Housing is Health Care Medicaid Project

Position Paper

The National AIDS Housing Coalition (NAHC) envisions an international community where housing is a human right and HIV disease ends. Housing clearly improves health outcomes of those living with HIV disease and reduces the number of new HIV infections. The end of HIV/AIDS critically depends on an end to poverty, stigma, housing instability, and homelessness. Since its inception, NAHC's mantra has been *"Housing is a Human Right."*

The overall goal of the Housing is Health Care Medicaid Project is a "future state" of integrated health care delivery that includes federal support for state-level innovation to provide non-institutional housing as a health care intervention to improve health outcomes and lower public costs for medically underserved Medicaid beneficiaries, particularly low-income homeless and unstably housed people living with chronic and/or disabling conditions. Such a sustainable Medicaid funding stream would significantly expand available housing supports toward a goal of meeting a real need.

To realize this goal NAHC will advocate for the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies to:

1. Implement CMS' recommendations expressed in the June 26, 2015, Informational Bulletin, "*Coverage of Housing-Related Activities and Services for Individuals with Disabilities"* that clarifies the circumstances under which Medicaid reimburses for certain housing-related activities.
2. Implement the 2014 Home and Community Based Settings (HCBS) rule, particularly as it relates to HIV/AIDS populations covered under HCBS waivers and state plan amendments. The HCBS rule requires services to be delivered outside of institutional settings and in community-based, supportive-housing environments.
3. Shift Medicaid resources from institutional models to integrated community models such as supportive housing and reimburse for both the services and housing operations costs to ensure people with low incomes and signficant health needs, such as those living with HIV/AIDS, can have access to supportive housing as a medically necessary, health care intervention.
4. Re-invest any cost savings from shift to integrated community models into the creation of additional services and housing supports for vulnerable populations.

This paper will lay out the research that shows that safe, affordable, is a cost-effective structural intervention that improves health outcomes for people living with HIV/AIDS and other chronic conditions, provide an overview of current efforts to integrate healthcare and housing resources and layout the NAHC Advocacy strategies and action steps that will move the US towards a

sustainable, integrated housing and health care delivery system that lowers public costs for medically underserved Medicaid beneficiaries, particularly low-income homeless and unstably housed people living with HIV/AIDS, chronic and/or disabling conditions.

Current Research: Housing Interventions Improve Health Outcomes and Cut Costs

Research shows that housing assistance is an effective health care intervention. Consistent findings show that an increase in housing stability is significantly associated with better health-related outcomes in studies examining housing status and HIV transmissions, risk behaviors, medication adherence, and utilization of health and social services. (Leaver, et.al, 2007; Wilson, et.al, 2011; Marshall, 2011)

Receipt of housing assistance is 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 system (Aidala, et.al, 2007). Homeless persons with HIV who received a housing placement were twice as likely to achieve an undetectable viral load as a matched comparison group that remained homeless (Buchanan, et.al, 2009). Injection drug users with stable housing were 1.5 times more likely to access antiretroviral therapy (ART) than those who lacked stable housing, and among intravenous drug users (IDUs) on treatment, those with stable housing were 3.7 times more likely to achieve viral suppression (Knowlton, 2008). In fact, housing status is a more significant predictor of health outcomes than individual characteristics such as demographics, drug and alcohol use, and receipt of social services (Kidder, et.al, 2007; Aidala, 2007).

Housing assistance improves health regardless of co-occurring behavioral issues. 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 on-site supports (Wolitski, 2010; Larimer, 2009; Sadowski, 2009).

Housing status is perhaps the most important factor in determining HIV-positive persons' access to health care, their health outcomes, and how long they will live (Kidder, et.al., 2007;Aidala,et'al., 2007). A study by Riley, et.al., which empirically ranked factors that affected the health status of HIV-infected homeless and unstably housed women, found that unmet subsistence needs (i.e., food, hygiene, shelter) had the strongest effect on overall physical and mental health. In this population, an inability to meet basic subsistence needs had at least as much effect on overall health as adherence to antiretroviral therapy, suggesting that "…advances in HIV medicine will not fully benefit indigent women until their subsistence needs are met." (Riley, et.al, 2011)

Two random controlled trials – the first of their kind to examine housing as an independent determinant of health – have linked housing assistance to improved health outcomes for homeless and unstably housed persons with HIV and other chronic health conditions, as well as to sharp reductions in avoidable health care costs:

- The Housing and Health (H&H) Study conducted by the U.S. Centers for Disease Control and Prevention (CDC) and the HUD Housing Opportunities for Persons with AIDS

(HOPWA) program assessed 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 in Baltimore, Chicago, and Los Angeles between 2006 and 2008. At the end of the 18-month study period, only 18% of participants who got study vouchers remained homeless or unstably housed, compared to 49% of the comparison group. Despite high levels of baseline connection to case management (93%) and regular health care (85%), 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.[i] Even stronger differences were found in analyses that compared study participants who experience 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 detectable 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., 2010)

- In an 18-month randomized controlled trial, the Chicago Housing for Health Partnership (CHHP) – an integrated system of housing and supports for individuals with chronic medical illnesses who are homeless upon discharge from hospitalization – 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" (i.e., emergency shelters, family, and recovery programs). Among the one-third of CHHP study participants living with HIV/AIDS, those who received housing upon discharge from the hospital were almost twice as likely at 12 months to have an undetectable HIV viral load compared to HIV-positive participants randomly assigned to "usual care" (Buchanan, et.al., 2009). Overall, CHHP participants were three times more likely to achieve stable housing at 18 months than the usual care group with significantly fewer housing changes. 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).

Housing assistance for people living with HIV and other chronic illnesses not only improved health but is also is a key cost containment strategy. People coping with homelessness are frequent users of expensive crisis services including shelters, jails, and avoidable emergency and hospital care. (City of Toronto, 2006; Flaming 2009) For the chronically ill, many with co-occurring conditions, housing instability translates into poor health outcomes, inappropriate health care utilization, and mounting public costs.

The CHHP cost analyses show that improved housing stability for chronically ill persons reduces emergency, inpatient, and nursing home care costs by amounts that more than offset the costs of the housing intervention. Compared to "usual care," the CHHP housing program generated average net public cost savings of over $6000 per person (Basu, et.al, 2011). Evaluation of a Seattle program for homeless people with chronic alcohol addiction showed that a "Housing First" supportive housing model created stability, reduced alcohol consumption, and decreased health costs (53%), sobering center use (87%), and county jail bookings (45%) compared to a matched group who remained homeless (Larimer, 2009). The Toronto Streets to Home Post-

Occupancy study found that housing with appropriate supports not only improved the quality of life for formerly homeless individuals but also resulted in significant reductions in the use of costly emergency, health, and justice services (City of Toronto, 2006). 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. The average public costs for impaired homeless adults decreased 79% when they were placed 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 by persons with HIV/AIDS who moved from homelessness into housing (Flaming, 2009).

These analyses demonstrate the cost-effectiveness of housing assistance for persons with chronic illness even before taking into account the costs of HIV treatment failure and heightened HIV risk among people who are homeless. Each new HIV infection prevented through increased housing stability saves over $300,000 in lifetime medical costs (Schackman, 2006).

Findings show that housing is a cost-effective HIV health care intervention with a cost per quality adjusted life year (QALY) of $35,000 to $62,000, 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) (Holtgrave, 2011; see also Holtgrave et.al. 2007).

Current State and Federal Policy

Work is currently being done on the state level with support from federal guidelines and policy, marrying housing and healthcare services and resources. Some of these examples follow.

- The District of Columbia is using a 1915(c) waiver for one time transitional services including security deposits, furniture and linens, set-up fees or deposits for utilities
- Louisiana is using a 1915 (c) waiver for support in acquiring housing, budgeting, establishing credit, meeting tenancy obligations, communicating with landlords and providing assistance when housing is jeopardized.
- New York is using the Health Home State Plan Amendments (SPA) for comprehensive case management and partnering with supportive housing providers. New York is also using the Delivery System Reform Incentive Payment (DSRIP)/1115 waiver for supportive housing services
- Oregon is using the 1115 waiver to for support in locating and obtaining housing, care coordination, transitional services to a supported environment, case management and room and board
- Texas is using the DSRIP for supportive housing services, transitional housing services and patient navigators.
- Washington is using Section 2703 Health Home SPA for care coordination including referrals to housing resources.

An up-to-date list of strategies that states are employing to improve health through housing services can be found at https://www.statereforum.org/health-housing

The NAHC Advocacy Strategy

The research supports our goal of providing supportive housing based on chronic condition and financial need. Current scan of the environment shows that there is only one structure that provides services based on chronic condition and financial need – Medicaid. Also, research shows that there is a correlative connection between housing and improved health outcomes. Studies have shown that there is shared savings across local government agencies when there is an investment in housing as a structural medical intervention. NAHC will advocate for CMS to either include housing as a covered medical intervention or that they create a specific service category that bundles support and housing. This long-term goal would require both legislative and regulatory revisions.

In the short term NAHC will urge CMS to take an active role in implementation of their June 25, 2015, Bulletin, "*Coverage of Housing-Related Activities and Services for Individuals with Disabilities,"* providing technical assistance to communities that will maximize the referenced housing-related activities and services.

Maximizing coverage of housing-related activities and services is also the responsibility of states. NAHC will continue to lead and support efforts that educate states on the possibilities of comprehensive implementation of CMS's guidance by encouraging contractual and fiduciary partnerships that not only benefit people with chronic conditions and disabilities, but improve the sustainability of supportive service and health providers.

Moving forward, NAHC will partner with national health and housing entities to advocate for both the short-term goal of maximizing current opportunities to marry CMS supported services with housing and for a change in CMS for Medicaid to cover supportive housing operating costs and subsidies.

NAHC Action Steps

- Promote research showing the direct connection between housing and improved health outcomes;
- Showing the cost-effective business case at the community level where shared savings have been demonstrated when there is a targeted investment in housing; and
- Assisting states in developing strategies that invest savings generated from housing as a structural medical intervention into rental subsidies and supportive housing development.

[i] Over 50% of "usual care" comparison group members secured stable housing during the 18-month study period. This "cross-over" limited the ability to identify significant differences between the intervention and control groups. However, as housing stability improved for the group as a whole, so did health outcomes.