NATIONAL HEALTH CARE for the HOMELESS COUNCIL

The Nexus of Health Reform, Housing & Homelessness:

Recommendations for the Obama Administration from the National Health Care for the Homeless Council

Summary of Recommendations

- **Everyone should have guaranteed access to comprehensive medical and mental health services of high quality at affordable cost.** A single-payer solution is the most rational and cost-effective approach. Less comprehensive interim approaches can contribute to improved health status for people who are homeless or at risk of homelessness.
- **Housing-based community support services for people with the most complex and disabling health problems should be an integral part of comprehensive national health care reform.** Evidence of the relationships between housing and health is compelling; housing *is* health care, particularly for people with severe and chronic health conditions.
- **Reimbursement rules should be aligned with emerging evidence-based practices for people with co-occurring mental illness, substance use disorders, and chronic or life-threatening medical conditions**. Health care financing should support coordination of care and services that enable effective therapies.

Current housing and economic crises and the health care crisis are closely linked. Poverty, lack of affordable housing, and lack of comprehensive health insurance are among the underlying structural causes of homelessness. For those struggling to pay for housing and other basic needs, the onset of a serious illness or disability can easily result in homelessness following the depletion of financial resources. Indeed, 50 percent of all bankruptcy filings are attributed in part to medical expenses.[1] It is estimated that lack of health insurance causes 22,000 unnecessary deaths a year in the U.S.[2]

Lack of stable housing is a very significant determinant of health. Homelessness causes medical problems, greatly exacerbates existing illness, and seriously complicates treatment. People without homes are exposed to the elements, violence, communicable diseases in overcrowded living situations, and the debilitating effects of malnutrition and chronic stress. Persons experiencing homelessness are 3 to 4 times more likely to die than their housed counterparts.[3]

Indeed, stable, sanitary housing is central to effective health care. Mounting evidence suggests that housing status is itself a stronger predictor of HIV risk and health outcomes than individual characteristics.[4] For people with disabilities or serious health problems who lack stable housing, supportive housing provides an essential foundation for access to primary care and chronic disease management; and housing-based services reduce utilization of more costly emergency, inpatient, and long term care.

- 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 care 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 the Downtown Emergency Service Center's 1811 Eastlake Supportive Housing project in Seattle reduced clients' medical expenses by 41%, jail bookings by 45%, sobering center usage by 87%, and shelter usage by 92%.
- The Denver Housing First Collaborative demonstrated improved health status of permanent supportive housing residents and reduced costs of emergency room care by 73%, hospitalizations by 66%, incarceration by 76%, and detox by 82%.
- Rates of HIV/AIDS and rates of high risk behaviors (needle sharing, unsafe sex, trading sex for money or place to stay) are much higher when people are homeless (controlling for other demographic characteristics). Most risk behaviors are significantly reduced with housing placement; people are more likely to access appropriate health care and take medications consistently if they are in housing.

The vast majority of homeless persons lack health insurance, primarily because they do not qualify for public insurance and cannot afford private insurance. More than half of surveyed homeless people nationwide, two-thirds of homeless adults unaccompanied by children, and 70% of patients served by HRSA's Health Care for the Homeless (HCH) program have no health insurance. The following chart illustrates the urgent need for expanded health insurance coverage among low-income people served by Federally Qualified Health Centers (FQHCs) who are homeless or at risk of homelessness:

Income & Health Insurance Status	HCH patients 2007 § 330(h), Public Health Services Act n=742,588	All FQHC patients 2007 § 330 PHS n=16,050,835
Income ≤ 100% FPL	91.4% of known	70.4% of known
Income ≤ 200% FPL	98.4% of known	91.4% of known
Uninsured	69.8%	38.9%
Medicaid (Title XIX) + SCHIP Medicaid	22%	35.4%
Non Medicaid S-CHIP	.4%	1.2%
Medicare (Title XVIII)	3.5%	7.6%
Other public health insurance	2.5%	1.4%
Private insurance	2.1%	15.5%

Source: www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm

Even if access to primary care is assured, lack of health insurance coverage severely restricts access to specialty care and prescription drugs; this is especially detrimental to homeless people, who suffer disproportionately from acute and chronic health problems. Restricted access to comprehensive health services only prolongs homelessness. Additional barriers to health care access include lack of transportation, inflexible clinic hours, complex requirements to qualify for public health insurance, and unaffordable co-payments for various services.

Homelessness creates obstacles to Medicaid enrollment, even for those who are likely to be eligible.[5] Poor and homeless adults who are not pregnant, disabled, elderly, or accompanied by dependent children are ineligible for Medicaid in most states.

- Only 33% of surveyed homeless people nationwide and 22% of those receiving services from HCH providers are Medicaid beneficiaries, although more are thought to be eligible but not enrolled.
- Welfare reforms in 1996 terminated SSI/SSDI eligibility for individuals whose substance dependence is "a contributing factor material to the determination of their disability." The continuing exclusion of such persons from SSI/SSDI benefits disregards medical knowledge about the nature of addictions and ignores the survival needs of individuals with disabilities, including access to medical services and treatment for these progressive and often fatal disorders.

Homeless SSI claimants often are denied benefits for failure to negotiate the arduous application process, rather than for lack of serious medical impairments meeting Social Security disability criteria. Systemic barriers include poor access to health services, insufficient documentation of functional impairments, remote application offices, complex application processes, disability evaluators unfamiliar with the plight of homelessness, and inconsistent implementation of SSA disability determination policy across jurisdictions. Barriers often are exacerbated by an applicant's mental illness or the lack of personal stability necessary to maintain contacts and meet deadlines throughout the multiple steps of an application review.[6]

Recent studies of interventions targeting homeless adults with disabilities or serious chronic health conditions highlight low rates of Medicaid eligibility / enrollment:

- Only 35% of participants in HUD's study of Housing First programs for homeless adults with serious mental illness had Medicaid coverage at the time of enrollment.
- In a Chicago study that enrolled people who were homeless (at least 30 days) and receiving inpatient care for chronic illness (e.g. HIV/AIDS, liver disease, cancer, diabetes, etc.), 55% of participants were uninsured.
- In vulnerable families involved with the child welfare system, mothers lose Medicaid eligibility if children are placed in foster care. Families that 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.
- Eligibility for SSI and Medicaid is usually terminated during incarceration. There are substantial obstacles to re-establishing eligibility upon re-entry, making it difficult 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 19 and face a very high risk of homelessness and/or incarceration. For young adults who hope to pursue education and opportunities for work and recovery, establishing eligibility for SSI may not be appropriate.

Across America, the number of adults over age 50 seen in homeless clinics and shelters is increasing.[7] While some of these individuals have long histories of homelessness, a significant proportion are newly homeless. Harsh economic realities have increased the tension between fixed incomes and the high costs of housing, food, transportation, and health care. In many cases, homelessness is precipitated by job loss, eviction, or the death of a spouse or other supportive family member before the survivor is eligible for Social Security or Medicare benefits.

- In some locations, as many as one-third of homeless adults are between 55 and 64 years of age. Many of these individuals have serious chronic medical conditions but are ineligible for Medicaid or Medicare; hospital emergency rooms are their only source of care.
- Nearly 1/3 of homeless people living in San Francisco in 2003 were over age 50; the median age of homeless adults increased from 37 in 1990 to 46 in 2003. Similar trends have been reported in Los Angeles, Pittsburgh, and St. Louis. These numbers are increasing due to a record number of home foreclosures and layoffs. 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.
- Aging homeless adults have high rates of hypertension, diabetes, heart disease, COPD, cancer, arthritis, mobility impairments, HIV/AIDS and liver disease.

Health care should cost less and provide more. The United States pays twice as much as other industrialized nations for health care ($7,129 per capita in FY 2007) but performs poorly in comparison on major health indicators such as life expectancy, infant mortality, and immunization rates (The World Health Organization ranks the U.S. 37th in health outcomes).The rapid growth of our health spending (about twice the rate of inflation) is untenable, unproductive, and unnecessary. Investor profits and excessive administrative costs consume resources that could be directed toward the delivery of care and prevention of disease.

- Administrative costs account for nearly one out of every three dollars spent on health care in the U.S.[8]
- In 2007, employer-sponsored health insurance premiums increased by 6.1% — far ahead of the 3.7% increase in employee wages and the 2.6% inflation rate.[9]
- US tax-financed health spending – 59.8% of taxes – is the highest in the world.[10] Approximately one-third of these tax dollars is spent on private insurers to cover government employees; meanwhile, uninsured Americans pay thousands of dollars in taxes to fund the health care of others.

Out-of-pocket expenses and fragmented systems of care deter people – particularly those who are poor and uninsured – from seeking early intervention and preventive services. Emergency room care is thus overused and in many cases uncompensated. A significant contributing factor to the unsustainable growth of Medicaid expenditures is the avoidable use of the most costly services by a small subset of individuals with

complex health problems who, despite repeated encounters with emergency and inpatient health care services, experience little to no improvement in their health. These individuals are typically very poor, homeless or unstably housed and living alone, and have multiple, co-occurring chronic medical and behavioral health disorders.

A very small number of Medicaid beneficiaries are responsible for substantial 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, detoxification, jail, EMS, etc.) in just one year.

Cost-effective primary care and care management services can be provided to persons with multiple chronic conditions by community health teams that include nurses, social and mental health workers, and peer counselors – but current payment systems make it difficult to finance these effective models of care. States and some health plans are beginning to use predictive modeling techniques to identify persons with complex conditions who are at risk for high 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 are hard to locate or engage in appropriate care. Face-to-face service delivery, interagency coordination, and multidisciplinary clinical teams that include culturally competent peer counselors or paraprofessional staff can improve program effectiveness.

Effective interventions combine the following elements: [11]

- A continuum of supportive / affordable housing options tailored to the needs of individuals, including "low demand" or "housing first" models.
- Data integration and analysis to identify high-cost, "frequent users" of emergency and/or inpatient care, and vulnerability assessments to identify those with greatest risks of mortality or avoidable hospitalizations.
- Medical respite care—short-term medical care during recuperation from an acute or chronic illness or injury for people without homes—which has been demonstrated to reduce hospitalizations.
- Integrated services that assure coordinated care for co-occurring health problems (e.g. integrated treatment for mental health and substance use disorders, integration of primary care and psychosocial supports through multidisciplinary treatment teams).
- Flexible, individualized, client-centered services that include outreach and engagement, trust-building, motivational enhancement, education and support for self-care, self-management of chronic health conditions, risk / harm reduction, and the active involvement of consumers in planning and delivery of services.
- A chronic care model instead of episodic acute care, including coordination and continuity of care across time and service sites, sustained engagement during relapse, and early intervention to prevent or manage health crises.

Recommendations

1. **<u>Every American should have guaranteed access to comprehensive medical and mental health services of high quality at affordable cost.</u>**
   - We strongly believe that **the most efficient way to attain this goal is through universal health insurance with a single payer mechanism** financed by a progressive tax system, which would reduce administrative costs and waste, eliminate financial barriers to quality care, improve public health, protect the freedom of provider choice, and save thousands of lives and billions of dollars each year.
   - As the nation works toward comprehensive, universal health insurance, the following steps will help to mitigate the unhealthy effects of the current realities:
     - **Assure universal health coverage through the expansion of public programs and increased regulation of private health insurance** (e.g., require community-based coverage, prohibit denial of coverage for pre-existing conditions; eliminate financial barriers created by co-pays and deductibles);
     - **Provide immediate health insurance coverage for individuals with income at or below 200% of the federal poverty level** ($35,200 for a family of 3 in 2008) to ensure access to (and a source of reimbursement for) primary care and chronic disease management;
     - **Require all public and private health insurance plans to cover behavioral health services in parity with coverage for other services**;
     - **To help assure access to primary care, dramatically expand the Consolidated Health Center Program** established under section 330 of the Public Health Service Act, **and allow Federally Qualified Health Centers to include specialty services in their Scope of Project**; and
     - **Establish policies and programs that incorporate a broad recovery model of behavioral health care**, consistent with emerging evidence-based practices.[11]

2. **<u>Housing-based community support services for people with the most complex and disabling health problems should be an integral part of comprehensive national health care reform.</u>**
   - **Reform payment systems** to cover more effective health care services and align incentives to reduce avoidable hospitalizations and improve health outcomes.
   - **Withdraw Medicaid 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.
   - **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.
   - **Provide targeted grant funding** to expand the availability of services linked to permanent housing and medical respite care for vulnerable adults and the most fragile families.

3. **<u>Medicaid reimbursement rules should be aligned with emerging evidence-based practices for people with co-occurring mental illness, substance use disorders, and chronic or life-threatening medical conditions</u>**.
   - **Assist states in modifying Medicaid programs** to eliminate obstacles to coordination of care for beneficiaries with complex co-occurring medical and behavioral health conditions.
   - **Ensure that medical respite care is a reimbursable service** under Medicaid and other insurance programs.
   - **Increase federal funding for supportive services** that enable people with disabilities or serious chronic health problems to obtain / maintain stable housing, improve health, and enhance quality of life.

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