U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation, Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Avenue, SW
Washington, DC 20201

Electronic Address: HHSPlan@hhs.gov
Re: Draft HHS Strategic Plan FY 2018-2022

The National Health Care for the Homeless Council appreciates the opportunity to submit comments on the Draft HHS Strategic Plan for FY 2018-2022. We are a membership organization that represents approximately 300 federally qualified health centers (FQHCs) that receive Health Care for the Homeless funding, as well as other community-based homeless health care providers. In 2016, 1.2 million people experiencing homelessness received care at America's health centers. Our primary interest is to ensure access to comprehensive, high-quality care for a very poor and vulnerable population that lacks housing.

The draft Strategic Plan spans many areas of the health care arena, and we cannot address all the issues that currently exist that prevent a population that is homeless from improving health outcomes. While we agree with many of the goals and objectives outlined in this draft, we also recognize that many of these are seriously compromised when people lack housing, which is a key social determinant of health. As a larger issue, we are also concerned that many of the strategies described in this draft Strategic Plan do not appear to be congruent with the Administration's recent budget decisions and policy positions, which appear to be directly in conflict with the stated goals in this plan. Below are areas we would specifically like to highlight as important for us as health care providers for people experiencing homelessness.

Strategic Goal 1

Objective 1.1: Promote affordable health care, while balancing spending on premium, deductible, and out-of-pocket costs

We agree with the many measures outlined in this objective on improving outreach and enrollment, particularly for Medicaid, which is the primary program through which our patients receive health insurance. Given the Administration's significant reductions in outreach and enrollment funding and support for policies that would greatly reduce the number of Americans who are eligible for (or could afford) health insurance, we have strong concerns how this this objective would be achieved. In states that did not expand Medicaid, 69% of our patients remain uninsured and ineligible for any other insurance option that would make it possible to afford comprehensive care needed to address health conditions.[1] Of particular note is the strategy to "provide information on the prevalence, causes and consequences of high health care financial costs, including social factors that exacerbate costs." There is a large body of research

[1] National Health Care for the Homeless Council, "Insurance Coverage at Health Care for the Homeless Projects 2013-2015," March 2017. Available at: https://www.nhchc.org/wp-content/uploads/2017/06/insurance-coverage-at-health-care-for-the-homeless-projects-2013-2015.pdf.

that shows the impact of housing on health care costs and outcomes, and we hope that HHS plans to work together with the U.S. Department of Housing and Urban Development (HUD) to support a broad expansion of housing to low-income Americans as well as include housing as a variable it uses in its health care analyses.

Objective 1.2: Expand safe, high-quality healthcare options, and encourage innovation and competition

We appreciate the emphasis on the need for more research to identify disparities, monitor health outcomes, and improve access to affordable care and recommend including instructions on evaluating health outcomes by income level to document disparities based on poverty. We would call attention to the strategy to "conduct, fund, and apply research on the role of social determinants of health, as appropriate, to improve health outcomes, including access, quality, and safety." Again, we cite the impact that the lack of housing has on health care utilization and health status outcomes.

We also draw attention to the strategy to "promote and implement models that connect primary care, acute care, behavioral health care, and long-term services to facilitate transitions between care settings…" Medical respite care programs are increasingly being used to achieve precisely this goal, serving as a cost-effective and safe discharge option for hospitals when patients have no permanent home to rest and recuperate from illness or injury.[2] We would like to see these innovative and community-based programs expanded to better meet the needs of vulnerable Americans.

Objective 1.3: Improve Americans' access to health care and expand choices of care and service options

We fully support the emphasis on expanding coverage options, but note that this section does not acknowledge the significant contributions the Medicaid program has made to the health and livelihood of low-income people, particularly for those experiencing homelessness. Medicaid is the only coverage option for many of our patients, and is a lifeline for the millions with chronic and acute health care conditions that need comprehensive treatment at low or no cost to them.

We support the strategies to "reduce disparities in access to health care" and to "simplify, eliminate barriers to retention, and address shortages of health care providers who accept Medicare or Medicaid." Unfortunately, recent policy priorities and decisions from the Administration appear to be in conflict with this goal given the budget reductions to outreach and enrollment; barriers to care such as support for block grants, work requirements and premium assistance at very low income levels; and moves to eliminate presumptive eligibility and important benefits from the Medicaid program.

While faith-based organizations play an important role in the health care system, we find that efforts by faith-based organizations to limit the information and access that patients are entitled to receive stands in contradiction to the measures in the Draft Strategic Plan that call for comprehensive care. We recommend removing line 359-374.

Objective 1.4: Strengthen and expand the healthcare workforce to meet America's diverse needs

We fully support the development of strategy around reducing the provider shortage in underserved communities and supporting professional development in the workforce. We recommend including the

[2] For more information on medical respite care, please see the resources at our website: https://www.nhchc.org/resources/clinical/medical-respite/.

expansion of programs such as the National Health Service Corps and peer support initiatives in SAMHSA in your implementation plans to accomplish this objective.

Strategic Goal 2

Objective 2.2: Prevent, treat, and control communicable diseases and chronic conditions
Objective 2.3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support

We strongly support the emphasis on providing high-quality care within a continuum for those with a wide range of serious health care conditions, including access to supportive services and supportive housing. This section would benefit from the inclusion of measures that address harm reduction policies such as safe injection sites, needle exchanges, and other evidence-based practices related to risk-reduction initiatives. Harm reduction measures such as these are proven to benefit public health, as well as prevent disease transmission and reduce death rates. Particularly in light of the opioid crisis, we feel these measures are an important part of any health care strategic plan.

While we are glad the Draft Strategic Plan mentions the importance of parity and increased access to behavioral health, we believe it is crucial to include specific language on the need for parity in insurance coverage policies on medical and behavioral health conditions, as this lack of parity serves as a barrier to receiving necessary treatment. We hope that HHS will strongly enforce current federal law requiring parity in insurance plans.

Objective 2.4: Prepare for and respond to public health emergencies

We strongly support the strategy to "ensure that the needs of disadvantaged and at-risk populations are met in emergencies, through effective integration of traditionally underserved populations into planning, response and recovery efforts." People experiencing homelessness are routinely treated differently in disaster responses and recovery efforts, and their needs are frequently set aside in favor of other groups. We would like to see a focus on equity in future responses.[3]

Strategic Goal 3

Objective 3.1: Encourage self-sufficiency and personal responsibility, and eliminate barriers to economic opportunity

As outlined in this objective, we hope that HHS will continue to invest in safety net programs that assist specific populations in preparing for, acquiring, and sustaining employment. However, we are strongly opposed to work requirements of any kind, which directly conflict with many other objectives in this draft Strategic Plan to eliminate barriers to coverage and care. Work requirements are a barrier to care, do not increase employment, and stand in stark contradiction to the Draft Strategic Plan's strong emphasis on evidence-based practices.[4] In our 30 years' experience serving people who are homeless, having low-barrier access to health care and housing provides the stability needed to then engage in work, not the other way around.

Furthermore, we strenuously object to the "personal responsibility" reference (line 868) as the barrier to

[3] For guidance see National Health Care for the Homeless Council resources on emergency preparedness at <https://www.nhchc.org/resources/clinical/tools-and-support/emergency-preparedness/>
[4] Ladonna Pavetti, "Work Requirements Don't Cut Poverty Evidence Shows," Center on Budget and Policy Priorities, June 2016, <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>

employment for formerly incarcerated individuals. This fails to acknowledge wide-ranging discriminatory hiring practices based on criminal record, disability, trauma, untreated health conditions, lack of housing, and/or other factors as major reasons for unemployment. In order to accomplish the goal of avoiding recidivism we recommend providing the needed comprehensive health care, housing, and social support services that formerly incarcerated individuals need to become gainfully employed.

Objective 3.2: Safeguard the public against preventable injuries and violence

We strongly support HHS's emphasis on rigorous dissemination of evidence-based practices to reduce violence, and we note that living without a home leaves a person vulnerable to violence.[5] The acknowledgement of childhood trauma and violence as a pre-determinant of poor health outcomes throughout the entire life must be incorporated in all efforts to reduce violence and address social determinants. We note that this section does not acknowledge the escalating rate of gun violence in America, which has direct public health implications for deaths, injuries and trauma across all demographic groups. We believe HHS [and the Centers for Disease Control and Prevention (CDC) in particular] have a responsibility to conduct research on this growing problem, and make evidence-based recommendations to reduce gun tragedies.

Other Comments:

- We strongly support the multitude of objectives in this Draft Strategic Plan that call for increased consumer engagement. During the promulgation of these measures, we recommend that HHS consult with our National Consumer Advisory Board, which is the vehicle for consumers of Health Care for the Homeless projects to become a collaborative voice on national issues.

- This plan contains numerous references to collaboration with federal partners, but we feel strongly about calling attention to the collaborative efforts that already exist with the U.S. Interagency Council on Homelessness (USICH), which coordinates the federal response to homelessness. Because of USICH's catalyzing role in framing goals, objectives and strategies to prevent and end homelessness, we have a national coordinated framework already in place to collaborate across agencies and external partners. We hope to see USICH formally acknowledged as a partner in this Administration and included in the collaborative efforts outlined in this Draft Strategic Plan.

- We strongly support the inclusion of language on the importance of housing and supportive services (line 692, line 879, line 1035). We encourage the administration to continue to expand their acknowledgement of housing status as a social determinant of health and driver of health outcomes.

Thank you for the opportunity to submit comments on the Draft HHS Strategic Plan. We welcome further discussion. Please direct any questions to Barbara DiPietro, Senior Director of Policy, at bdipietro@nhchc.org or 443-703-1346.

Sincerely,

G. Robert Watts
Chief Executive Officer

[5] Molly Meinbresse *et al*, "Exploring the Experiences of Violence Among Individuals Who Are Homeless Using a Consumer-Led Approach," *Violence and Victims*, Volume 29, 2014, < http://www.nhchc.org/wp-content/uploads/2014/08/vv-29-1_ptr_a8_122-136.pdf>