



HUD-HHS Partnerships: A Prescription for Better Health

EXECUTIVE SUMMARY

Among the most important public health findings over the last two decades has been that there are a number of factors, beyond medical care, that influence health and contribute to premature mortality. The Bipartisan Policy Center has worked extensively to highlight the importance of one such factor—safe, affordable housing—recognizing that the integration of health and housing has the potential to improve health outcomes and reduce costs borne by the health care system.



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There are many ongoing and productive partnerships between the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS) at this nexus of health and housing. Generally, these collaborations help the departments to break down their siloed decision-making, more fully capitalize on their respective expertise, maximize limited funding, and more efficiently and impactfully fulfill both their missions. Yet their work is far from finished; pressing challenges make continued and close collaboration between the two departments during the Trump administration more important than ever.

In any administration, given limited resources, limited time, and a host of pressing challenges, only certain priorities can rise to the top. To better understand the priorities of the new leadership teams in HUD and HHS, we conducted dozens of interviews with housing and health experts, stakeholders, and HUD and HHS staff—career and politically appointed. We also relied on the input of a bipartisan advisory group of former HUD and HHS leaders.

In addition to this qualitative outreach effort, the departments' strategic plans and President Trump's proposed 2019 budget also provided us with a guide to the administration's key priorities. For FY2019, the president requests \$1,216 billion for HHS and \$42 billion for HUD. The requests reflect strategic and analytical input from across the two departments. From these sources, we have identified the following process and programmatic areas as the most promising partnership opportunities.



Interagency Priorities and Recommended Partnerships

PROCESS IMPROVEMENTS

LEADERSHIP AND RESOURCES

The secretaries of HUD and HHS should commit to regularly occurring meetings.

In addition to the attention of each department's leadership, HUD and HHS should designate departmental liaisons or offices, with adequate resources, focused on advancing interdepartmental health and housing collaborations. To this end, creating a "joint planning and development office" between HUD and HHS could provide a high-level and systematic platform for the articulation, budgeting, and organization of health and housing operations.

DATA SHARING

Building off successful data-matching collaborations, HUD and HHS should expand the data matching process by launching an initiative that focuses on aligning and connecting local housing data with state Medicaid data.

Additionally, to further the potential advancements that could emerge from an interagency national data-matching initiative, HUD and HHS leadership could establish an external Research Advisory Board of academics and stakeholders. With assistance and feedback from the board, the interdepartmental staff can better evaluate newly matched datasets for further research and potential applications.

PROGRAMMATIC COLLABORATIONS

INTEGRATION OF HOUSING AND BEHAVIORAL HEALTH

Opioid Overdose Epidemic

HUD and HHS should identify public housing complexes with high overdose rates and encourage local law enforcement to carry naloxone, a medication designed to rapidly reverse opioid overdose. HUD and HHS could provide training and funding for such a pilot program allowing first responders to carry naloxone. In addition, making naloxone available in public housing to health care practitioners as well as family and friends of people who have an opioid use disorder could increase access to this life-saving medication.

HUD and HHS should jointly explore increasing recovery housing options in communities with high rates of opioid use disorder. New funding, for example, may present an opportunity to evaluate and support recovery housing models linked to community health centers.

Coordination is needed between HUD and HHS to ensure that qualified health care practitioners in the Public Housing Primary Care program have waivers to prescribe buprenorphine to individuals with opioid use disorders. (The Public Housing Primary Care program provides health care in public housing developments.)

Severe Mental Illness

Consistent with recommendations from HHS' Interdepartmental Serious Mental Illness Coordinating Committee, HUD should consider issuing guidance for state and local housing authorities on establishing tenant selection preferences for non-elderly people with severe mental illness, consistent with federal fair housing requirements. HUD should also consider targeting resources such as Housing Choice Vouchers for individuals with severe mental illness experiencing chronic homelessness or transitioning from settings such as correctional facilities, nursing homes, or board and care homes.

HUD and HHS should jointly study the feasibility of a pilot program in which patients with severe mental illness at Federally Qualified Health Centers are screened for housing insecurity and prioritized for housing vouchers, consistent with federal fair housing requirements.

Lead Poisoning

CDC's National Center for Environmental Health, CMS' Center for Medicaid & CHIP Services, and HUD's Office of Lead Hazard Control and Healthy Homes should initiate a strategic dialogue to better coordinate activities related to surveillance of lead poisoning, diagnosis and treatment of children with elevated blood lead levels, and prevention of lead poisoning. As part of the dialogue, the agencies should consider the following specific actions:

- Coordinate blood lead level surveillance efforts to support CDC and HUD's respective goals.
- Coordinate activities between CDC and HUD to improve surveillance of housing conditions across all 50 states to better target geographic areas and types of housing with high lead home contamination and elevated blood lead levels.
- Launch a public-private partnership to replace lead-contaminated windows in pre-1940 housing. HHS' Low Income Heating Assistance Program (LIHEAP) could be a partner to HUD in this effort. Windows have the highest lead paint and lead dust levels compared to other building components and replacement provides energy savings and increases home value.
- Encourage public housing authorities to conduct testing of soil for lead in properties with histories of lead-based paint, with such testing being explicitly identified as eligible for funding through HUD's Lead Hazard Reduction Program and Healthy Homes Initiatives programs.
- Work with state Medicaid agencies to submit timely and accurate data to CMS on the number of blood lead screening tests and positive blood lead screening tests; require Medicaid managed care plans to report on lead screening quality metrics; and support lead investigations, screenings, and follow-up services.
- Improve states' awareness of regulatory flexibilities to augment efforts. As an example, Rhode Island's Medicaid program covers window replacement for children with lead poisoning under its Section 1115 waiver and Michigan's Medicaid program pays for lead abatement services through a CHIP health services initiative. Beyond waivers, state Medicaid agencies could also use value-based purchasing contracts with managed care plans to incentivize, finance and scale evidence-based healthy housing interventions. Managed care plans could also pay for these interventions out of their administrative funds.

Asthma Prevention

CDC's National Center for Environmental Health, CMS' Center for Medicaid & CHIP Services, and HUD's Office of Lead Hazard Control and Healthy Homes should begin a dialogue to better coordinate activities related to surveillance of asthma exacerbation "hot spots" and targeted remediation of homes to reduce environmental triggers.

HUD's Healthy Home grants should be coordinated with local public health and state Medicaid program efforts to reduce asthma environmental triggers. Case management of asthma cases should enable housing remediation when appropriate.

CMS should develop an informational bulletin to clarify for states the various pathways to Medicaid reimbursement for pediatric asthma services. This could include options such as the use of 1115 waivers and CHIP amendments, Medicaid "health homes," social impact financing, managed care contracts that promote community-based asthma interventions, and new payment and delivery system reforms.

DISASTER PREPAREDNESS, RESPONSE, AND RECOVERY

Data Sharing

HUD and HHS should jointly review the current capacity of state and local agencies to conduct successful data sharing operations in the event of a natural disaster. Preemptively establishing the necessary data standardization and MOUs will enable agencies to immediately share data during an emergency, increasing preparedness and familiarity of each agency prior to a disaster, and shortening response times during a disaster.

In collaboration with HUD property data, HHS should continue to improve and expand the data collected for the emPOWER Map. Additionally, HUD and HHS should conduct a joint review of the available datasets that could be utilized to further inform federal, state, or local disaster preparedness.

Program Coordination

Building on the past successes of DHAP and similar alternative housing pilot programs, HUD and HHS should support legislation to permanently authorize DHAP as a primary housing program for disaster response and recovery.

HUD and HHS should align their disaster funds and programs along a targeted goal of improving health and housing conditions among vulnerable and low-income populations. Given the decentralized nature of the HUD and HHS disaster programs, an alignment of the existing resources will hinge on implementation at the state and local levels. Through the review and approval of the state, local, tribal, and territorial action plans required for various federal programs, HUD and HHS should advise state and local agencies to develop collaborative health and housing programs with the capacity to respond to a potential disaster.

Additionally, given the unique circumstances of the disaster response and recovery in Puerto Rico and the U.S. Virgin Islands, HUD and HHS should ensure that all available programs operating with the Joint Field Offices are coordinating to provide the optimal health and housing services. With an acute safe and affordable housing shortage, combined with an increased risk of physical health problems, mental health problems, and environmental exposures, HUD and HHS should ensure that vulnerable and affected populations have access to all available resources, across all local, state, and federal programs.



Home Modifications

Both HHS and HUD have programs that can provide support and resources for home assessments and modifications, including in some cases, apartments that serve low-income people. Greater coordination between HHS and HUD, could result in development of an analysis of households served and approximate dollars invested for senior households by program. The Aging Network, supported by HHS, could disseminate information on public and private resources available for home assessments and modifications to the 10 million low-income seniors currently served by senior centers.

Health Care and Supportive Services

CMS, through its Center for Medicare and Medicaid Innovation, should solicit proposals for a demonstration project with health care entities willing to be accountable for quality health outcomes and total costs of care for Medicare beneficiaries living in publicly assisted housing.

State Leadership and Flexibility

CMS, in partnership with state Medicaid agencies, should track to what extent older beneficiaries—specifically beneficiaries who are dually eligible for Medicare and Medicaid at risk for institutionalization—are utilizing supportive housing services and activities.

Medicaid's Innovation Accelerator program should continue efforts to bring together state Medicaid and housing agencies to identify affordable housing options for beneficiaries ready to be transitioned from institutionalized settings.

Conclusion

The policy case for better connecting health and housing programs and resources is increasingly apparent. HUD and HHS—given their expertise, history, and challenges—are uniquely positioned to demonstrate such benefits. By partnering together and incorporating a data-driven and evidence-based approach, the departments can materially improve the health and quality of life of the populations their programs serve. They can also make more efficient use of limited resources, which is a key consideration given the federal government's increasingly precarious fiscal situation.



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In sum, the opportunities identified in *HUD-HHS Partnerships: A Prescription for Better Health* represent key areas for collaboration in the coming years that would help the two departments jointly tackle their most pressing priorities with the most efficient use of the taxpayer's dollar.



Read the report at bipartisanpolicy.org

