"Housing America: Addressing Challenges in Serving People Experiencing Homelessness"
U.S. House Financial Services Committee:
Subcommittee on Housing, Community Development, and Insurance Hearing
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Written Testimony Prepared by Adrienne Bush
Executive Director at the Homeless and Housing Coalition of Kentucky

Chairman Cleaver, Ranking Member Hill, and members, thank you for the opportunity to share our thoughts on working to end homelessness in the Commonwealth of Kentucky.

My name is Adrienne Bush, and I am the executive director of the Homeless and Housing Coalition of Kentucky (HHCK), a statewide nonpartisan advocacy organization with a unique perspective on administering housing assistance to people experiencing homelessness. Our mission is to eliminate the threat of homelessness and fulfill the promise of affordable housing. To that end, we also step into identified gaps to provide Continuum of Care and Emergency Solutions Grant assistance when requested. Additionally, we convene and staff the Kentucky Interagency Council on Homelessness, the statewide homeless policy and planning body authorized by Kentucky statute. HHCK is a State Partner of the National Low Income Housing Coalition. We abide by the principles that (a) housing is a human right, and (b) housing ends homelessness.

I. Recent Data on Homelessness

According to the most recent Annual Homeless Assessment Report to Congress,[1] 4,011 Kentuckians were experiencing street or sheltered homelessness on the night of the Point in Time Count in 2020 (p. 85). 3 out of 4 people counted that night were individuals, and of those 629 were deemed chronically homeless. Additionally, 895 people in families with children, and 221 were unaccompanied youth. 399 of the people counted were veterans.

The Point in Time Count can be useful when trend line analysis is applied. From 2007 to 2020, Kentucky's percentage of people counted has declined 50.2%, the highest percentage in the country (p. 12).[2]

At HHCK, to gain a better understanding of the numbers of Kentuckians experiencing homelessness throughout the year, we have begun working with two additional data sources. First, we have worked with the Continuum of Care Collaborative Applicants to determine the number of times a household completes the Common Assessment or Coordinated Entry process to be prioritized for homeless assistance. In the calendar year 2020, across Kentucky,

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[1] U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2021, March). The 2020 Annual Homeless Assessment Report (AHAR) to Congress. Retrieved from HUD Exchange: https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf

[2] U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2021, March). The 2020 Annual Homeless Assessment Report (AHAR) to Congress. Retrieved from HUD Exchange: https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf

4100 assessments and entries were completed, according to personal correspondence with the staff of the three Continuum of Care jurisdictions.

Secondly, we have been working closely with other systems that have a stake in ending homelessness, including the healthcare sector. In 2020 and 2021, in partnership with a colleague at the University of Louisville, we submitted a data request to the Kentucky Office of Health Data Analytics (KY OHDA) to obtain the number of people discharged from hospitals into street or sheltered homelessness in 2019. Our data request was enhanced by peer-reviewed research conducted in Illinois, which found that "using additional data sources may help to augment the Department of Housing and Urban Development point-in-time estimates to provide more accurate estimates of homelessness that are used to direct resources and assess policy…."[3] In Kentucky, we found that 4,162 individuals were discharged back into homelessness in the time period studied.[4]

While these data sources point to a decline in homeless population in Kentucky, we understand that nationally homelessness is increasing, and Kentucky is not immune to national trends. We also know that homeless assistance funding through the Continuum of Care is just one small piece of ending homelessness within the larger housing crisis.

A. **Racial Disparities among the Homeless Population**
   According to the 2020 Census,[5] selected racial and ethnic identities of Kentuckians are as follows:
   - 8.5% Black or African American
   - 1.6% Asian
   - 2.0% Two or More Races
   - 3.9% Hispanic or Latino
   - 87.5% White alone

   However, the number of people presenting through the Point in Time Count and KY OHDA data request indicate a disproportionate number of non-White Kentuckians experiencing homelessness when compared to the racial and ethnic categories of the population as a whole.

   Point in Time Count data indicates the following:[6]
   - 24.8% of people counted identified as Black or African American (overrepresentation compared to Census figures)

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[3] Madigan, D., Forst, L., & Friedman, L. S. (2020). Comparison of State Hospital Visits With Housing and Urban Development Estimates of Homeless: Illinois, 2011-2018. American Journal of Public Health, e1-e3. doi:10.2105/AJPH.2019.305492

[4] Walton, M., & Lile, A. (2021). OHDA Homeless Indicator Statistics Reference Sheet. Frankfort, KY: Kentucky Cabinet for Health and Family Services Office of Health Data Analytics. Attached as Appendix A.

[5] U.S. Census Bureau. (n.d.). QuickFacts Kentucky; United States. Retrieved from QuickFacts: https://www.census.gov/quickfacts/fact/table/KY,US/PST045221

[6] U.S. Department of Housing and Urban Development. (2021, March). 2007 - 2020 Point-in-Time Estimates by State. Retrieved from HUD Exchange: https://www.huduser.gov/portal/sites/default/files/xls/2007-2020-PIT-Estimates-by-state.xlsx

- 0.4% of people counted identified as Asian (underrepresentation)
- 6.5% of people counted identified as two or more races (overrepresentation)
- 3.3% of people counted identified as Hispanic or Latino (roughly similar)
- 70.4% of people counted identified as White (overrepresentation)

Figure 1.

Racial/Ethnic Comparisons in KY Homeless Data
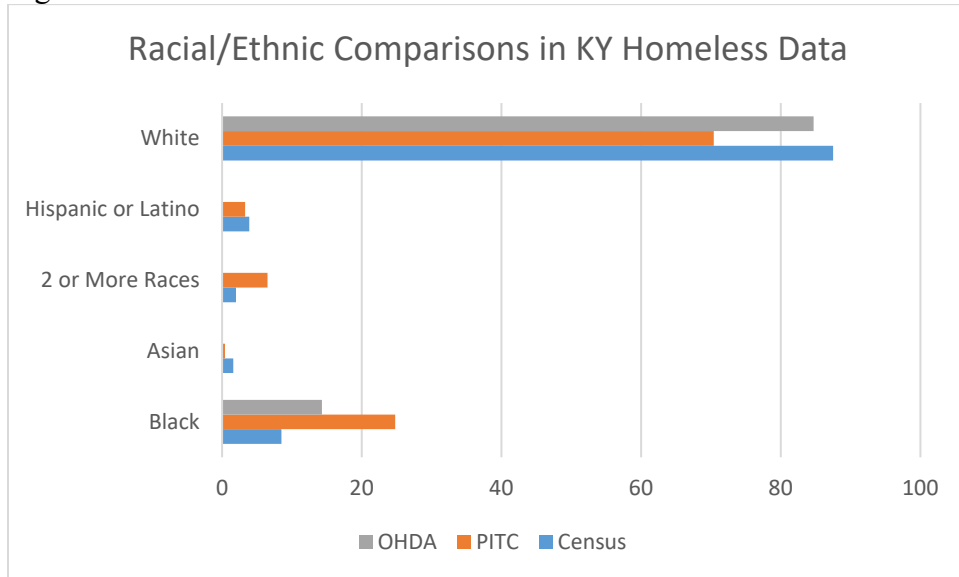
The KY OHDA reports that while 14.3% of the individuals in this hospital discharge data were identified as Black, which is lower than the Point in Time Count data, it is still significantly higher than the Census figure. Further, by analyzing the total number of discharges in 2019 (35,943), the OHDA calculated "the odds ratio of a Black hospital patient being identified as experiencing homelessness was 70% higher than the odds for a White patient."[7]

II. Continuum of Care Function
A. Coordinating Federal and Other Resources
In Kentucky, there are 3 Continuum of Care (CoC) jurisdictions: Lexington/Fayette County; Louisville/Jefferson County; and the 118 counties outside of our 2 largest cities comprise the Balance-of-State.
- The Lexington CoC is coordinated within the Lexington-Fayette Urban County Government through a dedicated Office of Homelessness Prevention and Intervention, and was awarded $2.1M for 10 projects in the FY20 CoC competition.
- The Louisville CoC is coordinated by a nonprofit organization, the Coalition for the Homeless, and was awarded $13.3M for 27 projects in the FY20 CoC competition.

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[7] Walton, M., & Lile, A. (2021). OHDA Homeless Indicator Statistics Reference Sheet. Frankfort, KY: Kentucky Cabinet for Health and Family Services Office of Health Data Analytics. Attached as Appendix A.

- The Balance-of-State CoC is coordinated by Kentucky Housing Corporation (KHC), our state housing finance agency, and was awarded $11.7M for 35 projects in the FY20 CoC competition.[8]

The coordination with Emergency Solutions Grant (ESG) programming, which complements the longer term assistance furnished by the CoC, varies across the 3 CoCs. In the case of Lexington, ESG assistance is administered by the Grants and Special Programs office within the consolidated local government. Louisville's ESG allocation is granted to Louisville Metro Government's Office of Resilience and Community Services. In the Balance-of-State, KHC serves as both CoC Collaborative Applicant and ESG grantee. In contrast to CoC funding, the ESG formula funding allows for about $3.8M to the state annually.[9]

Similarities among KY CoCs
Each CoC maximizes federal funding to the extent possible, as Kentucky does not match or provide additional shelter, outreach, or voucher support through its general fund. While Lexington and Louisville often are able to offer additional local tax revenue to support homeless assistance activities, homeless service providers in the Balance-of-State rarely have that option and use much smaller allocations of ESG and CoC to the extent possible divided across 118 counties.

KHC also serves as the Homeless Management Information System (HMIS) lead for the Balance-of-State and works with the Lexington and Louisville HMIS reporting staff. HMIS remains an important tool for both understanding the demographics of population experiencing homelessness as well as measuring how successful CoCs are in both getting people into housing and minimizing recidivism in homelessness.

Each CoC prioritizes projects that implement Housing First principles and strategies. Unlike the private housing market or many public housing authorities, they do not screen out applicants based on past involvement in the criminal justice system. They offer housing with case management and connection to employment and other services, tailored to the needs of the household and community. It is the very opposite of a one-size-fits-all, top-down approach. [10] Having worked in the Balance-of-State first as a local provider in Appalachian Kentucky, when the Bush administration first adopted Housing First as a guiding principle for the U.S. Interagency Council on Homelessness, and now in my role at HHCK, I am less concerned with ideology and political alignments and more concerned with what works for my neighbors across the Commonwealth. Housing First works. There is more than enough evidence predating my career and over the last

[8] U.S. Department of Housing and Urban Development. (n.d.). Fiscal Year 2020 Continuum of Care Competition Homeless Assistance Award Report. Retrieved from FY 2020 CoC Competition Grants: https://files.hudexchange.info/resources/documents/2020-kentucky-coc-grants.pdf
[9] U.S. Department of Housing and Urban Development. (n.d.). HUD Awards and Allocations. Retrieved from HUD Exchange: https://www.hudexchange.info/grantees/allocations-awards/?csrf_token=32D9BFB6-775F-4DC8-AB05A052CC76184B&params=%7B%22limit%22%3A20%2C%22COC%22%3Afalse%2C%22sort%22%3A%22%22%2C%22min%22%3A%22%22%2C%22years%22%3A%5B%5D%2C%22dir%22%3A%22%22%2C%22multiStateA
[10] National Alliance to End Homelessness. (2019, March 18). What Housing First Really Means. Retrieved from National Alliance to End Homelessness: https://endhomelessness.org/what-housing-first-really-means/

twenty years to make the case for prioritizing federal housing assistance for high-fidelity, adequately scaled Housing First programs.[11] It is time to move the conversation forward over whether or not Housing First works – it does – and ensure that Housing First programs are sufficiently funded so that homelessness does in fact become brief, rare, and nonrecurring.

Differences
Lexington and Louisville serve 1 county each, respectively. They are able to have a single point of entry for people experiencing homelessness, i.e. a shelter bed hotline, a common assessment team that prioritizes people for HUD-funded homelessness assistance. In contrast, the Balance-of-State CoC is divided into 15 regions, with a no-wrong-door system of regional Coordinated Entry access points to homeless assistance. In such a large CoC, however, access varies based on local providers' capacity and willingness to administer CoC funding (see section III.B.). In the Balance-of-State CoC, especially in counties with no emergency shelter, people may couchsurf or be doubled up with friends or family, more so than in our cities. It is harder to document homelessness for CoC or ESG assistance in communities without shelter or robust street outreach teams. In communities with a homeless shelter, there may not an adequate number of beds, or types of facilities for people to get shelter based on their household composition. The number of projects entering data into HMIS varies between CoCs; in the Balance-of-State, if programs are not receiving CoC or ESG funding, they are likely to not participate in HMIS, which can lead to limitations in access to homeless assistance vouchers and meaningful data.

Other Federal Resources
ESG-CV: Lexington, Louisville, and the Balance-of-State have been using additional ESG-CV passed through the CARES Act to prevent, prepare, and respond to coronavirus. In addition to bolstering and decompressing its shelter capacity, the Balance-of-State was able to make Rapid Re-Housing (RRH) vouchers available in all fifteen regions for the first time since the passage of the HEARTH Act. Additionally, the Balance-of-State funded street outreach teams in several of the regions, the first time such street outreach was funded and therefore available to provide services in rural communities.

Emergency Housing Vouchers: We support the policy that Public Housing Authorities (PHA) who have been awarded must cooperate with the CoC and the Coordinated Entry process to prioritize these valuable vouchers for people experiencing homelessness. Kentucky has received 582 of these vouchers. In the Balance-of-State, KHC as the CoC Collaborative Applicant and PHA for 87 counties, has used its Coordinated Entry process to work with local providers, as well as its internal PHA team to allocate Emergency Housing Vouchers. The challenge has been matching households who do not meet the PHA's criteria, as discussed in Section III.C.

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[11] National Low Income Housing Coalition and National Alliance to End Homelessness. (2020, January 28). The Case for Housing First. Retrieved from https://endhomelessness.org/wp-content/uploads/2020/03/Housing-First-Research-NAEH-NLIHC-Handout.pdf

Emergency Rental Assistance: One of the goals of CoCs and homeless service providers is to prevent homelessness from occurring. The state's Emergency Rental Assistance Program, funded through the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) and the American Rescue Plan Act (ARPA), has committed $145.5M in landlord and renter relief for households at risk of eviction for nonpayment due to COVID-19 hardship. The CoCs have expanded their role in homeless service provision to (a) in the case of KHC, administer Emergency Rental Assistance or (b) collaborate with Lexington and Louisville local governments to get the assistance distributed before people become homeless. Traditionally, ESG recipients might be able to distribute a fraction of their grant to agencies under the Prevention component. This is the first time Kentucky has had meaningful rental assistance designed to pay substantial rent arrears.

Medicaid: In Kentucky, we coordinate with Medicaid stakeholders for the benefit of people experiencing homeless. This includes meeting with the state Department for Medicaid Services monthly, to analyzing Managed Care Organizations' plans and advocating for contracts that address homelessness and housing issues, and collaborating with consumer health advocacy groups to strengthen Kentucky Medicaid implementation. Currently, we are working with partners to obtain a supportive housing waiver through either Section 1915(c) or 1115 specifically for people with Severe Mental Illness, including those who are experiencing chronic homelessness. While we have regional Community Mental Health Centers, and other local behavioral health providers, and some do participate in the CoC and provide homeless assistance, our goal is to strengthen homeless service providers so that Medicaid can pay for the ongoing support services needed for housing stability.

Recent research on Medicaid implementation across the states indicate Medicaid coverage and housing security are linked. In 2019, researchers "found a 2.9% reduction in evictions per capita associated with early expansion [of Medicaid]."[12] While Medicaid may positively reduce the number of evictions, evictions may disrupt and drive up Medicaid costs for federal and state governments: "[p]reventing evictions may improve access to care and lower Medicaid costs."[13]

Supplemental Nutrition Assistance Program (SNAP): To the extent that Kentucky's local eligibility offices are adequately staffed and able to take applications, SNAP has been beneficial to people who have recently been housed and have a fixed mailing address. While expedited SNAP is designed for people currently experiencing homelessness, the inability to do face-to-face interviews and staffing shortages to take phone applications, as well as lack of mailing address for some folks remains a challenge. The Division of Family Support Director, who oversees Kentucky's implementation of SNAP, serves as the co-chair of the Kentucky Interagency Council on Homelessness.

[12] Schwartz, G. L., Feldman, J. M., Wang, S. S., & Glied, S. A. (2022, February). Eviction, healthcare utilization, and disenrollment among New York City Medicaid Patients. American Journal of Preventive Medicine, 157-164. doi:https://doi.org/10.1016/j.amepre.2021.07.018

[13] Allen, H. L., Zewde, N., & Gross, T. (2019, September). Can Medicaid expansion prevent housing evictions? Health Affairs, 38(9). doi:https://doi.org/10.1377/hlthaff.2018.05071

HHCK's Experience with CoC, HOME Tenant-Based Rental Assistance, and ESG-CV Funding

Because of our statewide footprint and experience in working in rural communities, KHC as the CoC Collaborative Applicant and ESG lead has approached HHCK multiple times in the last ten years to directly serve people experiencing homelessness. This is something we do when there is a clear gap in services, and we know that we can address geographic inequities. We have administered permanent supportive housing for chronically homeless households with a disabling condition in the Balance-of-State since 2013 using CoC funds after KHC turned over their project to us as a subrecipient. This program has largely been successful; its limitation has been in the number of new vouchers issued and available for use under the CoC renewal model. Since the central Kentucky region was the first to implement the Coordinated Entry process, many of our program participants reside in this region. In 2016, in response to lack of vouchers available, we began using HOME Tenant-Based Rental Assistance slots. In 2020, KHC again approached us to administer ESG-CV funds passed through the CARES Act to respond to COVID-19. This would add much needed Rapid Re-Housing (RRH) vouchers to the Central Kentucky region, and provide RRH vouchers for the first time to regions in South Central and Western Kentucky. Seeing that there were no local providers with the capacity to take on this funding, yet not wanting rural Kentuckians left out from access to homeless assistance, we accepted and our grants were executed in November 2020. After expanding our staff to serve in these projects, our primary challenge has been locating rental homes that meet rent reasonableness requirements, habitability standards, and a willing landlord. At this time, we are providing assistance to 150 households across Kentucky, but we have 50 households in process and searching for housing. Not wanting to hoard federal funding, we have voluntarily returned some grant funding back to KHC to be used in other parts of the state and to supplement shelter activities, but the fact is that all RRH subrecipients are struggling to rehouse households in this environment. The affordable housing shortage is all too real for the folks whose homelessness is prolonged.

B. Efforts to Affirmatively Further Fair Housing

The CoCs in Kentucky are critical in the effort to Affirmatively Further Fair Housing through the spirit of the current Interim Final Rule, primarily by funding projects that use Housing First principles. This includes not screening people out based on past involvement with the criminal justice system, which has a disproportionate impact on Black Kentuckians,[14] and adhering to the Office of General Counsel Guidance issued in 2016, which stated that "a discriminatory effect resulting from a policy or practice that denies housing to anyone with a prior arrest or any kind of criminal conviction cannot be justified, and therefore such a practice would violate the Fair Housing Act." Secondly, using client choice for the basis of housing search and placement allows for people to live in places of opportunity and mitigate the effects of longstanding racist housing policy, to the extent that such housing exists that meets voucher use requirements.

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[14] Mitchell, C., Thomas, P., Spalding, A., & Pugel, D. (2021, December 9). In Decade Since Major Criminal Justice Reform, the Kentucky General Assembly Has Passed Six Times as Many Laws Increasing Incarceration as Decreasing It. Retrieved from KyPolicy: https://kypolicy.org/kentucky-general-assembly-has-passed-six-times-as-many-laws-increasing-incarceration-as-decreasing-it-since-2011/

Additionally, the CoCs have embraced HUD's Equal Access Rule as it currently stands through contractual measures as well as funding programs that serve all types of households and people, regardless of a person's sexual orientation, gender identity, or marital status. One example of this is the expansion of ESG-CV RRH projects with the requirement to serve all household types.

It should be noted that the CoC resources alone cannot possibly end discrimination in the larger housing market, but CoCs and homeless service providers should be leading the way in implementing anti-discriminatory shelter and housing options while advocating for systemic changes at the federal, state, and local levels of government.

III. Barriers Local Service Providers Face
A. Lack of Affordable Housing

As the members of this subcommittee are well aware, the housing crisis is prevalent nationwide. In Kentucky, where our cost of living is theoretically lower than the coasts, prior to the pandemic, we were short 77,701 affordable and available rental homes for Kentuckians at or below 30% of the Area Median Income.[15] The average wage renters earn in Kentucky is $14.25 per hour, while the hourly wage required to pay for a 2 bedroom rental home is $15.78.[16] Service and care sector jobs, where many labor shortages are occurring, have a median hourly wage of $9-10 per hour. It is also important to recognize that not all job openings with living wages are spread equitably across regions within a state, and this is acutely true in areas of longstanding depressed economies, such as Appalachian Kentucky. Kentucky renters who are not fortunate enough have a Housing Choice Voucher start off at a deficit from the beginning. We know that 1 in 4 Kentuckians are paying more than 30% of their income toward housing, including those who have a mortgage according to the Housing Assistance Council's Rural Data Portal, and 6 out of 10 extremely low income renters are paying more than 50%.[17] Further, we are dealing with the legacy of longstanding racist practices in the public and private housing sectors, which has both decoupled the ability for employment to fully cover housing costs and resulted in 38.2% Black homeownership rate[18] in the context of a 72.5% overall state homeownership rate.[19]

The high cost of housing and subsequent shortage is what drives homelessness, both in terms of who loses housing and enters the CoC system, as well as who gets housed with

[15] National Low Income Housing Coalition. (n.d.). Housing Needs By State / Kentucky. Retrieved from National Low Income Housing Coalition: https://nlihc.org/housing-needs-by-state/kentucky

[16] National Low Income Housing Coalition. (n.d.). Out of Reach 2021: Kentucky. Retrieved from National Low Income Housing Coalition: https://reports.nlihc.org/oor/kentucky

[17] National Low Income Housing Coalition. (n.d.). Housing Needs By State / Kentucky. Retrieved from National Low Income Housing Coalition: https://nlihc.org/housing-needs-by-state/kentucky

[18] U.S. Census Bureau. (2019). Tenure (Black or African American Alone Householder). Retrieved from American Community Survey: https://data.census.gov/cedsci/table?q=B25003b&g=0400000US21&d=ACS%201-Year%20Estimates%20Detailed%20Tables&tid=ACSDT1Y2019.B25003B

[19] Federal Reserve Bank of St. Louis. (2021, March 9). Homeownership Rate for Kentucky. Retrieved from FRED Economic Data: https://fred.stlouisfed.org/series/KYHOWN

CoC resources. Thanks to Congressional action, we have one piece of the policy solution in the form of a substantial amount of ESG-CV RRH, but without available homes, people's homelessness is prolonged. This is an indicator of larger housing market failures, which the federal government has the responsibility and the imperative to correct through fully funding housing assistance as an entitlement in a housing market with the capacity and will to support vouchers for all who need them.

B. **Capacity Issues**

For many years, homeless service providers have been working within the confines of austere budgets and contractual obligations to serve a certain amount of people. While funders and the organizations themselves want to see direct assistance go to as many households as possible, that may put a constraint on the number of staff and/or their compensation.

With the implementation of ESG-CV, CRRSAA, and ARPA, there is suddenly more money than has been available in years to do this work. But after years of hollowing out through attrition the federal government and HUD in particular, the quasigovernmental agencies who pass through these funds, and the nonprofits themselves, it is difficult to suddenly reverse course and start building up numbers of experienced staff and compensation packages to compete with the private sector. The House Financial Services Committee has observed this phenomenon in the deployment of Emergency Rental Assistance; state housing finance agencies on skeleton staff had to quickly pivot and hire and train inexperienced new employees to administer the funds. This work is hard and requires multiple skillsets within the same organization, and sometimes within the same employee, and it takes time and experience to build up the skills to administer high quality federally-funded homeless assistance. In my own organization, we have increased from 2.5 FTE in our housing services team when I started in 2017 to 13.0 FTE as of January 2022. We are grateful for the federal funding to be able to bring on new staff and retain staff. But while we have grown in direct service, our administrative profile remains the same while the day-to-day work to support clients and direct service staff increases. Artificially low caps on administrative costs do not help this situation, especially when reporting and accountability are so critical to assuring the funds are well-spent.

C. **Institutional Silos**

Public Housing Authorities and CoCs

It stands to reason that Public Housing Authorities (PHA) should share the CoC's mission of ending homelessness. However, due to longstanding policies at the local level, that may not always be the case. One of the biggest mismatches we see between PHAs and CoC and ESG vouchers relates to involvement with the criminal justice system. Under the Clinton Administration's "One Strike and You're Out" policy, 103 PHAs in Kentucky, or 70% of our PHAs, adopted 1 strike policies.[20] While they were quick to enact such policies, they have not been so quick to rescind them. When trying to help people obtain public housing that can respond to changes in income and rising housing

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[20] U.S. Department of Housing and Urban Development Office of Public and Indian Housing. (1997, September). Meeting the Challenge: Public housing authorities respond to the "One Strike and You're Out" initiative. Retrieved from NCJRS.gov: https://www.ojp.gov/pdffiles1/Photocopy/183952NCJRS.pdf

costs, our staff dread the criminal background check piece because they know what our clients face as barriers to entry. The highly localized nature of approximately 150 PHAs, each with their own admission criteria, makes federal action to correct this issue imperative.

The PHA in my community explicitly states: "The HA is neither required nor obligated to assist families who: … E. Have been convicted of drug-related criminal activity or violent criminal activity" and requires a three-year waiting period for applying if they have been previously evicted from public housing or Section 8 because of drug-related criminal activity.[21] Three years is a long time to be excluded from even applying for mainstream housing assistance.

Further, PHAs should have the duty to work with clients to avoid eviction, just as CoC programs work with participants to avoid evictions. Anecdotally – because we do not have a comprehensive, accessible system of eviction filings on either a state or nationwide basis – we perceive that too often many of the court filings we see in Central Kentucky are initiated by local PHAs.

Medicaid and Supportive Housing Competing Policy Priorities
Many states have amended their state plans to coordinate housing and supportive services for people experiencing homelessness, and Kentucky hopes to join the ranks of states that have used the waiver process to enhance services to target populations. Within the existing structure, there are a significant number of behavioral health services organizations participating in the CoC and offering housing to their clients. But compliance with billing practices may conflict with voluntary supportive services and meeting people where they are. We encounter people who need behavioral health case management but have been "non-compliant" with therapy and Medicaid, and therefore are cut off from the services they need and want. The profit motives embedded into the Managed Care Organization (MCO) model may not always produce the best outcomes for people who need ongoing case management and tenancy support services, for which Medicaid should pay. In Kentucky, prior to the pandemic, some MCOs would approve Targeted Case Management, a billable service under Kentucky Medicaid for only 1 month. As members of this committee understand, voluntary case management for any type of family after any duration of homelessness needs to last longer than one month. Since the onset of the pandemic, Kentucky Medicaid has agreed to suspend the prior authorization requirements regarding behavioral health services and study the Targeted Case Management data and health outcomes while the state of emergency lasts – a temporary victory we hope to make permanent. This is one critical example of institutional silos among programs that should have compatible policy goals.

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[21] Frankfort Housing Authority. (2017, November 3). Admissions and Continued Occupancy Policy (ACOP). Retrieved from Housing Authority of Frankfort: https://frankforthousing.org/wp-content/uploads/2020/10/ACOP-NEW.pdf

IV. New Challenges under COVID-19
Making Public Health Decisions as an Employer and Service Provider

In April 2020, a reporter from the Lexington Herald-Leader contacted me about the novel coronavirus and how it could affect people experiencing homelessness and the providers that serve them. At the time, I stated "Shelters were already operating on razor-thin margins…. Now with the demand for homeless services and the need to isolate people, we don't have the facilities or staffing to handle this during a pandemic."[22] Unfortunately, this statement is accurate 21 months later.

Congressional action in the form of ESG-CV has been a godsend in terms of financial assistance, and allowed for rural shelters to finally receive more than an annual $50-100,000 grant to operate. But as the virus mutates, homeless service providers have had to adapt repeatedly. With the onset of the latest surge in cases, my own organization has been hit; 3 out of 20 of us had mild to severe cases of COVID in December alone. Kentucky's positivity rate hit 30% on January 18. This does not account for the ancillary public health and workforce issues, including isolation needed due to exposures and needing to care for family members, rotating staff so as to not have too many people in the office simultaneously while allowing for people to be absent, whether planned or unplanned, and the compounding instability in the child care and K-12 environment for our staff who are parents of small children. It is still less challenging to operate in this environment than it is for emergency shelters who are often tasked with staffing 24/7/365 and in much tighter quarters than a traditional office space.

I can attest that as someone with a deep sense of duty to the folks we serve and the staff who work here, I struggle with maintaining the balance between being open to walk-in visits and mitigating the spread of COVID-19, especially knowing people who are experiencing or have experienced homelessness are more likely to die than the general population. If we were solely an advocacy organization, it would be an easy decision to keep staff working remotely indefinitely. But I also know that when we were open by appointment only before vaccines were widely available, and we were not able to do intensive in-home case management visits, the quality of our service delivery suffered. Advocacy can be done from anywhere; meeting the needs of vulnerable people requires an open office. I am balancing all of this while knowing that I have an ethical imperative to mitigate the risks of spreading COVID-19 among our participants and staff and minimizing the chances they contract it through the workplace.

As I work with many direct service providers in tougher situations, including those operating congregate shelter, I know that they are exhausted for having to think like a public health expert and lurch from crisis to crisis. This work was hard prior to a global pandemic, and the constant stress has profoundly increased the difficulty.

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[22] Musgrave, B. (2020, April 6). Kentucky homeless shelters on the brink: 'We need help now' or COVID-19 will spread. Retrieved from Lexington Herald-Leader: https://www.kentucky.com/news/coronavirus/article241716361.html

Western Kentucky Tornado Disaster

The tornadoes that ravaged a four state area in December hit rural communities in Western Kentucky particularly hard and killed at least 77 Kentuckians.[23] While the Federal Emergency Management Agency (FEMA) and Kentucky Emergency Management are still in the assessment phase, we know from our staff on the ground that there were significant rental home losses in Graves County in particular. This is also the area where we have experienced difficulty expending rental assistance due to the housing shortage. The trauma of such a widespread physical disaster has compounded the effects of COVID-19 on our work in Western Kentucky, as well as other agencies, and the need for long-term, sustained recovery that centers extremely low-income Kentuckians has the potential to affect housing organizations' capacity for years after the disaster. We will advocate for the best possible use of Kentucky's HOME-ARP allocation, but what this and other physical disasters require is long-term housing investments, such as what is in the Build Back Better Act.

V. Legislative Recommendations

Pass H. R. 5376, the Build Back Better Act with Housing Provisions – The provisions include $25B to bridge the gap between income and housing costs through vouchers for 24,000 Kentuckians.[24] The housing provisions would increase Kentucky's National Housing Trust Fund allocation from $6.7 million to $376 million,[25] restore $65B nationally to aging public housing for seniors and people with disabilities, and start to sufficiently fund rural housing programs. All of these provisions are critical to establishing housing stability and economic mobility, and advancing racial, education, and health equity. We also know we cannot end homelessness without adding to the housing stock for the lowest income Kentuckians first.

Pass H. R. 4496, the Ending Homelessness Act of 2021 – Housing is a human right, and therefore mainstream housing assistance should be treated and funded as such. Much of my work is spent educating others on our broken housing system, and many in other fields ask why housing assistance is so difficult for people to access. Unlike Medicare, Medicaid, and SNAP, public housing and Housing Choice Vouchers are "the Golden Ticket," where luck is more of a factor than eligibility or need. Further, it would prohibit landlord discrimination against voucher holders by adding Source of Income as a protected class to the Fair Housing Act, which would help create the conditions for which vouchers can fulfill their promise of choice and opportunity.

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[23] Bellware, K. (2021, December 18). In rural Kentucky, small towns were already on the margins. Then came the tornadoes. Retrieved from Washington Post: https://www.washingtonpost.com/nation/2021/12/18/cambridge-shores-tornado/

[24] Oliva, A. (2021, November 4). BBB Includes Major Investments in Housing Affordability. Retrieved from Center on Budget and Policy Priorities: https://www.cbpp.org/blog/bbb-includes-major-investments-in-housing-affordability

[25] National Low Income Housing Coalition. (2021, October 26). National Housing Trust Fund Estimated Allocations. Retrieved from National Low Income Housing Coalition: https://nlihc.org/sites/default/files/housed_NHTF_allocations-15B.pdf

Pass the Housing Emergencies Lifeline Program Act of 2021 – One of the largest challenges during the course of the pandemic has been obtaining comprehensive eviction data. As discussed in Section III.C., what we do know is often anecdotal and reliant on observation, which cannot begin to paint a full picture. At the very least, we should have an understanding of what covered housing assistance providers are producing the highest volume of eviction activity, in an effort to bridge the silos of housing assistance and the court system. It also would strengthen the capacity of legal services corporations to begin to address the unmet demand for civil representation in housing matters.

VI. Conclusion

At HHCK, we believe that ending homelessness is our moral imperative to carry. We know what works in Kentucky communities, whether in larger cities like Louisville to our small rural towns in the Eastern and Western parts of the state. Given the challenges the United States faces in coming out of the pandemic, now is the time to correct course away from the affordable housing crisis and provide the foundation to end homelessness through legislation and correctly-scaled funding. Thank you for your consideration of our remarks this morning.

Appendix A

<table>
<tr><td colspan="3" align="center">OHDA Homeless Indicator
Statistics Reference Sheet</td></tr>
</table>

Table 1. Demographics and Total Number of Identified Individuals in Kentucky[1.1]

Characteristics	Count (#)	Percent (%)
Sex		
Female	1,490	35.8%
Male	2,672	64.2%
Race		
Black	596	14.3%
White	3,526	84.7%
Neither Black nor White[1.2]	40	1.0%
Age		
0 – 17 years	71	1.7%
18 – 35 years	1,356	32.6%
36 – 44 years	942	22.6%
45 – 64 years	1,594	38.3%
65+ years	199	4.8%
Primary Health Insurance		
Medicaid[1.3]	2,805	67.4%
Medicare[1.4]	780	18.7%
Commercial	325	7.8%
Other[1.5]	252	6.1%
Total	**4,162**	**100%**

[1.1]Individuals identified by OHDA to meet criteria as experiencing homelessness during their episode of hospital care.
[1.2]Includes individual identified as "American Indian or Alaska Native"; "Asian"; "Native Hawaiian or Pacific Islander"; and "Other".
[1.3]Includes the sum of fee for service Medicaid plans and managed care organization Medicaid plans.
[1.4]Includes Medicare Advantage plans.
[1.5]Includes designations of "Other"; "Self-Pay"; "Charity"; and "Pending".
Note: The number of individuals identified as "Ethnicity = Hispanic" was sufficiently small that it could not be independently identified in this table. Therefore, racial demographics presented in this table include the sum of Hispanic and non-Hispanic individuals.

Table 2. Top Ten Most Common Diagnoses Among Patients Experiencing Homelessness

	MS-DRG[2.1]	Diagnosis (Abbreviated)	Count of Discharges
1.	885	Psychoses	3,552
2.	897	Alcohol/Drug Abuse or Dependence	2,130
3.	871	Septicemia (*without mechanical ventilation > 96 hours, with major comorbidities / complications*)	346
4.	881	Depressive Neuroses	292
5.	894	Alcohol/Drug Abuse or Dependence (*left against medical advice*)	237
6.	638	Diabetes (*with comorbidities/ complications*)	201
7.	291	Heart Failure & Shock (*with comorbidities/ complications*)	156
8.	603	Cellulitis	154
9.	918	Poisoning & Toxic Effects of Drugs	149
10.	872	Septicemia (*without mechanical ventilation >96 hours, without major comorbidities / complications*)	144

[2.1]Medicare-Severity Diagnostic Related Group
Note: The sum of these 10 diagnostic categories (7,359) accounts for ~65% of all total discharges for this sample in 2019.

CHFS
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Table 3. Race and Identification as a Patient Experiencing Homelessness

	Black Patients	%	White Patients	%
Patient Identified by Homelessness Indicator				
Yes	596	1.66%	3,526	0.98%
No	35,347	98.34%	355,480	99.02%
Total	**35,943**	**100%**	**359,006**	**100%**

Note: Due to sample size issues, Table 3 displays Black and White patients where those of Hispanic ethnicity and those of non-Hispanic ethnicity are summed together. Because Black and White racial groups are the two largest groups in terms of population size in this demographic category – and by comparison all other groups combined are so small – only Black and White patients are compared in this calculation. A chi-squared analysis results in a value of $\chi^2 = 144.6$; $p < 0.001$ – a statistically significant difference between Black and White patients. It is important to note that this statistic has at least two important limitations: (1) the sample of patients described here does not represent a random sampling of the population of Kentucky, which limits our ability to make strong conclusions about whether this result demonstrates true racial disproportionality, and; (2) this analysis does not consider important covariates and their relationship with homelessness (e.g., health insurance status, medical diagnosis, economic factors, etc.).

Figure 1. Race and Identification as a Patient Experiencing Homelessness (Odds Ratio)

$$\frac{596/35,347}{3,526/355,480} = \frac{0.0168614}{0.0099189} = 1.699$$

OR = 1.699; 95% Confidence Interval = 1.5575 – 1.8553; p < 0.0001

Note: The odds ratio above describes the odds of being identified as a patient experiencing homelessness. **What this odds ratio (OR) indicates is that the odds of a Black hospital patient being identified as experiencing homelessness was 70% higher than the odds for a White patient.** This difference is statistically significant – suggesting that this particular manifestation of homelessness was experienced to a greater degree by Black patients than White patients. It is important to note that this statistic has at least two important limitations: (1) because the OHDA homelessness indicator is entirely reliant on hospital records data – it is possible that this observed difference may be related to bias in documentation practices, and; (2) this analysis also does not consider important covariates and their relationship with homelessness (e.g., health insurance status, medical diagnosis, economic factors, etc.).

Table 4. Race and Health Insurance Coverage Among Patients Experiencing Homelessness[4.1,4.2]

	Medicaid[4.3]		Medicare[4.4]		Commercial		Other[4.5]	
Patient Race	#	%	#	%	#	%	#	%
Black	368	61.74%	142	23.83%	49	8.22%	37	6.21%
White	2,408	68.29%	636	18.04%	272	7.71%	210	5.96%
Total	**2,775**		**778**		**321**		**248**	

[4.1]Individuals identified by OHDA to meet criteria as experiencing homelessness during their episode of hospital care
[4.2]40 individuals were identified as "Neither Black nor White" (see Table 1) – they are not included in this analysis in order to maintain consistency with Table 3.
[4.3]Includes the sum of fee for service Medicaid plans and managed care organization Medicaid plans
[4.4]Includes Medicare Advantage plans
[4.5]Includes designations of "Other"; "Self-Pay"; "Charity"; and "Pending"
Note: The number of individuals identified as "Ethnicity = Hispanic" was sufficiently small that it was not able to contribute adequate value for interpretation in this table. Therefore, racial demographics presented in this table include the sum of Hispanic and non-Hispanic individuals. Table 4 describes that a greater percentage of Black patients were insured by Medicare as compared to White patients, while a greater percentage of White patients were insured by Medicaid as compared to Black patients in this sample.

This document is a companion to the primary data brief on the creation of the Homelessness Indicator in the HFSD data.

This brief was prepared by Matthew Walton and Allison Lile, Office of Health Data and Analytics