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the Network
Supportive Housing Network of NY

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Supportive Housing Network of New York
Ted Houghton, Executive Director

Good afternoon. My name is Ted Houghton, and I am the Executive Director of the Supportive Housing Network of New York. The Network represents more than 200 nonprofit providers and developers who operate over 43,000 supportive housing units throughout New York State, the largest supportive housing membership organization in the country.

Supportive housing – permanent, affordable housing linked to on-site services – is the proven, cost effective and humane way to provide stable homes to individuals and families who have difficulty finding and maintaining housing. The people we house and serve – people with mental illness, HIV/AIDS, substance abuse, and other barriers to independence – are typically frequent users of expensive emergency services like shelters, hospitals, prisons and psychiatric centers. Because placement into supportive housing has been proven to reduce use of these services, supportive housing saves State taxpayers' money, often far more than what was spent building, operating and providing services in the housing. This has been proven, time and time again, by dozens of peer-reviewed academic studies.

And although supportive housing was conceived as a response to homelessness and institutionalization, it has achieved great savings in this area of healthcare. Numerous studies have shown that by targeting chronically homeless individuals who are frequent users of emergency rooms, hospitals and medical detox programs, supportive housing can reduce inpatient Medicaid spending substantially and reduce emergency department and inpatient costs by 60%.

Some examples of this include:

- The University of Pennsylvania studied 4,679 homeless people with severe mental illness who were placed into supportive housing in New York City.[1] Looking at pre and post placement data, as well as a matched pair control group, the study found that those placed in supportive housing reduced their use of state psychiatric centers by 50%, and hospitals by 21%. While use of outpatient Medicaid went up as newly-housed people received medical and behavioral health treatment, inpatient Medicaid costs went down enough to produce overall Medicaid savings of $1,200 per person per year.

- The Chicago Housing for Health Partnership (CHHP) followed 407 chronically ill homeless persons (many living with HIV/AIDS) over 18 months following discharge from hospitals, with half placed in supportive housing and the other half receiving regular care. Supportive housing reduced hospital days by 46%, emergency department visits by 36%, and nursing home days by 50%. Placing 200 individuals into supportive housing saved $900,000 a year, minus the cost of housing.[2]

- In Seattle, supportive housing was provided to 95 homeless people with severe alcoholism, usually accompanied by other chronic illnesses.[3] Compared to a control group, the supportive housing residents reduced their total public costs by 74%, from $4,066 per person/month when homeless, to only $958/month after a year of being housed. Nearly 60% of these savings stemmed from a reduced need for medical services.

Because of this proven track record, supportive housing is naturally positioned to be partners in helping redesign New York's Medicaid system and help provide better coordinated care at a lower cost for this vulnerable population. This has most recently been acknowledged by the State's Medicaid Redesign Team (MRT) and demonstrated in the Governor's Executive Budget outlining efforts to expand supportive housing in 2012.

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[1] Culhane, D., Metraux, S., & Hadley, T. Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*. 2002;13(1):107-163.

[2] Sadowski, L., Kee, R., VanderWeele, T., & Buchanan, D. Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults: A Randomized Trial. *JAMA*. 2009;301(17):1771-1778.

[3] Larimer, M., Malone, D., Garner, M., Atkins, D. Burlingham, B., Lonczak, H., Tanzer, K., Ginzler, J., Clifasefi, S., Hobson, W. & Marlatt, A. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. *JAMA*. 2009;301(13):1349-1357.

I would like to briefly highlight for you today some of these initiatives:

1. Community Reinvestment

The Network agrees with other stakeholders that all savings from downsizing state institutional beds be reinvested into community services and supports, for both adults and children. The MRT recommends that "savings from better managed (Medicaid) behavioral and physical health care should be reinvested to the extent possible for improved outcomes and reduced health costs. (Such) reinvestment should prioritize non-clinical support services, such as housing, peer, employment, and family services."

We wholeheartedly agree. One immediate step that the Legislature could take would be to remove from the budget "notwithstanding" language that has prevented facility closure savings to be reinvested in community services for the past decade.

The system of care for disabled New Yorkers is undergoing a sweeping change toward preventive, community-based services and supportive housing. To ensure this transition is successful, all savings from improved manage care be reinvested in community supports such as supportive housing.

2. Supportive Housing Development Reinvestment Program

As part of its Phase II Recommendations, the MRT is suggesting both immediate and long term systematic changes to expand supportive housing for vulnerable people who are high-cost users of inpatient and emergency Medicaid services. One example of this is the establishment of a formal mechanism to set aside a portion of Medicaid and non-Medicaid savings related to any reduction of inpatient hospital, psychiatric center or nursing home capacity to a fund dedicated to supportive housing development. This recommendation has been accepted by the Governor and is included in the SFY 2012-13 Executive Budget by the establishment of a Supportive Housing Development Reinvestment Program.

The Supportive Housing Development Reinvestment Program will be used to fund housing development activities and other general programmatic activities to help ensure a stable system of supportive housing for vulnerable persons in the community. It will be funded by savings directly related to inpatient hospital and nursing home bed decertification and/or facility closure.

We fully support this recommendation and urge the Legislature to work with the Governor to see this recommendation implemented in this upcoming fiscal year.

2. Supportive Housing Program Targeted to Heavy Medicaid Users

To expand supportive housing opportunities for high-cost recipients of Medicaid and institutional care, the Department of Health has also allocated an annual appropriation of $75 million in the State budget for the creation and operation of supportive housing for high-cost Medicaid recipients. Developing a supportive housing program targeted to heavy Medicaid users is likely to return the greatest savings to the state, local and federal governments in terms of reduced hospitalizations, reduced lengths of stay in long term care facilities, and unnecessary Emergency Room visits as well as improved outcomes from supportive services provided in stable, affordable housing. A portion of the $75 million allocation will be transferred to the Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Temporary and Disability Assistance (OTDA) and Homes & Community Renewal (HCR) for distribution through OTDA's Homeless Housing and Assistance Program (HHAP), OMH programs and HCR's Housing Trust Fund and tax-exempt bond programs.

In order to truly expand housing opportunities for vulnerable and expensive users of public services, the MRT funds must add to, rather than replace, funding from these state agencies that is currently used for Supportive Housing.

The Network fully supports this initiative and strongly suggests that the $75m in MRT funds leverage additional capital and operating funds from other state agencies, localities and federal resources in order to reach a substantial percentage of the target population.

3. MRT 1115 Medicaid Waiver

A third recommendation the MRT has made significant to supportive housing is to include funding for ongoing housing-based services and operating costs in the State's MRT 1115 Medicaid waiver application to be submitted by the State to the U. S. Centers for Medicaid and Medicare Services in 2012.

People who are stably housed with sufficient services and resources to maintain that housing and the ability to receive needed services through their housing are much more likely to achieve expected outcomes such as health maintenance, reduced drug and alcohol abuse, and medication management. However, it is not enough to provide funding to support the development of additional housing units. Individuals must be able to transition to housing, pay the rent and access the support services they need to manage their condition. Expanded funding to support these costs is essential to the success of supportive housing and therefore, the state is proposing to include funding for ongoing housing-based services and operating cost in the 1115 Medicaid waiver application.

The Network supports exploring the use of an 1115 Medicaid waiver to fund services in supportive housing. This may be just the type of funding stream that will ensure that all people with disabilities and high healthcare costs have access to the services and subsidies they need to remain housed. But it's important to acknowledge that the services in supportive housing are so successful because they are adequately funded. Providers can deliver wraparound, comprehensive services and supports that do whatever it takes to keep people housed and healthy. Health home care coordination of healthcare can be an important part of these services, especially when delivered by housing providers fully integrated into case management efforts. But health homes cannot replace existing housing-based services. Whether funded through State general funds, as they are now, or partially through a Medicaid 1115 waiver, supportive housing services and supports need to continue to be funded under contract with State agencies to ensure that each residence have adequate, dedicated rental subsidies and services. We urge you to make sure the State does not back away from its current commitments to fund supportive housing, so that members of what will be a challenging population to house receive the care they need to succeed.

There are populations in need of supportive housing that are not high-cost users of Medicaid. Supportive housing has been, and must continue to be, a successful intervention for these households.

The MRT Affordable Housing workgroup identified and highlighted in its recommendations the importance of not working in silos or overly restricting use of supportive housing solely as a cost-savings model.

The report noted that "even those supportive housing eligible households who are not currently high-cost Medicaid users often belong to populations that

tend to be either high-cost users of other systems (for example, public hospitals, the criminal justice system and shelter systems) and/or at-risk of being high-cost users of Medicaid should their housing crises continue....There are certain groups who are not currently high-cost users of Medicaid, such as persons with HIV and persons at highest risk of HIV, who will become high-cost users in future years without appropriate interventions, which may include affordable or supportive housing."

I mention this today, because while the State is identifying Supportive Housing as an important Medicaid reform tool and is taking steps to expand supportive housing for these purposes, the Executive Budget underfunds the basic housing based services in existing supportive housing residences currently serve over 16,000 formerly homeless adults and children. Preserving this existing State funding will ensure that leveraged funding sources remain available and that services continue to be effective and allow the State to lower Medicaid and other State spending on additional members of high-cost populations. We must make sure not to neglect one vulnerable population over another.

Conclusion

Targeted investments in supportive housing for high-need, high-cost Medicaid populations can be an effective strategy for reducing Medicaid spending and improving care. We commend the Department of Health, as well as OMH and OASAS, for their tireless efforts in redesigning the Medicaid system. We believe that they are really doing their best to develop an improved system that provides better health outcomes for vulnerable people, while lowering costs to taxpayers.

While much will depend on how these recommendations are implemented over the next year, the State's supportive housing initiatives are likely to set the State firmly on the path of expanding access to supportive housing for vulnerable people who are high-cost users of inpatient and emergency Medicaid services. When put into place, these actions will yield substantial taxpayer savings, while improving the quality of life for thousands of New Yorkers with behavioral health issues and chronic conditions.

As the State continues to develop plans to lower Medicaid costs and improve care, I hope that the Legislature will do all it can to ensure that there is an explicit focus on reinvestment in robust community supports like the expansion of supportive housing opportunities for vulnerable populations.

Thank you for this opportunity to testify.

Respectfully submitted by:

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