



Major Recommendations

1. Every American living below the poverty level should have access to Medicaid. Health care reform should provide immediate coverage through Medicaid, to ensure access to (and a source of reimbursement for) essential health care services.
2. Providing community-based health services linked to housing - which allow homeless people with serious medical and behavioral healthcare needs to live in the community - should be an integral part of comprehensive health care reform, as such services can result in better health outcomes and reduce the utilization of more costly emergency, inpatient, and long-term care services.
3. To accomplish the goals of better health outcomes and reduce over-use of high-cost services, current payment systems must be adapted to finance community health services team models that integrate care for medical and behavioral health conditions as needed, providing a medical home or "person-centered health care home" model linked to a place to live.
4. The federal government should support state efforts to provide innovative care management strategies and medical home program models which focus on high-cost, high-need people with chronic disease and co-occurring behavioral health conditions, who have been hard to engage in appropriate care.

Issues to Address within Health Care Reform

Low Rates of Medicaid Eligibility and Enrollment

Recent studies of interventions that target homeless adults with disabilities or serious chronic health conditions highlight low rates of Medicaid eligibility and enrollment, despite high rates of vulnerability and serious health problems among this group.

Homelessness itself, combined with restrictive categorical eligibility requirements, creates obstacles to enrollment in Medicaid. Streamlining and simplifying eligibility for Medicaid for all Americans living below the poverty level would remove many of these obstacles that leave far too many vulnerable people uninsured, and strengthen Medicaid to fulfill its role as a safety net for groups that include:

- o Mothers with health or behavioral health problems whose children have been placed in foster care;
- o People with serious mental illness whose SSI and Medicaid benefits are terminated when they are incarcerated, and are difficult to restore when returning to the community;
- o Young people aging out of foster care (usually at age 19);
- o Unemployed and homeless adults with serious health problems who are not accompanied by children and are unable to establish eligibility for SSI.

Serious Medical and Behavioral Health Care Needs among Homeless Persons

Some of the health care needs among homeless persons can be attributed to age; as many as one-third of homeless single adults are between the ages of 55 and 64. Some older homeless persons are disabled adults who have been homeless for a decade or more, while others have become homeless more recently as they lost employment, affordable housing, or family support, often in conjunction with a health crisis.

Many more of the adults living on the streets or in emergency shelters have serious chronic medical conditions in addition to mental health and/or substance use problems which pose barriers to both accessing and maintaining housing.

High Medicaid Costs for “Frequent Users”

A significant contributing factor leading to the unsustainable pattern of growth in spending for Medicaid is the avoidable use of the most costly services by a small subset of individuals with complex health and behavioral health challenges who, despite their repeated encounters with emergency and inpatient health care services, experience little to no progress in their health and clinical conditions. These individuals are typically very poor, homeless or unstably housed and living alone, and have multiple, co-occurring chronic medical conditions and behavioral health disorders. *Our health care system can do a better job of containing costs by providing more cost-effective and appropriate care to people with complex health needs who are homeless.*

The Correlation Between Stable Housing and Positive Health Care Outcomes

For people with disabilities or serious health problems who lack stable housing, and for people who experience long-term homelessness, supportive housing provides an essential foundation for access to primary health care and chronic disease management services.

The costs of episodic care for homeless adults who have chronic medical or behavioral health problems are extraordinarily high. However, health services provided in supportive housing settings reduce utilization of more costly emergency, inpatient, and long-term care services. *Adequate housing is a significant determinant of health and healthcare costs.*

The Need for Financing Mechanisms and Policies that Allow Team and Coordinated Care Models

Home- and community-based health care services that incorporate elements of a medical home or “person-centered health care home” model are needed, and can be highly cost effective when designed to assist homeless people with complex health problems move to permanent supportive housing. Current financing mechanisms and policies make payment for team and coordinated care models difficult despite evidence of their cost-effectiveness. Payment systems should be reformed to cover more effective services and align incentives to reduce avoidable hospitalizations and improve health outcomes.

Access to More Appropriate and Adequate Health Care is an Essential Part of the Solution to Homelessness in America.

On any given night, 672,000 people experience homelessness in the United States. Most of them lack health care insurance and consistent access to health care. Homeless and low income Americans (who might be at risk of homelessness) rely heavily on expensive emergency room visits, free and homeless targeted clinics and Community Health Centers to receive health care services. However, these providers often do not receive payment because many homeless and low income adults are not eligible for Medicaid and do not have health insurance, this results in poor access to quality health care for these populations. *Poor health can be a barrier to obtaining and maintaining housing; therefore, health care reform must improve services to homeless and low-income Americans or we will miss an opportunity to move closer to ending homelessness.*

BACKGROUND

"In most faith and value systems, it is wrong to tolerate pain, suffering and even death that could be prevented with different policy choices. The challenge is to translate these deeply held values into action that ensures a better system and a healthier nation¹."

Every American living below the poverty level should have access to Medicaid

Recent studies of interventions that target homeless adults with disabilities or serious chronic health conditions highlight low rates of Medicaid eligibility / enrollment. Homelessness creates obstacles to enrollment in Medicaid.

- Only 35% of participants in a HUD study of Housing First programs for homeless adults with serious mental illnesses had Medicaid coverage at the time of enrollment.
- 55% of participants were uninsured in a Chicago study that enrolled people who were homeless (for at least 30 days) and who were receiving inpatient care for a chronic illness (e.g. HIV/AIDS, liver disease, cancer, diabetes, etc.)
- In vulnerable families involved with the child welfare system, mothers lose Medicaid eligibility if their children are placed in foster care. Families who experience housing instability (multiple moves and lack of social support) are at greater risk of homelessness; mothers are more likely to be living apart from their children if they have longer spells of homelessness.
- While states have some discretion, there are federal incentives for SSI and Medicaid eligibility to be terminated when people with mental illness or other disabilities are incarcerated. There are substantial obstacles to re-establishing eligibility for Medicaid upon re-entry into the community, making it difficult for ex-offenders to access community treatment for mental illness, addiction, and chronic medical conditions.
- Youth aging out of foster care usually lose their Medicaid eligibility at age 18 and at the same time face a very high risk of homelessness and/or incarceration after leaving foster care. For young adults who hope to pursue education and opportunities for work and recovery, establishing eligibility for SSI may not be appropriate, however current policies offer few options for continuing Medicaid eligibility without SSI in most states.

Health care reform should provide immediate coverage through Medicaid, to ensure access to (and a source of reimbursement for) essential healthcare services.

Many of the adults living on the streets or in emergency shelters have serious chronic medical conditions. Many such conditions, such as hepatitis, tuberculosis, asthma, diabetes and hypertension, are both caused and exacerbated by living on the streets. Furthermore, the homeless population is aging; as many as one-third of homeless single adults are between the ages of 55 and 64:

- Nearly 1/3 of homeless people in San Francisco were over age 50 in 2003, and the median age of homeless adults increased from 37 in 1990 to 46 in 2003. Similar trends have been reported in LA, Pittsburgh, St. Louis, and Toronto.
- Among adults entering shelter for the first time, older age (over 50) is associated with greater risk of long term homelessness.
- Aging homeless people develop chronic diseases 10-15 years earlier than housed populations with similar demographic characteristics.

¹ Jeanne Lambrew, John Podesta, and Teresa Shaw "Change in Challenging Times: A Plan for Extending and Improving Health Coverage" Health Affairs (March 2005)

- Aging homeless adults have high rates of hypertension, diabetes, heart disease, COPD, cancer, arthritis, mobility impairments, HIV/AIDS and liver disease.

A December 2006 study found that people with serious mental illnesses die an average of 25 years sooner than other Americans. The high mortality rates among people with mental illnesses are caused primarily by co-occurring chronic diseases such as asthma, diabetes, cancer, heart disease and cardiopulmonary conditions.

Health care reform should provide immediate coverage through Medicaid, to ensure access to (and a source of reimbursement for) primary care and chronic disease management.

Our health care system can do a better job of containing costs by providing more cost-effective and appropriate care to people with complex health needs who are homeless.

A significant contributing factor leading to the unsustainable pattern of growth in spending for Medicaid is the avoidable use of the most costly services by a small subset of individuals with complex health and behavioral health challenges who, despite their repeated encounters with emergency and inpatient health care services, experience little to no progress in their health and clinical conditions. These individuals are typically very poor, homeless or unstably housed and living alone, and have multiple, co-occurring chronic medical conditions and behavioral health disorders.

- A very small number of Medicaid beneficiaries are responsible for a large share of program costs.
- In Washington State's Medicaid program, 198 adults made 9,000 emergency room visits in 2002 – an average of 45 visits per person. These frequent users (less than 1% of aged, blind and disabled enrollees) incurred 19% of all costs for care to this category of people enrolled in Medicaid.
- The Boston Health Care for the Homeless program tracked 119 chronically homeless patients for 5 years. During this time 40 people (34%) in the group died or moved to nursing homes. The smaller group that remained homeless used 18,834 emergency room visits. Health care costs averaged \$28,436 annually for those living on the streets.
- A data analysis in Seattle, Washington identified 77 homeless individuals who used \$3.5 million in publicly-funded emergency services (shelter, detox, jail, EMS, etc.) in just one year.

Providing community-based services linked to housing - which allow homeless people with serious medical and behavioral healthcare needs to live in the community - should be an integral part of comprehensive health care reform, as such services can result in better health outcomes and reduce the utilization of more costly emergency, inpatient, and long- term care services.

Lack of housing is a very significant social determinant of health status. While serious illnesses are always challenging to manage, living on the streets or in a shelter creates multiple barriers to adherence to medical regimens. For example, homeless persons may lack access to refrigeration for medications, their prescribed diets may be compromised by limited menu choices at food banks or shelters, and getting adequate rest is challenging when shelters close early in the mornings. Their physical health is further compromised by exposure to extremes of heat and cold on the street, and by exposure to contagious illnesses in shelters. Rates of high risk behaviors (needle sharing, unsafe sex, trading sex for money or a place to stay) are also much higher when people are homeless (controlling for other demographic characteristics). Not surprisingly, rates of HIV/AIDS are much higher among homeless persons. Most risk behaviors are significantly reduced with housing placement, however, and people are more likely to access appropriate health care and take medications consistently if they are in housing.

For people with disabilities or serious health problems who lack stable housing, and for people who experience long-term homelessness, supportive housing provides an essential foundation for access to primary care and chronic disease management. As appropriate care is accessed, over-use of expensive emergency, inpatient and long-term care services goes down:

- In California the *Frequent Users of Health Services Initiative* established projects in 6 counties to deliver innovative, integrated approaches to the health and social service needs of frequent users of emergency departments and decrease avoidable emergency department visits and hospital stays. Nearly half of all participants enrolled in services were homeless. For homeless clients connected to permanent housing, days of inpatient hospitalization were reduced by 27%, and emergency departments declined by 34%. For homeless clients who were enrolled in services but not connected to housing, days of inpatient hospitalization *increased* by 26% and emergency department visits declined by only 12%.
- In preliminary findings from Chicago's Housing and Health Partnership, homeless patients who were offered medical respite and permanent supportive housing had 45% fewer days in nursing homes, 42% fewer days of inpatient hospitalization, and 46% fewer emergency room visits, compared to a randomly assigned comparison group.
- An evaluation found that Downtown Emergency Service Center's 1811 Eastlake Supportive Housing reduced the use of clients' medical expenses by 41%, jail bookings by 45%, sobering center usage by 87% and shelter usage by 92%.

To accomplish the goals of better health outcomes and reduce over-use of high-cost services, current payment systems must be adapted to finance community health services team models that integrate care for medical and behavioral health conditions as needed, providing a medical home or "person-centered health care home" model linked to a place to live.

States and some health plans are beginning to use predictive modeling techniques to identify persons with complex conditions who are at risk for incurring high healthcare costs. In states where innovative care management strategies and medical home programs have been implemented, a focus on high-cost, high-need Medicaid beneficiaries has identified patients with chronic disease and co-occurring behavioral health conditions who had been hard to locate or engage in appropriate care. Best practices for serving this group of patients include face-to-face service delivery, interagency coordination, and health services teams that include culturally competent peer counselors or paraprofessional staff.

Effective interventions combine these elements:

- Supportive or affordable housing using a "low demand" or "housing first" approach;
- Data integration and analysis to identify high-cost, "frequent users" of emergency and/or inpatient care, and vulnerability assessments to identify those with the greatest risks of mortality or avoidable hospitalizations;
- Services that are integrated to address co-occurring health conditions and disorders (e.g. integrated treatment for mental health and substance use disorders, integration of primary care and psychosocial supports);
- Flexible, individualized, client-centered services that include engagement, trust-building, motivational enhancements, education and support for self-care, self-management of chronic health conditions, and behavior change to reduce risks and harm;
- A chronic care model instead of episodic acute care, including coordination and continuity of care across time and settings, sustained engagement during relapse, and early intervention to prevent or manage health crises.

Federal policy and payment systems should be reformed to cover more effective services and align incentives to reduce avoidable hospitalizations and improve health outcomes.

Specific recommendations for federal policy reforms include:

1. Make community-based health services linked to housing for people with the most complex and disabling health problems an integral part of comprehensive national health care reform.
 - a. Withdraw regulations promulgated during the Bush Administration that limit the use of Medicaid for services to address the needs of homeless and disabled people who need or live in supportive housing.
 - b. Clarify Medicaid reimbursement guidelines for the integration of primary care with other stabilizing services, including mental health and substance abuse services and care management provided by Federally Qualified Health Centers and other community-based health care providers.
 - c. Provide targeted grant funding to expand the availability of services linked to permanent housing for vulnerable adults and the most fragile families.
2. Provide leadership to align CMS Medicaid reimbursement rules with emerging evidence about Evidence Based Practice for homeless people with serious mental illness, and for people with complex co-occurring mental illness, substance abuse disorders, and chronic or life-threatening medical conditions.
3. Assist states in modifying Medicaid programs to eliminate incentives for cost-shifting and obstacles to coordination of care for beneficiaries who have complex co-occurring medical and behavioral health conditions.
4. Support state efforts through waivers and targeted federal funding to provide innovative care management strategies and medical home program models with a focus on high-cost, high-need people with chronic disease and co-occurring behavioral health conditions who are hard to engage in appropriate care.