Housing for Persons Living with HIV/AIDS

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Summary

Since the beginning of the acquired immunodeficiency syndrome (AIDS) epidemic in the early 1980s, many individuals living with the disease have had difficulty finding affordable, stable housing. As individuals become ill, they may find themselves unable to work, while at the same time facing health care expenses that leave few resources to pay for housing. In addition, many of those persons living with AIDS struggled to afford housing even before being diagnosed with the disease. The financial vulnerability associated with AIDS, as well as the human immunodeficiency virus (HIV) that causes AIDS, results in a greater likelihood of homelessness among persons living with the disease. Further, recent research has indicated that those individuals living with HIV who live in stable housing have better health outcomes than those who are homeless or unstably housed.

Congress recognized the housing needs of persons living with HIV/AIDS when it approved the Housing Opportunities for Persons with AIDS (HOPWA) program in 1990 as part of the Cranston-Gonzalez National Affordable Housing Act (P.L. 101-625). The HOPWA program, administered by the Department of Housing and Urban Development (HUD), funds short-term and permanent housing, together with supportive services, for individuals living with HIV/AIDS and their families. In addition, a small portion of funds appropriated through the Ryan White HIV/AIDS program, administered by the Department of Health and Human Services (HHS), may also be used to fund short-term housing for those living with HIV/AIDS.

In FY2008, Congress appropriated $300 million for HOPWA in the Consolidated Appropriations Act (P.L. 110-161). This is the most funding ever appropriated for the program, exceeding the next highest appropriation (in FY2004) by approximately $6 million. HOPWA funds are distributed to states and localities through both formula and competitive grants. HUD awards 90% of appropriated funds by formula to states and eligible metropolitan statistical areas (MSAs) based on population, reported cases of AIDS, and incidence of AIDS. The remaining 10% is distributed through a grant competition. Funds are used primarily for housing activities, although grant recipients must provide supportive services to those persons residing in HOPWA-funded housing.

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Introduction

Acquired immunodeficiency syndrome (AIDS), a disease caused by the human immunodeficiency virus (HIV), weakens the immune system, leaving individuals with the disease susceptible to infections. As of 2006, AIDS had been diagnosed and reported in an estimated 448,871 individuals in the fifty states, the District of Columbia, and territories.[1] These estimates do not include those diagnosed with HIV where the disease has not yet progressed to AIDS or those who have not yet been diagnosed as HIV positive but are currently living with the disease. Currently there is no cure for HIV/AIDS, and in the early years of the AIDS epidemic, those persons infected with AIDS often died quickly. In recent years, however, medications have allowed persons living with HIV and AIDS to live longer and to remain in better health.

Despite improvements in health outcomes, affordable housing remains important to many who live with HIV/AIDS. This report describes recent research that shows how housing and health status are related and the effects of stable housing on patient health. It also describes the Housing Opportunities for Persons with AIDS (HOPWA) program, the only federal program that provides housing and services specifically for persons who are HIV positive or who have AIDS, together with their families. In addition, the report describes how a small portion of funds appropriated through the Ryan White HIV/AIDS program may be used by states and local jurisdictions to provide short-term housing assistance for persons living with HIV/AIDS.

Housing Status of Persons Living with HIV/AIDS

The availability of adequate, affordable housing for persons living with HIV and AIDS has been an issue since AIDS was first identified in U.S. patients in the early 1980s. The inability to afford housing and the threat of homelessness confront many individuals living with HIV/AIDS. From the early years of the epidemic, those individuals who have been infected with HIV/AIDS face impoverishment as they become unable to work, experience high medical costs, or lose private health insurance coverage. In recent years, the incidence of HIV/AIDS has grown among low-income individuals who were economically vulnerable even before onset of the disease.[2]

Not surprisingly, researchers have found a co-occurrence between HIV/AIDS and homelessness. Homeless persons have a higher incidence of HIV/AIDS infection than the general population, while many individuals with HIV/AIDS are at risk of becoming homeless.[3] Research has found that rates of HIV among homeless people may be as much as three to nine times higher than

[1] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report 2006*, vol. 18, Atlanta, GA, 2008, pp. 24-25, table 12, http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/pdf/2006SurveillanceReport.pdf.

[2] John M. Karon, Patricia L. Fleming, Richard W. Steketee, and Kevin M. DeCock, "HIV in the United States at the Turn of the Century: An Epidemic in Transition," *American Journal of Public Health* 91, no. 7 (July 2001): 1064-1065.

[3] See, for example, D.P. Culhane, E. Gollub, R. Kuhn, and M. Shpaner, "The Co-Occurrence of AIDS and Homelessness: Results from the Integration of Administrative Databases for AIDS Surveillance and Public Shelter Utilization in Philadelphia," *Journal of Epidemiology and Community Health* 55, no. 7 (2001): 515-520. Marjorie Robertson, et al., "HIV Seroprevalence Among Homeless and Marginally Housed Adults in San Francisco," *American Journal of Public Health* 94, no. 7 (2004): 1207-1217. Angela A. Aidala and Gunjeong Lee, *Housing Services and Housing Stability Among Persons Living with HIV/AIDS*, Joseph L. Mailman School of Public Health, May 30, 2000, http://www.nyhiv.org/pdfs/chain/CHAIN%20Housing%20Stability%2032.pdf.

among those living in stable housing.[4] Further, those who are HIV positive and homeless have been found to be more likely than those who are HIV positive and housed to engage in behaviors associated with the spread of HIV/AIDS. In one study, the use of injectable drugs, sharing needles, and exchanging sex for drugs or money were more likely among both homeless individuals and those who were unstably housed compared to those with stable housing.[5] (Those who were considered unstably housing lived in transitional housing, in jail, drug treatment or a halfway house, or were doubled up in someone else's home.[6]) When housing improved for individuals in the study, their odds of engaging in these behaviors were reduced. Another study found that homeless persons living with HIV/AIDS were almost twice as likely to engage in unprotected sex compared to those who had housing.[7] (Individuals were considered housed if they lived in a house or apartment alone or with others, a medical care facility, or a correctional institution.[8])

Creation of the Housing Opportunities for Persons with AIDS (HOPWA) Program

In 1988, Congress established the National Commission on AIDS as part of the Health Omnibus Extension Act (P.L. 100-607) to "promote the development of a national consensus on policy concerning acquired immune deficiency syndrome (AIDS); and to study and make recommendations for a consistent national policy concerning AIDS." In April 1990, in its second interim report to the President, the Commission recommended that Congress and the President provide "[f]ederal housing aid to address the multiple problems posed by HIV infection and AIDS."[9] About the same time that the Commission released its report, in March of 1990, the House Committee on Banking, Finance, and Urban Affairs held a hearing about the need for housing among persons living with HIV/AIDS. Witnesses as well as committee members discussed various barriers to housing for persons living with HIV/AIDS. Among the issues confronting those persons that were discussed at the hearing were poverty, homelessness, and discrimination[10] in attempting to secure housing. [11] Another issue discussed at the hearing was the

[4] Daniel P. Kidder, Richard J. Wolitski, and Scott Royal, et al., "Access to Housing as a Structural Intervention for Homeless and Unstably Housed People Living with HIV: Rational, Methods, and Implementation of the Housing and Health Study," *AIDS and Behavior*, vol. 11, no. 6 (November 2007, supplement), pp. 149-150.

[5] Angela Aidala, Jay E. Cross, Ron Stall, David Harre, and Esther Sumartojo, "Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy," *AIDS and Behavior* 9, no. 3 (2005): 251-265.

[6] Ibid., p. 254

[7] Daniel P. Kidder, Richard J. Wolitski, and Sherri L. Pals, et al., "Housing Status and HIV Risk Behaviors Among Homeless and Housed Persons with HIV," *Journal of Acquired Immune Deficiency Syndromes*, vol. 49, no. 4 (December 1, 2008), pp. 453-454.

[8] Ibid., p. 452.

[9] The second interim report was released on April 24, 1990. Its recommendations were reprinted in National Commission on Acquired Immune Deficiency Syndrome, *Annual Report to the President and Congress*, August 1990, pp. 106-109.

[10] Individuals living with HIV/AIDS have experienced housing discrimination even though they are protected as persons with a "handicap" under the Fair Housing Act (FHA). 42 U.S.C. §§ 3601-3631. A number of court cases have established that the definition of "handicap" protects persons who are HIV positive and persons with AIDS. See, for example, *Baxter* v. *City of Belleville, Ill.*, 720 F.Supp. 720, 729-730 (S.D.Ill.1989), and *Support Ministries for Persons With AIDS, Inc.* v. *Village of Waterford, N.Y.*, 808 F.Supp. 120, 129-133 (N.D.N.Y. 1992).

[11] Hearing before the House Committee on Banking, Finance, and Urban Affairs, Subcommittee on Housing and Community Development, "Housing Needs of Persons with Acquired Immune Deficiency Syndrome," March 21, 1990, (hereafter Hearing on Housing Needs). See also, Statement of Representative James A. McDermott, 135 Cong. (continued...)

eligibility for subsidized housing for persons living with the disease. A question raised during the hearing but left unresolved was whether persons living with HIV or AIDS met the definition of "handicap" in order to be eligible for the Section 202 Supportive Housing for the Elderly program (which also provided housing for persons with disabilities).[12] Another concern was that persons living with HIV/AIDS often had difficulty obtaining subsidized housing through mainstream HUD programs such as Public Housing and Section 8 due to the length of waiting lists; individuals often died while waiting for available units.[13]

In the 101st Congress, at least two bills were introduced that contained provisions to create a housing program specifically for persons living with AIDS. These proposed programs were called the AIDS Housing Opportunity Act (which was part of the Housing and Community Development Act of 1990, H.R. 1180) and the AIDS Opportunity Housing Act (H.R. 3423). The bills were similar, and both proposed to fund short-term and permanent housing together with supportive services for individuals living with AIDS and related diseases. The text from one of these bills, H.R. 1180, which included the AIDS Housing Opportunity Act, was incorporated into the Cranston-Gonzalez National Affordable Housing Act (S. 566) when it was debated and passed by the House on August 1, 1990. In conference with the Senate, the name of the housing program was changed to Housing Opportunities for Persons with AIDS (HOPWA). In addition, the several separate housing assistance programs that had been proposed in H.R. 1180 – one for short-term housing, one for permanent housing supported through Section 8, and one for community residences – were consolidated into one formula grant program in which recipient communities could choose which activities to fund. The amended version of S. 566 was signed by the President on November 28, 1990, and became P.L. 101-625, the Cranston Gonzalez National Affordable Housing Act.

The HOPWA program is administered by the Department of Housing and Urban Development (HUD) and remains the only federal program solely dedicated to providing housing assistance to persons living with HIV/AIDS and their families.[14] The program addresses the need for reasonably priced housing for thousands of low-income individuals (those with incomes at or below 80% of the area median income). HOPWA was last reauthorized by the Housing and Community Development Act of 1992 (P.L. 102-550). Although authorization for HOPWA expired after FY1994, Congress continues to fund the program through annual appropriations.

(...continued)

Rec. 23641, October 5, 1989.

[12] Hearing on Housing Needs, pp. 25-30. See footnote 11.

[13] U.S. Congress, House Committee on Banking, Finance, and Urban Affairs, *Housing and Community Development Act of 1990*, report to accompany H.R. 1180, 101st Cong., 2nd sess., June 21, 1990, H.Rept. 101-559.

[14] The law is codified at 42 U.S.C. §§ 12901-12912, with regulations at 24 C.F.R. Parts 574.3-574.655.

Distribution and Use of HOPWA Funds

Formula Grants

HOPWA program funding is distributed both by formula allocations and competitive grants. HUD awards 90% of appropriated funds by formula to states and eligible metropolitan statistical areas (MSAs) that meet the minimum AIDS case requirements according to data reported to the Centers for Disease Control and Prevention (CDC) in the previous year. (For the amounts distributed to eligible states and MSAs in recent years, see **Appendix**.) HOPWA formula funds are available through HUD's Consolidated Plan initiative. Jurisdictions applying for funds from four HUD formula grant programs, including HOPWA,[15] submit a single consolidated plan to HUD. The plan includes an assessment of community housing and development needs and a proposal that addresses those needs, using both federal funds and community resources. Communities that participate in the Consolidated Plan may receive HOPWA funds if they meet formula requirements. Formula funds are allocated in two ways:

- First, 75% of the total available formula funds, sometimes referred to by HUD as "base funding," is distributed to

  —the largest cities within metropolitan statistical areas (MSAs)[16] with populations of at least 500,000 and with 1,500 or more cumulative reported cases of AIDS (which includes those who have died); and

  —to states with at least 1,500 cases of AIDS in the areas outside of that state's eligible MSAs.[17]

- Second, 25% of total available formula funds – sometimes referred to by HUD as "bonus funding" – is distributed on the basis of AIDS incidence during the past three years.[18] Only the largest cities within MSAs that have populations of at least 500,000, with at least 1,500 reported cases of AIDS *and* that have a higher than average per capita incidence of AIDS are eligible.[19] States are not eligible for bonus funding.

Although HOPWA funds are allocated to the largest city within an MSA, these recipient cities are required to allocate funds "in a manner that addresses the needs within the metropolitan statistical area in which the city is located."[20] States that receive funds are to use them to benefit areas outside of eligible MSAs. In FY2008, 87 MSAs (including the District of Columbia) received funds, while 39 states and Puerto Rico received funds for use in the areas outside of recipient

[15] The others are the Community Development Block Grant, the Emergency Shelter Grants, and HOME.

[16] MSAs are defined as having at least one "urbanized" area of 50,000 or more and "adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties." See Office of Management and the Budget Bulletin 09-01, Attachment, "Update of Statistical Area Definitions and Guidance on Their Uses," November 20, 2008, p. 2, http://www.whitehouse.gov/omb/bulletins/fy2009/09-01.pdf.

[17] 42 U.S.C. § 12903(c)(1)(A).

[18] AIDS incidence is measured as the number of new AIDS cases during a given time period.

[19] 42 U.S.C. § 12903(c)(1)(B).

[20] 42 U.S.C. § 12903(f).

MSAs.[21] Jurisdictions that receive HOPWA funds may administer housing and services programs themselves or may allocate all or a portion of the funds to subgrantee private nonprofit organizations. HOPWA formula funds remain available for obligation for two years.

As a result of language included in every HUD appropriations law since FY1999 (P.L. 105-276), states do not lose formula funds if their reported AIDS cases drop below 1,500, as long as they received funding in the previous fiscal year. States generally drop below 1,500 AIDS cases when a large metropolitan area becomes separately eligible for formula funds. These states are allocated a grant on the basis of the cumulative number of AIDS cases outside of their MSAs.[22]

Competitive Grants

The remaining 10% of HOPWA funding is available through competitive grants. Funds are distributed through a national competition to two groups of grantees: (1) states and local governments that propose to provide short-term, transitional, or permanent supportive housing in areas that are not eligible for formula allocations, and (2) government agencies or nonprofit entities that propose "special projects of national significance."[23] A project of national significance is one that uses an innovative service delivery model. In determining proposals that qualify, HUD must consider the innovativeness of the proposal and its potential replicability in other communities.[24] Competitive grants may not be used to provide supportive services alone; instead, services can only be provided in conjunction with housing activities, and funds for services cannot exceed 35% of a project's budget.[25]

The competitive grants are awarded through HUD's annual SuperNOFA (Notice of Funding Availability), which is generally published in the *Federal Register* in the early spring. Since FY2000 (P.L. 106-377), Congress has required HUD to renew expiring contracts for permanent supportive housing prior to awarding funds to new projects. Beginning in FY2006, competitive funds remain available for obligation for three years (from FY2002 through FY2005, competitive funds had been available only for two years). The extension makes the rules for HOPWA's competitive program consistent with those of other competitive programs advertised in HUD's SuperNOFA.

[21] U.S. Department of Housing and Urban Development, Office of Community Planning and Development, Office of HIV/AIDS Housing, list of FY2008 grantees, http://www.hud.gov/offices/cpd/about/budget/budget08/index.cfm.

[22] States that have retained funding under this provision are Arizona, Delaware, Hawaii, Minnesota, Nevada, Oklahoma, and Utah.

[23] 42 U.S.C. § 12903(c)(3).

[24] Ibid.

[25] See, for example, U.S. Department of Housing and Urban Development, "FY2008 Notice of Funding Availability Housing Opportunities for Persons With AIDS," 73 Federal Register p. 27266, May 12, 2008.

Eligibility for HOPWA-Funded Housing

In the HOPWA program, individuals are eligible for housing if they are either HIV positive or if they are diagnosed with AIDS.[26] In general, clients must also be low income, meaning that their income does not exceed 80% of the area median income.[27] HUD reports area median incomes for metropolitan areas and non-metropolitan counties on an annual basis.[28] Housing and some supportive services are available for family members of persons living with AIDS. When a person living in HOPWA-supported housing dies, his or her family members are given a grace period during which they may remain in the housing.[29] This period may not exceed one year, however.

Individuals who are HIV positive or living with AIDS may also be eligible for other HUD-assisted housing for persons with disabilities. However, infection itself may not be sufficient to meet the definition of disability in these other programs. For example, in the case of housing developed prior to the mid-1990s under the Section 202 Supportive Housing for the Elderly program and those units developed under the Section 811 Supportive Housing for Persons with Disabilities program, an individual who is HIV positive or has AIDS must also meet the statutory definition of disability (in which HIV/AIDS status alone is not sufficient) to be eligible for housing.[30] The project-based Section 8 and Public Housing programs may also set aside units or entire developments for persons with disabilities. The definition of disability for these programs does "not exclude persons who have the disease of acquired immunodeficiency syndrome or any conditions arising from the etiologic agent" for AIDS.[31] However, the definition does not indicate whether the status of being HIV positive or having AIDS is alone sufficient to be considered disabled.

Eligible Uses of HOPWA Funds

HOPWA grantees may use funds for a wide range of housing, social services, program planning, and development costs. Supportive services must be provided together with housing. Formula grantees may also choose to provide supportive services not in conjunction with housing, although the focus of the HOPWA program is housing activities. Allowable activities include the following.

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[26] The HOPWA statute defines an eligible person as one "with acquired immunodeficiency syndrome or a related disease." 42 U.S.C. § 12902(12). The regulations have further specified that "acquired immunodeficiency syndrome or related diseases means the disease of acquired immunodeficiency syndrome or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV)." 24 C.F.R. § 574.3.

[27] 42 U.S.C. § 12908 and § 12909. The statutory provisions regarding short-term housing and community residences do not require individuals to be low-income, although to be eligible for short-term housing a person must be homeless or at risk of homelessness. See 42 U.S.C. § 12907 and § 12910.

[28] U.S. Department of Housing and Urban Development, Office of Policy Development and Research, *Fiscal Year 2008 HUD Income Limits Briefing Material*, January 18, 2008, p. 1, http://www.huduser.org/datasets/il/il08/IncomeLimitsBriefingMaterial.pdf. Tables showing area median incomes in recent years are available at http://www.huduser.org/datasets/il.html.

[29] 24 C.F.R. § 574.310(e).

[30] For more information about housing for persons with disabilities and the definitions of disability under these programs, see CRS Report RL34728, *Section 811 and Other HUD Housing Programs for Persons with Disabilities*, by Libby Perl.

[31] 42 U.S.C. § 1437a(b)(3).

- *The Development and Operation of Multi-Unit Community Residences, Including the Provision of Supportive Services for Persons Who Live in the Residences*.[32] Funds may be used for the construction, rehabilitation, and acquisition of facilities, for payment of operating costs, and for technical assistance in developing the community residence.
- *Short-Term Rental, Mortgage, and Utility Assistance to Persons Living with AIDS Who Are Homeless or at Risk of Homelessness*.[33] Funds may be used to acquire and/or rehabilitate facilities that will be used to provide short-term housing, as well as to make payments on behalf of tenants or homeowners, and to provide supportive services. Funds may not be used to construct short-term housing facilities.[34] Residents may not stay in short-term housing facilities more than 60 days in any 6-month period, and may not receive short-term rental, mortgage and utility assistance for more than 21 weeks in any 52 week period. These limits are subject to waiver by HUD, however, if a project sponsor is making an attempt to provide permanent supportive housing for residents and has been unable to do so. Funds may also be used to pay operating and administrative expenses.
- *Project-Based or Tenant-Based Rental Assistance for Permanent Supportive Housing, Including Shared Housing Arrangements*.[35] In general, tenants must pay approximately 30% of their income toward rent.[36] Grant recipients must ensure that residents receive supportive services, and funds may also be used for administrative costs in providing rental assistance.
- *The New Construction or Acquisition and Rehabilitation of Property for Single-Room Occupancy Dwellings*.[37]
- *Supportive Services, Which Include Health Assessments, Counseling for Those with Addictions to Drugs and Alcohol, Nutritional Assistance, Assistance with Daily Living, Day Care, and Assistance in Applying for Other Government Benefits*.[38]
- *Housing Information Such as Counseling and Referral Services*.[39] Assistance may include fair housing counseling for those experiencing discrimination.[40]

The majority of HOPWA funds are used to provide housing. According to HUD, 66% of HOPWA funds support housing activities.[41] Grantee performance reports indicate that clients who receive

[32] 42 U.S.C. § 12910.

[33] 42 U.S.C. § 12907.

[34] HOWPA funds may only be used for construction of community residences and single-room occupancy dwellings. See 24 C.F.R. § 574.300(b)(4).

[35] 42 U.S.C. § 12908.

[36] See 24 C.F.R. § 574.310(d).

[37] 42 U.S.C. § 12909.

[38] 24 C.F.R. § 574.300(b)(7).

[39] 42 U.S.C. § 12906.

[40] 24 C.F.R. § 574.300(b)(1).

[41] U.S. Department of Housing and Urban Development, *HOPWA Update for 2008*, Powerpoint Presentation, January 2008, slide 18, http://www.hud.gov/offices/cpd/aidshousing/library/2008perfreporting/2008hopwaupdate.ppt.

housing assistance through HOPWA are often at the lowest income levels; in its FY2008 Annual Performance Plan, HUD estimated that 81% of households served have either extremely-low incomes (at or below 30% of area median income) or very-low incomes (at or below 50% of area median income).[42]

HOPWA Program Formula and Funding

The HOPWA Formula

The HOPWA method for allocating formula funds has been an ongoing issue because the cumulative number of AIDS cases – including those who have died – is used to distribute funds. A 2006 Government Accountability Office (GAO) report found that the cumulative measure resulted in disproportionate funding per living AIDS case, depending on the jurisdiction. In 2004, the amount of money grantees received per living AIDS case ranged from $387 per person to $1,290.[43] According to the report, if only living AIDS cases were counted in that year, 92 of 117 grantees would have received more formula funding, while 25 would have received less.[44]

In each of the President's budgets from FY2007 through FY2009, the Administration proposed to change the way in which HOPWA funds are distributed. The FY2009 budget stated that "[w]hereas the current formula distributes formula grant resources by the cumulative number of AIDS cases, the revised formula will account for the present number of people living with AIDS, as well as differences in housing costs in the qualifying areas." The President's FY2007 and FY2008 budgets contained nearly identical language. HUD's budget justifications for FY2009 elaborated somewhat on the Administration's proposal to change the HOPWA distribution formula. HUD's explanation indicated that a new formula would use the number of persons living with AIDS, and that eventually, when consistent data on the number of persons living with HIV become available, that measure might also be used in determining the distribution of HOPWA funding.[45]

Discussions regarding the HOPWA formula and its use of cumulative AIDS cases to distribute funds are not new. In 1997, GAO released a report regarding the performance of the HOPWA program in which it recommended that HUD look at recent changes to the formula used by the Ryan White CARE Act (now called the Ryan While HIV/AIDS program) to "determine what legislative revisions are needed to make the HOPWA formula more reflective of current AIDS cases ..."[46] (At the time of the GAO report, Congress had recently changed the CARE Act formula to use estimates of persons living with AIDS instead of cumulative AIDS cases.[47]) In

[42] U.S. Department of Housing and Urban Development, *Annual Performance Plan FY2008*, September 2007, p. 48, http://www.hud.gov/offices/cfo/reports/pdfs/app2008.pdf.

[43] U.S. Government Accountability Office, *Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds*, GAO-06-332, February 2006, p. 23, http://www.gao.gov/new.items/d06332.pdf.

[44] Ibid., p. 24.

[45] U.S. Department of Housing and Urban Development FY2009 Congressional Budget Justifications, Housing Opportunities for Persons with AIDS, p. Q-2, http://www.hud.gov/offices/cfo/reports/2009/cjs/cpd1.pdf.

[46] U.S. Government Accountability Office, *HUD's Program for Persons with AIDS*, GAO/RCED-97-62, March 1997, p. 27, http://www.gao.gov/archive/1997/rc97062.pdf.

[47] Ryan White CARE Act Amendments of 1996, P.L. 104-146. In 2006, when the Ryan White HIV/AIDS program was reauthorized as part of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415), the formula (continued...)

response to the GAO report, the House Appropriations Committee included the GAO language in its report accompanying the FY1998 HUD Appropriations Act (P.L. 105-65) and directed HUD to make recommendations to Congress about its findings regarding an update to the formula.[48]

In response to the FY1998 Appropriations Act, HUD then issued a report to Congress in 1999 that proposed changes that could be made to the HOPWA formula.[49] The proposed formula in HUD's 1999 report would have used an estimate of persons living with AIDS (instead of all cumulative AIDS cases), together with housing costs, to distribute formula funds. It also would have included a protection for existing grantees. Those recommendations were not adopted by Congress.

No legislation to change the HOPWA formula was introduced in the 110th Congress. In the 109th Congress, two bills (S. 2339 and H.R. 5009) would have changed the way that HOPWA formula funds are allocated by counting the number of "reported living cases of HIV disease" instead of cumulative AIDS cases. Neither bill was enacted.

HOPWA Funding

As a result of advances in medical science and in the care and treatment of persons living with HIV and AIDS, individuals are living longer with the disease.[50] As the number of those with AIDS grows, so do the jurisdictions that qualify for formula-based HOPWA funds. Since 1999, there has been a steady increase in the number of jurisdictions that meet the eligibility test to receive formula-based HOPWA funds. Funding for the HOPWA program has increased in almost every year since the program was created, eventually reaching $295 million in FY2004, before declining to $282 million in FY2005. (See **Table 1**.) In FY2006 and FY2007, funding increased by 1.52% over FY2005, to $286 million, but still remained below the FY2004 funding level. In FY2008, Congress appropriated $300 million for HOPWA in the Consolidated Appropriations Act (P.L. 110-161), an increase of almost 5% more than the FY2007 funding level, and the most ever appropriated for the program.

The number of households receiving HOPWA housing assistance (including short-term housing assistance, housing provided through community residences, or rental assistance in permanent housing) has declined in every year but one from FY2003 through FY2008. (See **Table 1**.) In FY2003, 78,467 households were served; in FY2004, this number dropped to 70,779. The number of households served continued to fall in FY2005 (67,012 households), and in FY2006 (67,000 households).[51] Although the number increased in FY2007 to 67,850,[52] the number of

(...continued)

began to incorporate living HIV cases in addition to living AIDS cases.

[48] See U.S. Congress, House Committee on Appropriations, Subcommittee on VA, HUD, and Independent Agencies, *Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Bill*, report to accompany H.R. 2158, 105th Cong., 1st sess., July 11, 1997, H.Rept. 105-175, pp. 33-34.

[49] U.S. Department of Housing and Urban Development, *1999 Report on the Performance of the Housing Opportunities for Persons with AIDS Program*, October 6, 1999 (hereafter *1999 HUD Report*).

[50] According to CDC data, in 1993 there were 137,529 people reportedly living with AIDS in the 50 states, the District of Columbia, and the territories. By 2006, there were 509,681 people reportedly living with HIV/AIDS in the same areas. See Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report 1993*, Vol. 5, Atlanta, GA,1994, p. 26, table 3, http://www.cdc.gov/hiv/topics/surveillance/resources/reports/pdf/hivsur54.pdf, and *HIV/AIDS Surveillance Report 2006*, Vol. 18, Atlanta, GA, 2008, pp. 24-25, table 12, http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/pdf/2006SurveillanceReport.pdf.

[51] U.S. Department of Housing and Urban Development, *FY2006 Performance and Accountability Report*, November (continued...)

households assisted still remained below earlier levels in FY2001 through FY2004. In FY2008, the number of households served again declined to 62,210.[53] These general reductions in households served could be due to a number of factors, including the growth in jurisdictions eligible for HOPWA grants, the amount of available funds, and housing costs.

Table 1. HOPWA Funding and Eligible Jurisdictions, FY2001-FY2008

Fiscal Year	Number of Qualifying Jurisdictions	Households Receiving Housing Assistance[a]	Funding (thousands of dollars)
2001	105	72,117	257,432
2002	108	74,964	277,423
2003	111	78,467	290,102
2004	117	70,779	294,751
2005	121	67,012	281,728
2006	122	67,000	286,110
2007	123	67,850	286,110
2008	127	62,210	300,100

Source: Table prepared by the Congressional Research Service based on data from the Department of Housing and Urban Development budget justifications (number of qualifying jurisdictions and funding levels), and FY2004, FY2006, FY2007, and FY2008 HUD Performance and Accountability Reports (number of households assisted). For a breakdown of formula funding by jurisdiction, see **Appendix**.

a. Housing assistance includes short-term assistance with rent, mortgage or utilities, residence in short-term housing facilities, housing provided through community residences and single room occupancy dwellings, and rental assistance for permanent supportive housing.

Housing Funded Through the Ryan White HIV/AIDS Program

In addition to funds for housing provided through HUD, funds appropriated to the Department of Health and Human Services (HHS) Ryan White HIV/AIDS program may be used to provide short-term housing assistance to persons living with HIV/AIDS. The Ryan White Comprehensive AIDS Resources Emergency Act (P.L. 101-381) established the Ryan White program in 1990. The program provides funds to states and metropolitan areas to help pay for health care and support services for persons living with HIV/AIDS.[54] The statute governing the use of Ryan White funds does not specifically list housing as an eligible activity for which grantees may use

(...continued)

15, 2006, p. 136, http://www.hud.gov/offices/cfo/reports/2006/2006par.pdf.

[52] U.S. Department of Housing and Urban Development, *FY2007 Performance and Accountability Report*, November 15, 2007, pp. 167-168, http://www.hud.gov/offices/cfo/reports/2007/2007par.pdf.

[53] U.S. Department of Housing and Urban Development, *FY2008 Performance & Accountability Report*, November 17, 2008, p. 406, http://www.hud.gov/offices/cfo/reports/hudpar-fy2008.pdf.

[54] For more information about the Ryan White program, see CRS Report RL33279, *The Ryan White HIV/AIDS Program*, by Judith A. Johnson

funds. However, the statute provides that grantees may use Ryan White funds to provide support services for persons living with HIV and AIDS. These services are defined as those "that are needed for individuals with HIV/AIDS to achieve their medical outcomes ..."[55] In 1999, the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) within HHS released policy guidance regarding the type of housing that Ryan White grantees could provide for their clients.[56] According to the guidance, grantees may use funds for housing referral services and for emergency or short-term housing. Ryan White funds must be the payer of last resort, meaning that other sources of funds for housing must be exhausted before using Ryan White funds.

Initially, the policy regarding use of Ryan White funds for housing did not require that specific time limits be placed on short-term housing. In its report regarding the new guidance, HRSA stated: "Although we are restricting the policy to transitional/temporary housing, we don't define 'transitional/temporary.' Because we don't know yet what the recent changes in medical treatment of HIV/AIDS mean to the evolution of the epidemic, it is foolish to adopt any definition of 'short-term.'"[57] However, when the Ryan White program was reauthorized in 2006, the new law limited the amount of grants to states and urban areas that could be used for support services to no more than 25% by requiring that at least 75% of funds be used for "core medical services."[58] Previously the law did not limit the amount of funds that could be used for support services. In December 2006, in response to the "more restrictive funding limits established for support services in the 2006 reauthorization," HHS issued a proposed policy notice to limit the amount of time that any client could spend in Ryan White-funded transitional housing to 24 months in a lifetime, effective retroactively.[59] This would have meant that those individuals who had already exhausted the 24-month time period would not be able to receive housing benefits. After receiving over 200 comments regarding the policy proposal, HHS eventually removed the provision requiring retroactive application of the 24-month lifetime limit and released a final policy notice on February 27, 2008.[60] The policy took effect on March 27, 2008.

In 2007, HRSA reported that 476 Ryan White-funded service organizations provided housing services for individuals living with HIV/AIDS.[61] In 2006, an estimated 42,178 persons living with AIDS received some sort of housing service. Note that this estimate includes duplicated services,

[55] 42 U.S.C. § 300ff-14(d)(1) and § 300ff-22(c)(1). At the time that HHS established its housing policy, the statute stated that funds could be used "for the purpose of delivering or enhancing HIV-related outpatient and ambulatory health and support services, including case management and comprehensive treatment services ... " The statute was amended to read as stated in the text of this report as part of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, P.L. 109-415.

[56] The use of funds for housing was established in HIV/AIDS Bureau Notice 99-02. The notice is reproduced in U.S. Department of Health and Human Services, Health Resources and Services Administration, *Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau (HAB) Ryan White CARE Act Housing Policy*, 2001, p. 3, ftp://ftp.hrsa.gov/hab/housingmanualjune.pdf, (hereafter *Housing is Health Care*).

[57] *Housing is Health Care*, p. 7. See footnote 56.

[58] The program was reauthorized in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415). See Section 105.

[59] U.S. Department of Health and Human Services, "HIV/AIDS Bureau Policy Notice 99-02 Amendment #1," 73 *Federal Register* 10261, February 26, 2008.

[60] Ibid., pp. 10260-10261.

[61] Information provided to CRS by HRSA on December 4, 2008.

so an individual who received both housing referral services and spent time in emergency housing may be counted more than once.[62]

The Relationship Between Stable Housing and Health Outcomes

As mentioned earlier in this report, HIV/AIDS status is associated with homelessness: those persons who are homeless are more likely to be HIV positive than those who are housed. In addition, recent research has found that the health outcomes of homeless individuals living with HIV/AIDS may be improved with stable housing. For example, in a study of HIV positive individuals living in New York City that was conducted over twelve years from 1994 to 2006, those who were unstably housed – meaning that they were either living on the street, in a shelter, in some form of transitional housing, or temporarily living in someone else's home – were less likely to access and retain medical care for their disease than those receiving some form of housing assistance.[63]

In addition, preliminary findings from two recent studies have found favorable health outcomes for HIV positive individuals who are stably housed. In one of these studies, called the Housing and Health Study, HUD, together with the CDC, provided HIV positive individuals who were homeless or at severe risk of homelessness with HOPWA-funded rental housing. (The study considered individuals to be at severe risk of homelessness if they frequently moved from one temporary housing situation to another.) Those individuals in the comparison group received services, including assistance with finding housing, but did not receive HOPWA-funded housing.[64] Despite the differences in rental assistance provided between the treatment and comparison groups, both groups had a statistically significant increase in stable housing.[65] Although 4% of all participants were stably housed when the study began, 82% of HOPWA-assisted renters and 52% of individuals in the comparison group retained housing 18 months after the start of the study. Perhaps due to the fact that the comparison group also had some success in achieving and maintaining housing, both groups saw some improvements in health outcomes. Findings from the study show that individuals in both groups had fewer emergency room visits, fewer hospitalizations, reduced opportunistic infections (those infections that occur due to weakened immune systems), reduced participation in sex trade, and reductions in depression.

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[62] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Ryan White HIV/AIDS Program Annual Data Summary*, 2006, p. P11.

[63] Angela A. Aidala, Gunjeong Lee, and David M. Abramson, et al., "Housing Need, Housing Assistance, and Connection to HIV Medical Care," *Aids and Behavior*, vol. 11, no. 6 (November 2007, supplement), pp. 109-112.

[64] The methodology of the study is described in Daniel P. Kidder, Richard J. Wolitski, and Scott Royal, et al., "Access to Housing as a Structural Intervention for Homeless and Unstably Housing People Living with HIV: Rationale, Methods, and Implementation of the Housing and Health Study," *AIDS and Behavior*, vol. 11, no. 6 (November 2007, supplement), pp. 149-161.

[65] Preliminary findings from the Housing and Health Study were presented at the National Housing and HIV/AIDS Research Summit III, March 6, 2008. Findings are summarized in The National AIDS Housing Coalition, *Examining the Evidence: The Impact of Housing on HIV Prevention and Care*, Policy Paper from the Third Housing and HIV/AIDS Research Summit, 2008, pp. 6-7, http://www.nationalaidshousing.org/PDF/FinalSummit.pdf (hereafter *Examining the Evidence*).

A second study, called the Chicago Housing for Health Partnership study, identified homeless individuals with chronic illnesses, including HIV, for participation. Among those identified to participate in the study, 36% were HIV positive. The treatment group received housing funded through either HOPWA or HUD's Supportive Housing Program for homeless individuals, while the comparison, or usual care group, received available supportive services but no separate assistance with rent. The group receiving housing assistance had higher rates of intact immunity compared to the comparison group and were more likely to have undetectable viral loads 12 months after the study began.[66] In addition, the treatment group spent fewer days in emergency rooms, nursing homes, and hospitals during the 18 month period the researchers followed participants.

[66] Like the preliminary findings from the Housing and Health Study, the preliminary findings from the Chicago Housing for Health Partnership Study were presented at the National Housing and HIV/AIDS Research Summit III. The findings are summarized in *Examining the Evidence*, pp. 5-6. See footnote 65.

Appendix. Recent HOPWA Formula Allocations

Table A-1.HOPWA Formula Allocations, FY2004-FY2008

MSA, State, or Territory	FY2004	FY2005	FY2006	FY2007	FY2008
Alabama State Program	1,139,000	1,117,000	1,145,000	1,163,000	1,241,000
Birmingham	520,000	497,000	511,000	516,000	538,000
Arkansas State Program	752,000	723,000	707,000	720,000	766,000
Arizona State Program	164,000	164,000	173,000	180,000	191,000
Phoenix	1,434,000	1,391,000	1,433,000	1,456,000	1,541,000
Tucson	402,000	390,000	389,000	390,000	411,000
California State Program	3,042,000	2,869,000	2,929,000	2,926,000	2,746,000
Bakersfield	—	—	—	—	323,000
Los Angeles	10,476,000	11,848,000	10,310,000	10,393,000	10,437,000
Oakland	2,006,000	1,879,000	1,905,000	1,896,000	1,952,000
Riverside	1,772,000	1,683,000	1,684,000	1,689,000	1,751,000
Sacramento	844,000	795,000	786,000	784,000	818,000
San Diego	2,683,000	2,527,000	2,549,000	2,551,000	2,646,000
San Francisco	8,562,000	8,466,000	8,070,000	8,189,000	8,193,000
San Jose	792,000	736,000	738,000	739,000	767,000
Santa Anna	1,436,000	1,342,000	1,359,000	1,345,000	1,402,000
Colorado State Program	366,000	354,000	364,000	363,000	379,000
Denver	1,424,000	1,342,000	1,359,000	1,361,000	1,414,000
Connecticut State Program	251,000	242,000	253,000	252,000	263,000
Bridgeport	779,000	717,000	737,000	739,000	771,000
Hartford	1,023,000	1,285,000	1,108,000	1,098,000	1,140,000
New Haven	1,232,000	1,624,000	1,178,000	1,075,000	946,000
Washington, DC	11,802,000	10,535,000	11,370,000	11,118,000	11,541,000
Delaware State Program	164,000	162,000	166,000	167,000	179,000
Wilmington[a]	798,000	703,000	679,000	552,000	604,000
Florida State Program	4,063,000	3,581,000	3,312,000	3,316,000	3,191,000
Cape Coral[b]	—	—	336,000	332,000	350,000
Fort Lauderdale	6,240,000	6,106,000	6,637,000	6,878,000	7,351,000
Jacksonville	1,564,000	1,624,000	1,587,000	1,630,000	1,988,000
Lakeland[b]	—	378,000	445,000	418,000	509,000
Miami	10,715,000	10,351,000	11,189,000	11,689,000	12,370,000
Orlando	3,189,000	2,871,000	2,906,000	2,895,000	3,234,000
Palm Bay	—	—	—	—	311,000
Sarasota	397,000	548,000	390,000	391,000	409,000

MSA, State, or Territory	FY2004	FY2005	FY2006	FY2007	FY2008
Tampa	2,389,000	3,049,000	2,542,000	2,772,000	3,193,000
West Palm Beach	3,836,000	3,426,000	3,595,000	3,235,000	3,271,000
Georgia State Program	1,515,000	1,527,000	1,576,000	1,621,000	1,744,000
Atlanta	4,899,000	6,592,000	5,290,000	6,801,000	7,034,000
Augusta	373,000	418,000	376,000	394,000	385,000
Hawaii State Program	181,000	169,000	162,000	160,000	164,000
Honolulu	452,000	428,000	429,000	419,000	433,000
Iowa State Program	347,000	329,000	330,000	336,000	354,000
Illinois State Program	864,000	827,000	875,000	875,000	916,000
Chicago	8,338,000	5,379,000	5,561,000	5,572,000	5,819,000
Indiana State Program	836,000	806,000	818,000	822,000	863,000
Indianapolis	759,000	738,000	751,000	752,000	782,000
Kansas State Program	363,000	349,000	331,000	332,000	346,000
Kentucky State Program	423,000	407,000	410,000	408,000	431,000
Louisville	462,000	443,000	447,000	453,000	476,000
Louisiana State Program	940,000	932,000	951,000	975,000	1,034,000
Baton Rouge	1,813,000	1,659,000	1,572,000	1,409,000	1,433,000
New Orleans	2,992,000	3,398,000	2,997,000	2,914,000	2,769,000
Massachusetts State Program	525,000	178,000	168,000	166,000	173,000
Boston	1,829,000	1,721,000	1,719,000	1,690,000	1,747,000
Lowell	659,000	623,000	627,000	622,000	644,000
Lynn	—	316,000	317,000	312,000	326,000
Springfield	461,000	433,000	424,000	418,000	426,000
Worcester	369,000	348,000	354,000	349,000	368,000
Maryland State Program	345,000	335,000	348,000	345,000	357,000
Baltimore	7,936,000	7,754,000	7,649,000	8,038,000	8,195,000
Frederick[c]	535,000	518,000	524,000	539,000	575,000
Michigan State Program	911,000	862,000	877,000	893,000	941,000
Detroit	1,979,000	1,554,000	1,597,000	1,640,000	1,979,000
Warren	405,000	392,000	397,000	409,000	437,000
Minnesota State Program	110,000	105,000	112,000	114,000	119,000
Minneapolis	839,000	797,000	829,000	833,000	873,000
Missouri State Program	496,000	475,000	455,000	450,000	473,000
Kansas City	978,000	924,000	918,000	918,000	955,000
St. Louis	1,217,000	1,158,000	1,150,000	1,140,000	1,227,000
Mississippi State Program	756,000	749,000	778,000	783,000	833,000
Jackson	724,000	998,000	868,000	899,000	885,000

MSA, State, or Territory	FY2004	FY2005	FY2006	FY2007	FY2008
North Carolina Program	2,082,000	2,010,000	2,097,000	2,154,000	2,272,000
Charlotte	571,000	565,000	597,000	626,000	671,000
Wake County	352,000	337,000	366,000	382,000	434,000
Nebraska State Program	—	—	—	—	306,000
New Jersey State Program[a]	1,106,000	1,050,000	1,064,000	1,056,000	1,079,000
Camden	657,000	628,000	620,000	610,000	642,000
Jersey City	—	2,240,000	2,545,000	2,443,000	2,534,087
Newark	5,182,000	5,014,000	5,246,000	4,924,000	5,167,000
Paterson	—	1,265,000	1,282,000	1,250,000	1,286,736
Woodbridge	1,462,000	1,366,000	1,375,000	1,351,000	1,390,000
New Mexico State Program	533,000	503,000	514,000	514,000	532,000
Nevada State Program	238,000	219,000	219,000	219,000	228,000
Las Vegas	916,000	886,000	882,000	897,000	952,000
New York State Program	1,776,000	1,702,000	1,797,000	1,809,000	1,897,000
Albany	429,000	415,000	436,000	439,000	462,000
Buffalo	472,000	456,000	480,000	480,000	507,000
Islip	1,660,000	1,565,000	1,617,000	1,608,000	1,675,000
New York City	60,355,000	47,056,000	56,610,000	54,723,000	56,811,177
Poughkeepsie	604,000	577,000	679,000	812,000	947,000
Rochester	597,000	575,000	599,000	605,000	640,000
Ohio State Program	1,041,000	1,024,000	1,037,000	1,051,000	1,108,000
Cincinnati	550,000	517,000	518,000	530,000	562,000
Cleveland	854,000	822,000	826,000	840,000	870,000
Columbus	584,000	584,000	596,000	608,000	641,000
Oklahoma State Program	518,000	494,000	498,000	506,000	226,000
Oklahoma City	466,000	441,000	435,000	437,000	459,000
Tulsa	—	—	—	—	307,000
Oregon State Program	—	321,000	319,000	317,000	335,000
Portland	1,006,000	949,000	947,000	943,000	988,000
Pennsylvania State Program	1,540,000	1,511,000	1,548,000	1,527,000	1,670,000
Philadelphia	7,632,000	7,336,000	7,083,000	6,650,000	7,052,000
Pittsburgh	626,000	620,000	623,000	619,000	649,000
Puerto Rico State Program	1,748,000	1,636,000	1,633,000	1,616,000	1,679,000
San Juan	7,140,000	5,324,000	5,874,000	5,632,000	6,144,000
Providence	807,000	764,000	776,000	773,000	801,000
South Carolina State Program	1,387,000	1,356,000	1,387,000	1,403,000	1,491,000

MSA, State, or Territory	FY2004	FY2005	FY2006	FY2007	FY2008
Charleston	418,000	390,000	397,000	401,000	419,000
Columbia	1,270,000	1,160,000	1,041,000	1,034,000	1,138,000
Tennessee State Program	739,000	718,000	747,000	756,000	796,000
Memphis	2,134,000	1,462,000	1,882,000	1,879,000	2,115,000
Nashville	737,000	840,000	737,000	757,000	795,000
Texas State Program	2,736,000	2,634,000	2,691,000	2,733,000	2,841,000
Austin	988,000	931,000	940,000	947,000	987,000
Dallas	3,192,000	3,867,000	3,141,000	3,134,000	3,332,000
Fort Worth	835,000	805,000	813,000	819,000	863,000
Houston	5,068,000	9,669,000	6,039,000	6,579,000	6,038,000
San Antonio	1,027,000	960,000	971,000	972,000	1,025,000
Utah State Program	120,000	111,000	112,000	111,000	115,000
Salt Lake City	386,000	354,000	353,000	346,000	357,000
Virginia State Program	640,000	612,000	618,000	615,000	634,000
Richmond	692,000	658,000	665,000	660,000	690,000
Virginia Beach	1,022,000	958,000	941,000	937,000	968,000
Washington State Program	652,000	619,000	620,000	622,000	651,000
Seattle	1,688,000	1,611,000	1,615,000	1,604,000	1,663,000
Wisconsin State Program	405,000	383,000	389,000	391,000	407,000
Milwaukee	512,000	487,000	497,000	492,000	515,000
—*Subtotal formula grants*	*263,039,000*	*251,323,000*	*256,162,000*	*256,162,000*	*267,417,000*[d]
—*Subtotal competitive grants*	*29,227,000*	*27,925,000*	*28,463,000*	*28,463,000*	*29,713,000*
—*Subtotal technical asst.*	*2,485,000*	*2,480,000*	*1,485,000*	*1,485,000*	*1,485,000*
Total HOPWA	**294,751,000**	**281,728,000**	**286,110,000**	**286,110,000**	**300,100,000**

Source: U.S. Department of Housing and Urban Development, Office of Community Planning and Development Program Formula Allocations, available at http://www.hud.gov/offices/cpd/about/budget/budget08/index.cfm, and FY2006-FY2009 Congressional Budget Justifications.

a. According to directions in the HUD Appropriations Act, funds awarded to the Wilmington MSA are transferred to the State of New Jersey to administer the HOPWA program for the one New Jersey county that is in the Wilmington MSA (Salem county).

b. The State of Florida administers the grants for the Cape Coral and Lakeland MSAs.

c. The State of Maryland administers the grant for the Bethesda-Frederick-Gaithersburg MSA.

d. Subtotals and totals for FY2008 are estimates.

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