (Shubert et al., 2004). Recent changes in HRA policy have also sharply reduced broker's fees and eliminated cash security deposits for all rental assistance programs, making it much more difficult for PLWHA to use the program to exit homelessness.

We urge the MRT to support three initiatives that will remove barriers to this critical program and improve its effectiveness to meet the housing needs of PHWHA in all parts of New York State.

Enact an affordable housing protection for disabled PLWHA (better utilization of an existing resource)
Pending State legislation (A.6275/S.4098) would prevent homelessness for New Yorkers permanently disabled by HIV/AIDS and their families by enacting an affordable housing protection for PLHWA who rely on the State/local enhanced rental assistance program.

As with NYS housing programs for other disabled people, enhanced rental assistance program participants with income from disability benefits contribute a portion toward rent. Unlike other programs, however, the HIV/AIDS rental assistance program put in place in the 1980's does not include an affordable housing protection. All other state and federal disability housing programs – including most HIV/AIDS supportive housing – cap a tenant's rent contribution at 30 percent of income. In contrast, the NYS OTDA requires that persons with HIV/AIDS who receive income from any source be budgeted for the rental assistance program at a rent level that reduces their discretionary income to the level of the public assistance grant. Permanently disabled PLHWA are therefore required to contribute between 50% and 75% of their fixed income from disability benefits (SSI, SSDI, or Veteran's benefits) towards their rent, leaving less than $12/day to meet all other expenses. HUD defines payment of more than half of income towards rent as a "severe rent burden."

This policy has two pernicious impacts. First, it causes tenants to fall behind in rent leading to housing loss and disruption of care. Indeed, approximately 25% of formerly homeless people living with HIV/AIDS who receive housing assistance lose their housing within 6-12 months, according to the Columbia University "CHAIN" study funded by the NYC Department of Health & Mental Hygiene (DOHMH). The study also found that among people living with HIV/AIDS receiving rental assistance, 43% report not enough money for food, utilities, unreimbursed medical care or other health needs at least some time during the past six months. Second, the policy acts as a powerful disincentive to independence, as more stable residents opt to enter or stay in supportive housing in order to reduce their rent burden. As a result, there is very little turnover in the permanent supportive housing system, keeping people with more complex needs homeless. At any given time, over 1,800 HASA clients are in emergency housing, with 900 relegated to dangerous and costly single room occupancy hotels.

Re-enactment of the pending legislation (overwhelmingly passed by both Houses of the NYS Legislature but vetoed by former Gov. David Patterson) would cap rent contributions for extremely poor, chronically ill New Yorkers at 30 percent of their disability income. Thirty percent of income is the widely accepted standard for housing affordability among low-income persons, and research shows that capping the rent burden at 30% will have a dramatic impact on rates of non-payment and subsequent housing loss. A 2009 study by researchers at Harlem United compared the rates of payment of the client's rent share in two of their HIV housing programs – a federally funded program with rent burden capped at 30% of disability income, and a program that utilizes the State/local rental assistance program with no rent cap. They found that clients with the 30% affordable housing protection where more than twice as likely to make timely rent payments than persons with no rent cap (83% vs. 41%).

Reducing housing loss and freeing up existing supportive units will pay for this legislative change before even taking into account anticipated Medicaid savings from avoided crisis health care and prevented HIV infections. In NYC, we estimate that the $20.7million incremental annual rental assistance cost to the City and State but would be offset by annual cost savings of at least $21million in averted rent arrears payments and emergency housing costs.[2] While it is more difficult to calculate the direct additional benefits in reduced

[2] Based on: an incremental rental assistance cost of $175/month/person; a 20% reduction in current rental arrears payments; and prevention of a third of the 6,500 annual HASA emergency housing placements.

Medicaid costs, we estimate annual savings conservatively at $73million ($50.25million in averted crisis health care[3] and $22.5million through prevention of new HIV infections[4]).

Update program eligibility for HIV housing resources to include all extremely low-income New Yorkers with HIV in need of housing assistance (new investment)
New York State Department of Health action to update the definition of "HIV illness" to include all HIV infected persons would extend existing housing supports to income-eligible persons living with HIV who are homeless or unstably housed irrespective of disease progression.

The enhanced rental assistance program for PHWHA was established in the late 1980's by State regulation (18 NYCRR 352.3(k)). A 1990 Administrative Directive (90 ADM-8) entitled "The Emergency Shelter Allowances for Persons with AIDS or HIV- related Illness Faced with Homelessness" instructs local social service districts "to address the problem of homelessness faced by persons with AIDS or HIV-related illness (as defined by the AIDS Institute of the New York State Department of Health)." The NYS DOH definition of HIV-related illness (more recently described as "clinical/symptomatic HIV infection") has not been changed since the mid-1990's and so is now out of date and inconsistent with current treatment guidelines and HIV prevention strategies. Under current eligibility requirements, for example, HIV-specific housing supports are available only to asymptomatic HIV+ persons with a CD4 count <200, while NYS Department of Health AIDS Institute clinical guidelines call for initiation of antiretroviral therapy for HIV+ persons who are asymptomatic with a CD4 count <350, and discussion of early treatment with a much larger group.

As the result, an estimated 3,100 homeless and unstably housed people living with HIV in NYC (including 800 or more residing NYC shelters on any given night) remain medically ineligible for the publicly funded HIV-specific non-shelter housing assistance and case management provided for persons with symptomatic HIV infection through HASA.[5] As treatment for HIV has improved and initiation of treatment is recommended earlier and earlier in the course of HIV disease progression, homeless people with HIV are forced into the Hobson's choice of initiating treatment and remaining homeless or delaying treatment until they qualify for rental assistance or supportive housing. We urge the Affordable Housing Work Group to support immediate administrative action by the NYS DOH to change the definition to align with current knowledge and treatment guidelines. This change will encourage timely testing by persons at risk of HIV infection, will facilitate participation in treatment that significantly delays disease advancement, and will reduce transmission of

[3] Conservatively estimating improved housing stability for 1,500 HASA clients (among 10,000 severely rent burdened PLWHA using rental assistance and 1,800 HASA currently in emergency housing who might benefit from increased turnover in the supportive housing system), and based on the SF Department of Public Health findings comparing health care utilization by homeless/unstably housed PLWHA before and after placement in housing. The SF study found that health care costs decreased by 55% for the entire HIV+ group following housing placement – by a mean of approximately $15,000 person – and that cost savings among a minority of "high users" of avoidable health services offset the housing costs for the full group housed (Bamberger, 2011).
[4] Among 1,500 unstably housed persons you would expect between 36 and 162 new transmissions each year (transmission rates range from 2.4 and 10.79, with unstably housed persons likely closer to the higher end). Assuming at least 75 new HIV infections annually (a 5% annual transmission rate) and lifetime healthcare costs of at least $370,000 associated with each new infection, we estimate annual savings of at least $22.5million in lifetime HIV treatment costs, as well as countless life years.
[5] Assuming an immediate housing need equal to 800 PLWH in shelters plus one-third (n=2,300) of other income-eligible asymptomatic HIV-infected NYC residents (n=6,900).

HIV to others. The change will decrease the number of new HIV infections in NY and will improve the quality of life of NYC residents infected with and affected by HIV, and the costs of providing HIV housing and services to income-eligible HIV asymptomatic New Yorkers will be greatly offset by the decrease in Medicaid and other healthcare expenditures for treatment of advanced HIV disease and for treatment of averted HIV infections.

The total estimated incremental annual cost to the State and City to meet immediate housing need (including supportive housing for persons who need it) for approximately 3,100 PLWHA in New York City would be $44.6million.[6] Savings in avoidable health care costs are estimated at approximately $46.5million annually, outweighing the cost of housing[7]. Additional savings in lifetime medical costs of averted HIV infections is estimated at $57 million[8], for total offsetting savings of $103.5million. Other public savings from prevented HIV infections would equal an estimated $2.2million in annual housing and support service costs, or a lifetime savings of approximately $27.5million.[9]

Expand the reach of the rental assistance program to ensure equal access for New Yorkers living with HIV outside NYC (new investment)

NYS HASA for All legislation would mandate local social service participation in the enhanced rental assistance program for PLWHA, expanding the availability of the program to households living with HIV across the State.

Another significant barrier to the effectiveness of existing HIV housing supports is the reluctance of local governments to provide information on the enhanced rental assistance program or to contribute local matching funds for the program. Currently, only a handful of local social service districts outside NYC participate in the HIV enhanced rental assistance program, despite language in the 1990 administrative directive stating that "local districts must provide emergency shelter allowances to eligible persons with AIDS or HIV-related illness who are homeless or faced with homelessness." NYS HASA for All legislation would require every social service district to establish a mechanism to make this resource available.

The total estimated incremental annual cost to the State and localities to meet unmet need (including the staff and mechanisms to administer the program) for approximately 3,300 PLWHA[10] in the balance of NYS is estimated at $48million.[11] Savings in avoidable health care costs are estimated at approximately $49.5million[12], outweighing the cost of housing supports. Additional savings in lifetime medical costs from averted HIV infections is

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[6] 3,100 households at an average annual cost of $14,400/household.

[7] Estimate based on SF Department of Public Health findings comparing health care utilization by homeless/unstably housed PLWHA before and after placement in housing; health care costs decreased by 55% for the entire group – or by a mean of approximately $15,000 person, and cost savings among a minority of "high users" of health services offset the housing costs for the full group housed (Bamberger, 2011).

[8] Among 3,100 unstably housed persons you would expect between 74 and 334 new HIV transmissions each year (transmission rates range from 2.4 and 10.79, with unstably housed persons likely closer to the higher end). Discounted lifetime medical costs are conservatively estimated at $370,000 per transmission. Preventing 155 new infections (a 5% infection rate) would save $57million annually.

[9] Assuming annual housing and support service costs of $14,400 per person and an 11.5-year life span following HIV infection.

[10] Assuming immediate unmet housing among one-third of asymptomatic PLWH (n=10,000) outside NYC, less currently available HIV-specific housing units.

[11] 3,300 households at an average annual cost of $14,400/household.

[12] Estimate based on SF Department of Public Health findings (see footnote 3).

estimated at $61million,[13] for total health care savings of $110.6million. Other public savings from prevented HIV infections would equal an estimated $2.4million in annual housing and support service costs, or a lifetime savings of approximately $27million.[14]

Recommendation:
Support Housing as a Primary HIV Prevention Intervention for At-Risk Groups

Rates of homelessness are high among persons as yet HIV-negative but at greatest risk of HIV infection due to substance use, mental illness, intimate partner violence, and other co-occurring vulnerabilities. While it is difficult to estimate total housing need among at-risk persons, at any given time it can be assumed that at least one-half of homeless persons in any community fall into one or more of these highest-risk categories, and research indicates that the condition of homelessness itself places all persons who lack stable housing at increased risk of HIV infection.

We urge the MRT to promote and provide guidance on the role of housing assistance for homeless and unstably housed persons at heightened vulnerability for HIV infection as a "primary" HIV prevention activity to prevent HIV exposure among uninfected persons, and to monitor housing and HIV status to evaluate the impact of homelessness and housing instability on HIV acquisition.

Increase housing for homeless LGBTQ youth at high risk of HIV infection (new investment)
Housing resources for HIV-negative at-risk homeless youth will sharply reduce HIV risk behaviors and new HIV infections for this extremely vulnerable group.

The conditions of homelessness and survival needs place lesbian, gay, bisexual, transgender and queer (LGBTQ) adolescents at extremely high risk of acquiring HIV infection. In New York City the population of homeless youth is estimated at 8,000, and the percentage of these adolescents who identify as LGBTQ range from 13 percent to 36 percent or more (NYC Commission on LGBTQ Youth, 2010). Unmet housing need can therefore be estimated among one-third of homeless youth, or 2,640 persons.

The total estimated incremental annual cost to the State and localities to meet unmet need for approximately 2,640 homeless youth is estimated at $38million.[15] Annual savings in lifetime medical costs from averted HIV infections among this group is estimated at $49million,[16] far outweighing the cost of housing supports. Other public savings from prevented HIV infections would equal an estimated $1.9million in annual housing and support service costs, or a lifetime savings of approximately $22million.[17]

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[13] Among 3,300 unstably housed persons you would expect between 80 and 357 new transmissions each year (transmission rates range from 2.4 and 10.79, with unstably housed persons likely closer to the higher end). Discounted lifetime medical costs are conservatively estimated at $370,000 per transmission. Preventing 165 new infections (a 5% infection rate) would save $61million annually.
[14] Assuming annual housing and support service costs of $14,400 per person and an 11.5-year life span following HIV infection.
[15] 2,640 individuals at an average annual cost of $14,400/household.
[16] Assuming a 5% infection rate among 2,640 homeless youth and discounted lifetime medical costs of $370,000 per transmission.
[17] Assuming annual housing and support service costs of $14,400 per person and an 11.5-year life span following HIV infection.

Recommendation:
Adopt a Public Health Approach that Reduces Barriers to Housing

Many people living with and at risk of HIV infection and other chronic conditions are barred from housing resources due to stigma, categorical eligibility requirements, and/or the very co-occurring issues that make them most vulnerable, such as histories of incarceration and active drug use. Low-threshold, harm reduction housing interventions have repeatedly been shown to enable vulnerable persons to establish stability, improve health outcomes, and reduce risk behaviors, especially when coupled with onsite supports (Wolitski, 2010; Larimer, 2009; Sadowski, 2009).

We urge the MRT to support an evidence-based, public health approach that identifies and limits policy and other barriers to housing assistance for persons at greatest risk of poor health outcomes. Such a public health approach would: remove eligibility requirements that exclude the most vulnerable persons from housing assistance; lift public housing exclusions based on status, such as a history of incarceration or active drug use; prohibit restrictions on housing for chronically ill persons that would exclude applicants based on stages of disease, active substance use, or minimum income; and ensure the availability of assistance to overcome barriers to housing access and stability, including barriers related to immigration status.

Remove barriers to housing assistance based on drug use or history of incarceration (removing regulatory barriers)
Removing regulatory barriers to public housing assistance based on active drug use or a history of incarceration would enable homeless and unstably housing PLWHA to reunite with family members in public housing and to use existing housing resources to maintain or improve housing stability.

While it is difficult to estimate the number of homeless and unstably housed PLWHA who face this barrier to housing assistance, for purposes of this analysis we will assume at least 900 households in NYS who would benefit from this regulatory change. There would be no public cost associated with the removal of this restriction on currently available housing resources. However, for 900 PLWHA we could expect at least $30million in annual savings from avoidable crisis health services and prevented infections and an additional $680,000 in annual housing and support service costs associated with prevented HIV infections, or a lifetime savings of approximately $7.5million.[18]

Conclusion:
We recommend that the Affordable Housing Work Group of the MRT explore cost-effective ways to expand housing options for all homeless people living with multiple chronic

[18] Assuming an average reduction of $15,000 annually in avoided crisis heath care costs (Bamberger, 2011), 45 averted new HIV transmissions (a 5% infection rate), and $370,000 in avoided lifetime medical costs for each averted HIV infection, and $14,400 in annual housing and support service costs associated with each prevented HIV infection (over a 11.5 year life-span following infection).

conditions, irrespective of the nature of the chronic condition or an individual's present need for long term care services.

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Proposal to Redesign Medicaid

Reform: Yes

Date Submitted: September 9, 2011

Proposal Author: Charles King/Housing Works, Inc.

Proposal (Short Title): Medical Respite Care for Homeless Persons

Program Area:

Effective Date:

Implementation Complexity: Moderate

Implementation Timeline:

Proposal Description:

Establish Medicaid-reimbursed medical respite care programs for homeless persons who need a safe environment to recover from illness but are not ill enough to require hospitalization. These programs would be for short term residential stay and could be freestanding or located in existing facilities such as shelters and transitional housing facilities. Services could be provided by FQHC's through an 1115 demonstration waiver or through a SPA as part of the 1915(i) Home and Community Based Services Program.

Benefits of proposal: Better health outcomes for homeless persons experiencing illness, reduced hospital stays for homeless persons and reduced readmissions and emergency room visits post-hospitalization.

Concerns with proposal: Would require NYS submit an 1115 Waiver or SPA.

Impacted stakeholders: Homeless persons who experience hospitalization, hospitals, FQHC's and other homeless service providers.

Contact Information:

NYS Medicaid Redesign Taskforce
Affordable Housing Work Group - HIV/AIDS Housing Proposals

Proposal	Category	# Persons impacted	Estimated annual cost	Annual Medicaid savings	Other savings (per year)
Enhanced HIV/AIDS rental assistance affordable housing protection	Better utilization	10,000	$20.7 million	$73 million	$21 million*
Update HIV housing program eligibility to include all HIV+ persons	New investment	3,100	$44.6 million	$104 million	$2.2 million**
Expand access to enhanced HIV/AIDS rental assistance outside NYC	New investment	3,300	$48 million	$111 million	$2.4 million**
Housing as HIV prevention for at-risk homeless LGBTQ youth	New investment	2,640	$38 million	$49 million	$1.9 million**
Remove barriers to housing assistance based on drug use or history of incarceration	Correcting regulatory barriers	900	$0	$30 million	$648,000**

* Savings to NYC and NYS in averted rent arrears payments and emergency housing costs.
**Annual housing & support service costs saved when an HIV transmission is averted ($14,400 average annual cost per client).