

Gimme Shelter: Permanent Supportive Housing is Health Care for People Living With HIV/AIDS

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Capstone 2014

Abstract

Housing instability and HIV-positive status are inextricably linked. Permanent supportive housing (PSH) is an intervention to address chronic homelessness. Individuals who transition from housing instability to PSH experience an improvement in their health. Evidence has shown that PLWHA who have stable housing are more likely to obtain medical care and are better able to adhere to their antiviral therapy and related medical care. PSH dramatically reduces both HIV/AIDS mortality and the transmission of HIV. The cost of PSH roughly offsets the public costs to hospitals, mental health services, corrections, and the Department of Veterans Affairs (VA) that tenants living with HIV/AIDS would incur without housing. Despite the efficacy of the PSH model, federal funding for PSH is insufficient to meet the needs of housing-unstable and homeless PLWHA. As a result, thousands of Americans remain on PSH waiting lists. This Article argues that society has a responsibility to correct for special disadvantages resulting from the social lottery. It argues that PSH is such a remedy. Ultimately, this Article avers that PSH is a key element in the holistic treatment of housing-unstable PLWHA and advocates for increased federal funding for HIV/AIDS-specific PSH.

INTRODUCTION

Suppose for a moment that the world is your oyster. You received a full ride to a top university. You begin a successful career that allows you to travel the world. Out of nowhere, your life turns on its head. Suddenly you are thin as a rail and have what feels like the worst flu of your life. You are diagnosed with the human immunodeficiency virus (HIV). You begin to miss work, and soon lose your job as a result of your declining health. Because of your illness, you struggle to find and keep a job. Because you cannot keep a job, you cannot pay your rent and lose your home. When you do not have a place to stay the night, you sleep on a bench in the park or on the street. You grow sicker every day.¹

Since the dawning of the human immunodeficiency virus (HIV) epidemic thirty years ago, HIV and chronic housing instability² have been inextricably linked.³ In 2011, advocates estimated that there were 145,366 people living with HIV/AIDS (“PLWHA”) who required housing assistance.⁴ While 7% of the U.S. population at large will experience homelessness in their lifetime,⁵ at any given time, one-third to one-half of the more than 1.1 million people estimated to have HIV/AIDS in the United States (U.S) are either homeless or in imminent danger of losing their homes.⁶ Similarly, the prevalence of HIV infection has been shown to be 3 to 9 times higher among people in an unstable housing situation compared to those in stable and adequate housing.⁷ The social and cultural stigmatization and discrimination of PLWHA makes maintaining both stable housing and employment challenging.⁸ Unemployment decreases financial agency, which in turn increases a person’s risk of homelessness. Unstable housing is also a significant barrier to access to medical care and adherence to the rigors of an effective antiretroviral regimen.⁹ PLWHA who

¹ This vignette is based loosely on a testimonial available at: JERUSALEM HOUSE, *Success Stories*, <http://www.jerusalemhouse.org/success-stories/> (last visited March 12, 2014) [hereinafter *Success Stories*].

² The Stewart B. McKinney Homeless Assistance Act, 42 U.S.C. §11301 (1994) (classifying a person as homeless if he or she “lacks a fixed, regular, and adequate night-time residence...and has a primary night time residency that is (A) a supervised publicly or privately operated shelter designed to provide temporary housing accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings”).

³ NAT’L HEALTH CARE FOR THE HOMELESSNESS COUNCIL, *HIV/AIDS Homelessness: Recommendations for Clinical Practice and Public Policy*, (Nov. 1999), <http://www.nhchc.org/wp-content/uploads/2011/10/AIDS-Homelessness.pdf>.

⁴ U.S. DEP’T OF HOUSING & URBAN DEV., *Unmet HOPWA Needs PY2010-2011*, available at: http://portal.hud.gov/hudportal/documents/huddoc?id=hopwa_unmet_need.xls.

⁵ North American Primary Care Research Group, *P265: Cancer Screening in Individuals Experiencing Homelessness in Minnesota* (Nov. 15, 2010), available at www.napcrg.org/conferences/annualmeeting/meetingabstracts/2010annualmeeting?SID=8955.

⁶ CTR’S FOR DISEASE CONTROL & PREVENTION, *HIV in the United States: At a Glance*, www.cdc.gov/hiv/statistics/basics/ata glance.html (last visited Apr. 21, 2014) (the CDC estimates that 15.8% of the more than 1.1 million PLWHA in the United States do not know that they are infected, making it difficult to track the exact number of PLWHA who are homeless).

⁷ Angela A. Aidala, *Homeless, Housing Instability and Housing Problems among Persons Living with HIV/AIDS*, Address at the NAHC Research Summit (2005).

⁸ *See, e.g.*, Estate of Mauro v. Borgess Medical Ctr., 137 F.3d 398, 402 (6th Cir 1998).

⁹ Angela A. Aidala, *Housing Need, Housing Assistance, and Connection to HIV Medical Care*, 11 AIDS BEHAV. S101 (2007).

experience housing instability or homelessness have an 80% higher rate of mortality than those who are in stable housing.¹⁰

Health is necessary to maintain normal functioning over the course of our lives.¹¹ In recent years, advocates like Norman Daniels have taken a more holistic approach to defining human health needs, or “those things we need to maintain, restore, or provide functional equivalents (where possible) to normal human functioning.”¹² Population health is shaped less by the individual choice, however, and far more by social determinants.¹³ People on the lower end of the socioeconomic spectrum are disproportionately more likely to be in poor health and to have HIV than their more economically stable counterparts.¹⁴

Daniels writes that, as a matter of social justice,¹⁵ individuals should have a fair share of the normal opportunity range.¹⁶ It follows that society should correct for special disadvantages that stem from the social lottery, such as underdeveloped talents and skills.¹⁷ Distributive justice theorist John Rawls concluded that in order to ensure “fair equality,” society must implement measures to mitigate the effects of the social contingencies and inequalities that spring from the social lottery.¹⁸ If society worked to the advantage of all, then the distributions of what Rawls calls primary goods¹⁹—those things that are necessary to achieve fair equality of opportunity—and the resulting life prospects of individuals would be the outcome of a fair process.²⁰ Daniels extends Rawls’ theory of justice as fairness by adding health to Rawls’ list of primary goods.²¹ Health is of special importance because it helps us preserve our status as fully functioning members of society.²² Yet, in a society in which resources are finite, there must be a limit to the extent that we protect health. Daniels sets the necessary parameters, and argues that health inequities are only inequitable when they are “avoidable, unnecessary and unfair.”²³ Furthermore, the measures we take must be effective, efficient, and cost-effective.²⁴

¹⁰ D. Kidder et al., *Housing status and HIV risk behaviors among homeless and housed persons with HIV*, 49 JAIDS 451–5 (2008).

¹¹ Norman Daniels, *JUST HEALTH* 37 (Cambridge University Press, 1st ed. 2007).

¹² *Id.* at 42–43: (Identifying a broad, diverse set of health needs, including but not limited to: 1) preventive, curative, rehabilitative, and compensatory personal medical services; 2) nonmedical personal and social support services; 3) adequate nutrition; 4) sanitary, safe, unpolluted living and conditions; 5) avoiding substance abuse and practicing safe sex; and 6) an appropriate distribution of other social determinants of health).

¹³ Norman Daniels, Bruce P. Kennedy & Ichiro Kawachi, *Justice, Health, and Health Policy*, in *ETHICAL DIMENSIONS OF HEALTH POLICY* 8 (Marion Danis et. al eds., Oxford University Press 2002).

¹⁴ *Id.*; DANIELS, *supra* note 11, at 58.

¹⁵ *Id.* at 46.

¹⁶ *Id.* at 43 (defining the normal opportunity range as the array of life plans reasonable persons are likely to develop for themselves in a given society).

¹⁷ *Id.* at 44–45.

¹⁸ *Id.* at 49.

¹⁹ *Id.* at 50 (John Rawls counted liberty, opportunity, income, wealth, and the bases of self-respect among social primary goods).

²⁰ *Id.* at 51.

²¹ *Id.* at 57.

²² *Id.*

²³ *Id.* at 89.

²⁴ *Id.* at 253, (listing these parameters, and cautioning that efficiency can distort our analysis by overemphasizing a bottom line, but the systems that promote health must nevertheless be efficient to promote normal functioning).

Under Daniels’ extension of Rawls’ theory, society should, to the extent that our resources allow, remedy inequities that perpetuate the spread of HIV/AIDS.²⁵ As discussed above, individual, voluntary, and uninformed choices are not solely responsible for homelessness and HIV-positive status—people of low socioeconomic status are disproportionately more likely to be homeless and contract HIV.²⁶ As we will see in Part I(B) of this paper, this linkage is one for which a remedy is available. Daniels’ “avoidable, unnecessary, and unfair” framework therefore informs us that the link between HIV and homelessness is an inequitable one that society should remedy.

This paper demonstrates that housing stability protects the health of people living with HIV, breaks the causal link between HIV and housing instability, and promotes equal opportunity. It demonstrates that supportive housing meets Daniels’ criteria. It shows that current funding for supportive housing are inadequate, and that greater support is necessary. Finally, it recommends a comprehensive solution to housing instability among people living with HIV/AIDS.

I. HOUSING FIRST

A. THE BIRTH OF A MOVEMENT

Since the passage of the Housing Act of 1937, the United States Federal Government has provided for subsidies to help improve the living conditions of low-income families.²⁷ The resulting subsidies have funded several public housing agencies’ housing assistance programs, including emergency shelter or short-term rent, mortgage, and utility payments.²⁸ Early governmental efforts to aid the homelessness population were based predominantly on a disease model approach.²⁹ The disease model approach required that unstable individuals achieve stability through healthcare treatment before they could qualify for housing aid.³⁰ The model’s founding principle—treat first, house later—was fatally flawed. Repeat hospitalizations always ended the same way: patients were discharged back to the streets. This cycle led people to become disenchanted about treatment, often leading them to refuse it altogether.³¹ When people refused treatment under the disease model, they were disqualified from receiving housing aid.³² In order to become psychiatrically stable, clean, and sober, people experiencing housing instability or homelessness would need services beyond hospitalization.³³

²⁵ *Id.* at 57.

²⁶ *Id.* at 90.

²⁷ The Housing Act of 1937, Pub.L. 75–412, 50 Stat. 888.

²⁸ Diane Glauber, *The Evolution of Supportive Housing*, NATIONAL HOUSING INSTITUTE, <http://www.nhi.org/online/issues/88/suphousing.html>, (last visited Mar. 28).

²⁹ Wendy Evans, *Housing First: An Interview with Sam Tsemberis*, HOMELESSNESS RESOURCE CENTER: SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *available at* <http://homeless.samhsa.gov/Resource/Housing-First-An-Interview-with-Sam-Tsemberis-54965.aspx> (last visited Apr. 2).

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ *Id.*; Rachael Kenney, *Spotlight: PATH and Housing First*, PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS: SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (2008), *available at* <http://pathprogram.samhsa.gov/resource/spotlight-path-and-housing-first-37886.aspx>.

Despite the deep flaws in this model, it was not until the late 1980s that the national dialogue about how to aid the chronically homeless began to change its course. A new approach, called “Housing First,” emerged. Based on the proposition that housing is a right to which all are entitled, Housing First attacked homelessness at its roots by providing individuals with permanent housing and supportive services as quickly as possible. Today, the model that emerged out of the Housing First movement is called permanent supportive housing.

Although there are slight variations in how the permanent supportive housing (sometimes called supported housing) model is executed,³⁴ certain elements are consistent across all applications. Permanent supportive housing (PSH) providers always address the primary need of stable housing first.³⁵ This means that people qualify to move into housing without a precondition of treatment acceptance or compliance. Rather than unilaterally placing participants in housing, PSH providers involve participants in the process of selecting a residence.³⁶ This element is important because greater autonomy in selecting a residence is positively correlated with participation satisfaction and future housing stability.³⁷

PSH providers are obligated to bring robust support services to housing. These services are typically administered through an integrated comprehensive care model. A tenant’s primary care provider will collaborate with his or her case manager, social worker, and other care providers to treat and support that tenant.³⁸ Services such as medication management and optimization, crisis management, nutrition, dental, and substance abuse care, and even peer-support are hallmarks of the PSH model.³⁹ Some programs even provide support for finding and continuing employment, reconnecting with family and participating in the greater community.⁴⁰ These services and support programs are provided in the home and other normal day-to-day settings.⁴¹ By helping tenants learn and practice skills in the environment where they will use them, the PSH model helps encourage self-sufficiency. Although a patient’s participation in these services is based on assertive engagement, and continued tenancy is not based on participation, PSH tenants may lose their housing due to

³⁴ Martha R. Burt, Carol Wilkins & Danna Mauch, *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Literature Synthesis and Environmental Scan*, U.S. DEP’T OF HEALTH & HUMAN SERVICES (Jan 6, 2011) (explaining that permanent Supportive Housing includes single-site, all-PSH housing; single-site, mixed-use housing, scattered-site housing, and clustered-scattered housing. Configurations also range from a single agency providing housing and most services, including case management, to multiple agencies coordinating or working as a team, to a housing agency running the program).

³⁵ See BAZELON CENTER FOR MENTAL HEALTH LAW, *Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities*, 1, 2 (2009), <http://www.bazelon.org/LinkClick.aspx?fileticket=eRwzUzZdIXs%3D&tabid=126>; NATIONAL ALLIANCE TO END HOMELESSNESS, *Organizational Change: Adopting a Housing First Approach*, <http://www.endhomelessness.org/library/entry/organizational-change-adopting-a-housing-first-approach> (Aug. 24, 2009).

³⁶ *Id.*, at 3.

³⁷ *Id.*; NELSON, GEOFFREY, JOHN LORD, & JOANA OCHOCA, *SHIFTING THE PARADIGM IN COMMUNITY MENTAL HEALTH: TOWARD EMPOWERMENT AND COMMUNITY* 21 (Univ. of Toronto Press, 1st ed. 2001).

³⁸ See BAZELON, *supra* note 35, at 2.

³⁹ *Id.*

⁴⁰ *Id.*; See Generally, AIDS HOUSING OF WASHINGTON, *Creating Supportive Housing for People Living With HIV/AIDS: Local Lessons, National Strategies*, 1 http://wagner.nyu.edu/files/leadership/AIDS_Housing_Washington.pdf.

⁴¹ See BAZELON, *supra* note 35, at 2.

disruptive behavior. PSH providers try and avoid such situations through supports and extra accommodations.⁴²

There is no time limit on a tenant's stay under the PSH model.⁴³ If the ultimate goal is to create a supportive environment that can help patients better utilize preventive services and adhere to the sometimes-rigorous requirements of their chronic health challenges, then a time cap on participation is the antipode of that goal. If a tenant has made improvements and loses his or her housing, or perhaps is on the verge of a breakthrough, then the worst thing a system can do is remove supports. Just as people qualify to move into housing without a precondition of treatment acceptance or compliance, treatment compliance, sobriety, and even temporary absences from residency do not lead to disenrollment.⁴⁴ This element is particularly important because it compensates for the recidivist reality of substance abuse and addiction.⁴⁵

It is not enough for a tenant to simply continue to qualify to stay in housing; he must be able to afford his stay as well. Housing advocates agree that affordable housing requires a tenant's rent be capped at or below 30% of the participant's income.⁴⁶ PSH providers rely on grant money to subsidize the remainder of the Federal grant, and to ensure that 30% cap on participant contribution can be maintained.

B. AN EFFECTIVE SOLUTION

The care and support offered by PSH programs help to break the cycles of both homelessness and HIV transmission. The Permanent Supportive Housing (PSH) model both increases the health of PLWHA and reduces the transmission HIV. PLWHA who have stable housing are four times more likely to obtain medical care than those who remain housing unstable.⁴⁷ They are able to better adhere to their antiviral therapy and related medical care, lowering their viral load to an undetectable level.⁴⁸ Over the course of five years in stable housing, there is an 80% reduction in AIDS mortality.⁴⁹ Housing stability also halts the spread of HIV. Improved housing status reduces HIV risk behaviors in PLWHA by as much as half.⁵⁰ Maintaining one's viral load at an undetectable level also reduces the risk of transmitting the disease by 96%.⁵¹ If every person with HIV could reduce her viral load to an undetectable level, we could virtually eliminate the risk of

⁴² *Id.* at 2.

⁴³ *Id.* at 1.

⁴⁴ *Id.*

⁴⁵ Alexis Schroeder, *Joe Finn on the Housing First Movement and Long-Term Solutions to Homelessness (Part 1 of the MHSA Story)*, THE NEW PROSPERITY, <http://thenewprosperity.org/2010/01/joe-finn-on-the-housing-first-movement-and-long-term-solutions-to-homelessness-part-1-of-the-mhsa-story/>.

⁴⁶ NEW MEXICO BEHAVIORAL HEALTH COLLABORATIVE, *What is Supportive housing?* <http://www.bhc.state.nm.us/pdf/SupportHouseInfo.pdf>; GOVERNOR ANDREW M. CUOMO, *Governor Cuomo and Mayor De Blasio Announce Affordable Housing Protection for Low-Income New Yorkers Living with HIV/AIDS*, (Feb. 13, 2014) <https://www.governor.ny.gov/press/02132014-affordable-housing-protection>.

⁴⁷ SAN FRANCISCO AIDS FOUNDATION, *Housing Support*, <http://www.sfaf.org/client-services/housing-support/> (last visited Apr. 10, 2014).

⁴⁸ Kidder, *supra* note 10.

⁴⁹ *Id.*

⁵⁰ Angela Aidala et. al, *Housing status and HIV risk behaviors: Implications for prevention and policy* AIDS AND BEHAVIOR (2005).

⁵¹ Mark Mascolini, *HIV Transmission Risk Essentially 0 if Heterosexual Partner Has Undetectable Viral Load*, http://www.natap.org/2013/HIVwomen/HIVwomen_01.htm (last visited Apr. 11, 2014).

spreading the disease and stop it in its tracks.⁵² Stable housing decreases a person's risk of both transmitting and contracting the virus.⁵³ These numbers show that housing saves lives, but the PSH model accomplishes even more in terms of promoting equal opportunity.

When people are supported in permanent housing environments rather than merely targeted for services on streets or in shelters, they are able to move toward autonomy, personal responsibility, and ultimately self-sufficiency.⁵⁴ The stories told by PLWHA who have lived in supportive housing share a common trope: they are empowered by the supports available through the PSH model. They are able to pursue an education, reenter the workforce, and reconnect with their family and community. The scenario presented at the beginning of this paper was based on the real experience of a PLWHA, Andrew.⁵⁵ Andrew was diagnosed with HIV in 2007. He lost his job and fluctuated between housing instability and homelessness. In 2009, he moved into a home provided by Jerusalem House, the oldest and largest provider of PSH for PLWHA and their families in Atlanta.⁵⁶ Only a year later, he was studying for the LSAT and applying to law school, his goal since graduating from Wake Forest University.⁵⁷ He credits the PSH model for helping him regain his self worth and focus, a common trope among PSH participants.

The PSH model advances fair equality of opportunity for PLWHA by dramatically improving the health outcomes, but its supportive services also further equality of opportunity in access to jobs and education. Supportive housing treats the whole person, and the treatment works.

II. CURRENT SUPPORT

We have seen that supportive housing is transformative and that there is a strong correlation between housing stability and positive health outcomes. Nevertheless, there is no guarantee that the 145,366 PLWHA who need housing assistance will have access to permanent supportive housing programs, let alone healthcare.⁵⁸ Part II of this paper discusses the federal programs that fund housing for which people living with HIV/AIDS (PLWHA) are eligible. It describes how grants may be used, how much funding is available, and why current support is insufficient for adequately remedying the HIV/AIDS homelessness problem under Norman Daniels' equal opportunity framework.

A. FEDERAL PROGRAMS FUNDING HOUSING AND RELATED SERVICES

⁵² Aidala et. al, *supra* note 50; AIDS.gov, *What is Viral Load?*, <http://aids.gov/hiv-aids-basics/prevention/reduce-your-risk/blood-transfusions-organ-donation/> (last visited March 10, 2014).

⁵³ *Id.*

⁵⁴ See THE DISTRICT OF COLUMBIA, *Permanent Supportive Housing*, <http://dhs.dc.gov/service/permanent-supportive-housing> (last visited Apr. 14, 2014); see also BROWARD.ORG, *HUD Supportive Housing*, <https://www.broward.org/HumanServices/FamilySuccess/Pages/HARTSupportiveHousing.aspx> (last visited Apr. 13, 2014).

⁵⁵ *Success Stories*, *supra* note 1.

⁵⁶ JERUSALEM HOUSE, <http://www.jerusalemhouse.org/> (last visited March 12, 2014).

⁵⁷ *Success Stories*, *supra* note 1.

⁵⁸ THE NAT'L AIDS HOUSING COALITION, *HOPWA 2014 Budget Request: NAHC recommends \$365.2 million*, <http://www.nationalaidshousing.org/PDF/2014HOPWANeedPaper> (last visited Apr. 13, 2014).

The Ryan White program is the single largest federal program designed specifically for PLWHA in the United States.⁵⁹ The program works with cities, states, and local community-based organizations to improve access and retention to high quality care and treatment for PLWHA who have insufficient or no health care coverage or other financial resources, and often collaborates with HOPWA.⁶⁰ Historically, the program's funds supported primary and specialized medical care and essential support services to people living with or at high risk of HIV.⁶¹ As research has illuminated the essentiality of stable housing on health outcomes, organizations like the National Association for Home Care & Hospice have advocated for the allowance of Ryan White funds to keep people stably housed.⁶² In 2011, The Health Resources and Services Administration (HRSA) formally recommended the use of Ryan White funding for housing referral services and short-term or emerging housing without a limit on benefits.⁶³ HRSA acted in response to comments from the public concerning the ramifications of a limit on benefits on patient-tenants who rely on such funding.⁶⁴ A small portion of the program's funding now supports programs that help prevent and end homelessness, such as housing support services, and health care and medication support.⁶⁵ Federal funding for the Ryan White program totaled \$2,273,215,474 in 2013.⁶⁶ The program is estimated to reach more than half a million PLWHA each year.⁶⁷

Although the Ryan White program supports HIV/AIDS housing, the U.S. Department of Housing and Urban Development (HUD) is the largest source of funding for HIV/AIDS housing.⁶⁸ HUD specifically addresses HIV/AIDS homelessness and housing instability through Housing Opportunities for Persons With AIDS (HOPWA). HOPWA serves as a safety net for PLWHA who are also battling housing instability. It provides competitive and formula grants to all 50 states.⁶⁹ These grants may be used to provide: (1) housing—including short- and long-term rental assistance, live-in medical facilities, and housing sites created for PLWHA; (2) social services; (3) program planning; (4) development costs; (5) rental assistance; (6) health care and mental health services; (7) chemical dependency treatment; (8) nutritional services; (9) case management; and (10) assistance with daily living; among other supportive services.⁷⁰ Two-thirds of HOPWA expenditures fund housing assistance and 20% fund supportive services.⁷¹ HOPWA funds programs beyond PSH, including supportive services in emergency shelters and transitional housing. These can involve

⁵⁹ THE HENRY J. KAISER FAMILY FOUNDATION, *The Ryan White Program* (Mar 5, 2013) <http://kff.org/hivaids/fact-sheet/the-ryan-white-program/>.

⁶⁰ U.S. DEP'T OF HEALTH & HUMAN SERVICES, *About the Ryan White AIDS Program* <http://hab.hrsa.gov/abouthab/aboutprogram.html>.

⁶¹ *Id.*; U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 60.

⁶² *Id.*

⁶³ HIV/AIDS Bureau Policy Notice 11-01, 76 Fed. Reg. 92, 27649.

⁶⁴ *Id.*

⁶⁵ *Id.*; U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 60.

⁶⁶ KAISER FAMILY FOUNDATION, *Total Federal HIV/AIDS Grant Funding*, <http://kff.org/hivaids/state-indicator/total-federal-grant-funding/> (last visited Apr. 5, 2014).

⁶⁷ KAISER FAMILY FOUNDATION, *supra* note 59.

⁶⁸ Including the McKinney-Vento Homeless Assistance Act programs, as well as the separately authorized HUD-VA Supportive Housing, and Housing Opportunities for Persons with AIDS (HOPWA).

⁶⁹ AIDS UNITED, *Housing Opportunities for People with AIDS*, 1 (Mar. 2012) available at http://www.aidsunited.org/uploads/docs/HOPWA_Letter.pdf (commenting to the House Committee on Transportation Housing and Urban Development).

⁷⁰ KAISER FAMILY FOUNDATION, *supra* note 66.

⁷¹ THE NATIONAL AIDS HOUSING COALITION, *supra* note 58.

limiting the length for which PLWHA may participate.⁷² Such limitations mean that they are not replacements to PSH, but they remain important safety nets.⁷³

Overall U.S. federal funding for PLWHA has steadily increased over the past several years, whereas HOPWA funding has plateaued. In fiscal year 2012, the U.S. Federal Government provided \$27.8 billion total in HIV/AIDS grant funding,⁷⁴ and of that total, \$332 million in HOPWA funding. While total HIV/AIDS grant funding increased to \$28.2 billion in fiscal year 2013, HOPWA funding remained at \$332 million.⁷⁵ In fiscal year 2014, total HIV/AIDS grant funding increased to \$29.7 billion,⁷⁶ while HOPWA funding stayed constant at \$332 million.⁷⁷ This investment is insufficient to meet the housing needs of PLWHA. HIV/AIDS housing advocates have recommended that Congress increase federal HOPWA funding to a level as high as \$380 million.⁷⁸ This suggested increase would ensure that an additional 12,000 households affected by HIV that are currently in need would receive housing support.⁷⁹

The current funding level not only precludes PSH providers from aiding all of the PLWHA who would benefit from PSH, but it also often limits the ability of PSH providers to ensure that housing can be offered at an affordable price. Although advocates agree that affordable housing requires tenant rent to be capped at or below 30% of his or her income,⁸⁰ maintaining that 30% cap requires that subsidies cover the remainder of the cost. Because funding is insufficient, some PLWHA are required to pay up to 70% of the cost of housing, which they often cannot afford.⁸¹

The U.S. Department of Housing and Urban Development is the largest source of funding for housing for the homeless at large.⁸² The McKinney-Vento Homeless Assistance Act authorizes three Continuum of Care Homeless Assistance Programs that are administered through HUD: 1) the Section 8 Moderate Rehabilitation Single Room Occupancy Program; 2) the Shelter Plus Care program; and 3) the Supportive Housing Program.⁸³

⁷² See, e.g., LOS ANGELES HOUSING + COMMUNITY INVESTMENT DEP'T, *New HOPWA RFP Released*, <https://lahd.lacity.org/lahdinternet/PersonswithHIVAIDS/tabid/88/language/en-US/Default.aspx> (noting that a PLWHA may typically reside in emergency shelter for up to thirty days or transitional housing for up to two years).

⁷³ These temporary safety nets may be particularly important when there are waiting lists to access PSH.

⁷⁴ KAISER FAMILY FOUNDATION, *U.S. Federal Funding for HIV/AIDS: The President's FY 2014 Budget Request*, (Jan. 22, 2014) <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-the-presidents-fy-2014-budget-request/>.

⁷⁵ OFFICE OF MANAGEMENT & BUDGET, *Fiscal Year 2013 Budget of the U.S. Government*, (2013) available at <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf>.

⁷⁶ KAISER FAMILY FOUNDATION, *supra* note 74.

⁷⁷ OFFICE OF MANAGEMENT & BUDGET, *Fiscal Year 2014 Budget of the U.S. Government*, (2014) available at <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf>.

⁷⁸ AIDS UNITED, *supra* note 69.

⁷⁹ *Id.*

⁸⁰ NEW MEXICO BEHAVIOR, *What is Supportive Housing?* <http://www.bhc.state.nm.us/pdf/SupportHouseInfo.pdf> (last visited Apr. 12, 2014); New York Governor Andrew Cuomo, *Governor Cuomo and Mayor De Blasio Announce Affordable Housing Protection for Low-Income New Yorkers Living with HIV/AIDS* (last visited Apr. 3, 2014), <https://www.governor.ny.gov/press/02132014-affordable-housing-protection> (Feb. 13, 2014).

⁸¹ *Id.*

⁸² Including the McKinney-Vento Homeless Assistance Act programs, as well as the separately authorized HUD-VASH Supportive Housing, and Housing Opportunities for Persons with AIDS (HOPWA).

⁸³ *Id.* (Programs of note beyond the Continuum of Care programs include the HUD-Veterans Affairs Supportive Housing (HUD-VASH) program, the Homelessness Prevention and Rapid Re-Housing Program (HPRP), and the

The first of these, Section 8 Moderate Rehabilitation Single Room Occupancy (SRO) Program, aids low-income Americans in need of housing assistance, including those for PLWHA.⁸⁴ HUD to enter into annual contracts with public housing agencies and nonprofit organizations to help moderately rehabilitate residential properties. Public housing agencies make rental assistance payments to participating landlords to help with tenant's rent.⁸⁵ Under the program, a unit's rent must be within the fair market limit defined by HUD.⁸⁶

To say that Section 8 housing has a waiting list would be a gross understatement.⁸⁷ HUD recommends that public housing agencies close the waiting list for Section 8 housing altogether when it has "insufficient funds available to assist all applicants on the waiting list over a reasonable period of time,"⁸⁸ and indeed, in many cities, such as Seattle, Sacramento, and San Francisco, the waiting list is closed.⁸⁹ In cities where the waiting list is open, circumstances are not much better. In 2009, 127,825 people were on the Section 8 waiting list in New York City.⁹⁰ The same year in Washington D.C., there were 28,000 families on the waiting list—with an expected eight-year wait.⁹¹ Section 8 housing is not supportive housing. Some Section 8 programs will automatically deny applicants for current use of illegal drugs, or a record indicating alcohol abuse.⁹² They also do not allow easy reentry for those who were previously terminated from the program.⁹³ Although supportive services are typically not integrated into Section 8 programs, making the program an inadequate solution to PSH for many PLWHA, when available, it does provide a home. As discussed above, that home can improve the health of PLWHA and reduce the transmission of HIV.⁹⁴

Emergency Solutions Grants (ESG) Program. HUD-VASH has combined housing choice voucher rental assistance with case management and clinical services (provided by the VA) for homeless veterans since 2008. In 2011 alone, \$50 million was appropriated to serve about 7,000 voucher families. The ESG Program funds are available for street outreach, emergency shelter, homelessness prevention, rapid re-housing assistance, and data collection through the Homeless Management Information System or HMIS).

⁸⁴ *Housing Choice Vouchers*, NATIONAL AIDS HOUSING COALITION, <http://nationalaidshousing.org/legisadvocacy/section/> (last visited Apr. 12, 2014).

⁸⁵ These assistance payments are usually the difference between 30 percent of the tenant's adjusted income and the unit's rent, participating landlords on behalf of otherwise homeless individuals who rent the spaces.

⁸⁶ THE U.S. DEP'T OF HOUSING & URBAN DEV., Section 8 Moderate Rehabilitation Single Room Occupancy (SRO) Program, <http://portal.hud.gov/hudportal/HUD?src=/hudprograms/sro> (last visited Apr. 12, 2014).

⁸⁷ Dan Gorenstein, *Section 8 Shortfall Leaves Thousands Waiting*, NATIONAL PUBLIC RADIO (Aug. 22, 2009) <http://www.npr.org/templates/story/story.php?storyId=112080752>.

⁸⁸ THE U.S. DEP'T OF HOUSING & URBAN DEV., *Waiting List and Tenant Selection*, HOUSING CHOICE VOUCHER PROGRAM GUIDEBOOK, http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_11748.pdf.

⁸⁹ *See, e.g.*, SEATTLE HOUSING AUTHORITY, *Housing Choice Voucher (Section 8) 2013 waitlist lottery*, <http://seattlehousing.org/waitlist/>; SAN FRANCISCO HOUSING AUTHORITY, *Residents/Applicants*, <http://www.sfha.org/Residents-Applicants.html> (last visited Apr. 10, 2014); SACRAMENTO HOUSING & REDEVELOPMENT AUTHORITY, *Apply for Housing Choice Voucher*, <http://www.shra.org/Housing/HousingChoiceVoucherProgram/HowtoApply.aspx> (last visited Apr. 10, 2014).

⁹⁰ *Id.*

⁹¹ Gorenstein, *supra* note 87.

⁹² SEATTLE HOUSING AUTHORITY, *Housing Choice Voucher Eligibility*, <https://www.seattlehousing.org/housing/vouchers/eligibility/> (last visited Apr. 13, 2014).

⁹³ *Id.*

⁹⁴ Mascolini, *supra* note 51.

The second Continuum of Care program, the Shelter Plus Care program, provides long-term rental assistance for homeless persons with disabilities⁹⁵ in connection to separately funded supportive services.⁹⁶ The program targets individuals Shelter Plus Care serious mental illness, chronic problems with drugs, and AIDS, or related diseases. The S+C program loosely utilizes the PSH model, working to help households succeed in permanent housing and maintain their health through long-term rental assistance and supportive services. It differs from the PSH model in that participants must agree to participate in appropriate treatment while receiving rental assistance.⁹⁷ Like the Section 8 SRO program, however, Shelter Plus Care programs often involve a long waiting list.

The final Continuum of Care program, the Supportive Housing Program,⁹⁸ is designed to promote the development of supportive housing and services that allow homeless people to transition into residential stability, increase their skill levels, and obtain greater self-determination, so that they can ultimately live as independently as possible.⁹⁹ The program provides grants to local government, private and nonprofits for transitional or permanent housing, as well as supportive services.¹⁰⁰ No figure exists indicating how many people receive housing assistance through the Supportive Housing Program each year.

Because the Continuum of Care programs are not specific to PLWHA, it is difficult to track how many PLWHA are served by each program at a national level. It can be said that these programs do serve PLWHA, some better than others, and that funding for each of these programs is insufficient to meet the needs of all people coping with homelessness. The latter point will not be discussed here as it falls outside the scope of this paper, but the former point is critical. Permanent supportive housing not only yields better health outcomes, but as we will see in Part II(C), below, it is the most cost-effective housing model as well.

There are currently no data indicating how many PLWHA receive housing assistance and related supportive services each year through HOPWA and the Continuum of Care (CoC) program, yet one can roughly conjecture. Taken together, the length of the CoC waiting lists; the fact that, of the estimated 3.5 million people in the United States who are homeless every year, 3.4% are HIV positive;¹⁰¹ and the recommended increase to HOPWA funding all suggest that current government supports for people living with HIV and housing instability are insufficient.

⁹⁵ In the case of a homeless household, at least one adult member must be considered disabled, *see* THE U.S. DEP'T OF HOUSING & URBAN DEV., *Understanding Shelter Plus Care*, 4 (May 2002) <https://www.onecpd.info/resources/documents/Understanding-Shelter-Plus-Care.pdf>,

⁹⁶ Program grants include Tenant-based Rental Assistance (TRA), Sponsor-based Rental Assistance (SRA), Project-based Rental Assistance with or without rehabilitation (PRA[W]), and SRO Dwellings.

⁹⁷ KING COUNTY, *Permanent Housing: Shelter Plus Program*, <http://www.kingcounty.gov/socialservices/Housing/ServicesAndPrograms/Programs/Homeless/PermanentHousing.aspx>.

⁹⁸ Section 811 of the Cranston-Gonzalez National Affordable Housing Act (42 U.S.C. 8013), as amended by the Frank Melville Supportive Housing Investment Act of 2010 (Pub.L. 111-374).

⁹⁹ ONECPD RESOURCE EXCHANGE, *Supportive Housing Program*, <https://www.onecpd.info/shp/> (states, local governments, other governmental entities like PHAs, and private nonprofits are eligible to apply for these grants).

¹⁰⁰ THE U.S. DEP'T OF HOUSING & URBAN DEV., *The Supportive Housing Program*, <http://portal.hud.gov/hudportal/HUD?src=/hudprograms/supportive-housing> (last visited Apr. 12, 2014).

¹⁰¹ DOORWAYS, *Homelessness and HIV*, <http://www.doorwayshousing.org/about-housing-hiv/homelessnesshiv/> (Apr. 14, 2014).

B. HEALTHCARE FOR PEOPLE LIVING WITH HIV/AIDS

1. A New Vision

American healthcare reform marks a major paradigm shift in how providers will deliver care to their patients. The new vision of care is one that emphasizes quality of care. Fully realized, healthcare providers would no longer treat their patients' ailments in isolation. Instead, primary care providers, specialists, and other providers would work together to deliver coordinated, comprehensive, patient-centered healthcare.¹⁰² Coordinated healthcare would improve quality of care while reducing systemic costs by streamlining the inputs, delivery, management and organization of services.¹⁰³

This new vision is also a more inclusive one. The drafters of the Patient Protection and Affordable Care Act (ACA) strove to ensure coverage of a wider set of health care services, including preventive, wellness and behavioral care.¹⁰⁴ To achieve this goal, health care providers and specialists will need to coordinate with social workers, caseworkers, community health care workers, nutritionists, and other community-based organizations to improve the health and therefore the quality of life of the "whole person."

This new vision is congruous with supportive housing, which is a model of coordinated care in and of itself. The permanent supportive model involves early housing stabilization, integrated primary, dental, mental health and substance abuse care, medication optimization and management, and overall case management.¹⁰⁵ Some programs even provide support for entering and continuing employment, reconnecting with family and participating in the greater community.¹⁰⁶ The supportive housing model fits into this new vision of healthcare.

2. Healthcare Coverage

HIV healthcare is infamously expensive. A patient's life expectancy is 24.2 years from the time of entering HIV care.¹⁰⁷ Treatment regimen costs, which include antiretroviral medications (73%), inpatient care (13%), outpatient care (9%), and other HIV-related medications and laboratory costs (5%), can cost anywhere from \$2,000 to \$5,000 each month.¹⁰⁸ This adds up to anywhere from \$567,000 to \$618,900 in undiscounted costs or \$354,100 to \$385,200 in discounted costs over a lifetime (in 2004 dollars).¹⁰⁹ At sticker price, such a cost is out of reach for the average American.

¹⁰² AGENCY FOR HEALTHCARE RESEARCH & QUALITY, *What is Care Coordination?* <http://www.ahrq.gov/professionals/systems/long-term-care/resources/coordination/atlas/chapter2.html> (last visited Apr. 13, 2014).

¹⁰³ CTR'S FOR MEDICARE & MEDICAID, *The Affordable Care Act: Helping Providers Help Patients*, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/downloads/ACO-Menu-Of-Options.pdf>.

¹⁰⁴ UNITED STATES INTERAGENCY COUNCIL ON HOMELESSNESS, *The Affordable Care Act's Role in Preventing and Ending Homelessness*, http://usich.gov/usich_resources/fact_sheets/ACA/ (last visited Apr. 14).

¹⁰⁵ Martha Burt, et al., *supra* note 34 at 10.

¹⁰⁶ *Id.*

¹⁰⁷ Bruce R. Schackman, et al., *The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States*, 44 MED CARE 990 (Nov. 2006) http://www.natap.org/2011/newsUpdates/The_Lifetime_Cost_of_Current_Human.5.pdf.

¹⁰⁸ Jessica Camille Aguirre, *Cost Of Treatment Still A Challenge For HIV Patients In U.S.*, NATIONAL PUBLIC RADIO (Jul. 27, 2012) <http://www.npr.org/blogs/health/2012/07/27/157499134/cost-of-treatment-still-a-challenge-for-hiv-patients-in-u-s>.

¹⁰⁹ Schackman, *supra* note 107.

This is only one of several barriers that have historically stood in the way of a PLWHA's access to health insurance and the supportive services that it covers.¹¹⁰ This section will specifically address healthcare insurance access for PLWHA who could also qualify for housing assistance—that is, those who have a low-income and are housing unstable.

Because HIV disproportionately affects those of lower socioeconomic status,¹¹¹ Medicaid is the single largest source of coverage for PLWHA.¹¹² More than 230,000 Medicaid beneficiaries are HIV positive.¹¹³ Traditionally, Medicaid was only available for the categorically needy. A person with HIV had to receive an AIDS diagnosis before they could be deemed eligible.¹¹⁴ This meant that individuals had to get incredibly ill before they could access the very healthcare that could have allowed them to avoid AIDS in the first place. Prior to the ACA, fewer than 17% PLWHA had private insurance and nearly 30% did not have any coverage at all.¹¹⁵

The drafters of the ACA aimed to change this requirement and ensure that PLWHA who cannot afford private health insurance could access Medicaid.¹¹⁶ The ACA extended Medicaid eligibility to adults age 19-64¹¹⁷ with household incomes that do not exceed 133% FPL.¹¹⁸ Under this category, people with incomes up to 138% of the federal poverty level are eligible for Medicaid. This broadens coverage so that people who are HIV positive are eligible for Medicaid before developing full-blown AIDS. This is an important development because with the help of healthcare, individuals can avoid developing AIDS to the greatest extent possible.

Unfortunately, there is no mandate that States must expand Medicaid eligibility in accordance with the ACA. In *U.S. Department of Health and Human Services v. Florida*, the United States Supreme Court ruled that the federal government “may not compel the States to enact or administer a federal regulatory program.”¹¹⁹ In other words, Congress may not commandeer the states and

¹¹⁰ *Understanding High-Cost Patients*, IMS INSTITUTE, http://www.imshealth.com/deployedfiles/ims/Global/Content/Insights/IMS%20Institute%20for%20Healthcare%20Informatics/Healthcare%20Spending/Insurance_Report_Brief.pdf (last visited Apr. 14, 2014).

¹¹¹ AMERICAN PSYCHOLOGICAL ASSOCIATION, *HIV/AIDS & Socioeconomic Status*, <http://www.apa.org/pi/ses/resources/publications/factsheet-hiv-aids.aspx> (last visited Apr. 20); *See also* Daniels *supra* note 13, at 58.

¹¹² KAISER FAMILY FOUNDATION, *Medicaid and HIV/AIDS* (Mar. 5, 2013) <http://kff.org/hivaids/factsheet/medicaid-and-hivaids/>.

¹¹³ KAISER FAMILY FOUNDATION, *Medicaid Enrollment and Spending on HIV/AIDS*, <http://www.kff.org/hivaids/state-indicator/enrollment-spending-on-hiv/> (last visited Apr. 16, 2014).

¹¹⁴ AIDS UNITED, *supra* note 132; *see also* Maral Sharifi, *The Men Who Want AIDS—and How It Improved Their Lives*, OUT (Aug. 8, 2013) <http://www.out.com/news-opinion/2013/08/02/men-who-want-aids-bronx-new-york> (discussing how some men stop taking their medications to get full blown AIDS so that they can access healthcare services).

¹¹⁵ J. Fleishman et al., *Hospital and Outpatient Health Services Utilization Among HIV-Infected Adults in Care 2000-2002*, MED. CARE 40–52, available at <http://www.ncbi.nlm.nih.gov/pubmed/16116308>.

¹¹⁶ Timothy S. Jost, *Cost, Quality, Access, and Choice*, in THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 1, 5 (Barry R. Furrow et al., 2013) (a PLWHA who qualifies for housing assistance will not be able to afford private insurance, but the ACA's removal of barriers that have historically separated PLWHA from private health insurance access are worth noting. Historically, health insurance companies could deny people with pre-existing healthcare conditions, including PLWHA, health insurance through a practice called underwriting. Insurance underwriting is founded on the principle of actuarial fairness, the idea that everyone should pay only for his or her own financial risk. Insurance companies defend underwriting as the best way to keep healthcare costs low for the majority of the insured).

¹¹⁷ After the age of 64, Americans are eligible for Medicare.

¹¹⁸ 26 U.S.C. §§ 2001, 2002 (2010).

¹¹⁹ *U.S. Dep't of Health & Human Services v. Florida*, 648 F.3d 1235 (2011).

force them to accept a federal program.¹²⁰ To date, only 26 states and the District of Columbia have agreed to expand Medicaid coverage. In the other 24 states, people who have HIV without full-blown AIDS remain ineligible for Medicaid.¹²¹

Although Medicaid does not count housing among the essential health services it covers, it does cover many of the support services utilized within the PSH model. Just as Medicaid eligibility varies from state to state, so too does coverage. States have broad flexibility in determining aspects of their benefits packages. Although they must cover certain mandatory services specified in federal law, they may also choose to cover optional services and receive matching funds. Mandatory services include but are not limited to inpatient and outpatient hospital services; physician and nurse practitioner services; long-term care services; family planning; and federally qualified health center and rural health clinic services.¹²² Many of the optional services that states can opt to cover are particularly critical to PLWHA, including prescription drugs, dental care, personal care services, rehabilitation services, and home and community based care designed to help people with disabilities remain independent and live in their communities.¹²³ Although all states choose to offer prescription drug coverage, several limit the number of prescriptions allowed per month or year. Other states limit the number of hospital inpatient days and physician limits allowed. This means that PLWHA often need to rely on other programs such as the Ryan White program to fill the gaps in their health care coverage.¹²⁴

While Medicaid is a mandatory spending program, the Ryan White program is not. The ACA has many implications for the program. As more people are enrolled in Medicaid, less will utilize Ryan White as its primary source of funding. Advocates fear that this could trigger the phasing out of Ryan White funding. Until Medicaid is expanded in every state and keeps limits and cost-sharing at a level appropriate for the needs of PLWHA, however, it is essential that the government continue to fund the Ryan White program so that those gaps in coverage may be filled to the greatest extent possible.

III. A COMPREHENSIVE SOLUTION

A. SOCIETY'S RESPONSIBILITY

Norman Daniels wrote that, in order to promote fair equality of opportunity under reasonable resource restraints, society must distinguish unnecessary health inequalities from those that are unavoidable, and make efforts to remedy the former.¹²⁵ This paper has demonstrated that

¹²⁰ *Id.*

¹²¹ THE KAISER FAMILY FOUNDATION, *Status of State Action on the Medicaid Expansion Decision, 2014*, <http://kff.org/health-reform//state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (last visited Apr. 15, 2014).

¹²² THE KAISER FAMILY FOUNDATION, *supra* note 112.

¹²³ *Id.*

¹²⁴ Also of note is the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA The Substance works to improve the quality and availability of prevention, treatment, and rehabilitative services resulting from substance abuse and mental illnesses. SAMHSA offers some grants that may be able to fund services for supportive housing tenants. Total SAMHSA grant awards for services in supportive housing totaled \$14,737,408 in 2009. SAMHSA, FY 2009 SAMHSA Grant Awards, *available at* <http://www.samhsa.gov/Grants/2009/awards/sm0907.aspx>.

¹²⁵ DANIELS, *supra* note 11, at 89–90.

the HIV/AIDS homeless situation is avoidable, and that an effective remedy is available. Part I(B) of this paper discussed this remedy—Permanent Supportive Housing (PSH)—and its ability to improve the health of and opportunities available to PLWHA. Yet under Daniels’ framework, a solution must not only be effective; it must also be efficient under reasonable resource restraints. Supportive housing for PLWHA meets this requirement.

Numerous studies have shown that the more we invest in coordinated care within HIV/AIDS housing programs, the more cost-effective these programs are.¹²⁶ PSH is by far the most efficient of housing-aid models currently in use.¹²⁷ The cost of PSH roughly offsets the public costs to hospitals, mental health services, corrections, and the Department of Veterans Affairs (VA) that PSH tenants would incur without housing.¹²⁸ Placing PLWHA with the most complex health and behavioral health conditions and/or frequent stays in correctional institutions may even reduce public costs in excess of the cost of housing and supportive services, resulting in actual savings.¹²⁹ Further, the cost of serving a person within the supportive housing model is half the cost of a shelter, a quarter the cost of being in prison¹³⁰ and a tenth of the cost of a state psychiatric hospital bed.¹³¹ Supportive housing accomplishes this by improving “access and adherence to evidence evidence-based standards of care,¹³² reduc[tions in] viral load and mortality, improve[ments to] immune systems, and reduc[tions in] high risk behavior associated with HIV transmission.”¹³³ In addition to the offsetting healthcare and other public costs, PSH has a positive economic impact because it helps patient-tenants return to work and therefore increase their income.¹³⁴

These factors demonstrate that PSH meets Daniel’s requirements for a remedy. Part II of this paper demonstrated that the current implementation of this remedy is inadequate. This Part will

¹²⁶ Culhane, Metraux, and Hadley, *Accountability, Cost-effectiveness, and Program Performance: Progress Since 1998*,” (2002) at 1.

¹²⁷ *Id.*; NATIONAL ALLIANCE TO END HOMELESSNESS, *Supportive Housing is Cost Effective*, (Jan. 19, 2007) <http://www.endhomelessness.org/library/entry/supportive-housing-is-cost-effective>.

¹²⁸ Martha Burt et. al., *supra* note 34; DANIELS, *supra* note 11, at 5 (citing Culhane, et. al., (2002), discussing public service reductions associated with placement of homeless persons with severe mental illness in supportive housing); Culhane et. al., *supra* note 126 (examining the effects of the supportive housing offered to persons who are homeless with severe and persistent mental illness (SPMI) through the New York/New York (NY/NY) Initiative); see Rosenheck et. al., *Cost effectiveness of supportive housing for homeless persons with mental illness*, 60 ARCH. GEN. PSYCHIATRY, 940-951 (Sep. 2003) (finding significant cost-offsets when permanent supportive housing was provided. Although a proportion of public costs—about 17 percent—were not offset, the researchers concluded that the improved outcomes for the veterans were worth the difference).

¹²⁹ Martha R. Burt, et al., *supra* note 34.

¹³⁰ NATIONAL ALLIANCE TO END HOMELESSNESS, *supra* note 127.

¹³¹ BAZELON, *supra* note 35, at 2.

¹³² AIDS UNITED, *The Affordable Care Act: Support and Fully Implement the Affordable Care Act Including Medicaid Expansion*, http://www.aidsunited.org/uploads/docs/ACA_and_PLWHA.pdf (last visited Mar. 28, 2014) (“Full implementation of the Affordable Care Act could save up to \$237 in unnecessary HIV/AIDS treatment costs for the U.S. Healthcare system; to achieve these savings Congress must fully fund the ACA and all States must cover low-income people living with HIV by expanding Medicaid as provided for in the law.”).

¹³³ See e.g., Schwarcz, et al, *Impact of housing on the survival of persons with AIDS*. BMC PUBLIC HEALTH, 9, 220 (Jul. 7, 2009); Rosenheck et. al., *supra* note 128; See also Wolitski et. al., *Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV*, 14 AIDS BEHAV. 493, 493 (Dec. 1, 2009).

¹³⁴ NATIONAL ALLIANCE TO END HOMELESSNESS, *supra* note 127; see also JERUSALEM HOUSE, *supra* note 1 (telling the story of Andrew, who was taking the LSAT and applying to law school only a year after entering Jerusalem House’s supportive housing program).

discuss ways to improve our approach so that both PLWHA and society at large can reap the benefits of the PSH model.

B. DEFINING ADEQUACY

In order to remedy the inadequacy of current support, the Federal Government and the states must adopt several measures. First, the Federal Government must increase HOPWA funding to the recommended \$380 million.¹³⁵ This increase over the current \$332 million in HOPWA funding is negligible when compared to our \$3 trillion federal budget, the cost effectiveness of the PSH model demonstrates that greater investment in HOPWA will shift costs away from other public programs. Not only will the costs be greatly offset, but it would allow PSH providers to provide an additional 12,000 households with housing support that could save their lives. Greater investment in HOPWA will also help PSH providers to better ensure that the recommended cap on tenant contribution—30% of tenant income—can be followed. Ensuring that PSH is affordable for the people who qualify to participate is a necessary step toward ensuring consistency in the care and support of PLWHA.

Just as participation in PSH should be affordable, so too should the related supportive services. States have a significant role to play here. States should expand Medicaid as the ACA allows. As discussed in Part II (B), people living with HIV who have not developed AIDS only qualify for Medicaid in states that have expanded Medicaid to cover people below 138% of the federal poverty level.

Unfortunately, the insurance provided through Medicaid and the private insurance marketplace may not be sufficient for those living with certain chronic illnesses. As more states expand Medicaid, some may argue that the utility of programs such as Ryan White, the safety-net program for people living with HIV, have been exhausted. This is not so. Medicaid's essential core benefits do not currently include many of the supports that are needed to ensure the health of people living with HIV. "Affordable" marketplace insurance plans with low premiums often feature high cost sharing. These plans will be unaffordable for PLWHA in the long run due to the high cost of HIV care. People working in policy must simultaneously advocate for Medicaid expansion and work to ensure that patients can continue to receive important support services through safety-net programs.

With the future of the Ryan White Program uncertain, it is more important than ever that all PLWHA have a means to obtain adequate healthcare coverage. Similarly, the more supportive services that states opt to implement into Medicaid benefit packages, the more HOPWA allocations can focus on funding housing assistance specifically.

The PSH model strives to improve the health of PLWHA and its methods improve access to equal opportunity for its participants. Some are able to "graduate" out of PSH after obtaining a job with a salary sufficient to provide for rent. It is important that society ensure future consistency in care so that these individual do not need PSH in the future. As discussed in Part II(B) of this paper, the Affordable Care Act created several opportunities to improve the delivery of care in our country.

¹³⁵ AIDS UNITED, *supra* note 69.

The Medicaid Health Home state option dovetails particularly well with supportive housing.¹³⁶ The option is designed to facilitate better coordination between the healthcare providers that treat patients with high-cost and complex chronic conditions such as HIV.¹³⁷ States have the option to propose to CMS “State Plan Amendments” addressing how they will utilize the model, including which high-cost populations they plan to target.¹³⁸ CMS has already approved two State Plan Amendments that cater to the needs of PLWHA. Under these programs, health home providers will actively manage appropriate referrals, access to care, engagement with community and social supports, and coordinate behavioral, mental health, and other necessary services for patients.¹³⁹ This will involve establishing and strengthening linkages between these entities, and result in improved delivery and coordination of patient care.

CONCLUSION

As a matter of social justice, individuals should have a fair share of the normal opportunity range. Society should correct for special disadvantages resulting from the social lottery. Because there are strong causal links between low socioeconomic status and both HIV status and homelessness, society has a responsibility to promote fair equality of opportunity through an appropriate remedy. An appropriate remedy is one that is effective, efficient, and fair. The Permanent Supportive Housing model is such a remedy, yet federal support of the model remains insufficient.

Policymakers are charged with a challenging task. Although the United States has made great strides in improving healthcare access through federal reform, it must embrace a more inclusive view of comprehensive care in order to improve the health of low-income people living with HIV/AIDS. Housing stability is a necessary element in successful HIV treatment.¹⁴⁰ It is, in short, healthcare. Until society strengthens its commitment to people living with HIV/AIDS, thousands of PLWHA will continue to live on the waiting lists. The wait needs to end.

¹³⁶ 26 U.S.C. §2703 (2010); Kelly M. Doran et. al., *Housing as Health Care—New York's Boundary-Crossing Experiment*, THE NEW ENGLAND JOURNAL OF MEDICINE (Dec. 19, 2013), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1310121>.

¹³⁷ NEW YORK STATE DEP'T OF HEALTH, *Health Homes for Medicaid Enrollees with Chronic Conditions*, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ (last visited Apr. 20 2014).

¹³⁸ *Supra* note 87; 26 U.S.C. §2703 (2010).

¹³⁹ CTR'S FOR MEDICARE & MEDICAID SERVICES, *State-by-State Health Home State Plan Amendment Matrix: Summary Overview*, 36 (May 2013) available at <http://medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/State-by-State-HH-SPA-matrix-5-13.pdf>.

¹⁴⁰ See BAZELON, *supra* note 35, at 3.