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The Opportunity Cost of the Aging Adult Homeless Population

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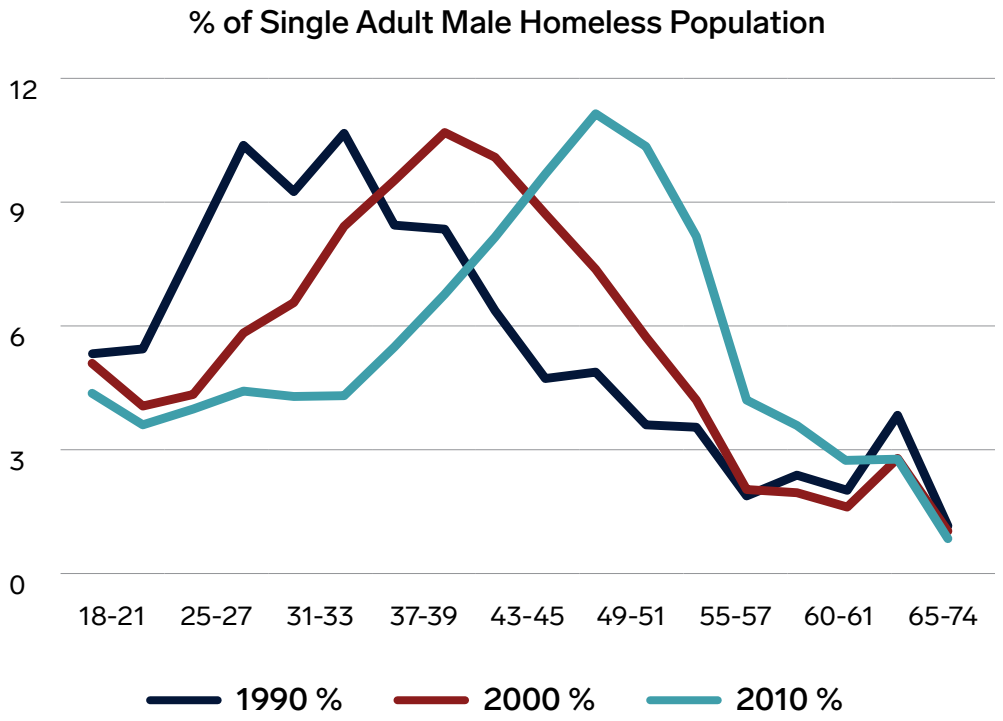
THE PROBLEM

The homeless population is aging. While the aging of the post-War baby boom population in general might suggest that this is not at all surprising, the age structure of the adult homeless population is distinct. As shown in Figure 1, three decennial censuses have revealed a "cohort effect" among the adult homeless population (Easterlin, 1979). Most of the adult homeless population since 1990, and likely for several years before, is concentrated among the latter half of the post-War baby boom population, born between 1955 and 1965 (Culhane et al., 2013). This has persisted for thirty years, and the 2020 Census will undoubtedly reveal a continuation of that trend. In 2020, the average age in this cohort will be 60 in a population with a life expectancy of 64 (Metraux et al., 2011). This trend has important implications for homelessness assistance programs, which have not in recent history experienced elderly homelessness in significant numbers.

FIGURE 1: Age Distribution of Adult Male Shelter Users in the United States



Source: Culhane et al. (2013)/U.S. Census Bureau Decennial Census Special Tabulation

In a recent three-city study (Los Angeles County, New York City and Boston), with colleagues we (Culhane et al., 2019) undertook a deeper examination of this trend; developed forecasts regarding implications for the health care and shelter systems; modeled a range of potential population-based interventions; and estimated how the costs of these interventions might be offset by reduced dependence on shelters, hospitals and nursing homes, based on the prior literature.

Among our key findings were these:

- The elderly homeless population (age 65 and over) is projected to triple between 2017 and 2030, even as the number of homeless adults from the 1955-1965 birth cohort declines due to mortality.
- As the adult homeless population ages, their health care costs are expected to increase to an average of about $15-20,000 annually, including significant nursing home costs. Shelter costs would also continue to rise, on average, to approximately $5-7,000 per person annually, resulting in a total estimated annual cost of about $20-27,000 per person.
- A population-based set of housing interventions (assuming some self-resolution) comprised of rapid rehousing, shallow subsidies, full subsidies, PSH (permanent supportive housing), and some assisted living, is projected to cost an average of $7,000-$11,000 annually per person per year.
- The average projected net offset in reduced hospital, nursing home and shelter use (approximately 1/3 of costs), is estimated to be roughly comparable to the overall average housing intervention costs, and under some scenarios could even save money. In other scenarios they would require only a modest additional investment.

The prospect that so many elderly people will be homeless, and the associated human misery that will result, should compel us to take action. That this will lead to disproportionate use of health, nursing home, and shelter services is further reason to respond. Even more compellingly, if we could instead fund housing solutions for this population, at no net increase in costs or even with some modest increase in costs, that would be an even clearer call to action. Unfortunately, shifting spending from health and shelter systems to housing solutions is not simple. Multiple stakeholders would have to be engaged, including the Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies, managed care organizations (MCOs), hospitals, homelessness assistance programs, and housing providers.

IMPLICATIONS FOR POLICY AND PROGRAM DEVELOPMENT

Caring for the more than 2 million people who experience homelessness each year has become the responsibility of a network of nonprofit shelter and housing providers throughout the U.S., funded largely by the US Departments of Housing and Urban Development (HUD) and Veterans Affairs, as well as state and local governments. Yet, even with those efforts as many as 200,000 people live unsheltered each night, in places not meant for habitation (Henry et al., 2018). Clearly, this network is not able to provide adequate shelter to the population of people who experience homelessness, let alone *solve* their homelessness. Hospitals have also increasingly been noted to fill some gaps in the social safety net, as some people who are homeless cycle between hospitals and shelters (Treglia et al., 2019). Solving homelessness—even for the subset of elderly adults—will require new commitments of resources, new partnerships, and the scaling up of programs that have shown promise to work.

SSI Outreach. Given the accelerated aging of people who experience homelessness, many in this large cohort will be eligible for SSI due to increased morbidity and disability, and eventually due to age (at 65). SSI outreach is therefore a fundamental component of any effort to address aging homelessness. By increasing the incomes of these individuals, many will have increased access to housing, most likely in shared living arrangements, with family and friends, or in board and care homes. While the income may not be sufficient, and some subsidy may be required for some to attain housing, SSI will provide an important income stream to eligible persons, while drawing on a federal entitlement source. The SSI/SSDI Outreach, Access, and Recovery (SOAR) program should therefore be re-envisioned and expanded to take into account the increasing number of aged homeless adults who could benefit from this program.

Homelessness Prevention and "Housing Advice." About one third to one half of people in this aged cohort are experiencing homelessness for the first time (Brown et al., 2016; Culhane, 2014). Homelessness prevention, including landlord-tenant mediation, emergency cash assistance, debt relief, and some light touch case management, referred to in some European countries as "Housing Advice," should be made available in neighborhoods with high rates of shelter entry, and through Area Agencies on Aging (AAA). Prevention services could also be provided or referred from local jails, emergency departments, housing courts, and as part of utility termination warnings and notices.

Rapid Rehousing and Critical Time Intervention. For people who do not self-resolve with housing advice or prevention services (based on previous patterns of shelter use, one-quarter to one-third of shelter entrants will self-resolve), and whose homelessness persists for thirty days or more, rapid rehousing services should be provided. Rapid rehousing typically includes an assessment of client needs and strengths, followed by the development of a plan for rehousing. This should include housing search, move-in assistance and assistance negotiating housing terms with landlords, friends, family and other housing providers (e.g. board and care homes). In many cases, rapid rehousing includes temporary rental assistance, perhaps up to a year, to facilitate a transition to benefits or other sources of housing assistance. Referral to health and social services should be provided as indicated, and a review done of benefits eligibility and enrollment. Given the limited availability of subsidies, shared housing will need to be sought as often as possible, including with family, friends and roommates.

Because many if not most of the aged adults who are homeless will have some aging-related disabilities, some of the rapid rehousing services could be potentially funded through Medicaid (Culhane & Byrne, 2019). Critical Time Intervention (CTI) is an evidence-based behavioral health intervention that could be used as a model for rapid rehousing services for people with disabilities, whose transition to housing is part of their recovery and rehabilitation. While there are limits to what Medicaid can cover for cash assistance or rent, Medicaid managed care organizations could be enlisted as the payer for CTI, as health payers will also benefit from the avoidance of excess acute health care costs and nursing home placements. Hospitals, jails and shelters can serve as recruitment sources for program enrollment. CTI teams could be placed in these high-volume client settings; indeed, hospitals may want to expand their social work departments and discharge planning staff to include CTI teams for this purpose, obtaining reimbursement from MCOs and reducing their own liability for uncompensated care days. Hospitals also already generally employ care management teams whose job it is to improve care and keep people out of the hospital. CTI teams could be seen as an extension though—importantly from the healthcare system perspective—they would be a bit different from traditional care management in roles (which would extend to services to help people stabilize in housing) and level of "touch" (which is higher for CTI than for traditional hospital care management).

Shallow Subsidies. Some communities have experimented successfully with shallow subsidies as a supplement to SSI to assist clients in obtaining housing. New York City's HIV/AIDS Services Administration (HASA) housing program, the nation's largest shallow subsidy program, provides $400 as a monthly supplement to SSI for formerly homeless persons with HIV. Nearly 30,000 people live in housing with this combination of assistance, very often in shared living arrangements. Shallow subsidies have the advantage of being lower cost than a full voucher and more flexible than a typical federal housing voucher in terms of living arrangements. Los Angeles County successfully experimented with a similar shallow subsidy for homeless clients receiving General Relief, many of whom were also transitioned to SSI, resulting in a net savings to the County through reduced use of county-funded acute care services and cash assistance (Moreno, Toros, & Stevens, 2012). Shallow subsidies could be potentially funded from existing revenue sources for shelter, and supplant shelter costs, which in our study were found to average about $5-7,000 per person per year, which is greater than the potential cost of an annual shallow subsidy of $400 per month, or $4,800 per year. But it is also likely that some communities will have to find other state or local sources for this funding.

All of these proposed strategies will require advocacy and organizing to put the political and organizational alliances in place for implementation.

Vouchers. For people for whom shared living arrangements are not possible, full housing vouchers may be necessary. Federal vouchers for people who are elderly (Section 202) or disabled (Section 811) could be targeted to address the population of homeless elderly persons who require them. Given their limited availability, additional vouchers may require Congressional authorization. The cost analyses developed from our multisite study could help to support a request for vouchers as an advance payment toward future health and shelter cost offsets. MCOs, hospitals, and local Continuums of Care (networks of local homeless service providers) could urge their local and state congressional leaders to support a program expansion for this purpose, as each would benefit from such a program, as well as their fellow homeless citizens.

Housing Support Services and Assisted Living. Some of the people assisted through either vouchers or shallow subsidies may have current or future needs for support services to help maintain their independence and to avoid nursing home placement. Like other aged persons receiving assisted living services and people with disabilities in supportive housing, these services should be eligible for reimbursement from Medicaid, including housing transition and stabilization services, case management or ACT services, and independent living services. At age 65, Medicare-funded services would also apply. Local services providers, continuums of care (CoCs), and hospitals should work with MCOs to make sure that funding is available for these supports, and to staff and train the workforce needed to deliver them. State Medicaid agencies will need to provide guidance to MCOs and may also need to provide support given that insured people often move among plans, and perhaps a pool of funds would need to be established to address shifting financial responsibility associated with "churn."

IMPLEMENTATION CHALLENGES

All of these proposed strategies will require advocacy and organizing to put the political and organizational alliances in place for implementation. At present, the likelihood of any major federal initiative seems slim, but federal leadership could certainly help. For example, the U.S.

Interagency Council on Homelessness could work with its federal agency partners to develop guidance for state Medicaid agencies, Area Agencies on Aging, and Continuums of Care on how they could collaborate in organizing a response. It would be useful to develop a "toolkit" that helps communities identify the scope of the problem, the potential interventions and collaboration opportunities, and the various roles and responsibilities that would need to be filled in a local or state plan. Federal technical assistance in support of local planning could also be developed. Local leadership councils could be organized to create plans with relevant stakeholders, including CoC leadership, hospital representatives, MCOs, housing authorities, landlords, and community agencies working on aging and housing issues.

Developing a plan that would work at the scale of the problem is always challenging. An incremental approach to local plans might be more realistic in the near term. In the immediate term, this could include piloting CTI programs at select hospitals with a high volume of homeless patients in order to work through the staffing and reimbursement model, while also demonstrating its cost effectiveness to payers. Initial efforts with shallow subsidies could be targeted to people over a certain age, like 62 or 65, and then moved progressively younger as capacity and experience with the program grows. Full subsidies could be targeted to people with higher threshold needs initially and then expanded with availability.[1]

CONCLUSION

As the second half of the post-War baby boom population ages, they are likely to remain disproportionately at risk for homelessness, and to dominate the ranks of the adult homeless population, as they have for the past three decades. With increased age will come increased costs for health and nursing home care, due both to increased morbidity and to the lack of stable housing in which they can manage their health care and recovery needs. Community partnerships across a variety of agencies will be required to develop and implement plans to address this problem at scale. Federal and state leadership will likely be critical to the success of those efforts. The prospect of ameliorating the human suffering that will accompany a forecasted tripling in the number of elderly homeless adults by 2030 should compel us to act. Our current system of homelessness assistance and the shuffling of people between hospitals, shelters, and nursing homes, is simply not adequate.

If we do nothing to address this emerging crisis directly, the costs to society will be significant. Alternatively, we can work proactively to identify housing solutions through which we can solve elderly homelessness and, in doing so, use those same resources more efficiently, effectively, and humanely.

[1] It is noteworthy that our multisite forecasting study found that the bulk of the health care savings from the range of proposed housing solutions accrued to the largest and lowest cost subgroup, not to the much smaller high cost population often exclusively targeted for PSH.