

November 2011

Will the Mayor Still Be Looking for Savings?:

Growth in AIDS Caseload Slows and Spending Per Case Eases Downward

Summary

Since its establishment two and a half decades ago in response to the expanding AIDS epidemic, the number of individuals and families receiving services from the city's HIV/AIDS Services Administration has risen from a few hundred cases in the first year to over 32,000 today. Not surprisingly, the steady increase in the number of cases served by the agency required regular increases in expenditures, but in the last few years the city's fiscal difficulties have put pressure on the agency to reduce expenses, although the nature of the agency's caseload makes finding savings difficult.

With World AIDS Day approaching on December 1, this report looks at changes in the HIV/AIDS Services Administration caseload, services, and expenditures over the last several years. Among our key findings:

- Advances in treatments for people with HIV and AIDS have resulted in a gradual slowdown in the growth of the agency's caseload. Since 2003 the HIV/AIDS caseload in the city has largely stabilized, although there has been a modest increase of about 2,000 cases (6.5 percent) over the last three years.
- From 2004 through 2009, annual HIV/AIDS services spending per case slowed due to a leveling off in demand for emergency and supportive housing. As a result of recent cost-cutting actions by the agency, spending per case fell slightly in 2010 and decreased by 3.3 percent in 2011.
- While some of the proposed savings initiatives have succeeded in curtailing HIV/AIDS services spending, others have run into legal or political roadblocks, and have never been implemented.

The Mayor's latest financial plan, released earlier this month, did not include any newly proposed spending cuts for AIDS services. This may be a reflection of several factors that make it likely that future efforts to find city savings in the AIDS services agency's budget will become increasingly difficult. These include the recent upturn in the caseload, legislative and legal requirements for providing services, and forceful political opposition to attempts to reduce services to a population that is defined by a serious and debilitating illness.

Background

AIDS is a chronic, potentially life-threatening condition caused by the human immunodeficiency virus (HIV). Individuals infected with HIV are not considered to have AIDS until the virus has done significant damage to their immune systems, thus interfering with their ability to fight the organisms that cause disease.

Since its establishment two and a half decades ago in response to the expanding AIDS epidemic, the number of individuals and families receiving services from the city's HIV/AIDS Services Administration (HASA) has risen from a few hundred cases in the first year to more than 32,000 today. HASA's budget for fiscal year 2012 is \$225 million, of which \$104 million, or 46.1 percent, is city funds. This total does not include the cost of providing other benefits or services such as public assistance and Medicaid to HASA clients.

HASA was originally established by New York City in 1985 as the Division of AIDS Services (DAS) to assist individuals with advanced HIV-related disease or AIDS in accessing public benefits and services provided by the city's Human Resources Administration (HRA). At that time, the Family Independence Administration, the unit of HRA that handles income assistance programs, was known as the Income Support Program (ISP). To assist people living with AIDS in applying for public assistance, food stamps and Medicaid, ISP created the Income Support AIDS Services (ISAS) division. ISAS units were co-located with DAS units throughout the city. In order to achieve administrative efficiencies, in 1996 DAS and ISAS merged into the Division of AIDS Services and Income Support (DASIS) and in 1997 the City Council codified its existence through Local Law 49. In 2001, DASIS became known as HASA.

Among the many services available to HASA clients are intensive case management; home and hospital visits; help with accessing public assistance (now known as cash assistance), Medicaid, and food stamp benefits; emergency, transitional, and permanent supportive housing; home care and homemaking services; and financial counseling.

To become eligible for HASA services an individual must be a city resident and must have been diagnosed with clinical/symptomatic HIV illness as defined by the New York State AIDS Institute or with AIDS as defined by the federal Centers for Disease Control and Prevention.¹

Individuals who have tested positive for HIV but do not meet the criteria for clinical/symptomatic HIV illness or AIDS are not eligible to receive services through HASA. Clients applying for income support programs must also meet the income and resource guidelines for the specific programs requested.

This report looks at changes in the HASA caseload, services and expenditures over the last several years. It focuses on the recent attempts to reduce HASA spending as part of the larger effort to deal with the fiscal difficulties faced by the city, and the significant hurdles that these attempts have encountered.

The AIDS Epidemic and the HASA Caseload

Advances in treating HIV and AIDS have led to a gradual slowdown in the growth of the HASA caseload by delaying the onset of the disease. At the same time, increases in the survival time of HASA clients have created the need for more long-term services, resulting in higher spending per case.

Underlying Trends in the AIDS Epidemic. Since eligibility for HASA services depends on a medical diagnosis of clinical/symptomatic HIV or AIDS, understanding changes in the size and service needs of the HASA caseload requires an examination of the underlying epidemiological trends. Historical information on AIDS cases is available from the city's Department of Health and Mental Hygiene going back to the beginning of the AIDS epidemic in the early 1980s.²

The data track not just the spread of the disease and the efforts by public health officials to contain its spread, but also the impact of advances in treatments for people with HIV and AIDS. Over the years, doctors and medical researchers have made a number of advances in treating HIV, AIDS, and a variety of conditions and diseases that can result from the deleterious effect of HIV on a person's immune system.

Perhaps the most important of these treatment breakthroughs occurred in the mid-1990s. In 1995 and 1996 the U.S. Food and Drug Administration approved three of a new class of anti-retroviral drugs known as protease inhibitors. These drugs act to inhibit the spread of HIV in the human body by interrupting the last step in the process that the virus uses to form new copies of itself. Also in 1996, HAART (Highly Active Anti-Retroviral Therapy) rapidly emerged as the new standard of HIV/AIDS care.

HAART involves taking three or more drugs that fight HIV at the same time, usually including one protease inhibitor. When taken by people who are HIV positive but not yet symptomatic, HAART can delay the onset of AIDS. In terms of the HASA caseload, such an outcome means postponing the movement of the affected individuals onto the HASA rolls. For people who have been diagnosed with AIDS, HAART can extend life, thereby swelling the HASA caseload.

The impact of these medical advances can be seen in the epidemiological data from the city's health department. The number of newly diagnosed AIDS cases in the city increased from 160 in 1981 to 7,769 in 1990, and then continued upward in the early 1990s to a peak of about 12,700 in 1993 and 1994. Starting in 1995 the number of new AIDS cases began a downward trend that eventually reduced the annual total by three-quarters, with 2,965 new cases diagnosed in 2009. Similarly, the annual number of deaths among people with AIDS increased from 59 in 1981 to 5,718 in 1990, before peaking at about 8,300 in 1994 and 1995. In 1996, AIDS deaths dropped to 6,065, and then continued downward to 1,377 in 2009, about a sixth of the mid 1990s peak.

Another important measure of the scope of the AIDS epidemic is the number of people living with AIDS at the end of each year. The health department data indicate that the number of people living with AIDS in the city has increased steadily from 138 in 1981 to 11,855 in 1990, 47,400 in 2000, and 66,398 in 2009. The therapeutic breakthroughs of the mid 1990s have had contradictory effects on this measure. By reducing the number of new AIDS cases the new drug regimens have slowed the increase in the number of people living with AIDS. At the same time, by reducing AIDS deaths they have acted to push this number upward. The data suggest, however, that on balance the new drug treatments have slowed the rate of growth in the AIDS population. From 1991 through 1994, the period just prior to the introduction of the new treatments, the number of people living with AIDS increased at an annual average of 4,516. From 1996 through 1999 annual growth fell to an average of 3,159, and from 2000 through 2003 it declined further to 2,733. In the most recent period, from 2006 to 2009, the increase in the number of people living with AIDS averaged 1,669 a year.

Impact on the HASA Caseload. This slower growth in the number of city residents who are living with AIDS means fewer potential HASA cases, resulting in a gradual deceleration in the growth of the HASA caseload.

**Living Longer: AIDS Population
In New York City, 1981–2009**

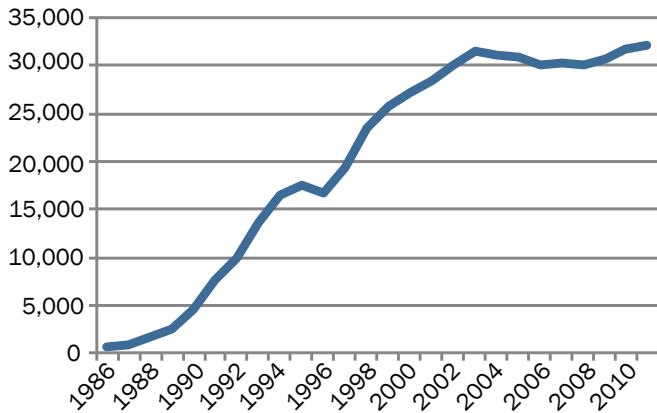
	New AIDS Cases	AIDS Deaths	People Living With AIDS	Survival Time in Months
Pre-1981	52	15	37	
1981	160	59	138	4.52
1982	540	201	477	6.33
1983	1,097	592	982	8.39
1984	1,841	1,106	1,717	10.08
1985	2,867	1,824	2,760	11.08
1986	4,225	2,719	4,266	12.06
1987	5,218	3,343	6,141	13.95
1988	6,436	4,299	8,281	15.84
1989	6,872	5,351	9,803	18.30
1990	7,769	5,718	11,855	20.29
1991	9,066	6,468	14,459	21.92
1992	10,855	6,973	18,354	22.67
1993	12,745	7,412	23,673	23.54
1994	12,677	8,339	28,008	25.91
1995	11,365	8,306	31,065	29.63
1996	9,388	6,065	34,391	34.24
1997	7,421	3,421	38,388	39.70
1998	5,667	2,785	41,271	46.31
1999	5,387	2,790	43,867	52.79
2000	6,226	2,692	47,400	57.93
2001	5,635	2,553	50,480	63.59
2002	4,754	2,515	52,719	70.02
2003	5,370	2,488	55,600	75.33
2004	4,392	2,376	57,617	81.72
2005	4,179	2,212	59,584	88.13
2006	3,790	1,983	61,390	94.90
2007	3,556	1,767	63,179	101.81
2008	3,290	1,658	64,810	109.12
2009	2,965	1,377	66,398	

SOURCES: IBO; Department of Health and Mental Hygiene
 NOTES: Based on calendar years. People living with AIDS is as of December of each year. Survival time is the average number of months since receiving a diagnosis.

By June of 1986, HRA's newly established AIDS services program served 617 cases (a case can be comprised of a single individual or an entire family). From that point on, the caseload increased steadily in response to the spreading AIDS epidemic, reaching 10,000 in 1992, moving past 20,000 in 1998, and topping 30,000 in 2002. By the late 1990s, however, the rate of growth had begun to slow. From 1991 through 1994, the period just prior to the treatment breakthroughs, the number of HASA cases increased at an average rate of 2,917 a year. By the 2000-2003 period, average annual growth had declined by half to 1,436 cases.

Since 2003, the HASA caseload has largely stabilized, with a slight decrease of about 1,400 cases from 2003 through 2006, and a modest increase of about 2,000

After A Sharp Increase, AIDS Caseload Levels Off



SOURCES: IBO; Human Resources Administration
 NOTE: HASA cases are as of June of each year.
 Exact annual caseload numbers available here.

cases over the last three years. There is no evidence that the recent increase is being driven by any change in the epidemiological trends.

Increasing Survival Time. The city health department data include another important measure of change in the AIDS epidemic, survival time. This indicator looks at the population of people living with AIDS at the end of each year and measures the average length of time that has passed since their AIDS diagnosis. While survival time for people living with AIDS has improved steadily since the early years of the epidemic as the result of advances in medical care, the therapeutic breakthroughs of the mid 1990s have accelerated the pace of improvement. Average survival time gradually increased from less than five months in 1981 to 26 months in 1994, and then jumped to 58 months by 2000, and 109 months by 2008.

The increase in survival time for people living with AIDS has had significant implications for HASA programs. While in its early years HASA was primarily an agency that provided services to people in their final stages of life, since the late 1990s the agency has been acting to provide more long-term services to its clients and their families. Most important has been the need to provide transitional and permanent supportive housing to a significant portion of its clients, which now accounts for a majority of HASA expenditures.

Spending Trends

Not surprisingly, the steady increase in the number of cases served by HASA required regular increases in expenditures. By 1999, with the caseload at about 25,000, total HASA

spending reached \$117 million.³ This total does not include the cost of providing other benefits or services to HASA clients such as public assistance and Medicaid. By 2003, when the caseload stabilized at about 31,000, spending had increased to \$177 million, and by 2010 expenditures had risen to \$222 million. In 2011 spending decreased slightly to \$219 million. The 2012 budget projects that total HASA spending will again increase to \$225 million.

Since the size of the caseload is such an important factor driving total spending, it is useful to examine changes in inflation-adjusted spending per case in order to gain insight into the other factors that have impacted HASA expenditures. From 1999 through 2004, annual spending per case increased from \$4,691 to \$6,223, an average growth of about 6.5 percent a year in nominal dollars and 2.1 percent adjusted for inflation. The relatively rapid growth in spending during this period resulted primarily from a significant increase in HASA contracted housing, especially supportive housing. The number of HASA cases in contracted emergency or supportive housing increased from 4,398 in June 1999 to 6,406 in June 2004. The increased demand for longer term, service-intensive housing reflected the increase in survival time for HASA clients due to the advances in treating AIDS.

From 2004 through 2009, annual spending per case increased more slowly from \$6,223 to \$7,133, an average nominal growth of about 2.9 percent a year. Some of

Spending Per Case Begins to Decline

	Expenditures <i>Dollars in Thousands</i>	Average Number of Cases	Spending Per Case	Percent Change Per Case
1999	\$117,193	24,985	\$4,691	
2000	132,451	26,526	4,993	6.5%
2001	167,536	27,929	5,999	20.1%
2002	172,734	29,271	5,901	-1.6%
2003	177,100	30,760	5,757	-2.4%
2004	193,317	31,064	6,223	8.1%
2005	185,890	31,161	5,965	-4.1%
2006	193,638	30,335	6,383	7.0%
2007	205,651	30,262	6,796	6.5%
2008	212,070	30,256	7,009	3.1%
2009	217,104	30,435	7,133	1.8%
2010	221,689	31,191	7,107	-0.4%
2011	219,350	31,919	6,872	-3.3%
2012	224,757			

SOURCES: IBO; Mayor's Office of Management and Budget; Human Resources Administration

NOTES: Years are city fiscal years; 2012 is projected as of the 2012 Adopted Budget (June 2011).

the growth in spending during this time resulted from a technical adjustment which shifted expenditures for homemaking services for HASA clients from the Medicaid budget to the HASA budget. When the impact of this technical adjustment is removed, average growth over this period was negative after adjusting for inflation. The slower growth during these years primarily reflected a leveling off in the number of clients that the agency determined to be in need of HASA contracted housing. While the overall number of HASA housing units stabilized during these years, the agency continued to shift hundreds of clients from emergency single-room occupancy units to more expensive supportive housing.

Due to the increasing fiscal difficulties faced by the city, as well as reductions in state and federal funding over the last few years, HRA, like other city agencies, has been required to propose several rounds of actions to reduce city spending at its programs including HASA. As a result of these actions, HASA spending per case fell slightly in 2010 and more significantly in 2011.

How AIDS Services Money is Spent

Before considering how the growing fiscal pressure has affected HASA spending, it is important to first examine the components of the HASA budget. Total HASA spending for 2011 was \$219 million. About \$60 million (27.3 percent) was for personal services, the salaries of HASA staff directly employed by the city. These funds paid for about 1,240 HASA staff, of which about 890 were employed in case management. The case managers, required under Local Law 49, serve as a bridge between HASA clients and other government entities that provide a variety of benefits.

Most HASA spending, however, was for contracted services. The largest share, about \$147 million, or 66.9 percent, paid for HASA contracted housing for clients who are homeless or require additional social services. Currently, about 800 HASA cases reside in emergency single-room occupancy units, with another 5,400 living in transitional or permanent supportive housing. Supportive housing residents receive enhanced services from contracted case managers, in addition to their HASA case managers. While most HASA clients reside in their own private housing units rather than HASA contracted housing, the vast majority receive cash assistance benefits to help pay the rent. These payments for private housing, however, are from the cash assistance budget rather than the HASA budget.

The remaining share of HASA spending, about \$13 million (5.8 percent) was for contracted services other than housing. The largest portion of this, about \$9 million, was for homemaking services which provide assistance to needy clients with activities of daily living such as housekeeping, shopping, and meal preparation. The remainder paid for a variety of services including: medical assessments of HASA clients seeking supportive housing; financial advocacy and counseling; and food preparation, distribution, and nutrition counseling.

Agency Cost-Cutting Efforts

Among the many cost-cutting proposals advanced by the Bloomberg Administration over the last three years are several that were intended to reduce spending by HASA. Many of these proposals have encountered legal and political road blocks and as a result, HASA spending has not been curtailed as much as originally intended by the city.

Number of AIDS Services Cases in Emergency or Supportive Housing Remains Fairly Stable

	2003	2004	2005	2006	2007	2008	2009	2010	2011
Emergency Housing									
Single-Room Occupancy Hotels	1,810	1,762	1,543	856	788	905	978	953	791
Supportive Housing									
Transitional Congregate Facility	553	462	422	865	893	909	911	903	889
Permanent Congregate Facility	1,290	1,349	1,345	1,568	1,691	1,791	1,850	1,891	1,993
Scatter Site I	1,932	1,967	1,946	2,099	2,020	2,108	2,198	2,547	2,517
Scatter Site II	525	780	880	698	579	581	116	0	0
Homeless Services-Contracted Congregate Facility	103	86	75	0	0	0	0	0	0
Supportive Housing Subtotal	4,403	4,644	4,668	5,230	5,183	5,389	5,075	5,341	5,399
TOTAL	6,213	6,406	6,211	6,086	5,971	6,294	6,053	6,294	6,190

SOURCES: IBO; Human Resources Administration

NOTE: Figures are from June of each year.

Obstacles to Reducing HASA Spending. While it can be difficult and painful to cut any city program, there are several factors that make reducing HASA spending especially challenging. First is the lack of control over the size of the HASA caseload, the most important factor driving spending over the years. Since eligibility for HASA services depends on a medical diagnosis of clinical/symptomatic HIV illness or AIDS, the size of the caseload depends primarily on the underlying epidemiological trends. Therefore, unlike many other public programs, reducing the number of participants to cut costs is not an option.

A second factor is a provision in Local Law 49 that sets maximum caseloads for HASA case managers. Specifically, the law requires HASA to maintain an overall average of no more than 34 individual cases per case manager, and no more than 25 family cases per case manager. In a 2000 federal class action lawsuit, *Henrietta D. v. Giuliani*, the court ordered the city and state to hire and retain sufficient case managers to satisfy the ratios. A recent federal court decision reaffirmed this order, and made it clear that contracted case managers or social workers cannot be counted in fulfilling these ratios, rejecting an argument offered by the city. This legal requirement means that the number of HASA case managers will be determined by caseload trends. Since there has been a recent increase in cases, this effectively rules out cutting HASA case managers as a means of reducing costs. More broadly, it makes it difficult to reduce spending on personal services for the agency because case managers account for about two thirds of HASA staff.

A third factor that makes it difficult to cut spending is a requirement, based on local law and various court decisions, that HASA provide medically appropriate housing to needy clients. Because of their compromised immune systems, homeless HASA clients cannot be housed with the general shelter population, and many of them are too incapacitated or in need of intensive services to live in private apartments. As a result, about 1 in 5 cases currently reside in HASA contracted emergency or supportive housing. Since housing placements are largely based on a client's mental and physical health status, HASA officials have limited leeway to reduce these numbers.

Agency Proposals to Cut HASA Spending. Despite these obstacles, over the last three years the Bloomberg Administration has advanced a number of proposals to decrease HASA spending on case managers, housing costs, and other service contracts. Many of these proposed

reductions have run into legal or political roadblocks, and have not been implemented.

Proposals to decrease the number of case managers have generally foundered as the Bloomberg Administration has responded to intense opposition from the City Council and advocacy groups, as well as unfavorable court decisions. In January 2009, the agency proposed reducing the number of contracted case managers in supportive housing for a savings of \$1.9 million in city funds each year. In June 2009, however, the City Council restored these funds, but only for one fiscal year—2010.

Then in January 2010, the Bloomberg Administration reversed course and restored the contracted case managers for all years, while proposing instead to eliminate 248 HASA case managers, or about 30 percent of all HASA case management staff, for all years beginning in 2011. When fully implemented this proposal was expected to save \$7.7 million in city funds each year. At that time the Bloomberg Administration argued that even with these cuts the agency would still be in compliance with the case manager ratios specified in Local Law 49, by including contracted case managers in its calculation. The proposal met with significant opposition and the plaintiff's attorneys in *Henrietta D.* filed an enforcement order in federal court to block the cuts. City attorneys agreed to withdraw the cuts, and in June 2010 funding was restored for the 248 HASA case managers for 2011 only. Because the funds available for restoration were limited, this action resulted in a funding shortfall for contracted case managers for 2011. This issue was resolved in October 2010, when HRA and the City Council reached an agreement to fully fund the contracted case managers as well for the balance of the fiscal year.

In response to another motion by the *Henrietta D.* attorneys, in April 2011 a federal Magistrate Judge ordered the Bloomberg Administration to fully restore funding for the 248 HASA caseworkers for all years, based on the order in *Henrietta D.* In the Executive Budget for 2012 released in May 2011, the Bloomberg Administration complied with the order by restoring funding for the agency's case managers in each year of the city four-year financial plan. At the same time, however, HRA revived its proposal to reduce the number of contracted case managers, which was expected to yield annual city savings of \$2.7 million beginning in 2012. But in June, the City Council once again rejected this proposal and restored the funds for the contracted case managers in the 2012 Adopted Budget.

In addition to attempting to reduce the number of contracted case managers, HRA has proposed other measures to reduce the cost of HASA contracted housing. In 2009, the agency began eliminating Scatter Site 2 housing, a service-intensive type of supportive housing designed to assist clients in shifting to private apartments. The action saved the city \$4 million a year, by moving the most able clients to private housing and the rest into other types of supportive units. In addition, the recent Executive Budget included a proposal for across the board reductions in supportive housing contracts to achieve \$2.4 million in annual city savings beginning in 2012. The latter proposal was also rejected by the City Council, which restored the funds for 2012. A more modest proposal to save \$150,000 annually by encouraging HASA supportive housing clients who are working and stable to move into private housing was incorporated in the Adopted Budget for 2012.

The 2012 Adopted Budget also includes a recent proposal by the agency to save \$1.3 million a year by reducing enhanced rental assistance to some HASA cases in private housing. Although this action affects the cash assistance budget rather than the HASA budget, it would have an impact on individual clients. Similarly, the 2012 budget includes a proposal made by HRA in November 2010 to reduce city cash assistance spending by \$4.8 million a year by cutting payments for brokers' fees by 50 percent, and replacing cash payments to landlords for security deposits with vouchers they can use to request compensation for damages caused by a tenant. Although this proposal, which took effect in March 2011, is not specifically aimed at HASA cases and does not affect the HASA budget, advocates claim that it is making it more difficult to place HASA clients in private apartments.

The agency has also taken actions to reduce spending on other service contracts. Reestimates of the number of HASA clients requiring homemaking services have resulted in \$1.6 million in annual city savings. Less successful has been a proposal made in January 2009 to save \$500,000 a year by cutting in half a contract to provide food preparation, distribution and nutrition counseling to HASA clients; thus far the City Council has restored these funds each year through 2012. Undeterred by this political opposition, last spring's Executive Budget proposed the complete elimination of this contract as well as a contract to provide financial advocacy and counseling, in order to achieve an additional \$700,000 in annual savings. The City Council also restored these funds in the 2012 Adopted Budget.

Budget Pressures Likely to Continue

While the growth in HASA spending has slowed over the last few years, many of the Bloomberg Administration's specific cost-cutting proposals have thus far not been fully implemented. The recent court ruling on case manager ratios forced HRA to withdraw the plan to cut HASA case managers, and the City Council has repeatedly restored funds for contracted case managers and nutrition services each year, albeit one year at a time. The City Council's rejection of most of last May's Executive Budget proposals for additional spending cuts provides further evidence of how difficult it is to reduce HASA spending.

The Mayor's most recent financial plan, released November 19, did not include any new proposals for cuts to HIV/AIDS services. This may reflect that the city's efforts to find savings in HASA are not likely to get any easier in the future. Since eligibility for HASA services depends on a medical diagnosis, agency officials cannot control the size of the caseload, and in the last few years the number of cases has been slowly increasing. The local law codifying the existence of HASA includes firm requirements for providing services, as does the order in *Henrietta D.*, and the courts have consistently enforced these rules. In addition, attempts to reduce services to a population that is defined by a serious and debilitating illness have met with forceful opposition from advocates and officeholders.⁴ Looking ahead, fiscal difficulties at the state and federal levels could result in reductions in intergovernmental funding for HASA; if so, additional city funds might be needed to minimize service disruptions.

Report prepared by Paul Lopatto

Endnotes

¹According to the Centers for Disease Control and Prevention, a person who has tested HIV positive is diagnosed with AIDS when the person's CD4+ T cell count falls below 200 cell/ml, or the person is diagnosed with any of a variety of conditions or diseases that are considered AIDS indicator diseases. The New York State AIDS Institute definition of clinical/symptomatic HIV illness is very similar.

²Specific DOHMH sources for data on the AIDS epidemic are as follows: Data on newly diagnosed AIDS cases, AIDS deaths, and people living with AIDS at the end of each calendar year are from [New York City HIV/AIDS Annual Surveillance Statistics 2009](#), published by the city Department of Health and Mental Hygiene. They include all information reported to the agency by September 30, 2010.

Data on survival time in months for people living with AIDS at the end of each calendar year through 2008 were provided directly to IBO from DOHMH on April 19, 2010, and include all information reported by September 30, 2009.

³Spending data is unavailable for years prior to 1999.

⁴A key argument advanced by many advocates and officeholders is that providing supportive housing and other services helps to stabilize thousands of HASA clients medically, thus reducing medical costs for these individuals.

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