



## **2009 Policy Statements**

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### **The Universal Declaration of Human Rights, Article 25 (1):**

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

*These annual Policy Statements are developed through the consensus processes of the National Health Care for the Homeless Council, a membership organization involving homeless and formerly homeless people, individuals and agencies that provide health care to poor and homeless persons, and advocates for human rights.*

# Homelessness and Health

## **Summary of Recommendations:**

- **Guarantee access to comprehensive, affordable health services high quality for everyone in the United States**
- **Expand and strengthen the Health Care for the Homeless (HCH) and other targeted homeless health programs**
- **Strengthen mainstream health programs that respond to and prevent homelessness**
- **Increase investment in and accessibility of affordable housing for low-income people**
- **Assure that federal support for targeted services currently funded by the HUD McKinney-Vento Homelessness Assistance program is maintained and augmented**

**Poverty, lack of affordable housing, and the lack of comprehensive health insurance are among the underlying structural causes of homelessness.** For those struggling to pay for housing and other basic needs, the onset of a serious illness or disability easily can result in homelessness following the depletion of financial resources. Indeed, Harvard University researchers found that 50 percent of all bankruptcy filings were partly the result of medical expenses.<sup>1</sup>

**The experience of homelessness causes poor health.** As a consequence of poor nutrition, inadequate hygiene, exposure to violence and to the elements, increased contact with communicable diseases, and the constant stress of residential instability, people without homes suffer from health problems at much higher rates than those in the general population.<sup>2</sup> Forty-six percent of homeless individuals report chronic health conditions, including high blood pressure, diabetes, and cancer.<sup>3</sup> Unstably housed people are at significantly higher risk for emotional trauma secondary to physical or sexual abuse and family estrangement. The realities of homelessness seriously complicate the delivery of care for the effective treatment of these and other ailments. Health conditions requiring regular, uninterrupted treatment (such as diabetes, cardiovascular disease, tuberculosis, HIV/AIDS, addiction, mental illness) are extremely difficult to manage without a stable residence.

**Poor health is exacerbated by restricted access to appropriate health care.** The acute and chronic medical conditions of people without stable housing are exacerbated by limited access to health services: cuts become infected; routine colds develop into pneumonia; and manageable chronic diseases such as asthma, hypertension, diabetes, and HIV become disabling, life-threatening and costly conditions if left untreated. Indeed, homeless individuals are three-to-four times more likely than their housed counterparts to die prematurely due to untreated acute and chronic medical problems.<sup>4</sup>

**Access to health care is impeded by lack of health insurance and other structural barriers.** More than half of surveyed homeless people nationwide, two-thirds of homeless adults unaccompanied by children, and 70% of clients served by HCH projects have no health insurance.<sup>5,6</sup> Restricted access to comprehensive health care only prolongs their homelessness. Additional barriers to health care access include lack of transportation, inflexible clinic hours, complex requirements to qualify for public health insurance, and mandatory unaffordable co-payments for various services.

**Mainstream health care safety net providers fail to meet the needs of homeless people.** In the absence of universal health care, the Federal government supports a separate health care system for low-income and uninsured people. Community Health Centers and publicly funded mental health and addictions

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<sup>1</sup> Himmelstein D, Warren E, Thorne D, Woolhandler S Illness and Injury as Contributors to Bankruptcy, *Health Affairs* Web Exclusive W5-63, 02 February, 2005. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>

<sup>2</sup> Zenger. *Chronic Medical Illness and Homeless Individuals. A Preliminary Review of the Literature.* National Health Care for the Homeless Council, 2002. [www.nhchc.org/Publications/literaturereview\\_chronicillness.pdf](http://www.nhchc.org/Publications/literaturereview_chronicillness.pdf)

<sup>3</sup> National Resource and Training Center on Homelessness and Mental Illness. Who is Homeless? 2006.

<sup>4</sup> O'Connell, *Premature Mortality in Homeless Populations: A Review of the Literature.* National Health Care for the Homeless Council, 2005. [www.nhchc.org/PrematureMortalityFinal.pdf](http://www.nhchc.org/PrematureMortalityFinal.pdf)

<sup>5</sup> Burt M et al. *Homelessness: Programs and the People They Serve – Findings of the National Survey of Homeless Assistance Providers and Clients.* The Urban Institute, Dec 1999. [www.huduser.org/publications/homeless/homelessness/contents.html](http://www.huduser.org/publications/homeless/homelessness/contents.html)

<sup>6</sup> Health Resources and Services Administration, DHHS. *Health Care for the Homeless Rollup Report for CY 2007...* [www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm](http://www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm)

programs form the core of this “mainstream” health care safety net. Unfortunately, limited resources, lack of experience with this population, and insufficient linkages to the full range of health and supportive services seriously restrict the ability of mainstream providers to meet the unique needs of people experiencing homelessness.

**Targeted programs improve public health and health care access for people experiencing homelessness.** When displaced people with poor health do not receive the care they need, the communities in which they live experience negative consequences. The high prevalence among homeless populations of infectious diseases, mental illnesses, and addiction disorders (often occurring together) attests to the seriousness of this public health risk. Recognizing that homelessness restricts access to mainstream resources, Congress established Health Care for the Homeless (HCH) in 1987 to provide targeted services for people without stable housing. HCH has been reauthorized three times, most recently in 2008 with passage of the Health Care Safety Net Act.<sup>7</sup> The HCH program has demonstrated that community-level health services tailored to the special needs of people experiencing homelessness can dramatically improve their access to appropriate care. HCH projects provide primary and behavioral health care along with social services, including intensive outreach and case management to link clients with appropriate resources. These programs are designed to meet the health and supportive service needs of individuals without stable housing far more effectively than mainstream health care safety net providers have done in the past.

## Recommendations

1. **Guarantee access to comprehensive, high quality, affordable health services for everyone in the United States.** In 2007, 45.7 million Americans (15.3% of the U.S. population) had no health insurance,<sup>8</sup> including approximately 70% of clients served by HCH projects.<sup>9</sup> There is compelling evidence that people with health insurance have better access to health care than do those receiving safety net services alone.<sup>10</sup> We urge Congress and the Administration to provide universal health coverage and access to comprehensive and affordable health care of high quality. (For additional information, see our Policy Statement on Universal Health Care at [www.nhchc.org](http://www.nhchc.org).)
2. **Expand and strengthen the Health Care for the Homeless (HCH) and other targeted homeless health programs.** Last year, Congress unanimously passed the Health Care Safety Net Act of 2008, which reauthorized the Community Health Center program (Section 330 of the Public Health Service Act, including the HCH program) for five years. The HCH Program currently supports 205 HCH projects in all 50 states, the District of Columbia, and Puerto Rico, serving 742,588 in 2007—a sizable number, but far below the 3.5 million Americans who annually experience homelessness, as reported by the Urban Institute.

In FY 2009, Congress appropriated \$2.2 billion for Community Health Centers, including \$191 million (8.7%) for the HCH program. We urge Congress and the Administration to strengthen and expand community health centers through the Access for All America Act (S. 486/H.R. 1296) and appropriate \$2.9 billion for health centers, including at least \$252 million for the HCH program in FY 2010. Additional funds for all Health Center programs would enable Health Centers to provide primary care and related services to a growing number of uninsured people, including those who are experiencing, at risk of, or in transition from homelessness. Additional funds for the Health Care for the Homeless program would assist grantees to:

**A) Care for more people experiencing homelessness.** As increasing numbers of people fall below Federal poverty guidelines, join the ranks of the uninsured and experience homelessness, many seek services from HCH projects, whose clientele includes: families with children exiting the welfare system, persons with disabling addictions denied access to Medicaid, uninsured workers, unaccompanied youth,

<sup>7</sup> Public Health Service Act, Title III, Section 330(h), 42 U.S.C. Sec. 254b.

<sup>8</sup> Center on Budget and Policy Priorities. Poverty and share of Americans without health insurance were higher in 2007... 26 August, 2008. [www.cbpp.org/files/8-26-08pov.pdf](http://www.cbpp.org/files/8-26-08pov.pdf)

<sup>9</sup> Health Resources and Services Administration, DHHS. Health Care for the Homeless Rollup Report for CY 2007. [www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm](http://www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm)

<sup>10</sup> Holahan, J. and Spillman, B. “Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance.” *The Urban Institute*. Jan 2002. [www.urban.org/url.cfm?ID=310414](http://www.urban.org/url.cfm?ID=310414)

and veterans unable to obtain VA health services. Additional funds would establish HCH projects in communities where they do not exist and enable existing HCH projects to manage caseloads and address the increased demand better.

**B) Maintain financial viability.** Expansions of health center services cannot be effective without a viable base. In the FY 2009 Appropriation for Community Health Centers, base grant awards were adjusted by an average of only 3%, far below the inflationary cost increases faced by health centers. Recruitment and retention of provider staff in a competitive health care environment and maintenance of core services require annual base adjustments that recognize the reality of cost increases.

**C) Expand addiction and mental health services.** HCH projects are required to provide access to addiction and mental health services. Regrettably, inadequate funding levels limit the capacity of many projects to provide these services, even though clinicians report that behavioral health disorders are among the health problems most commonly experienced by their homeless patients. Additional funds would allow HCH projects to offer a more robust array of addiction and mental health services in integrated health care settings. Funding for these services could potentially come from annual grants awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Section 506 of the Public Health Service Act.

**D) Develop medical respite care arrangements.** In the absence of a safe place to recuperate from illness, medical interventions may be ineffective. Lack of appropriate accommodations for those who require supervised medical care but are not ill enough to remain hospitalized makes it difficult for them to recover from illness and resolve homelessness. With support from HRSA, several HCH projects have pioneered responses to this service gap in the form of medically-supervised medical respite care in residential settings (see detailed policy statement on Medical Respite Care at [www.nhchc.org](http://www.nhchc.org)). Additional funds could assist HCH projects in developing and strengthening 24-hour acute and subacute recuperative care arrangements for their patients.

3. **Strengthen mainstream health programs that respond to and prevent homelessness.** Mainstream programs such as Medicaid and Federal block grants administered by SAMHSA and other agencies play an important role in homeless health care. We urge Congress and the Administration to ensure that mainstream health care safety net providers are adequately funded and accountable for serving unstably housed people. (Detailed recommendations regarding mainstream programs appear in other policy statements in this series, available at [www.nhchc.org](http://www.nhchc.org).)
4. **Increase investment in and accessibility of affordable housing for low-income people.** Residential stability is a critical component of effective health care. Affordable housing stock has declined substantially over the past decade in most localities. We urge Federal, state, and local governments to substantially increase funding for affordable housing, including permanent housing with supportive services for people with chronic and disabling health conditions. (Further recommendations regarding housing policy are detailed in the policy statement on Housing and Homelessness, available at [www.nhchc.org](http://www.nhchc.org).)
5. **Assure that Federal support for targeted services currently funded by the HUD McKinney-Vento Homelessness Assistance program is maintained and augmented.** Competitive funding incentives established by HUD through annual NOFAs in recent years have created very strong pressures to reduce spending of McKinney grant funds for supportive services. In many parts of the country there is little or no funding available from HUD for services. To date, no Federal funding streams large enough to replace lost HUD service dollars have been identified, although the U.S. Department of Health and Human Services has the greatest potential to do so, as well as the expertise to administer service dollars effectively. There must be adequate Federal funding and judicious oversight of these services by an agency with expertise in the coordination of comprehensive health care services for homeless people. Reliance on mainstream programs such as Medicaid to fund these services is unwarranted without significant eligibility expansions, given the low rate of Medicaid enrollment among people experiencing homelessness.

# Universal Health Care and Homelessness

*The central focus of the National Health Care for the Homeless Council is to reduce the incidence of homelessness by bringing about comprehensive health care reform and ensuring universal accessibility of essential health services.*

## **Summary of Recommendations**

- **Establish a national health care plan with a single-payer financing mechanism guaranteeing access to comprehensive, affordable health services of high quality for everyone in the U.S.**
- **Adopt House Joint Resolution 30 to institute the universal right to health care in the Constitution of the United States**
- **Ratify the International Covenant on Economic, Social and Cultural Rights (ICESCR)**

**Poor health and lack of access to health care are among the causes of homelessness.** For people struggling to pay for rent, food, and other basic needs, the onset of a serious illness or disability can result in homelessness as financial resources are depleted. Half of personal bankruptcies can be attributed to an unexpected medical illness, and more than three-fourths of those filing for bankruptcy are actually insured at time of their emergency or onset of illness.<sup>1</sup> Timely access to affordable health care of high quality would alleviate health problems and reduce the incidence of homelessness.

**The vast majority of homeless Americans lack health insurance,** primarily because they do not qualify for public insurance and cannot afford private insurance. Among those served by Health Care for the Homeless (HCH) projects, 70% are uninsured. Most remain uninsured, often because they cannot afford non-group coverage or do not qualify for public insurance programs. Only 45% of surveyed homeless people nationwide and 30% of clients receiving services through the Health Care for the Homeless program (223,980 individuals in 2007) have any health insurance coverage.<sup>2</sup>

The number of uninsured Americans continues to grow. One in 5 adults under age 65 and nearly one in 10 children are uninsured.<sup>3</sup> To close the gap between health care needs and access to needed services, incremental expansions of public insurance programs have targeted vulnerable populations such as the elderly and children. Despite these initiatives, 45.7 million people (15.3% of the US population) were uninsured in FY 2007; and an estimated 86.7 million people—one out of every three Americans under the age of 65—was uninsured for some period during 2007 and 2008.<sup>4</sup> Although the number of uninsured declined from 47 million in 2006 to 45.7 million in 2007, analysts remind us that the drop is statistically insignificant and that uninsurance is likely to increase due to the rising unemployment rate, since most Americans still receive health insurance through their employer. Employers are not required to provide health insurance, however, and more than 80% of the uninsured live in working families. Only 7% of Americans under age 65 purchase health insurance for themselves or their families without the financial advantage of group coverage through employer-sponsored health plans. Despite myriad efforts to fill the gaps in health coverage and health care access—including valuable yet insufficient expansions of the Community Health Center program—the uninsured population has steadily increased by approximately one million individuals per year since 2000.

**Uninsurance and underinsurance increase costs for every American.** Out-of-pocket expenses deter people—particularly those who are poor and uninsured—from seeking early intervention and preventive services. Emergency departments are overused and in many cases uncompensated. Unpaid bills undermine credit ratings of uninsured patients and pressure medical institutions to raise prices to replace lost revenue. In response to these rising costs, insurers increase premiums or scale back benefits, pricing many people out of the market and leaving others with inadequate coverage. It is estimated that 25 million people (14% of non-elderly adults in 2007) are underinsured—lacking sufficient health coverage to protect them from catastrophic

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<sup>1</sup> Himmelstein DU, Warren E, Thorne D, Woolhandler S. "Illness and Injury as Contributors to Bankruptcy." *Health Affairs: The Policy Journal of the Health Sphere*. Feb. 2005. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>

<sup>2</sup> Health Resources and Services Administration, DHHS. Health Care for the Homeless Rollup Report for CY 2007. <http://www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm>

<sup>3</sup> Institute of Medicine. *America's Uninsured Crisis: Consequences for Health and Health Care*. February, 2009. <http://www.iom.edu/CMS/3809/54070/63118.aspx>

<sup>14</sup> Families USA and The Lewin Group. *Americans at Risk: One in Three Uninsured*. <http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf>

health care expenses. Underinsured individuals are almost as likely as those who are uninsured to have difficulty paying for medical care and forego necessary services; 53% of the underinsured and 68% of the uninsured report going without needed care.<sup>5</sup>

**Health care should cost less and provide more.** The United States pays twice as much as other industrialized nations for health care (\$7,129 per capita in FY 2007) but performs poorly in comparison on major health indicators such as life expectancy, infant mortality, and immunization rates. (The World Health Organization ranks the U.S. 37<sup>th</sup> in health outcomes.) It is estimated that lack of health insurance causes 22,000 unnecessary deaths a year.<sup>6</sup> The rapid growth of our health spending (about twice the rate of inflation) is untenable, unproductive, and unnecessary. Investor profits and excessive administration consume resources that could instead be directed toward the actual delivery of care. For every dollar spent on health care, 30 cents is utilized for administration. In 2007, employer-sponsored health insurance premiums increased by 6.1%—far ahead of the 3.7% increase in employee wages and the 2.6% inflation rate.<sup>7</sup> Additionally, U.S. tax-financed health spending—59.8% of taxes—is the highest in the world.<sup>8</sup> Approximately one-third of these tax dollars is spent on private insurers to cover government employees; meanwhile, uninsured Americans pay thousands of dollars in taxes to fund the health care of others. Comprehensive national health insurance with a single-payer financing mechanism would reduce administrative costs and waste, eliminate financial barriers to quality care, improve public health, protect the freedom of provider choice (maintaining competition), and save thousands of lives and billions of dollars each year.<sup>9</sup>

## Recommendations

**1. Establish a national health care plan with a “single payer” financing mechanism.** We urge Congress to codify a right to health care by guaranteeing insurance – universally and continuously – for all medically necessary services. The most efficient way to attain this goal is through a single payer mechanism financed by a progressive tax system. This would be realized by House Resolution 676, the Expanded and Improved Medicare for All Act. Until this goal is accomplished, we support State efforts to ensure universal health coverage for their residents and incremental efforts to expand access to health insurance for vulnerable populations.

**2. Adopt House Joint Resolution 30** so that all persons benefit from the human right to health care. Congress has reintroduced H.J. Res. 30 proposing that the Constitution should be amended to articulate and defend the right of citizens of the United States to equal, high quality health care.

**3. Ratify the International Covenant on Economic, Social and Cultural Rights.** The ICESCR and the International Covenant on Civil and Political Rights (ICCPR) were drafted by the United Nations in 1966 to codify the rights enumerated in its Universal Declaration of Human Rights (UDHR) in 1948. Member States typically endorse a treaty to signal their intent to ratify it at a later time; signing a treaty or covenant is a non-binding act of goodwill, whereas ratification is the process by which a national government agrees to be subject to the international law detailed in the document thus ratified. The United States signed both the ICESCR and the ICCPR in 1977, and the ICCPR was subsequently ratified in 1992; but there has been no progress toward ratification of the ICESCR, which includes the right to “the highest attainable standard of physical and mental health.” The United States’ ratification of this document would advance the campaign for global human rights and direct the Covenant’s ratifying parties into a discussion of international health standards and concerns. We urge the Administration and Congress to proceed with the ratification of the ICESCR and the full employment of the rights specified therein.

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<sup>5</sup> Schoen C, Collins SR, Kriss JL, et al. How many are underinsured? Trends among U.S. adults, 2003 and 2007. *Health Affairs* 2008; 27(4): w298-w309. <http://www.commonwealthfund.org>

<sup>6</sup> Institute of Medicine. *Knowing What Works in Health Care: A Roadmap for the Nation*. January 2008. <http://www.iom.edu/CMS/3809/34261/50718.aspx>

<sup>7</sup> The Kaiser Family Foundation. Employer-Sponsored Health Insurance Premiums Increased by 6.1% in 2007....*Kaiser Daily Health Report*, Sep 12, 2007. [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=47450](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=47450)

<sup>8</sup> Woolhandler S, Himmelstein DU. “Paying for National Health Insurance--and Not Getting It.” *Health Affairs*, 2002 Jul-Aug;21(4):88-98. <http://www.pnhp.org/publications/payingnotgetting.pdf>

<sup>9</sup> Physicians for a National Health Program. [http://www.pnhp.org/facts/single\\_payer\\_resources.php](http://www.pnhp.org/facts/single_payer_resources.php); American Medical Student Association. Single Payer 101. <http://www.amsa.org/uhc/SinglePayer101.pdf>; Krugman P. The Health Reform Imperative. *The Conscience of a Liberal*. New York: W.W.Norton & Company, 2007, 214–243.

# Medicaid, SCHIP, and Homelessness

## Summary of Recommendations

- **Protect and strengthen the Medicaid entitlement**
- **Simplify application, enrollment, and recertification processes and expedite health coverage for eligible homeless persons**
- **Guarantee the affordability of necessary services for all Medicaid beneficiaries**
- **Guarantee access to comprehensive services for homeless enrollees**
- **Fully fund SCHIP to cover all uninsured children and their parents with family income at or below 200% FPL**

**Current Medicaid/SCHIP policies exclude most homeless people.** Most people experiencing homelessness do not qualify for Medicaid under current policy, regardless of their degree of impoverishment or medical need. Only 33% of surveyed homeless people nationwide and 22% of clients receiving services through the Health Care for the Homeless program (162,986 individuals in 2007) are Medicaid or SCHIP beneficiaries,<sup>1</sup> although more are thought to be eligible but not enrolled. Poor adults who are not pregnant, disabled, elderly, or the parents of dependent children—approximately 60% of all those known to be homeless—are ineligible for Medicaid in most states.

Since July 1, 2006, persons applying for or renewing Medicaid coverage have been required to present a birth certificate or passport as proof of citizenship. Although this regulation was intended to keep illegal immigrants from fraudulent enrollment, it threatens Medicaid coverage for eligible U.S. citizens who lack necessary documentation and disproportionately affects people experiencing homelessness. States are given flexibility to impose heavier cost-sharing burdens upon beneficiaries, which further undermine the Medicaid entitlement for people with limited resources who are homeless.<sup>2</sup>

**Medicaid and SCHIP help to prevent and end homelessness.** Research has shown that people with health insurance generally have better access to health care than do those receiving safety net services alone.<sup>3</sup> Nevertheless, there is also evidence that Medicaid coverage does not assure access to needed services for people experiencing homelessness. For example, increased use of most health care, including behavioral health services, is more strongly associated with having non-Medicaid health insurance than with having Medicaid.<sup>4</sup> Access to the full array of health services, including appropriate treatment of mental illness and substance use disorders, is essential for the prevention and successful management of the serious and complex health problems that afflict homeless people and those at risk of homelessness.<sup>5</sup>

## Recommendations

### 1. Protect and strengthen the Medicaid entitlement.

- **Expand eligibility to include everyone at or below 200% of the Federal poverty level.** As employment-based health coverage becomes less common and more costly, particularly for low-wage workers, the health care safety net must expand (until universal coverage is achieved) to include people currently experiencing or financially at risk for homelessness. Increased Federal funding must accompany eligibility expansions to hold current beneficiaries harmless.
- **Mandate a comprehensive benefits package for all covered populations.** Administrative waivers and budget reconciliation measures have allowed States to reduce covered services or increase out-of-pocket costs for even the poorest Medicaid beneficiaries. To protect these individuals and the public

<sup>1</sup> Health Resources and Services Administration (HRSA), DHHS. Health Care for the Homeless Rollup Report for CY 2007.

[www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm](http://www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm)

<sup>2</sup> Judith Solomon. Cost-sharing and Premiums in Medicaid: What Rules Apply? Center for Budget and Policy Priorities, Feb 2007.

[www.cbpp.org/2-28-07health.htm](http://www.cbpp.org/2-28-07health.htm)

<sup>3</sup> Holahan J, Spillman B. Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance. The Urban Institute, Jan 2002. [www.urban.org/url.cfm?ID=310414](http://www.urban.org/url.cfm?ID=310414)

<sup>4</sup> Burt M, Sharkey P. The Role of Medicaid in Improving Access to Care for Homeless People. The Urban Institute, 2002.

[www.urban.org/publications/410595.html](http://www.urban.org/publications/410595.html)

<sup>5</sup> Bonin E et al. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*. Health Care for the Homeless Clinicians' Network, Jun 2004. [www.nhchc.org/practiceadaptations.html](http://www.nhchc.org/practiceadaptations.html)

health, we recommend a required comprehensive benefits package (as specified in the Social Security statute) for all covered populations. Behavioral health services should be a mandatory Medicaid benefit, in parity with other health services. States also should be required to meet the medical needs of homeless persons in medical respite care facilities to the same extent that home health care needs of people with stable housing are met. Moreover, supportive services that enable people with disabilities or serious chronic health problems to obtain / maintain stable housing, improve health, and enhance quality of life should be eligible for Medicaid reimbursement. These services provide significant cost savings to the Medicaid program and prevent future hospitalizations.<sup>6, 7</sup>

- **Restore Medicaid and SSI eligibility to all groups that lost it under Federal welfare reforms.** Two bills enacted in 1996 terminated Medicaid eligibility for individuals whose addiction was “a contributing factor material to the determination of their disability” and for immigrants who legally entered the United States after August 1996, including those who became disabled *after* they immigrated. Eligibility for these persons must be restored, as their lack of insurance increases health risks and costs for everyone.
2. **Simplify application, enrollment, and recertification processes and expedite health coverage for eligible homeless persons.** Many State Medicaid programs have created enrollment barriers that disproportionately affect homeless applicants, including lengthy and complex enrollment procedures, excessive documentation requirements, poorly trained eligibility workers, and lack of accommodation for persons with limited English proficiency and/or educational and functional limitations.<sup>8, 9</sup> Application, enrollment, and recertification processes must be streamlined to prevent excessive waiting periods, inappropriate rejections, and undue administrative expenses. Expedited access to covered benefits for homeless individuals who are highly likely to qualify for Medicaid, SCHIP, or SSI (which automatically triggers Medicaid coverage in most states) would decrease administrative costs, hasten access to preventive/primary care, and reduce the need for more costly acute/emergent care.
  3. **Guarantee the affordability of necessary services for all Medicaid beneficiaries.** Cost-sharing (e.g., co-payments and premiums) indiscriminately deters utilization of primary and preventive health services that could preclude the need for more expensive services later. This is especially true for persons with low income and those in poor health.<sup>10</sup> Even a small co-payment for office visits has been shown to reduce utilization of primary care and increase the frequency and duration of hospitalizations. Increases in cost-sharing must be avoided, and all cost-sharing for households with income at or below 200% FPL eventually should be eliminated.
  4. **Guarantee access to comprehensive services for homeless beneficiaries.** Medicaid or SCHIP enrollees who are homeless often have difficulty obtaining services provided through managed care plans.<sup>11</sup> States have enrolled homeless people into Medicaid managed care plans without the benefit of cost and utilization data, practice guidelines, or targeted access and quality standards.<sup>9,12</sup> We recommend that State Medicaid programs take the following actions to protect unstably housed people who are enrolled in managed care plans:

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<sup>6</sup> Buchanan D, Doblin B, Sai T, Garcia P. The Effects of Respite Care for Homeless Patients: A Cohort Study. *American Journal of Public Health*; 96 (7): 1278-1281, Jul 2006.

<sup>7</sup> Post P. *Defining and Funding the Support in Permanent Supportive Housing: Recommendations from Health Centers Serving Homeless People*. Prepared by the National Health Care for the Homeless Council for the Corporation for Supportive Housing, Feb 2008. [www.nhchc.org/PSHReport.pdf](http://www.nhchc.org/PSHReport.pdf)

<sup>8</sup> Post P. *Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid*. National Health Care for the Homeless Council, May 2001. [www.nhchc.org/Publications/CasualtiesofComplexity.pdf](http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf)

<sup>9</sup> Eiken S, Galantowicz S. *Improving Medicaid Access for People Experiencing Chronic Homelessness: State Examples*. The MEDSTAT Group, Inc. for CMS/ DHHS, Mar 2004. [www.cms.hhs.gov/PromisingPractices/Downloads/homeless32904.pdf](http://www.cms.hhs.gov/PromisingPractices/Downloads/homeless32904.pdf)

<sup>10</sup> Solomon J. Cost-Sharing and Premiums in Medicaid: What Rules Apply? Center on Budget and Policy Priorities, 28 Feb., 2007. [www.centeronbudget.org/cms/index.cfm?fa=view&id=1125](http://www.centeronbudget.org/cms/index.cfm?fa=view&id=1125)

<sup>11</sup> Wunsch D. *Can Managed Care Work for Homeless People? Guidance for State Medicaid Programs* [www.nhchc.org/Publications/guidance.html](http://www.nhchc.org/Publications/guidance.html) and *Searching for the Right Fit: Homelessness & Medicaid Managed Care* [www.nhchc.org/Publications/search.html](http://www.nhchc.org/Publications/search.html). National Health Care for the Homeless Council, Sep 1998.

<sup>12</sup> O'Connell J. *Utilization & Costs of Medical Services by Homeless Persons: A Review of the Literature & Implications for the Future*. National Health Care for the Homeless Council, Apr 1999. [www.nhchc.org/Publications/utilization.html](http://www.nhchc.org/Publications/utilization.html)

**a. Adapt eligibility determination processes to accommodate homeless enrollees.**

- **Assess and record housing status** at initial enrollment and on a regular basis thereafter, noting health risks associated with housing instability and providing specialized services accordingly.
- **Ensure access to appropriate enrollment/recertification information** that addresses the distinct needs of people experiencing homelessness and is conveyed in understandable language.
- **Ensure the adequacy of plans into which homeless beneficiaries are auto-enrolled.** Providers must have a working knowledge of health problems associated with homelessness.
- **Expedite voluntary disengagement from managed care plans** for homeless enrollees who choose to switch plans, obtain services from Federally Qualified Health Centers, or use fee-for-service Medicaid.

**b. Tailor services to meet the special needs of people experiencing homelessness.**

- **Involve homeless beneficiaries and their advocates** in the design, implementation, and evaluation of Medicaid managed care programs.
- **Conduct face-to-face health and social assessments** shortly after enrollment.
- **Establish linkages to integrated health and social services** through HCH projects and other providers offering comprehensive, coordinated, and culturally appropriate care.
- **Provide coverage of medically necessary addiction and mental health services** in parity with coverage for treatment of other health conditions.
- **Provide an appropriate range of wrap-around services** including outreach, transportation, case management, 24-hour acute and subacute recuperative care in a residential facility, and social and housing services.
- **Deliver services at accessible locations** where people experiencing homelessness feel comfortable and are willing to receive care (e.g., soup kitchens, drop-in centers, shelters).
- **Cover and facilitate use of out-of-network services** if appropriate health and social services are not available to homeless beneficiaries within the managed care plan's provider network.

**c. Ensure responsible oversight and financing.**

- **Conduct targeted quality assurance and improvement activities** that focus on beneficiaries experiencing homelessness.
- **Develop fiscally responsible payment methodologies and reimbursement rates** for services provided to homeless beneficiaries, based on cost and service utilization data specific to people experiencing homelessness.

**5. Fully fund SCHIP to cover all uninsured children and their parents with family income at or below 200% FPL.** The State Children's Health Insurance Program (SCHIP) provides high quality, comprehensive, affordable health coverage to children who would otherwise be uninsured. Among children under the age of 19 served by the Health Care for the Homeless Program in 2007, 1,509 (1%) were SCHIP recipients, 54,834 other homeless children (44%) were Title XIX Medicaid recipients, and 63,956 (51%) were uninsured.<sup>13</sup>

SCHIP was reauthorized in February 2009 for five years and will cover approximately 9 million children. Unfortunately, the law eliminates the authority of the Secretary of HHS to grant CHIP waivers for family-based coverage and phases out existing CHIP waivers that allow states to cover parents and childless adults.<sup>14</sup> For this reason, we urge Congress and the Administration to revisit the issues debated prior to the 2009 SCHIP reauthorization within the context of a broader effort to reform the U.S. health care system and provide health insurance coverage for everyone, including adults.

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<sup>13</sup> HRSA. Health Care for the Homeless Rollup Report for CY 2007.

<http://bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm>

<sup>14</sup> Horder D, Guyer J, Mann C, Alker J. The Children's Health Insurance Program Reauthorization Act of 2009. Center for Children and Families, February 2009. <http://ccf.georgetown.edu/index/the-children-s-health-insurance-program-reauthorization-act-of-2009>

# Addiction, Mental Health, and Homelessness

## Summary of Recommendations:

- **Appropriate at least \$2.5 billion for SAPT and \$500 million for CMHS in FY10**
- **Strengthen the Treatment for Homeless Persons (THP) and Projects for Assistance in Transition from Homelessness (PATH) programs**
- **Establish policies and programs that incorporate a broad recovery model of behavioral health care**
- **Establish federal policy that requires all public and private health insurance plans to cover behavioral health services in parity with coverage for other services**

Addiction and mental illness—which are frequently co-occurring—often lead to and prolong homelessness and tend to be exacerbated by the experience. Among surveyed homeless people, 39% report a mental health problem, 38% report alcohol use problems, and 26% report problems with other drugs.<sup>1</sup> In a 2008 survey conducted by the U.S. Conference of Mayors, 26% of homeless individuals had a serious mental illness, compared to 6% of the U.S. population. The top three causes of homelessness among singles identified by the 25 cities responding to this survey were: substance abuse (cited by 68% of cities), lack of affordable housing (60%), and mental illness (48%).<sup>2</sup> Among homeless veterans, the need for mental health and substance use treatment continues to grow. According to the U.S. Department of Veterans Affairs, 45% suffer from mental illness, and half have substance abuse problems.

Homelessness presents serious barriers to treatment for these conditions. People without stable housing often are impoverished, uninsured or underinsured, and alone. Lack of documentation, lack of transportation, and difficulty adhering to treatment regimens prevent many homeless individuals from succeeding in mainstream behavioral health care. In 2004, homeless individuals accounted for more than 175,300 admissions to addiction treatment facilities (13% of all such admissions). People who are homeless are more than twice as likely as their housed counterparts to have had five or more previous treatment episodes.<sup>3</sup> Untreated addictions and mental illnesses present serious barriers to employment and permanent housing, perpetuating an ever-worsening cycle of poor physical health, hospitalization, social dysfunction, useless incarceration, poverty, and homelessness. Without stable housing, even those who are *recovering* from addiction or are *managing* a mental illness often will return to the same high-risk environment following release from incarceration or hospital discharge, thus increasing the potential for relapse (See Policy Statement on Institutional Discharge and Homelessness, [www.nhchc.org](http://www.nhchc.org)).

Mainstream behavioral health care that is universally affordable, readily accessible, and linked to housing would reduce the incidence of homelessness; achieving this goal must be paramount. People who are already experiencing homelessness, however, present complex challenges for which mainstream providers may be ill equipped or untrained. To reach and treat these individuals, adequate funding for targeted programs such as THP and PATH is essential.

## **Recommendations**

**1. Appropriate at least \$2.5 billion for SAPT and \$500 million for CMHS in FY09.** Early and prompt intervention is critical when treating persons with addiction and mental health disorders. Due to monetary constraints and limited understanding of homelessness, however, many mainstream service providers are unable to offer the full range of care necessary to address the complex needs of people experiencing homelessness. The Federal government attempts to meet these needs through a safety net system for people without insurance. The Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Community Mental Health Services (CMHS) Block Grant, and various state programs form the core of the behavioral health safety net, but current funding for these block grants fails to provide adequate addiction

<sup>1</sup> "Homelessness – Provision of Mental Health and Substance Abuse Services." Substance Abuse and Mental Health Services Administration. March 2003. <http://mentalhealth.samhsa.gov/publications/allpubs/homelessness/>

<sup>2</sup> U.S. Conference of Mayors. *Hunger and Homelessness: A Status Report on Hunger and Homelessness in America's Cities, A 25-City Survey*. December 2008. [www.usmayors.org/pressreleases/documents/hungerhomelessnessreport\\_121208.pdf](http://www.usmayors.org/pressreleases/documents/hungerhomelessnessreport_121208.pdf)

<sup>3</sup> "Homeless Admissions to Substance Abuse Treatment: 2004." *The DASIS Report*, Issue 26. Office of Applied Studies, SAMHSA. 2006. <http://www.oas.samhsa.gov/2k6/homeless/homeless.pdf>

and mental health services to the uninsured and the homeless. Interagency collaboration also must be prioritized, including the integration of behavioral and primary care (SAMHSA/HRSA) and the integration of preventive and treatment services in shelters, respite care programs, and supportive housing programs (HHS/HUD).

**2. Strengthen Treatment for Homeless Persons (THP) and Projects for Assistance in Transition from Homelessness (PATH).** Recognizing that homelessness restricts access to mainstream addiction and mental health services, Congress established the THP (PHSA Section 506) and PATH (PHSA Title V, Part C) programs to provide these services specifically for people experiencing homelessness. Insufficient funding for the two programs, however, prevents many people in need of treatment from receiving services. SAMHSA is redirecting half of THP funds to services in Permanent Supportive Housing—reducing treatment resources for those currently homeless. **We urge Congress to appropriate at least \$100 million for THP and \$75 million for PATH. Congress also must affect statutory changes through SAMHSA reauthorization to improve these programs:** First, Health Care for the Homeless grantees—already required by statute to provide addiction services—should be added as preferred entities for THP grants. Second, effective THP grantees whose funding would otherwise expire should be prioritized for renewal. Third, SAMHSA must include “harm reduction” models of addiction treatment among its “best practices” and encourage such approaches within an array of treatment strategies for THP grantees and others providing addiction treatment for homeless persons. Lastly, to end perpetual flat funding for rural and frontier populations, the minimum PATH allocations for States and territories must be doubled to \$600,000 and \$100,000 respectively.

**3. Establish policies and programs that incorporate a broad recovery model of behavioral health care.** Public education has produced positive outcomes in reducing the demand for illicit drugs. For many, however, the narrow focus upon abstinence-only programming within the publicly funded addiction services system is a barrier to successful recovery. Effective treatment systems must include outreach and engagement, “harm reduction” strategies, a “housing first” approach with appropriate supports, multidisciplinary treatment teams, integrated treatment for co-occurring disorders, motivational enhancement interventions, risk reduction, and the active involvement of consumers in planning and delivery of services. We urge Federal, State, and local governments to establish policies and programs, consistent with emerging evidence-based practices, that respond to the needs of the full range of people with addiction.

**4. Establish federal policy that requires all public and private health insurance plans to cover behavioral health services in parity with coverage for other health services.** Restrictions imposed by private insurers on the duration and scope of treatment for behavioral health and addiction services often force people to utilize publicly-funded services despite having other insurance. This trend has contributed to significant increases in the public share of spending for mental health and addiction treatment. Responding to insufficient coverage for behavioral health coverage, Congress passed the Mental Health Parity Act of 2008, which partially addressed this inequity. To strengthen this initiative, we urge Congress and the Administration to require all health care plans, including state Medicaid plans, to cover behavioral health services in parity with medical care. For poor and disabled individuals lacking private insurance, Medicaid benefits also must include the full scope, amount, and duration of necessary addiction and/or mental health services. We urge Congress and the Administration to amend the Medicaid statute to designate behavioral health services as mandatory rather than optional benefits and to direct State administrators to assist Federally Qualified Health Centers in obtaining funding for mental health services from all available revenue streams, including block grants and Medicaid billing.

# Child & Youth Homelessness

## Summary of Recommendations:

- **Guarantee access to comprehensive and affordable health insurance, including coverage for mental health services and treatment of substance use disorders, for every person under age 21**
- **Fully fund the State Children’s Health Insurance Program (SCHIP) to cover all uninsured children and their parents with family income at or below 200% FPL**
- **Provide sufficient Federal funding to support participation of all eligible children in the Head Start program**
- **Fully fund Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act at \$210 million**

**The transition to adulthood should be supported with adequate access to medical care, including treatment for mental illness and substance use disorders,** particularly for low-income uninsured youth. Over nine million children and youth in the United States currently have no form of health insurance and are ineligible for public insurance programs. The most effective and efficient way to assure that all people—children and adults—receive adequate medical care, mental health services, and addiction treatment is through a universal health insurance program with a single-payer financing mechanism. Until true universal coverage is achieved, however, we must continue to support and strengthen existing safety net programs. Medicaid and the State Children’s Health Insurance Program (SCHIP) provide high quality, comprehensive, affordable health coverage for low-income children and youth. Of those under age 19 served by the Health Care for the Homeless Program in 2007, 1,509 (1%) were SCHIP recipients, 54,834 (44%) were Title XIX Medicaid recipients, and 63,956 (51%) were uninsured.<sup>1</sup> To help low-income youth retain their health care coverage as they transition into adulthood, 17 states have extended Medicaid coverage up to age 21, in addition to expanding SCHIP eligibility.<sup>2</sup>

**Impoverished youth are at high risk of experiencing homelessness.** Each year, 800,000 children and youth become homeless in the United States,<sup>3</sup> and an estimated 520,000 children reside in foster care.<sup>4</sup> Research indicates that children from low-income families are at especially high risk for mental health and substance use problems but often lack access to necessary treatment. Seventy-five percent of adults with mental health disorders had been diagnosed prior to age 18.<sup>5</sup> The increased incidence of attention-deficit/hyperactivity disorder (ADHD), depression, and other psychological disorders among homeless youth and children in the foster care system indicate a need for expanded mental health services.<sup>6</sup> Uninsured and underinsured parents who are unable to access mental health and addiction services for their children are increasingly dependent on the child welfare system to provide these services. The GAO reported that an estimated 12,700 children in 19 states were placed into child welfare or juvenile justice systems so that these children could receive mental health services.<sup>7</sup>

## **Educational opportunities for homeless youth are essential to break the cycle of homelessness.**

Research shows that children learn better when they have strong mental and physical health. The Head Start program has a long tradition of providing comprehensive and high-quality services that advance healthy development for low-income youth; however, Federal support for this program has

<sup>1</sup> Health Resources and Services Administration (HRSA). Health Care for the Homeless Rollup Report for CY 2007.. <http://bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm>

<sup>2</sup> Patel, S. & Roherty, M. (2007). Medicaid Access for Youth Aging Out of Foster Care. *The American Public Human Services Association*.

<sup>3</sup> U.S. Department of Education. Education for Homeless Children and Youths Grants for State and Local Activities. <http://www.ed.gov/programs/homeless/index.html> (page last modified on 9/09/08)

<sup>4</sup> U.S. Department of Health and Human Services, Administration on Children and Families (AFCARS), Administration on Children, Youth and Families, Children’s Bureau. The AFCARS Report: Interim FY 2003 Estimates as of June 2006. [http://www.acf.hhs.gov/programs/cb/stats\\_research/afcars/tar/report10.htm](http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report10.htm)

<sup>5</sup> Kim-Cohen, et. al (2003), Prior Juvenile Diagnoses in Adults With Mental Disorder, *Archives of General Psychiatry*, 60: 709-717.

<sup>6</sup> Warfield, M. & Gulley, S. (2006). Unmet Need and Problems Accessing Specialty Medical and Related Services Among Children with Special Health Care Needs. *Maternal and Child Health Journal*, 10 (2). 201-216.

<sup>7</sup> “Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the number of Children Placed Solely to Obtain Mental Health Services”, Government Office of Accountability (GAO), 2003. <http://www.gao.gov/new.items/d03397.pdf>

decreased by 11% since 2002.<sup>8</sup> This has caused Head Start programs to reduce transportation, social services, educational programming, parental support, and other essential services. In an effort to revitalize the program, the Improving Head Start for School Readiness Act of 2007 (H.R. 1429) was signed into law with the goal of improving young children's preparation for kindergarten by increasing income eligibility to 130% of the Federal poverty level. Expanding eligibility requirements for Head Start has improved homeless children's access to essential services.

## Recommendations

1. **Guarantee access to comprehensive and affordable health insurance, including mental health and substance use treatment, for every person under age 21.** Until universal health insurance is enacted, we recommend that this be achieved by expanding Medicaid and the State Children's Health Insurance Program (SCHIP). Currently, the Federal government allows states to extend Medicaid coverage to children up to age 21; however, not all states take advantage of this federally-matched option. The Federal government should also provide funding to support an extension of Medicaid coverage up to age 23 for youth transitioning out of foster care. It is unreasonable to ask those from the most difficult circumstances to be self-sufficient when their more advantaged counterparts are still dependent on parents for the majority of their needs.<sup>9</sup>
2. **Fully fund the State Children's Health Insurance Program (SCHIP) to cover all uninsured children and their parents with family income at or below 200% FPL.** SCHIP currently provides high quality, comprehensive, affordable health coverage to children who would otherwise be uninsured. SCHIP was reauthorized in February 2009 for five years and will cover approximately nine million children, but the reauthorization act prohibits approval of any new State waivers to cover parents with CHIP funds.<sup>10</sup> When parents have health insurance, children are more likely to be covered and have access to health care.<sup>11</sup> Therefore, we urge Congress to revisit the issues debated as part of the 2009 SCHIP reauthorization, within the context of a broader effort to reform the U.S. health care system and assure health coverage for adults as well as children.
3. **Provide adequate federal funding to support participation of all eligible children in the Head Start program.** In the FY 2008 Appropriations bill, funding to Head Start was cut by more than \$10 million. Only 42% of eligible children are able to enroll in the Head Start program due to lack of funding. We call upon Congress to increase Federal funding for the Head Start program so that all eligible children may be served.
4. **Fully fund Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431) at \$210 million.** Between the 2006-2007 school year and the 2007-2008 school year, there was an 18% increase in the number of homeless children and youth identified and enrolled in public schools. In the current school year, 2008-2009, schools are reporting even more dramatic increases. In the first few months of the school year, many school districts had already identified the entire previous year's caseload. Congress must strengthen the education of homeless children by ensuring that every homeless child can enroll in and attend school and receive the services needed to succeed.

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<sup>8</sup> Office of Head Start, U.S. Department of Labor, Bureau of Labor Statistics and the Congressional Budget Office. 2007.

<sup>9</sup> Ammerman SD, Ensign J, Kirzner R, Meininger ET, Tornabene M, Warf CW, Zerger S, Post P. *Homeless Young Adults Ages 18–24: Examining Service Delivery Adaptations*. National Health Care for the Homeless Council, Inc., 2004. <http://www.nhchc.org/Publications/101905YoungHomelessAdults.pdf>

<sup>10</sup> Georgetown University Health Policy Institute, Center for Children and Families. The Children's Health Insurance Program Reauthorization Act of 2009 [CHIPRA]: Overview and Summary. March 2009. <http://ccf.georgetown.edu/index/schipreauthorization>

<sup>11</sup> Artiga S and C Mann. "Family Coverage Under SCHIP Waivers." Kaiser Commission on Medicaid and the Uninsured. (#7644; May 2007). <http://www.kff.org/medicaid/upload/7644.pdf>

# Housing and Homelessness

## **Summary of Recommendations:**

- **Reauthorize and appropriate \$3 billion for McKinney-Vento Homeless Assistance** programs within the Department of Housing and Urban Development (HUD) through the HEARTH Bill (S. 808/H.R. 1877)
- **Align the HUD definition of homelessness with other Federal definitions** to include people sharing the housing of others due to loss of housing, economic hardship, or a similar reason, and to people living in hotels or motels due to lack of adequate alternatives
- **Provide dedicated sources of funding for the National Housing Trust Fund** to build, preserve, and rehabilitate 1.5 million units of housing affordable to low-income people over the next ten years
- **Preserve and increase current publicly assisted housing.** Fund all Section 8 housing vouchers currently in use, and provide additional funding for 200,000 new vouchers a year.
- **Restore the requirement for a one-to-one replacement of low-income housing units** to increase the availability of affordable housing
- **Assure access to affordable housing with a full range of supportive services for people experiencing homelessness**—emphasizing client choice and models that eliminate preconditions to housing and provide immediate access regardless of treatment compliance
- **Fund renewals of the Shelter Plus Care and Supportive Housing Programs** from HUD's Housing Certificate Fund
- **Support public and private initiatives that keep people from becoming homeless**
- **Assure that targeted services funded by HUD are maintained** as HUD support is withdrawn

## **Affordable housing shortages serve as the major barrier to the elimination of homelessness.**

Between 1976 and 1983, HUD budget authority shrank from \$83 billion to \$18 billion (in 2004 constant dollars), and has languished below \$35 billion since. Today, HUD maintains about 1.8 million units of public housing; however, only 1.01 of these units is occupied.<sup>1</sup> Drastic Federal disinvestment in affordable housing has unsurprisingly led to a greater number of low-income households that experience housing problems. More than 60% of extremely low-income households spend more than 30% of their income on housing<sup>2</sup> – exceeding HUD's affordability standard – and 3.5 million people experience homelessness each year – the most visible and vicious symptom of our affordable housing crisis.

The cost of housing is increasingly out of reach. While the Federal minimum wage has risen only nominally since 1997, housing costs have significantly increased across the nation. Nationwide, 9 million extremely low income renter households compete for 6.2 million rental homes they can afford. Currently, there is no jurisdiction in the U.S. where a minimum wage worker can afford even a one-bedroom apartment at fair market rent. A person working full time must earn an hourly wage of \$16.31 to rent an average two-bedroom apartment.<sup>3</sup> As the subprime mortgage crisis forces moderate-income households to lower-cost rental housing, the poor find themselves increasingly squeezed out. The widening gap between housing cost and income puts millions of people at risk of losing their homes and facing life on the street or in shelters.

**Housing is health care.** Homelessness causes medical problems, greatly exacerbates existing illness, and seriously complicates treatment. People without homes are exposed to the elements, the violence of the streets, diseases that are rampant in overcrowded shelters, and the debilitating effects of poor diet and lack of rest. A person experiencing homelessness is 3 to 4 times more likely to die than their housed counterparts.<sup>4</sup> Indeed, stable, sanitary housing is central to effective health care. Mounting evidence suggests that housing status is itself a stronger predictor of HIV risk and health outcomes than individual

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<sup>1</sup> National Housing Law Project. Housing Justice Network Training. Washington, DC. December 2008.

<sup>2</sup> Western Regional Advocacy Project. *Without Housing: Decades of Federal Housing Cutbacks Massive Homelessness and Policy Failures*. Nov 2006. [http://www.wrphome.org/wh\\_press\\_kit/Without\\_Housing\\_20061114.pdf](http://www.wrphome.org/wh_press_kit/Without_Housing_20061114.pdf)

<sup>3</sup> National Low Income Housing Coalition. *Out of Reach 2007-2008*. Dec 2007. <http://www.nlihc.org/oor/oor2008/>

<sup>4</sup> O'Connell, James. *Premature Mortality in Homeless Populations: A Review of the Literature*. December 2005. <http://www.nhchc.org/PrematureMortalityFinal.pdf>

characteristics.<sup>5</sup> Local, State, and Federal leaders must target housing assistance to people experiencing homelessness, assist those with the greatest housing needs, and change the housing policies that reduce the supply of affordable housing and produce homelessness. The Homeless Prevention and Rapid Re-housing Program (HPRP) funded by the American Recovery and Reinvestment Act of 2009 will provide welcome relief to many individuals and families across the country who are homeless or at imminent risk of becoming homeless. Nevertheless, longer term solutions are needed to prevent and end homelessness in the United States.

## Recommendations

1. **Reauthorize and appropriate \$3 billion for HUD's McKinney-Vento Homeless Assistance programs through the HEARTH bill (S.808/ H.R. 1877).** This legislation broadens the definition of homelessness; expands homeless prevention activities, for individuals and families at risk of becoming homeless; consolidates the Shelter Plus Care, Supportive Housing Program, and Moderate Rehabilitation/SRO programs into a single "Continuum of Care Program;" provides new incentives that emphasizes rapid re-housing, especially for homeless families; and continues to fund the continuum of care necessary to ameliorate homelessness.
2. **Align HUD's definition of homelessness with other Federal definitions.** Federal agencies administering targeted homeless assistance programs utilize diverse definitions of homelessness reflecting differing agency missions and authorizing legislation. As a result, extremely vulnerable people assisted by one Federal program are sometimes prevented from receiving needed services provided by another. For example, families and youth who "double up" due to economic hardship or loss of housing are served by HCH projects but excluded from HUD homeless programs. In order to foster interagency collaboration, HUD's definition of homelessness must be broadened to a common, comprehensive Federal definition that includes people sharing the housing of others (due to loss of housing, economic hardship, or a similar reason), and people living in motels, hotels, or campgrounds due to lack of adequate alternatives.
3. **Provide dedicated sources of funding for National Housing Trust Fund** to build, preserve, and rehabilitate 1.5 million units of housing affordable to low-income people over the next ten years. The Obama Administration has included \$1 billion in its FY 2010 budget proposal to capitalize and launch the NHTF to help prevent homelessness and preserve families. We urge Congress to support the Administration in this effort.
4. **Preserve and increase current publicly assisted housing.** Fund all Section 8 housing vouchers currently in use and provide additional funding for 200,000 new vouchers per year as necessary. Congress also must restore the requirement that local authorities give preference to people experiencing homelessness when granting public housing assistance.
5. **Restore the requirement for a one-to-one replacement of low-income housing units** to reverse the decreased availability of affordable housing. Many states and cities, with Federal support, are replacing outdated public housing units and unsightly high-rise buildings with more attractive and community-oriented buildings. These new developments are usually mixed-income with only a fraction of the new units dedicated to low-income individuals and families. This reduction in the affordable public housing stock only increases the incidence of homelessness; cities and states must strictly prohibit the loss of public housing units. Necessary public housing renovation should provide for replacement of low-income units – onsite or in the neighborhood – on at least a one-to-one ratio, and planning for renovations must always involve the residents affected.

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<sup>5</sup> Aidala, Angela, Columbia University. "Risky Persons vs. Contexts of Risk – Housing as a Structural Factor Affecting HIV Prevention and HIV Care." November 2007.  
[http://www.champnetwork.org/media/CF2007.11.14-Presentation2-Angela\\_Aidala-Risky\\_Contexts.ppt](http://www.champnetwork.org/media/CF2007.11.14-Presentation2-Angela_Aidala-Risky_Contexts.ppt)

6. **Assure access to affordable housing with a full range of supportive services for people experiencing homelessness.** The human right to housing should be assured for homeless individuals and families through a range of options based upon the populations served as well as client choice. Housing should be considered “permanent” with a full array of “transitional” services available as long as needed to keep people stably housed and off the streets. Beyond housing coupled with recovery-driven services, Congress also should expand models that eliminate preconditions to housing and ensure immediate access regardless of compliance in any particular form of treatment. Such approaches – which provide a range of optional services – have proven effective in ending homelessness even for individuals with complicated health-related problems including addiction, mental illness, and HIV/AIDS. Success in housing requires sufficient availability of affordable units, adequate funding for flexible and integrated supportive services, and high-quality property management.<sup>6</sup>
7. **Fund renewals of the Shelter Plus Care and Supportive Housing Programs from HUD’s Housing Certificate Fund.** Homeless program resources must remain available for new housing and other supportive services for people who remain homeless. These programs combine rent subsidies with intensive support services and treatment, including mental health assistance, substance use counseling, employment training, and a range of other supportive services that keep people housed while they build the skills to live as independently as possible.
8. **Support public and private initiatives that keep people from becoming homeless.** We urge policy makers to support regulatory mechanisms such as rent control and vacancy decontrol to shield tenants against the market forces that cause displacement. Laws that protect tenants from unfair evictions and high rent increases should be enacted or restored. Further, we urge public officials to pursue initiatives to protect low-income housing against “gentrification” and to support tenant organizing by enforcing the laws that protect tenants against harassment or threat of eviction for joining a tenant association. Because there is not enough public housing to meet current needs, we urge the creation of more “socially owned” housing, such as limited equity cooperatives and condominiums, where buildings are collectively owned by their residents and remain affordable to future owners. Local communities should expand nonprofit ownership alternatives, such as community development corporations that own and develop non-speculative, permanently affordable housing. It is time for policy makers to treat housing as a right rather than merely a business venture.
9. **Assure that targeted services funded by HUD and HHS are maintained as HUD support is withdrawn.** Supportive services must be overseen by an agency with expertise in the coordination of comprehensive physical and behavioral health care for people experiencing homelessness, such as the Department of Health and Human Services. Targeted supportive services must be funded with new dollars, not by diminishing already-strained service programs, and the Congress should require that HUD maintain current levels of funding for homeless services until new funding is established.

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<sup>6</sup> Post, Patricia. *Defining and Funding the Support in Permanent Supportive Housing: Recommendations of Health Centers Serving Homeless People*. National Health Care for the Homeless Council, prepared for the Corporation of Supportive Housing, 2008. <http://www.nhchc.org/PSHReport.pdf>

# Disability Benefits and Homelessness

## Summary of Recommendations

- **Assure timely and accurate disability determinations for SSI/SSDI claimants who are homeless.**
- **Assure the adequacy of SSI/SSDI benefit amounts to meet the needs of homeless recipients.**
- **Ensure that individuals with substance use disorders and co-occurring impairments who meet current Social Security disability criteria receive SSI/SSDI benefits.**
- **Restore SSI/SSDI eligibility to persons whose substance use is “material to their disability.”**

**Disability precipitates and prolongs homelessness.** It is a national disgrace that people with disabilities constitute a large percentage of the “chronically homeless” population in America.<sup>1</sup> Diminishing access to income support and health insurance coverage over the past two decades<sup>2</sup> has placed an increasing number of individuals and families with disabling health conditions at risk of homelessness. Any strategy to prevent and end homelessness must include adequate financial supports for persons whose disabilities prevent them from earning income through employment sufficient to secure housing, health care, and other basic needs.

**Disability assistance can also mitigate health risks associated with homelessness.** Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) constitute a safety net for persons with disabilities, providing cash assistance and, usually, eligibility for public health insurance (Medicaid/Medicare). Those who qualify for SSI/SSDI are also more likely than others to obtain available low-cost housing, including supportive housing. By increasing access to housing and health care, these programs can mitigate the extraordinary health risks associated with homelessness, expedite recovery, improve the quality of lives, and help beneficiaries to achieve stability and resume productivity.

**Barriers to accessing SSI/SSDI benefits can increase the risk of protracted homelessness.** Homeless SSI/SSDI claimants often are denied benefits for failure to negotiate the arduous application process, rather than for lack of serious medical impairments that meet SSA disability criteria. Systemic barriers include poor access to health services, insufficient documentation of diagnosis and functional impairments by an approved medical source, remote application offices, complex application processes, disability evaluators unfamiliar with the plight of homelessness, and inconsistent implementation of SSA disability determination policy across jurisdictions. Barriers often are exacerbated by an applicant’s mental illness or by the lack of personal stability necessary to maintain contacts and meet deadlines throughout the multiple steps of an application review.<sup>3</sup>

## Recommendations

### **1. Assure timely and accurate disability determinations for SSI/SSDI claimants who are homeless.**

Waiting periods between application and eligibility determination that average one to three years are especially devastating for homeless claimants. To expedite disability assistance for persons likely to be eligible for SSI or SSDI, the National Health Care for the Homeless Council urges Congress and the Administration to:

- **Continue and augment funding for the SSI/SSDI Outreach, Access & Recovery (SOAR) Project<sup>4</sup> and other initiatives that have demonstrated success in expediting disability**

<sup>1</sup> According to the federal definition, a chronically homeless person is “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years” (Collaborative Initiative to Help End Chronic Homelessness, notice of funding availability, 2000).

<sup>2</sup> Center on Budget and Policy Priorities. (Dec. 2007). Poverty and Hardship Affect Tens of Millions of Americans. <http://www.cbpp.org/12-20-07pov.htm>

<sup>3</sup> O’Connell et al. (2007). *Documenting Disability: Simple Strategies for Medical Providers*. Health Care for the Homeless Clinicians’ Network, National Health Care for the Homeless Council, Inc. <http://www.nhchc.org/DocumentingDisability2007.pdf>

<sup>4</sup> Launched in 2005 with SAMHSA and HUD support, SOAR helps states and communities develop strategies and provide training to case workers who assist individuals in preparing accurate and complete SSI or SSDI applications. Outcomes for 19 states reporting to date indicate that SSI/SSDI allowances for homeless applicants averaged 70% on initial application with decisions received in an average of 93 days. For more information see: [www.prainc.com/soar](http://www.prainc.com/soar)

**benefits for eligible homeless claimants** by improving allowance rates at initial consideration and reducing the interval between SSI/SSDI application and receipt of benefits.

- **Encourage Federal interagency support for SSI/SSDI** and other programs and activities which mitigate the effects of homelessness and reduce its incidence and duration.
- **Assure better cooperation between the Social Security Administration (SSA), State Disability Determination Services (DDS) and community initiatives nationwide to expedite disability benefits for eligible homeless claimants.** Encourage SSA to flag all applications from individuals who are homeless so as to expedite processing at the DDS. Encourage all DDS agencies to establish a Homeless Claims Unit with designated examiners responsible for processing SSI/SSDI claims filed by homeless persons and for expediting disability determinations for such claimants. Direct SSA to consider repeated episodes of homelessness *per se* as an indicator of functional impairment. Encourage SSA field offices to develop partnerships with community health and social services providers to help homeless people with SSI/SSDI applications.
- **Revise the SSA Homelessness Plan to incorporate lessons learned from HOPE,<sup>5</sup> SOAR, and the Baltimore SSI Outreach Project.<sup>6</sup>** SSA-funded demonstration projects have confirmed policies and procedures that can expedite access to SSI/SSDI for applicants who are homeless. Successful strategies include: (1) educating SSA and DDS staff about issues related to homelessness; (2) designating SSA and DDS staff to assist homeless claimants; (3) ensuring that all such applications are flagged for expedited processing; (4) tracking outcomes of applications from homeless applicants separately from those of other applicants; and (5) developing processes to ensure that eligibility determinations are made as soon as possible. Such strategies should be incorporated into a revised SSA Homelessness Plan that includes timelines for implementation.
- **Ensure prompt decisions at the administrative law judge hearings level.** Case backlogs are resulting in delays of 22 months or longer to get a hearing. Encourage efforts to expedite and improve the accuracy of disability determinations at initial consideration (exemplified by the SOAR initiative) which can reduce these backlogs. Encourage hearings offices to process as many reviews on record as possible to help reduce the hearings backlog.
- **Develop special SSI eligibility determination processes for claimants who are homeless and who have mental illness, and train designated SSA claims representatives to respond appropriately to such claimants.** Add homelessness with diagnosed schizophrenia to criteria for Presumptive Disability, which allows claimants to receive six months of benefits pending determination of their eligibility for extended benefits.
- **Expand the list of "acceptable medical sources" that can provide medical evidence of impairment to include nurse practitioners, physician assistants, and licensed clinical or psychiatric social workers,** for purposes of documenting disability in applications for SSI/SSDI benefits.
- **Develop a policy to identify homeless SSI/SSDI applicants.** Report aggregate numbers of homeless SSI/SSDI claimants, rates of approval, and average length of time between application and final determination.
- **Eliminate the 2-year waiting period for Medicare.** Claimants meeting the stringent eligibility criteria for SSDI are considered to have a significant disability and should have immediate access to health coverage. The 2-year waiting period for Medicare after qualifying for SSDI presents significant barriers to health care for individuals who have already insured themselves for benefits

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<sup>5</sup> The Homeless Outreach Projects and Evaluation (HOPE) program, established by the Social Security Administration, provided grant funding to 41 agencies in 2004 to assist chronically homeless individuals in applying for SSI and SSDI benefits. <http://www.ssa.gov/homelessness/outreach.htm>

<sup>6</sup> The University of Maryland Medical System Baltimore SSI Outreach Project began in 1993 as SSA funded outreach demonstration project, designed to assist homeless adults with severe and persistent mental illness in obtaining SSI benefits. Over 10 years, the project achieved a 96% success rate on application for those whom project staff believed to be eligible for benefits.

by virtue of their contributions to the Social Security trust fund through a tax on their earnings. Health insurance should be included among SSDI benefits.

- **Expand the list of Compassionate Allowance<sup>7</sup> categories to include disabling health conditions that are disproportionately experienced by homeless applicants**—such as uncontrollable diabetes and chronic neuropathies.

2. **Assure the adequacy of SSI benefit amounts to meet the needs of homeless recipients.** The SSI program was “designed to provide a positive assurance that the Nation’s aged, blind, and disabled people would no longer have to subsist on below poverty-level incomes.”<sup>8</sup> Yet Federal policy ensures that SSI recipients remain nearly destitute. We urge Congress and the Administration to:

- **Ensure disability benefit levels high enough to enable program participants to meet basic needs, including housing.** Index disability payments to local costs of living (e.g. HUD Fair Market Rent calculations). Minimally, the federal SSI payment should equal the Federal Poverty Level (\$903 for an individual in 2009).
- **Update income disregards.** Increase the earned income disregard, which has remained unchanged since 1972, to ensure incomes at or above the Federal Poverty Level (\$903 for an individual in 2009).
- **Update asset eligibility criteria.** Increase SSI asset limits (\$2,000 for an individual) to reflect current costs and indexed for future costs of living. (Current asset limits have not been adjusted since 1989, failing to keep up with inflation.)
- **In all states, assure automatic linkage between SSI cash assistance and Medicaid coverage,** which are essential to persons with disabilities who are homeless. Timely Medicaid coverage should be guaranteed for all persons determined eligible or presumptively eligible for SSI benefits.

3. **Ensure that individuals with substance use disorders and co-occurring impairments who meet current Social Security disability criteria receive SSI/SSDI benefits.** The 1996 termination of SSI/SSDI eligibility for individuals whose substance use is material to their disability was not intended to disqualify individuals with other impairments that meet Social Security disability criteria. Such denials have nevertheless been widely reported to occur at the initial stage of disability determination, frequently requiring later reversal at the appeals level. Exclusion of these persons from SSI/SSDI benefits disregards the intent of Congress. We therefore urge Congress and the Administration to restate this intent and provide sufficient oversight to assure that SSI/SSDI eligibility is more consistently granted to persons whose disability is not materially affected by their alcohol or drug use.

4. **Restore SSI/SSDI eligibility to persons whose substance use is material to their disability.** Welfare reforms in 1996 terminated SSI/SSDI eligibility for individuals whose substance dependence is “a contributing factor material to the determination of their disability.” The continuing exclusion of such persons from SSI/SSDI benefits disregards medical knowledge about the nature of addictions and ignores the survival needs of individuals with disabilities, including access to medical services and treatment for these progressive and often fatal disorders. We therefore urge Congress and the Administration to restore SSI/SSDI eligibility to persons whose alcohol or drug use is material to their disability.

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<sup>7</sup> Compassionate allowances (CAL) enable Social Security to provide SSI/SSDI benefits quickly to applicants whose medical conditions are so serious that their conditions obviously meet disability standards. <http://www.ssa.gov/compassionateallowances/>

<sup>8</sup> “Social Security Amendments of 1972, S. Rpt. 92-1230.” *U.S. Senate Committee on Finance*.

# Fair Wages and Homelessness

## **Summary of Recommendations:**

- **Enact a Universal Living Wage**
- **Adopt House Joint Resolution 35**
- **Ratify the International Covenant on Economic, Social, and Cultural Rights (ICESCR)**
- **Promote living wage policies among homeless service providers and advocacy organizations**

**Homelessness is fundamentally a symptom of poverty.** Approximately 3.5 million people experience homelessness each year, and the federal government estimates that 42% of them are working.<sup>1</sup> Minimum wage jobs, primarily in the service sector, pay below even modest calculations of the cost of living. As a result, many working individuals and families find themselves with nowhere to turn but shelters and the streets. The Federal minimum wage was established in 1938 by the Fair Labor Standard Act to ensure that a full-time worker could afford basic food, clothing, and shelter. In 1997, Congress set the minimum wage at an already-inadequate \$5.15 per hour. After allowing inflation to corrode its value for a decade, Congress passed legislation to increase the Federal hourly minimum wage to \$5.85 in 2007, \$6.55 in 2008 and \$7.25 in 2009. With these increases, 14.9 million workers will receive raises.<sup>2</sup> Although warranted, these incremental reforms still force many individuals and families to make impossible choices among housing, food, clothing, medical care, and transportation. Because rent inflation, job losses, health care costs, and other factors quickly can destabilize the housing status of a working individual or family, plans purporting to address homelessness first must combat the causes of poverty.

**The declining value of the Federal minimum wage and the economic recession threatens working families.** Throughout the 1960s and much of the 1970s, the Federal minimum wage for one full-time worker was sufficient to keep a family of three out of poverty. Today, an employee who works 40 hours per week at the minimum wage earns \$15,080 annually, four-fifths of the 2009 poverty threshold for a family of three (\$18,310).<sup>3</sup> There is no jurisdiction in the United States where a renter with a full-time job paying the prevailing minimum wage can afford even a one-bedroom apartment priced at the Fair Market Rent.<sup>4</sup> The purchasing power of the Federal minimum wage is now at a 51-year low. At its peak in 1968, the real value of the minimum wage was equivalent to \$7.71 an hour.<sup>5</sup> The percentage of Americans below 50% of the Federal poverty level has increased every year since 2000. The rate of poverty in the United States has risen from 11.3% (31.3 million people) in 2000 to 12.5% (37.3 million) in 2007—witnessing a slight decline from 12.6% in 2005, though not statistically different—and approximately 65% of those families include at least one worker.<sup>6</sup> With the unemployment rate up to 8.5% in March 2009, the highest in 14 years, more people are expected to fall into poverty as a result of job loss.<sup>7</sup>

**Increasing the minimum wage does not create unemployment.** Opponents of wage increases contend that they hurt businesses and force massive layoffs. Following the 1997 minimum wage increase the country observed no surge in the unemployment rate; in fact, unemployment continued to decrease. Accordingly, the 1999 Economic Report of the President stated: “Many studies have examined this issue and the weight of evidence suggests that modest increases in the minimum wage have had very little or no effect on employment.”

<sup>1</sup> National Coalition for the Homeless. *Welfare to What II*, 2001. Available from the National Coalition for the Homeless, 2201 P St NW, Washington, DC 20037, Phone: 202.462.4822 | Fax: 202.462.4823. [www.nationalhomeless.org](http://www.nationalhomeless.org)

<sup>2</sup> Fox, Liana. “Minimum Wage Trends.” *Economic Policy Institute Briefing Paper*. 8, November 2006. <https://www.policyarchive.org/bitstream/handle/10207/8032/bp178.pdf?sequence=1>

<sup>3</sup> U.S. Department of Health and Human Services. Federal Register, Vol. 74, No. 14. 23, January 2009.

<sup>4</sup> Crowley, Sheila, et al. “Out of Reach 2007-2008.” National Low Income Housing Coalition. The Fair Market Rent is an amount determined by the US Dept. of Housing and Urban Development (HUD) to be the cost of modest, non-luxury rental units in a specific market area. <http://www.nlihc.org/oor/oor2008/>

<sup>5</sup> Center on Budget and Policy Priorities. Bernstein, J. and Shapiro, I. *Buying Power of Minimum Wage at 51 Year Low: Congress Could Break Record for Longest Period Without Increase*. June 20, 2006. <http://www.cbpp.org/cms/?fa=view&id=405>

<sup>6</sup> DeNavas-Walt, Carmen, et al. “Income, Poverty, and Health Insurance Coverage in the United States: 2007.” U.S. Census Bureau. August 2008. [www.census.gov/prod/2008pubs/p60-235.pdf](http://www.census.gov/prod/2008pubs/p60-235.pdf)

<sup>7</sup> U.S. Department of Labor. *Employment Situation*. April, 2009. <http://www.bls.gov/news.release/empsit.nr0.htm>

## Recommendations

1. **Enact a Universal Living Wage**—either through Federal legislation or through support of state and local efforts. The calculation of a universal living wage is based on the premise that if a person works 40 hours a week, then he/she should be able to afford basic housing and other basic needs. In addition to enabling full-time workers to support their families, a living wage would improve workplace morale, increase productivity and retention rates, and reduce the reliance of wage workers upon public benefits. Most importantly, living wages would reduce the likelihood that workers and their families will experience homelessness.
2. **Adopt House Joint Resolution 35.** This resolution, introduced in the House by Congressman Jesse Jackson, Jr. (D-IL), would amend the Constitution to include the rights to free choice of employment, favorable working conditions, unemployment protections, equal pay for equal work, sufficient income, and formation of and participation in trade unions.
3. **Ratify the International Covenant on Economic, Social and Cultural Rights.** The ICESCR and the International Covenant on Civil and Political Rights (ICCPR) were drafted by the United Nations in 1966 to codify the rights enumerated in its Universal Declaration of Human Rights (UDHR) in 1948. Member States typically endorse a treaty to signal their intent to ratify it at a later time; signing a treaty or covenant is a non-binding act of goodwill, whereas ratification is the process by which a national government agrees to be subject to the international law detailed in the document. The United States signed both the ICESCR and the ICCPR in 1977, and the ICCPR was subsequently ratified in 1992, but there has been no progress toward the ratification of the ICESCR, which includes the right to a living wage. The United States' ratification of this document would advance the campaign for global human rights and direct the Covenant's ratifying Parties into a discussion of international standards for workers' remuneration. The National Health Care for the Homeless Council urges the Administration and Congress to proceed with the ratification of the ICESCR and the full realization of the rights specified therein.
4. **Promote living wage policies among homeless service providers and advocacy organizations.** As the National Council strives to end and prevent homelessness in the United States, HCH clinics and other organizations committed to the nationwide implementation of living wages must work to ensure that their own employees are paid wages sufficient to prevent homelessness. Such efforts have proven difficult for certain agencies struggling with small budgets, limited funding sources, and pressing unmet human need. The National Council acknowledges these legitimate budgetary challenges, applauds the leadership of those organizations which nonetheless have prioritized living wages, and encourages all HCH projects and other agencies to work toward living wage policies within their organizations.

# Incarceration, Homelessness, and Health

## Summary of Recommendations:

- **Decriminalize the condition of homelessness** by repealing federal, state, and local statutes that criminalize life-sustaining activities performed in public spaces that are permissible in the privacy of a home
- **Ensure continuity of health care for persons detained by criminal justice authorities**, including appropriate treatment for addictions, mental illness, and other chronic conditions
- **Ban discrimination against ex-offenders in housing, employment, and voter registration**

**Homelessness contributes to heightened risk for incarceration, and incarceration contributes (upon release) to a heightened risk of homelessness.**<sup>1</sup> Of surveyed homeless individuals, 54 percent report spending time in a city or county jail, in state or federal prison, or in juvenile detention. People experiencing homelessness are arrested more often, incarcerated longer, and re-arrested at higher rates than are people with stable housing.<sup>2</sup> A number of city governments utilize incarceration as a misguided attempt to deter people from living on the streets. Many local jurisdictions criminalize homelessness by adopting and enforcing ordinances that prohibit activities such as sleeping, standing, or begging in public spaces.

**Homeless people with behavioral health disorders are overrepresented in the criminal justice system.** State prisoners and local jail inmates who had a mental health problem were twice as likely as inmates without a mental health problem to have experienced homelessness in the year before their incarceration.<sup>3</sup> Yet the reality that few have access to adequate medical or behavioral health care in the community or during incarceration only exacerbates behaviors that lead to arrest. The U.S. Department of Justice reports that more than half of adults in jails or prisons are mentally ill. The Los Angeles County Jail, Cook County Jail (IL), and Riker's Island (NY) each has more mentally ill inmates than any hospital in the U.S.<sup>4</sup> The lack of effective diversions from the justice system into the mental health system leads to the costly and unethical warehousing of people in need of psychiatric treatment. People with substance use disorders also comprise a large percentage of jail and prison populations. Despite evidence that addiction treatment greatly reduces the likelihood of repeat offenses and is far less expensive than incarceration, few inmates in need of such services receive them while incarcerated.

## Recommendations

1. **Decriminalize the condition of homelessness.** An increasing number of local governments enforce ordinances that prohibit public begging, sleeping on sidewalks, and placing one's belongings under park benches. Unnecessary arrests and incarcerations for such acts disrupt tenuous arrangements for shelter and services and complicate access to housing and employment. Communities should reverse policies that jail those in need of greater supports and instead work for effective solutions, such as affordable housing, adequate incomes, and comprehensive health services including treatment for addiction and mental health disorders.
2. **Ensure continuity of health care services for those detained by criminal justice authorities.** Regular health services are prone to disruption upon entry to jails and prisons, often aggravating serious health problems such as mental illness, addiction, or HIV. Health care providers in penal

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<sup>1</sup> Metraux S, Caterina R, Cho R. "Incarceration and Homelessness" Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research. Ed. Deborah Dennis, Gretchen Locke & Jill Khadduri. Washington DC: US Department of Housing & Urban Development, 2008. <http://works.bepress.com/metraux/1>

<sup>2</sup> HCH Clinicians' Network. Keeping Homeless People Out of the Justice System. *Healing Hands* 8(6): Dec. 2004. [http://www.nhchc.org/Network/HealingHands/2004/HealingHands12\\_17\\_04.pdf](http://www.nhchc.org/Network/HealingHands/2004/HealingHands12_17_04.pdf)

<sup>3</sup> James, D. and Glaze, L. Bureau of Justice Statistics. Mental Health Problems in Prison and Jail Inmates. Sep 2006. <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>

<sup>4</sup> Cox, Judith F., et al. "A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems." *Journal of Behavioral Health Services and Research* 28:2 (May 2001). 177-87.

institutions should coordinate closely with community-based providers to continue appropriate services and medications.

3. **Ban discrimination against ex-offenders in housing, employment, and voter registration.** More than 5.3 million Americans are barred from the polls because of a felony conviction. (No other democratic country in the world denies people the right to vote once jail time has been served.) Forty-nine states disenfranchise individuals while incarcerated, with 18 states permanently disenfranchising individuals convicted of felonies, unless or until they are pardoned.<sup>5</sup> The Department of Housing and Urban Development even bars certain felons from public housing. Homelessness and recidivism are among the consequences of these discriminatory policies. Studies have proven that supportive housing reduces criminal justice involvement and mitigates risk for re-incarceration.<sup>6, 7</sup> Congress should enact legislation to restore full civil rights—including the right to vote, work, and have shelter—to individuals who have paid their debt to society for unlawful behavior.

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<sup>5</sup> The National Law Center on Homelessness and Poverty. *Voter Registration and Voting: Ensuring the Voting Rights of Homeless Persons*. July, 2008. [http://www.nlchp.org/content/pubs/2008\\_Voting\\_Report\\_final2.pdf](http://www.nlchp.org/content/pubs/2008_Voting_Report_final2.pdf)

<sup>6</sup> Metraux S, Caterina R, Cho R, op.cit.

<sup>7</sup> Larimer, Mary, et. al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems," *Journal of the American Medical Association*. January, 2009. <http://www.seattlepi.com/dayart/pdf/alcoholic01.pdf>

# Institutional Discharge and Homelessness

## Summary of Recommendations:

- **Support discharge planning policies and prohibit institutional discharge into homelessness from all publicly funded institutions**
- **Require publicly funded institutions to help residents secure all available entitlements prior to discharge**

**Ineffective discharge from institutional and custodial settings plays a troubling role in generating homelessness.**<sup>1</sup> Institutional discharge, as defined by the federal government, is “the process to prepare a person for return or reentry to the community by connecting the individual to essential community treatment, housing, and human services.”<sup>2</sup> In the 1994 report *Priority Home*, the U.S. Interagency Council on Homelessness identified inadequate institutional discharge as a significant factor contributing to homelessness, particularly for persons with mental illnesses and/or substance use disorders.<sup>3</sup> Low-income individuals are increasingly more susceptible to experience homelessness upon departure from a hospital, treatment facility, penal institution, or the foster care system. In 2006-2007, one in five homeless individuals admitted to shelter programs came from either in-patient medical facilities (12%) or correctional institutions (9%).<sup>4</sup> The lack of comprehensive discharge planning increases the chance that these individuals will return to jails, treatment facilities, or relapse into substance use, which ultimately is a more costly burden on society. Placing people into permanent or supportive housing provides a stable alternative to life on the streets, and research demonstrates that this type of housing coupled with supportive services provides significant cost savings.<sup>5</sup> Numerous studies have indicated that homeless persons who are discharged into supportive housing experience significant reductions in shelter use, hospitalizations, length of stay during hospitalization, and incarceration.<sup>6</sup>

**Improper institutional discharge represents a failure of publicly-operated or regulated institutions to fulfill their responsibilities to persons in their care.** The U.S. Department of Health and Human Services asserts that effective discharge planning should ensure linkages to “adequate housing arrangements, as well as access to health, mental health, and substance use treatment, entitlements and income support, and vocational training or employment support.”<sup>7</sup> It is important to highlight that discharge planning will have very little impact unless adequate housing and proper services and community resources are available. (See the policy statement on Medical Respite Services at [www.nhchc.org](http://www.nhchc.org) for an explanation of a crucial approach to this problem.) These linkages, however, are far from guaranteed, and there remains a paucity of community support to meet the housing, health care, and other basic needs of discharged individuals. Advocates, institutional administrators and staff, and elected officials must therefore work to create adequate and responsive service infrastructures and to break the untenable cycle of discharge into homelessness.

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<sup>1</sup> Discharge Planning from Publicly Funded Institutions: Customized Bibliography. Office of Community Planning and Development, U.S. Department of Housing and Urban Development. 2005. <http://www.hud.gov/offices/cpd/homeless/library/bibliobyauthor.pdf>

<sup>2</sup> Substance Abuse and Mental Health Services Administration. “Exemplary practices in discharge planning.” 1997. <http://www.ich.gov/innovations/1/IV%20B%20Exemplary%20Practices%20in%20Discharge%20Planning.PDF>

<sup>3</sup> Interagency Council on Homelessness (IHC). *Priority Home: The Federal Plan to Break the Cycle of Homelessness*. 1994.

<sup>4</sup> National Health Care for the Homeless Council. “Tools to Help Clinicians Achieve Effective Discharge Planning.” *Healing Hands*, Vol.12, No. 5, October 2008. <http://www.nhchc.org/Network/HealingHands/2008/Oct2008HealingHands.pdf>

<sup>5</sup> Corporation for Supportive Housing. *Benefits of Supportive Housing: Changes of Residents’ Use of Public Services*. 2004. <http://documents.csh.org/documents/doclib/HHISNEvaluationFINAL.pdf>

<sup>6</sup> Backer, Thomas E., Howard, Elizabeth A., Moaran, Garrett E. *The Role of Effective Discharge Planning in Preventing Homelessness*. *Journal of Primary Prevention*, online publication June 2007. <http://www.springerlink.com/content/58864pn68610j9r1/fulltext.html>

<sup>7</sup> Moran, Garrett, et al. “Evaluability Assessment of Discharge Planning and the Prevention of Homelessness.” U.S. Department of Health and Human Services. September 2005. <http://aspe.hhs.gov/hsp/05/discharge-planning/index.htm>

## Recommendations

1. **Support discharge planning policies and prohibit institutional discharge into homelessness from all publicly funded institutions, including hospitals, treatment facilities, jails and prisons, and the foster care system.** Effective discharge into stable permanent housing should be an imperative outcome measure for any residential program. Policies that support discharge planning are becoming more prevalent at state and local levels, and nearly every state 10-Year Plan to End Chronic Homelessness has incorporated discharge planning as a prevention strategy. Some programs and agencies already have established housing as a goal of discharge planning, but scarce oversight and inadequate funding for supportive housing has resulted in limited success. Accountability for securing housing upon discharge should be a condition of public funding at every level of government, and institutions must have staff persons trained to provide housing placement assessment and assistance as part of their case management and social services activity. Naturally, consistent with the principle that people should be fully involved in decision-making that affects their lives, programs and agencies must not retain individuals against their will solely because suitable housing has not been arranged.
2. **Require publicly funded institutions to help residents secure all available entitlements prior to discharge.** Frequently, due to poor exit planning from institutional placements, individuals lose or are kept from accessing health insurance, food stamps, and income supports to which they are legally entitled. Programs and agencies should be required as part of their discharge planning to arrange for the immediate resumption (or initiation) of entitlements upon discharge, and existing policy barriers at entitlement agencies should be eliminated (See the policy statement on Disability Benefits at [www.nhchc.org](http://www.nhchc.org)).

A packet of resources to aid communities and policy-makers in improving institutional discharge practices is available at: <http://www.nhchc.org/dischargeplanning.shtml>

# Medical Respite Services and Homelessness

## Summary of Recommendations

- **Ensure access to comprehensive medical care for people experiencing homelessness or at risk of becoming homeless, and designate medical respite care as a reimbursable service under Medicaid and other insurance programs.**
- **Secure adequate and stable funding for Health Care for the Homeless projects and other entities to provide medical respite services.**
- **Secure adequate and stable funding for the housing component of Medical Respite Care programs.**

**Homelessness exacerbates health problems, complicates treatment, and disrupts the continuity of care.** People experiencing homelessness encounter high rates of physical and mental illness, increased mortality, and frequent hospitalizations. Homeless persons are three to four times more likely to die than their housed counterparts.<sup>1</sup> These deaths are most highly associated with acute and chronic medical conditions exacerbated by life on the streets or in shelters. Homeless adults are hospitalized more frequently than those in the general population and often require longer inpatient stays; however, their lack of a stable home environment diminishes the long-term effectiveness of their hospital care. Living on the streets after hospital discharge creates competing priorities for homeless patients. Challenges such as obtaining food, clothing and shelter, or achieving or maintaining sobriety can compromise adherence to medications, other physician instructions, and follow-up appointments, thus increasing the probability of future hospitalizations.<sup>2</sup>

**Medical Respite Care services are an essential component within the continuum of care needed to serve individuals experiencing homelessness or at risk of homelessness.** Medical Respite Care provides short-term residential care that allows homeless individuals to rest while receiving medical care for acute illness or injury. The provision of Medical Respite services to homeless individuals after hospital discharge reduces the incidence of future hospitalization. Medical Respite Care closes the gap between acute medical services provided in hospitals and clinics and the unstable environments of emergency shelters and the streets. Combined with housing placement services and effective case management, Medical Respite Care allows individuals with complex medical and psycho-social needs to recover from an acute medical condition in a stable environment.

**Health Care for the Homeless projects are well equipped to provide the comprehensive medical care and supportive services necessary to effectively serve homeless individuals.** Several of these programs have found ways to ensure that their clients in need of Respite Care have access to a safe bed and access to medical supervision. Typically, HCH programs collaborate with existing community services, such as homeless shelters and nursing homes, to creatively address this need. A multi-year evaluation of 10 HCH Respite programs using varied service provision models showed improvements in client health outcomes and increased access to housing and income. In addition, research demonstrates that even brief stays in stand-alone Respite Care facilities decreases hospitalization, reduces readmissions, and results in overall cost savings for hospitals and the health care system.

## Recommendations

1. **Ensure access to comprehensive medical care for people experiencing homelessness or at risk of becoming homeless, and designate medical Respite Care as a reimbursable service under Medicaid and other insurance programs.** Since the first Respite programs opened in 1985 in Boston (Barbara McGinnis House) and in Washington, DC (Christ House) Respite Care programs have faced funding challenges and have struggled to become an institutionalized component in the

<sup>1</sup> O'Connell JJ. Premature Mortality in Homeless Populations: A Review of the Literature. National Health Care for the Homeless Council, Dec 2005. <http://www.nhchc.org/PrematureMortalityFinal.pdf>

<sup>2</sup> Buchanan D, Doblin B, Sai T, Garcia P. The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health*, 96(7), 1278-1281, July 2006.

continuum of health care services for homeless persons. The Centers for Medicare and Medicaid Services (CMS) should designate Respite Care as a reimbursable service for homeless clients who are covered by Medicaid. Furthermore, states should take the opportunity under the Deficit Reduction Act of 2005 to provide community-based services, including medical respite care, to Medicaid beneficiaries with income below 150 percent of poverty.<sup>3</sup> When adopted, a national health insurance plan must include Medical Respite Care services as part of comprehensive health coverage.

**2. Secure adequate and stable funding for Health Care for the Homeless projects and other entities to provide Medical Respite Care services.**

Providing homeless health care programs stable funding to incorporate Medical Respite services into their existing care models is the most effective and cost-efficient solution to address this gap in the safety net. We recommend that the Congress and HRSA designate \$50 million for Service Expansion and Expanded Medical Capacity funding opportunities for HCH grantees and other Health Centers to provide Medical Respite Care. We further recommend meaningful cost-of-living adjustments to Health Center grants to provide a stable base for these activities.

**3. Secure adequate and stable funding for the housing component of Medical Respite Care programs.**

The US Department of Housing and Urban Development should designate funding to support room and board costs of Medical Respite Care programs. HUD should furthermore develop mechanisms to coordinate such funding with HRSA, the Department of Veterans' Affairs, the Center for Medicare and Medicaid Services, hospitals, and state and local health care funders.

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<sup>3</sup> Section 6086 [DRA 2005] gives states, at their option, the ability to provide home- and community-based services (H&CBS) to elderly individuals and people with disabilities with incomes up to 150% of the federal poverty level without requiring a waiver or demonstrating cost neutrality. A state need only amend its Medicaid plan to provide any of the services now covered under H&CB waivers. ... States that select this option can then cover (for people it selects as eligible) a range of community services that includes supported employment, respite care [for caregivers], family support and other community services. Services permitted under this option, however, must be services that could have been covered through the H&CB waiver. (Bazelon Center for Mental Health, <http://www.bazelon.org/newsroom/reporter/2006/3-21-06-reporter.html#ExpandedAccess>)

Section 1915(i) of the Act allows the provision of specific HCBS under the State plan. These services are listed in section 1915(c)(4)(B) of the Act that governs HCBS waivers. *The services listed in section 1915(c)(4)(B) of the Act are: case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. In addition, the following services may be provided for individuals with chronic mental illness: day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).* As with other State plan services, States may impose criteria of medical necessity or requirements for prior authorization and utilization control to ensure the appropriate level of services furnished to an eligible individual. In addition, States may establish a maximum utilization level of a particular service furnished under the State plan HCBS option. (CMS SMDL #08-001: [http://www.ancor.org/issues/medicaid/state\\_medicaid\\_director\\_letter.pdf](http://www.ancor.org/issues/medicaid/state_medicaid_director_letter.pdf))

# Military Spending and Homelessness

*“There is no way in which a country can satisfy the craving for absolute security, but it can bankrupt itself morally and economically in attempting to reach that illusory goal through arms alone.”*

— President Dwight D. Eisenhower

## **Summary of Recommendations:**

- **Redirect 15% of the Administration’s proposed \$533.7 billion FY 2010 Department of Defense budget toward affordable housing, comprehensive universal health insurance, and other domestic priorities**
- **Ensure ongoing review of the balance between military and domestic spending**
- **Create a Federal Department of Peace and a U.S. Peace Academy**
- **Assure that all veterans have access to permanent, safe, and affordable housing**

**Homelessness as we know it will end only when its root causes are attacked with the same vigor and financial investment with which we currently support our defense programs.** Military spending has accelerated dramatically since the events of September 11, 2001, while spending for domestic programs has been decreased and in some cases eliminated. The FY 2010 budget proposal recommends \$533.7 billion for the Department of Defense base budget, a four percent increase over the 2009 enacted level. Since 2001, military spending has jumped an annual average of 8% after adjusting for inflation and population—four times faster than the average rate of growth for Social Security, Medicare, and Medicaid, and 27 times faster than the average rate of growth for domestic discretionary programs.<sup>1</sup> The Office of Management and Budget estimates that if this trend continues, military spending will reach \$2.3 trillion by FY 2011. This spending is disproportionate in relation to the military budgets of all other countries; the U.S. accounts for nearly two-fifths of worldwide military spending, outpacing China, the second largest military spender, seven to one.<sup>2</sup>

**Recognizing the strong relationship between military spending and homelessness, the National Health Care for the Homeless Council opposes increases in the defense budget and supports careful reallocations of military spending.** Because Federal resources are finite, large annual boosts in funding for the military inevitably increase our national debt and draw resources away from other discretionary programs, accounting for frequent reductions or “flat funding” in most essential non-military categories, such as housing and human services. This diversion of resources undermines the Federal government’s ability to reduce the widening disparity between the very wealthy and the very poor, leaving our most vulnerable neighbors with few options other than shelters or the streets. The growing military budget precludes the necessary Federal investment in a restored national affordable housing infrastructure, a comprehensive system of national health insurance, a national “living wage,” and other efforts to end and prevent homelessness.

**War expenditures will further aggravate the growing deficit and cause even deeper cuts to social programs than those currently proposed.** War disproportionately affects low-income Americans, including those seen by Health Care for the Homeless projects. Poor individuals voluntarily enlist in greater numbers to escape the circumstances of poverty – amounting to an “economic draft.” Upon returning from extended military operations, including the wars in Iraq and Afghanistan, many veterans find themselves without housing or necessary medical, mental health, and/or addiction treatment. Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder (PTSD) or addictions acquired during, or worsened by, their military service. The Department of Veterans Affairs estimates that at least 45 percent of homeless veterans suffer from mental illness, while over 50 percent have substance abuse problems. Many are dually-diagnosed, which

<sup>1</sup> Kogan, Richard. *Federal Spending, 2001-2008: Defense Is a Rapidly Growing Share of the Budget, While Domestic Appropriations Have Shrunk*. Center on Budget and Policy Priorities. 8, March 2008. <http://www.cbpp.org/3-5-08bud.htm>

<sup>2</sup> Meyerscough, Rhea. “Military Spending: CDI Analysts Take a Close Look at Defense Budgets.” *The Defense Monitor*, (Vol. 35,2). March/April 2006. <http://www.cdi.org/PDFS/DMMarApr06.pdf>

especially challenges existing service-delivery systems. As services providers for homeless individuals long have realized, the country experiences a surge in homelessness when our soldiers return home to lost jobs, a scarcity of social support networks, and reduced funding for human services.<sup>3</sup>

## Recommendations

1. **Redirect 15% of the Administration's proposed \$533.7 billion proposal for the FY 2010 Department of Defense budget toward affordable housing, comprehensive universal health insurance, and other domestic priorities.** Given the large proportion of discretionary spending dedicated to the military, even small increases can shift billions of dollars from domestic priorities to military purposes. With a Defense Department budget consuming more than half of discretionary spending and with the mounting cost of wars in Afghanistan and Iraq, resources remain insufficient to address the important domestic priorities of comprehensive health care, affordable housing, and livable incomes. Many organizations and analysts, including Business Leaders for Sensible Priorities, recommend a conservative 15% reduction in military spending. Fifteen percent of the FY 2010 defense budget is \$80.1 billion. Just a portion of these savings, applied over the next ten years, would adequately fund initiatives for health care, housing, and other programs to prevent and end homelessness. We urge Congress to divert this funding to these domestic priorities.
2. **Ensure ongoing review of the balance between military and domestic spending.** There is little Congressional or public oversight for military spending. Indeed, the Pentagon continues to resist an independent financial audit. Until the Pentagon complies with Federal law requiring a satisfactory financial audit and the public is assured that these dollars are spent effectively, no additional resources should be allocated to the Department of Defense. Through rigorous oversight and frequent evaluation, Congress should ensure ongoing review of the Department of Defense to maintain fiscally responsible operations and promote reductions in wasteful or unnecessary spending. The Obama Administration seems to support this goal by seeking greater transparency within the Department. The notion of security should receive an objective evaluation, defining the roles of the military and of social programs. We urge Congress to regularly and thoroughly evaluate the Defense Department's operational efficiency and its proclaimed need for increased military spending.
3. **Create a Federal Department of Peace and a US Peace Academy.** We urge Congress and the Administration to build peace-making efforts among conflicting cultures in the Middle East and around the world and to increase diplomatic efforts with members of the world community. Toward this end, we support the creation of a Federal Department of Peace (H.R. 808) and a US Peace Academy.
4. **Assure that all veterans have access to permanent, safe, and affordable housing with necessary supportive services.** The Homes for Heroes Act of 2009 (H.R. 403) would establish a supportive housing program for very low-income veterans, with housing assistance financed by HUD and supportive services financed by the VA. Additionally, Congress should ensure adequate VA funding levels sufficient to provide the full range of services needed by returning veterans—including addiction treatment and mental health services.

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<sup>3</sup> Aguilar, Rose. *Gimme Shelter*, AlterNet, 2/8/05. <http://www.alternet.org/story/21191/>

# Federal Tort Claims Act

## Summary of Recommendations

- **Reintroduce and pass the Community Health Center Volunteer Physician Protection Act**, extending the full malpractice protections of the FTCA to volunteer medical providers at community health centers and Health Care for the Homeless projects.
- **Provide FTCA malpractice protections to volunteer nurses, mid-level practitioners, and contractors**, enabling health centers and HCH projects to expand their workforce to meet the needs of their patients and the goals of the Administration.

**Volunteers remain susceptible to lawsuits.** The recruitment and retention of medical staff is a consistent challenge for Health Care for the Homeless projects. The prohibitive cost of malpractice insurance often limits the ability of nonprofit health care organizations to recruit volunteer medical providers. Congress sought to address this problem in 1997 when it passed the Volunteer Protection Act (VPA), which was enacted to protect volunteer physicians at health centers against claims of “ordinary negligence.” Despite its intentions, however, the legislation failed to fully protect volunteers; a legal loophole still leaves these doctors vulnerable to “gross negligence” claims and punitive damages.<sup>1</sup>

**The Federal Tort Claims Act expands liability coverage.** Federal employees receive medical malpractice coverage from the Federal Tort Claims Act. The FTCA holds the United States legally responsible for the acts of its employees (acting within the scope of their job).<sup>2</sup> In 1992 FTCA coverage was given to paid employees at community health centers. Malpractice insurance under the FTCA covers ordinary negligence, gross negligence, and punitive damages, whereas the Volunteer Protection Act only deals with the first of the three. If extended to include community health center volunteers, the FTCA would fill the gap left by the VPA.<sup>3,4</sup> Since the inception of FTCA for paid providers, health centers have saved about \$88 million a year in malpractice insurance costs through no-cost coverage provided under the Federal Torts Claims Act. To help cover judgments, \$5 million is routed each year from health center appropriations into the FTCA judgment fund.

**As health centers grow, so must their workforce.** Congress has strongly supported the Administration’s initiative to expand the reach of the nation’s health centers to address the unmet needs of vulnerable communities. Continued expansion of CHCs/HCHs increases the demand for volunteer health care providers. To implement fully the Administration’s initiative, all impediments to volunteerism, including lack of medical malpractice coverage, must be removed.

## Recommendations

1. **Reintroduce and pass the Community Health Center Volunteer Physician Protection Act in the 111<sup>th</sup> Congress.** This legislation was introduced in the 109<sup>th</sup> Congress in both chambers of Congress; however, it has not been reintroduced since. It aims to close the loophole in the Volunteer Protection Act of 1997 through which volunteers at health centers are still susceptible to claims of “gross negligence.” Its passage would extend the thorough malpractice protections of the FTCA to these physicians.
2. **Extend to health center volunteers (physicians, nurses, and mid-level practitioners) and all health center contractors the same FTCA malpractice protections granted to health center employees.** Many health centers (particularly HCH projects) rely heavily on the work of nurses, nurse practitioners, physician assistants, clinical nurse specialists, and contract employees. Extending the coverage of the FTCA to include these providers would show appreciation for their contributions, further promote the spirit of volunteerism, and improve the health of the medically underserved by strengthening health centers and HCH projects.

<sup>1</sup> Carpenter, Mark. “Protect Volunteer Physicians at Community Health Centers.” *US Congressman Tim Murphy, Working for the 18<sup>th</sup> District of Pennsylvania*. Feb 2005.

<sup>2</sup> Center for Risk Management. “Federal Tort Claims Act and Health Centers.” *Bureau of Primary Health Care*. Apr 2005.

<sup>3</sup> Carpenter.

<sup>4</sup> Post P, Martin L. Clinical Volunteers in Homeless Health Care. National Health Care for the Homeless Council, 2005. <http://www.nhchc.org/Publications/ClinicalVolunteersinHomelessHealthCare.pdf>