Mari Cantwell
Medicaid Director
California Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 94815
WaiverRenewal@dhcs.ca.gov

Re: 1115 Medicaid Waiver Renewal Proposals to Increase Access to Housing & Supportive Services Program, and to Improve Whole-Person Care

Dear Director Cantwell:

On behalf of the undersigned organizations, we are writing in support California's proposals to increase access to housing and supportive services and improve whole-person care through the 1115 Medicaid Waiver renewal. Critical to addressing the needs of homeless beneficiaries, we look forward to working with you to transform Medicaid in California,

- To pay for pre-tenancy and tenancy services through a tiered per member, per month case rate,
- To create whole-person care that incorporates social services, and
- To allow collaborative partnerships to fund interventions, including housing, that produce ongoing cost savings.

As stated in the proposal, homelessness determines health outcomes. Without access to a home, a beneficiary cannot access healthy food, refrigerate or take their medication routinely, maintain their hygiene, access transportation to get to appointments, or, most importantly, rest to recover from illness. As such, beneficiaries experiencing homelessness, particularly chronic homelessness, incur high health costs, yet have poor health outcomes.[1] A study of homeless people in Los Angeles County showed

[1] Mary Larimer, Daniel Malone. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *Journal Am. Medical Assoc.* 2009; 301(13):1349-1357 (2009). David Buchanon, Romina Kee. "The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial." *Journal Am. Medical Assoc.* (June. 2009) 99;6; David Buchanan, Romina Kee, Lisa Sadowski, et. al. "Effect of a

homelessness costs health systems almost $2,000 per month, per person, on average, [2] and that the 10% most expensive homeless people incur an average of almost $5,000 per month in health care costs.[3] Though these individuals receive intensive medical and sometimes behavioral care, their conditions continue to deteriorate. Many of these beneficiaries will return to the hospital again and again, with more serious or complex problems. In fact, at least half of beneficiaries who frequently use emergency departments for avoidable reasons are homeless, and homelessness is a strong predictor of hospital readmissions.[4] As long as these beneficiaries remain homeless, they continue to acquire disproportionate costs over the long term as they cycle in and out of institutionalized facilities.[5] Finally, chronically homeless beneficiaries have high early mortality rates, dying 25-30 years younger than housed counterparts.

Our health care systems have lacked the capacity, framework, and incentives to address the needs of homeless beneficiaries. We therefore welcome California's commitment to change the tide of health and health care costs for many of our most vulnerable Californians.

Pre-tenancy and tenancy supports that work to achieve "whatever it takes" to get someone healthy—supports like assistance with housing applications, with locating an affordable place to live, with promoting housing stability once housed, and with accessing community-based social service programs—improve health outcomes and decrease costs, reducing emergency department visits by between 24% and 65%, and hospital inpatient days by between 29% and over 72%.[6]

We fully support the proposal to strengthen our Medicaid structure for coordinating care, including measures to coordinate more deliberately with behavioral health, hospital systems, and existing community supports. However, despite evidence demonstrating the efficacy of pre-tenancy and tenancy services, providers offering these services often rely on private sources to fund these supports, and so pre-tenancy and tenancy services are too often either unavailable altogether or not sustainably funded to address the needs of all beneficiaries who need them. Payment for these services is key to making them accessible to beneficiaries who cannot otherwise achieve triple aim outcomes. ***We therefore fully support opportunities through the Waiver to ensure an ongoing, consistent, tiered, per member, per month case rate for the services that improve health outcomes among homeless beneficiaries.***

Housing & Case Management Program on Emergency Department visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Controlled Trial." *Am. Journal Public Health. (May* 2009) 301;17.

[2] D. Flaming, P. Burns & M. Matsunaga. "Where We Sleep: Costs When Homeless & Housed in Los Angeles." *Economic Roundtable.* 2009.

[3] D. Flaming, S. Lee, P. Burns, G. Sumner. "Getting Home: Outcomes from Housing High-Cost Homeless Hospital Patients." *Economic Roundtable*. 2013.

[4] M. Raven, J. Billings, M. Gourevitch. "Medicaid Patients at High Risk for Frequent Hospital Admission: Real-Time Identification & Remediable Risks." J. Urban Health. Mar. 2009. 86(2); 230-241.

[5] Frequent hospital users do not "regress to the mean" over time, according to studies. On the contrary, inpatient costs rise over time. M. Raven, J. Billings, M. Gourevitch. "Medicaid Patients at High Risk for Frequent Hospital Admission: Real-Time Identification & Remediable Risks." J. Urban Health. Mar. 2009. 86(2); 230-241.

[6] Impact depends on population targeted and time period services are received. David Buchanon, Romina Kee. "The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial." *Journal Am. Medical Assoc.* (June. 2009) 99;6; David Buchanan, Romina Kee, Lisa Sadowski, et. al. "Effect of a Housing & Case Management Program on Emergency Department visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Controlled Trial." *Am. Journal Public Health. (May* 2009) 301;17. D. Flaming, S. Lee, P. Burns, G. Sumner. "Getting Home: Outcomes from Housing High-Cost Homeless Hospital Patients." *Economic Roundtable*. 2013.

If managed care plans contract with culturally-competent community-based providers to offer supportive services, reliable funding through Medicaid would create opportunities to move beneficiaries from streets and hospitals to homes, opportunities that currently do not exist for thousands of beneficiaries experiencing homelessness.

We further support fostering the collaborations that make true whole-person care possible. We agree partnerships should include a flexible, broad array of government, health plan, and community-based agencies working to improve the whole health of vulnerable beneficiaries.

Most importantly, these collaborative bodies should be able to leverage other funding sources, coordinate Medicaid reimbursement with existing resources, and use savings to pay for evidence-based interventions that improve health outcomes and bend the cost curve among homeless beneficiaries, such as payment for interim and permanent housing. Study after study reveals housing is the most critical intervention in stemming the costs and poor outcomes of people experiencing homelessness. Indeed, the federal government has recognized as evidence-based moving high-cost homeless beneficiaries into housing, before expecting care coordination or tenancy supports to improve outcomes. In this way, and for this population, housing is a health care intervention. Similarly, for people residing in institutional settings who could live independently if connected to a permanent, safe place to live, housing works not only to reduce costs, but to fulfill the goals of *Olmstead*. ***Allowing collaborative bodies to pay for interim or permanent housing is critical to achieving both the cost savings the State is assuming and improved health for these populations. The structure included in the proposal allows savings to contribute to funding the exact intervention—housing—that is a key ingredient to producing ongoing, sustainable savings.***

For the above reasons, we fully support payments and other positive incentives that work to align financing interventions that address determinants of health. This transformation of our Medicaid program will not only serve to address the needs of our most vulnerable Californians, it will also result in substantial savings that could be used to institutionalize these transformations.

Sincerely,

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