



**The Intersection of Health and Housing:  
Opportunities and Challenges  
Centene  
Alliance for Health Reform  
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Ed Howard: My name is Ed Howard. I'm with the Alliance for Health Reform, and I want to welcome you on behalf of the Alliance Board of Directors, our Honorary Co-chairs Senators Cardin and Blunt, to today's program on Health and Housing, with an emphasis on the relationship between Medicaid and governmental housing policy at the community level, at the state level, and the federal level as well. This is actually the first in a three part series that will explore the intersection of health and social policy over the next couple of months. In October, I believe it's October 9<sup>th</sup>, we'll be looking at how well health services coordinate with nonmedical home and community-based services.

Then in December, we'll be examining some of the emerging issues in the connection between health and incarceration, which is a growing area of concern and activity. Now there is a connection between health and various social determinants, and we're going to be looking at the nature and the strength of that connection in this briefing, and in the subsequent ones in the series. Some of you may have seen that yesterday, New York City Mayor Bill de Blasio announced a \$22 million program to connect more homeless people with mental health care. I think just another sign of the growing activity, at every level, to connect the dots that link better health and better housing.

So today, we're going to shine I hope a lot of light on that topic. Our discussion is going to center on how housing stability affects health outcomes and healthcare costs, look at what Medicaid's role is in addressing this problem, and how much flexibility there is in federal policy to allow states and communities to meld housing and healthcare funding streams. And importantly, we want to look at what the obstacles might be, the biggest obstacles, to making these two program areas more compatible. We're pleased very much to acknowledge support for today's program by the Centene Corporation, one of America's largest private insurers that operates Medicaid and other kinds of programs in what, two dozen states, I believe.

So before we get to the program, let me do just a little bit of housekeeping. In your packets, there is important information, including speaker biographies, one page materials list in your kits, and the PowerPoint presentations in hard copy, so that you can follow along. There will be a video recording of this briefing available on the Alliance website, [allhealth.org](http://allhealth.org), probably Monday, followed by a transcript a few days later, along with all of the materials that are in your kits and links to more materials that we think might be helpful to you.

At the appropriate time, you can ask our panel a question, by filling out one of the green cards that are in your packets, or you can come to the microphones. There's one on either side of the room. You can use the hashtag, health and housing to tweet us questions, or to tweet generally. And if you're watching on C-SPAN, and want to ask a question, you can also tweet a question. We'll be keeping an eye on that, and having them brought forth for the panel to respond to. And at the end of the briefing, there's a blue evaluation form in your packets, that I'd very much appreciate your filling out, so that we can improve these briefings, and target them to the needs of the folks who come and need the guidance.

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So, enough of that. Let's hear from our very well informed panel. I'm going to give them inadequate introductions. So, and I'll do it serially, so that we won't disrupt the flow of the discussion, as we go along. So we're going to start, on my far left, with Barbara DiPietro, who's the Director of Policy at the National Health Care for the Homeless Council. She's also active in Healthcare for the Homeless of Maryland. So she's got a multi-level perspective on how to deal with these problems. And we've asked Barbara to highlight the connection between healthcare and housing in general, why it's important, and the opportunities on the state, federal, and local levels to address it.

Then, we'll hear from Jennifer Ho, Senior Advisor for Housing and Services to HUD Secretary Julian Castro. And she'll explain the current federal activities, and describe how her agency and others are collaborating on health and housing issues. Gretchen Hammer will be next. She's Director of Colorado's Department of Health Care Policy and Financing, and thus of Colorado's Medicaid and CHIP programs. And we've asked Gretchen to tell us about Colorado's efforts to bridge health and housing policy, and what gets in the way of those efforts.

And our final panelist is Sister Adele O'Sullivan. She's a family physician, and she's the Founder of Circle the City, which is a Phoenix nonprofit that brings private and public sectors together, to help those experiencing homelessness and illness. And Sister Adele will describe Arizona's innovative supporting housing model, and what gets in the way of this approach. So, we've come to the part of the program that's actually got some substance to it, and that is to say, Barbara DiPietro. Barbara?

Barbara DiPietro: Thank you so much. Really appreciate so many people being here today. I think it really is a testament to a growing awareness of how healthcare is changing in our country, an awareness of the importance of social determinants of health, and in particular, the impact that housing has on people's health status. Just a little bit, the National Health Care for the Homeless Council, we represent federally qualified health centers, and the homeless patients that they serve, particularly the special populations health centers, about 250 nationally. Over a million patients are being seen in America's health centers each year. And the depth and breadth of their needs, specifically because of their lack of housing, is really an issue for not only health centers, but for the larger healthcare industry that we are all looking to change.

So, one of the things that might not be intuitive is how housing is healthcare. Back in the '80s, the Institute of Medicine, it did a seminal study looking at that very impact, and they found three major findings. One is that poor health causes homelessness. And so, typically what we were seeing was a spiral of people who had an injury or an illness, unable to work. And when you're unable to work, of course, eventually the work goes away. You get fired, or you get laid off, or you can no longer bring in income. Pretty soon after that, you can't make rent or mortgage. You move in with family and friends.

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Pretty soon, that doesn't work out well. And then, you slide into a shelter situation or on the streets. We were seeing that regularly.

We also see the converse, that homelessness causes poor health. If you can imagine living on the street, or living in a shelter, it's stressful. And if you didn't have issues before, you tend to develop issues when you are homeless. It's very difficult to live on the street and be exposed to extremes of weather, cold and hot, without getting hospitalizations, or emergency department visits tend to be very frequent. High blood pressure. If you weren't stressed out before you lost your housing, you're definitely stressed out afterwards. Depression, alcoholism, and mental health issues of all kinds really tend to be developed -- if again, didn't have them before -- you tend to develop after or they get exacerbated.

You also tend to think about, lack of housing complicates treatment. We are putting billions of dollars into our healthcare industry every year, trillions. None of that funding works well and is efficient. As healthcare providers, nothing that we do works well when someone is living on the street. Every time we churn somebody through 28 day or 90 day recovery treatment, and we get somebody into behavioral treatment they need, only to discharge them to the street, we have complicated and in fact compromised the treatment we've just invested. When we've discharged people from our hospitals, to a shelter or to the street, the inpatient's stay that we just paid for, the wound care that we've just paid for is now compromised.

These are the things that are really just all bundled up together in the intersection of health and housing. So we really need to appreciate how we can rectify that through housing. One of the things that we are seeing -- as again, we represent the doctors and nurses, and mental health therapists, and addiction counselors, and case managers, and the workforce that goes behind caring for these patients. And what we see, not surprisingly, is very high rates of acute and communicable diseases. Respiratory illnesses, all of the things that you would expect, infections from cuts getting infected, you can't keep clean on the street. Try being a diabetic, with needles on the street, is actually hazardous to your health.

The rate at which we replace medications is astronomical, because of the rate that they are stolen. When you can't keep things safe, when you can't keep your medications refrigerated, it's very difficult to maintain compliance with your healthcare. How many times has anybody here gone to the doctor, and had a prescription given to them, that may cause them to visit the bathroom a little bit more often? That's just not possible --

Jennifer Ho: Don't ask them for a show of hands.

Barbara DiPietro: Yeah, no need for a show of hands. [laughter] But that's just not possible, when many places don't afford homeless people an opportunity to use the bathroom. And so, what we see is very high arrest rates, for things like living your private

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life in a public space can be extremely indecent. And we have local ordinances increasingly that criminalize that activity. So really, what we see as healthcare providers is that our clients come in and said oh, I didn't take that medication because otherwise I'd get arrested, or I was afraid of getting arrested, or I didn't have any place to go, or my meds were stolen, or my needles were stolen. Or oh, it's not safe for me to have needles. This is what we hear.

So we see, when we look at the literature, the literature shows that people who are homeless have got rates of acute and chronic disease at three to six times of what everyone else has. Now of course, being like everyone else, there's still we've got asthma and diabetes, and hypertension and high cholesterol, and heart disease, and all of the rest that everybody else has, but still in higher rates. We see a lot of really intensive needs to coordinate this care, and we see both extremes of use of a healthcare system. We're getting a lot of attention in the frequent user, a very high end user, where we're putting a lot of money into a very small number of people that we need to stabilize.

But what we also see are people who are living on the outskirts of our society, who avoid our healthcare system, but have intensive needs, usually in the mental health and substance abuse treatment area. How is it that we're reaching those people, too, very fragile and in need of care? So when we look at our hospital systems, hospitals are really strapped. I really get it. When you are a hospital, what are you supposed to do when you have no safe discharge option for a client that is ready for discharge? It is illegal to discharge to the street, but absent anything else. We get discharged home for rest and recuperation. What do you do for somebody who doesn't have a place to go?

These are the real issues that local healthcare systems are struggling with, is finding capacity, so that we can be safe and ethical treatment for people. We also see a lot of people, where when they are ill, it's very difficult to get back out of homelessness. So working on housing, working on getting a job. If you're fighting your addiction, or fighting mental health or not in treatment, very hard to get out of a shelter or off the street. You've got the slides. This is just one example of how even in a health center population, people who are homeless have got disproportionately high rates of just about every disease and condition you can imagine.

And so, that brings us to supportive housing. When we think about what is supportive housing, typically it's helpful to think about it in terms of a traditional model that emphasizes recovery first. Traditionally, in our communities, we've required people to get clean and sober. We've required people to enter into treatment, and really be successful with that, before then we get them into a housing unit. So if everyone follows the rules, and you continue to follow the rules, then maybe one day you can be in independent housing. And while that certainly works for some, where it didn't work was for people who have really serious healthcare conditions. It's hard to get clean when you're living on the street.

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So the supportive housing flips that model. It's not time limited. It's the same lease as anybody in the community. Frankly, any number of any of us can go home tonight, and we can have a drink, and that's perfectly all right to do in our home. It needs to be an opportunity as well, is that we need to work with people where they are, in the stabilizing unit of housing. So that we've got that stability. So people have a place for their medications. They have a place to put an appointment card, keep track of time. We have a stable place where we can visit them. Our outreach workers can't find people when they're shifting around on the street, and typically encampments will change a lot. So we really need to think about, how are we supporting housing in this way? A wide range of team-based services is really the secret to making this work. When you combine the stability of housing with the healthcare services, again a wide range of the things listed here, we can really help people be stable in their housing.

This is mainstream right now for seniors and people with disabilities. My grandmother can have meals delivered to her. She can have in-home care to help her with her bathing, help her with keeping the house clean. All of these things are things that we're now taking for granted, really, in a home and community based services. Thinking about extending that into this population, so that we're both supporting the housing and the services that people need, really is in keeping with that same theme. Really want to talk about relapse is part of recovery. These are the kinds of things that we need to expect.

Recovery in mental health, and recovery in addiction doesn't look like black and white, and yes and no. It looks like a struggle. And when we have people who are in zero tolerance, or very recovery oriented housing, even just that one slip up jeopardizes your housing, and you can be back on the street. So it's really important that we're able to work with people and adjust services as they need that. And again, there's no requirement for sobriety and where the services are voluntary. But what we have found is that people are really excited when they get into a unit, that now, that so many things look possible that didn't before. We've been evaluating the effect of supportive housing in the peer reviewed literature for about 25 years now.

And consistently, what we find is that housing improves health and it improves health outcomes, and it lowers the total cost of healthcare. And I think this is really where we need to be in rethinking housing, because we're so focused on cost right now, understandably so. But we need to think about, where is it that we can be making inroads and partnerships? You can read this slide here. There's consistent findings along all of these issues. But again, we really want to focus on, how is it that bringing these two sectors together is really bringing out the things that we need? There's a lot of opportunities at both the federal, state, and local level that's really important to be aware of. All of your states are working on strategies to end homelessness, and to improve health, and we're also looking at greater determinants of health.

But one of the things that I think is really important, particularly here in D.C. to remember, is that we need federal support for the housing piece that goes along to

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making this work. My colleagues here will talk a lot about what they're seeing in their sectors. But again, the cuts that are being required by sequestration, if we don't have the housing supports to put people in, no amount of our healthcare services are going to make this work well. We need these to come together. Another thing I would really recommend as a takeaway point, for all of you who are health [LA's] or health staffers, and all of you who are housing staffers, get to know each other, because you have a lot in common.

And a lot of times, we're not talking and working together at the federal level, like we're asking people to do at the local level. And so, those would be a couple of things that I would recommend. But really, what we're doing at the federal level is trying to build that bridge between health and housing. And as healthcare providers, we are in a rapidly changing environment. Medicaid is one of those rapidly changing areas. But really, the system as a whole is changing. We're focused on outcomes and costs. But we also need to be focused on really vulnerable people, and getting them what they need. But nothing works well, as a healthcare provider, when people are living on the street.

So we really want to reorient housing as a healthcare intervention that we really need. And my colleague from HUD here will talk about how HUD is focused on building this bridge from housing to health. But really, as an illustration of how we're trying to work together to make this model of care work, and achieve the outcomes we are all looking to achieve. I want to point out my colleague, Matt Warfield, here. If anyone's interested in learning more about this, Matt can take your card and get back to you. But just again, really appreciate your being here today. Thank you.

Ed Howard: Thank you, Barbara. We'll turn to Jennifer Ho.

Jennifer Ho: Great, thanks Barbara. And great, there I am. So I'm Jennifer Ho. I am the HUD's Secretary's Senior Advisor on Housing and Services. I like to joke. That means I'm the one person at HUD who knows the difference between Medicare and Medicaid every day. [laughter] You know what I'm talking about, don't you? My background actually, I spent the first 10 years of my career in managed care, largely Medicaid and Medicare managed care. And it was in that work that I was first brought to a table, to consider the relationship between homelessness and health. And the impact that supportive housing would have on both health outcomes, but also healthcare utilization and spending, and have been doing that ever since, for the last 18 years.

I want to assure you that there is an unprecedented level of collaboration happening today between HUD and HHS, not just because that's my job, but because it really is the case. HUD is talking to the Center for Medicaid almost every day. We're talking with folks at the Center for Medicare & Medicaid Innovation, and we're talking to folks at HERSA. We're talking to folks at SAMHSA. We're talking to folks at the Administration on Children and Families almost every day. So, I know that it feels sometimes like housing and healthcare are miles apart, and no one's talking. I just want to promise you that in this administration, there is an unprecedented level of collaboration.

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Now, there's a simple fact about how we invest in housing federally, that healthcare people don't always know, because you operate in a world of mandatory budgets and entitlement programs. Federal housing assistance is the only means-tested federal benefit that is not an entitlement. When someone becomes eligible for Medicaid or Medicare, they get it. If you go fill out an application for a housing choice voucher, you get in line. When we ask Congress to invest in more affordable or supportive housing, they worry about the renewal burden. The fact that this increases our total budget in future years, something that I like to call keeping people in their homes.

So the conundrum is today, HUD pays for a lot of services and housing that Medicaid could pay for. Medicaid has a lot of financial incentives for there to be a lot more affordable, accessible, and supportive housing. And the budget environment is such that we're not doing what we know works, and not doing anything at scale that matches the need. But that's why I'm excited to be here with you today, because your interest in housing could help create the consensus that we need to make the investments that will matter. So, thanks for being here and thanks for allowing me to be on this incredible panel. I'm going to talk about how this plays out in three areas, aging, disability, and homelessness.

Americans are living longer, and the aging baby boom is going to test our commitment to the relationship between housing and health. You know, age is the great equalizer. As we grow older, we're more likely to live alone, have more chronic health conditions, less mobility, and we grow poorer. Sorry for that downer over lunch. The Harvard Joint Center on Housing Studies projects that the number of older households eligible for rental assistance will increase by 2.6 million people between 2011 and 2030. Today at HUD, we provide rental assistance for 1.2 million seniors. That's one out of every three seniors who is income eligible for it. So that means that we would need 900,000 more subsidized housing units by 2030, just to keep up with one in three people who need it, getting it. Yet we have not made significant new investments in more HUD assisted housing for seniors for some time.

Now think about where you live today, or where your parents or grandparents live. Less than one half of one percent of existing housing is currently accessible to someone who uses a wheelchair. Only five percent is livable for someone who has mobility impairments, and only 40 percent of it is modifiable. Most of Americans existing housing stock is not designed for them to age in place safely. So imagine 20 something million people over the age of 80 fall, and they can't return to their home. Or, they don't fall, but they just can't afford where they live. Where will they go? How do we have a strategy for aging in place, if people will not be able to afford or navigate the place that they call home today? The healthcare system, I would argue, has a huge stake in meeting the housing affordability and accessibility needs of an aging America. Yet there is not consensus that this is an investment the federal government should be making.

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Now, a lot of the work that we're doing with HHS has been around disability, and deinstitutionalization. Money Follows the Person, Olmstead, largely through our new and improved program called Section 811, supportive housing for individuals with disabilities. 811 forces partnerships between a state housing finance agency and a state Medicaid agency. In some places like Colorado, it didn't have to be forced. The partnership was there. It leverages multiple sources of funding, to create integrated housing, where Medicaid provides home and community based services in a unit, that has a deep rent subsidy through HUD. We have two rounds of funding. Thirty-five states now have this money. In the last round, we funded \$150 million for about 4,500 units. A drop in the bucket, but at least we have made some investments.

The healthcare system, I would argue, has a huge stake in creating more integrated housing options for individuals with disabilities, who would otherwise be in an institutional setting. Yet there is not consensus that this is an investment the federal government should be making each year. It is not in the House or Senate marks for 2016. And I came to Washington to help end chronic homelessness, and I appreciate Barbara for covering all the arguments, and Sister Adele, who's going to be the closer on this, and Gretchen who's going to provide the state perspective.

But I just want to add a couple things. First, the President's budget requests last year and this year have included investments to create a sufficient supply of supportive housing, to end chronic homelessness in America. In 2016, he requested \$265 million, which would create 25,500 additional units of supportive housing, but leveraged the creation of many, many more. Supportive housing is a proven intervention to end chronic homelessness. It works for people. It improves health. It reduces unnecessary ER visits, and extended hospitalizations. So the healthcare system, I would argue, has a huge stake in our creating a sufficient supply of supportive housing to end chronic homelessness in America. Yet there is not consensus that this is an investment the federal government should be making. It isn't in the House or Senate mark.

Second, we're learning something in the work that we're doing with the VA, ending Veterans homelessness. Here, there has been consensus on investments in a program called HUD-VASH, combining HUD rental assistance with case management from the VA. We have seen a one third reduction in veterans' homelessness between 2010 and 2014, and we are on a path to effectively end veterans' homelessness. Imagine if we could get an investment and supportive housing aligned with Medicaid, to repeat this for individuals with disabilities, who have lived on our streets and in our shelters for years, sometimes decades.

Now, my focus has been to work with CMS, to think about ways in which we can better align housing and Medicaid. And I'm really thrilled with the new informational bulletin on housing related services that CMS just published. I think there's a link to it in the documents, all the information that you have in your packets. I'm increasingly meeting State Medicaid Directors, like Gretchen, who understand that if they're going to achieve

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the goals of health reform, bend the curve, they will need to deal with housing instability and homelessness, and they have a new best friend who's a houser. This document helps bring clarity to something that has felt pretty unclear.

If housing is over here, and healthcare is over here, there's a whole lot that's in the middle. What can Medicaid pay for, for whom, and when? I believe if Medicaid were paying for all the services in supportive housing, that it can pay for, we would have better health outcomes for seniors, better options for individuals with disabilities, and we could end chronic homelessness. I believe if Medicaid became a major player in supportive housing, we could build the consensus needed, to make the level of investments necessary, to help seniors age in a home that they can navigate and afford. Individuals with disabilities who have the rights to live in a [NOS] integrated setting, in the community, would have more choices about where to live. And more housers would make their housing available, because they value the service partnership.

So, let me finish where I started. The conundrum is today, HUD pays for a lot of services in housing that Medicaid could pay for. Medicaid has a lot of financial incentives for there to be a lot more affordable, accessible, and supportive housing. And the budget environment is such that we're not going to do what we know works, and we're not doing anything at scale. But that is why I'm excited to be here. Because your interest in housing, your understanding of the relationship between housing and health, your advocacy for more targeted investments in supportive housing for older Americans, individuals with disabilities, including folks with disabilities living on the street, could help create the consensus we need to make the investments that will matter. Thank you.

Ed Howard: Thank you, Jennifer. Before we go on, if I can, let me just ask you a clarifying question if I could.

Jennifer Ho: Sure.

Ed Howard: You were talking about the services that Medicaid could pay for in supportive housing. And I wonder if you could be a little more explicit, and say a couple of words about what's stopping that from happening now.

Jennifer Ho: Well, for example, in our homeless assistance programs, we spend over \$400 million a year on services. We only need \$265 million to create more supportive housing to end chronic homelessness, but we're spending \$400 million a year on services. And that's everything from some things that Medicaid can't pay for, like employment assistance. But a lot of that is exactly the type of in-reach, engagement, assistance that's described in the new housing related services bulletin. The biggest barrier is that states don't know what CMS is going to approve. They don't know what to ask for.

There's this -- everybody's afraid that what we're saying is Medicaid should pay for housing. We're not saying Medicaid should pay for housing. We're saying Medicaid should pay for health. And that these housing related services, that as Barbara said, you know, we're doing pretty naturally now, to keep grandma out of the nursing home or to keep somebody out of an institution. We just need to extend that. You know, we're also paying for services, for service coordinators in our senior housing. We pay for service coordinators in public housing. And I mean, a lot of that service coordination is really health system navigation, and wellness activity, so that we don't have an ambulance pulling up every night, and we can keep people in their homes as long as we can.

Ed Howard: Okay. Very good. We'll turn now to Gretchen Hammer from Colorado.

Gretchen Hammer: Terrific. Well, thank you all for inviting Colorado to participate in this very, very interesting conversation. As Jennifer mentioned, Colorado is working very diligently on this issue, and it's a privilege to be able to share with you some of the things we're doing. First, I think I'd like to just provide a little bit of context. Everything we do within our state government, at this point in time, is really driven by our Governor's platform for health, which is what we call the State of Health. Our very bold goal is to be the healthiest state in the nation, and we take that goal very, very seriously. Not only because we have a great place to live, but we have health disparities within our communities that are holding us back, and we're working very hard to move those forward. So it really is around this interconnected nature of health for our economic growth, for our social conditions, for our healthcare system to work more effectively than it does today, to have healthier people, and to create a healthier business environment.

We believe when we look at those things holistically, we're able to put the right services, supports, and efforts in place to make Colorado the healthiest state in the nation. And if anyone is familiar with the Triple Aim, you'll note the background of the best health, the best care for the best value, which is our translation of that very important concept. And really a commitment to both starting with prevention and wellness, which is a lot of what we talk about when we think of the issues we're discussing today. The nature of the healthcare system needing health insurance most of the time, to access the services that you need, and making sure that we have the capacity within our healthcare system to meet the citizens of Colorado's needs.

Then also looking at a healthcare system that could have better value for what it provides today. We invest a lot of money, and across the nation, in our healthcare system. And I think we have some opportunities to get better value for the dollars that we invest. And some of that requires infrastructure investments, things like healthcare capacity, primary care medical homes, having integrated care between physical, behavioral, and oral healthcare services, so we don't have one person with one body going to three different locations to get their healthcare needs met. And also looking at our health information technology. So the State of Health really is our very, very high level, holistic view of Colorado, and how we're looking to move our agenda forward.

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We did expand Medicaid in Colorado. One of those buckets, as you'll remember, is a coverage and capacity area of focus. Prior to September, or in September of 2013, so prior to the first open enrollment period of the Affordable Care Act, Colorado had about 750,000 Coloradans that were covered by Medicaid. As of this month, we're up to 1.2 million Coloradans who get their healthcare coverage through the State Medicaid Program. And about 52,000 pregnant women, and children, who get their coverage through what our version of CHIP, which is the Child Health Plan Plus. You can see in the breakdown, there's a diversity of populations that we cover, and this housing conversation has really been accelerated by this expansion.

Colorado did some state-based activity and expanded early for those living at 10 percent of the federal poverty or less. And let me just remind you, that's \$11,000 a year in income. So we expanded to 10 percent of poverty or less, prior to the full expansion of the Affordable Care Act, and then built on that as we moved into January 1<sup>st</sup> of 2014. It was an important step for us, to understand the needs of most of those primarily homeless individuals, to understand how to best engage with them, how to support them in getting access to coverage. And to begin to understand what the breadth of their healthcare needs would be, and what kinds of other services. So our expansion has been an important piece of our work. And coupled with that expansion has been an additional commitment at the Governor's Office, around permanent supportive housing.

There is a specific individual who works within the Governor's Office, working on issues of homelessness. When our current Governor was Mayor of the City of Denver, he had a very important platform around homelessness, and that has continued on into our state-based administration. A lot of that focus has been around permanent supportive housing, which is a theme I think you'll notice across the three of the comments so far. And that really has required us to look at the capacity of our housing system. How can we identify and mobilize existing state resources? And then, what other innovations do we need? Colorado is a very, very nice place to live. I have lived there almost all of my life, and it is also a very expensive place to live.

And so, given that housing is one of those issues that is directly impacted by the other components of the marketplace, that are around area median income and other things, it's really a challenge at times in a very expensive environment, housing environment overall, -- Colorado has one of the hottest real estate markets in the nation at this point in time -- to figure out how affordable housing can be made available. So, piloting of innovation models is incredibly important. So this dual focus of both a health platform and a housing platform has really set us up very well, to look at how we can begin to expand the relationship between these two areas.

So health and housing has been an important piece of what we've been working on. We've engaged in some discussions that have created this crosswalk, that I think Jennifer was referring to, which is, how can we be sure that we're using investments

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appropriately? So that the medical related supports and services are being paid for in a way that makes sense, and that other housing related services can be leveraged in the same way. So we've engaged in a crosswalk study, and I wanted to just take a moment to talk a little bit about the findings from that. We looked at state fiscal year '13-'14, which is July 1 of '13 to June 30<sup>th</sup> of '14, which again begins to look at the first six months of our full expansion of Medicaid.

And when we looked at our data, there were about 37,000 enrollees who reported homelessness during the year. 24,000 or so had reported homelessness during the entire year, and the rest of them had talked about being homeless at least at some point. So I think that's an important piece to just call out. That when we think of homelessness, just like when frankly we think of coverage, it's a point in time piece for many people. There can be a period of time in your life where you're homeless, or a period of time in your life when you have coverage. And during the day, you pick up that survey, or you're part of the point in time homeless survey, that's where you are. But it may not be how you exist in the world throughout the year. And so, it's an important piece when we look at programming, to recognize that variance in people's lives.

When we did an analysis of the spend on those services for those individuals, it was about \$160 million. And through this exercise of this crosswalk and of this business case, we began to break those 37,000 into deciles. And as we looked at the top decile, so the 3700 people who were the most expensive, \$97 million. And I know we've been talking a lot about money, and I'd like to believe that what we can also recognize from that number is that those people were very, very ill, and probably didn't feel very good. And I think it's important for us to recognize that we have an opportunity to not only potentially save resources, if we do this work better, but also help people feel better and help people have a better existence as they move through the world.

And so, this is a very important piece that we're looking at, both from a budget perspective and from an overall health perspective. When we say we want to be the healthiest state in the nation, that's for everybody. And so, it's a really important balance to look at both the spend and the experience that people have.

So, as we hear about these new opportunities, the clarity that came out from CMS in June of this year, June 26<sup>th</sup> I believe is the date on that memo, it's really a chance for us to have more clarity, as we work to see, what can we do to bridge between health and housing? To not only address these individuals, but put more permanent structures in place overall. And so to do that, as I think we have talked about a little bit, these services can also exist in silos at the state government level. And so, we have created a cross agency workgroup that has members of the Department of Health Care Policy & Financing, so our state Medicaid agency, our Division of Housing in our Governor's Office, and that group meets twice a week.

And some of the basic work that we've had to accomplish is just clarifying language. All bureaucratic programs have our own speak, and we use acronyms that only we understand. And so, you have to step back and say, what are all those letters together? What do they mean? And so, it's really been an important clarifying of language. And also recognizing that if it's taking us some time, at the agency level to know how to interact with one another, in the 64 counties across the State of Colorado, which is the sixth largest land mass state in the nation, there's obviously probably going to be some confusion and opportunities for better education. And so, that's where we're focusing our energies now, is helping all of our providers, both on the housing side and on the healthcare side understand, what are the opportunities to be working together? How can we begin to bring alignment in and synergy into the funding that's available to all of us?

We're also looking at some of the new waiver authorities that have been made available. So there's a recent document out again from CMS around 1115 waivers related to substance use disorder. Again, that's a piece of perhaps this conversation that we haven't highlighted, but an important piece of how those services can be delivered. And then lastly, some of the technology pieces. We have a homeless management information system, and a medical management information system. And as our state is going through a reprocurement of those, we're looking to see if there's opportunity to have connection between those, since we are now in a time where technology could help us, if we let it.

So lastly, I guess I would just conclude with again, circle back on the reality of the people that are at the heart of these efforts. We had the chance, in my formal life, in a partnership with some folks to talk about and learn about what the experience of those living in affordable housing, their healthcare experiences. And one of the most heartbreaking things about that was the lack of dignity that they felt like they were afforded from the healthcare system. Treated as if it was a gift that they had the chance to be there. That if they were just smarter, they could figure out how to navigate our very complex healthcare system, that I frankly struggle to navigate at times.

And so, what we concluded from that piece, and talked with our partners about, is it doesn't cost us any additional resources to have respect and to provide dignity to folks. And so, it is important that we think through these. But there are some basic things we can do that can help improve people's health, their mental wellbeing, and all of our society and communities, with just some recognition that these are hard issues. And the folks who are in the middle of them need some support and respect as we work to solve them.

Ed Howard: Great, thank you, Gretchen. We'll turn to Dr. O'Sullivan.

Sister Adele O'Sullivan: Good afternoon everyone. I'm very happy to be here today. I speak from another additional perspective. I'm a family physician, and I have cared for an exclusively homeless population. Is that better? Can you hear me?

Ed Howard: Yes.

Sister Adele O'Sullivan: For an exclusively homeless population since 1996. So, I experience every day in trying to give good patient care, the trickle down effects of policy and of spending decisions in the lives of my patients. And how our ability to make good policy and spending decisions influences the health outcomes of very real people. I come from Arizona. I'm going to speak to you about our local situation, which as all of our environments are, is somewhat unique. Arizona is a Medicaid expansion state, I'm happy to say. There is, however, still a legal challenge pending in the courts to that expansion. We have other successes that I'd like to tell you about.

One is that Arizona decreased chronic homelessness by 15 percent between 2013 and 2014. On a note, which I experienced personally, we began in the Phoenix area, which is a very large and sprawling county, with a homeless population of approximately 17,000. I started a nonprofit called Circle the City. And we did that as a community, as a grassroots effort to bring people together, to meet the incredible need of those who were too sick, too frail to be in our streets and in our shelters. In 2012, we opened a 50 bed facility in the Phoenix area. The name for this service is called medical respite. The respite word is somewhat confusing. It's recuperative care for persons experiencing homelessness. You could think of it as bridge housing with very intensive medical support. This has been a crucial part of our ability to provide for the sickest, the frailest, and the most vulnerable.

Another good piece that's happened is that the number of supportive housing units is growing. In Maricopa County, 1600 supportive housing units were funded for individuals with a seriously mentally ill designation, by the Continuum of Care who funded the rental subsidies and Medicaid who funds the supportive services. Through a regional public and private initiative, it was actually our United Way bringing partners together. Another 1,000 units of supportive housing were targeted to chronically homeless individuals in Maricopa County. However, the challenge. We still have a supportive housing need and resource challenges. We think it would take about 1,000 more supportive housing units to end chronic homelessness in Maricopa County.

Our Arizona Medicaid plan covers a comprehensive bundle of services. The flip side of that is that in supportive housing, those services are only available to persons with the seriously mentally ill designation. Our nonprofit participated in a Fuse pilot project with one of the local large medical centers. Frequent users of systems engagement is an acronym of the corporation for supportive housing, a tremendous, active, wonderful partner in trying to get supportive housing available to us. In this pilot project, we engaged the most frequent, most expensive homeless utilizers of care. We engaged, we offered the services of our medical respite center, in order to stabilize, assess, and then quickly move to supportive housing. The vouchers were donated by several agencies in the community.

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That pilot project realized a 73 percent reduction in emergency room visits, and a 74 percent reduction in inpatient utilization, after patients are placed in permanent supportive housing. So, the diagnosis is homelessness. These are the patients that we took care of through the Fuse pilot. They didn't have just one chronic disease. Some had two. Most had three, four, or five. That doesn't take into account the acute problem, the diabetic foot ulcer, the heart failure exacerbation, the crises for which people cycle in and out of emergency room care. Why do people cycle in and out of emergency care? Well, in our population, these are the reasons we probably believe. And as you can see, the last one on there is that the primary care system might not be responsive to the population issues, or the multiple issues that Barbara talked about earlier, that are simply the co-occurring phenomenon of being homeless and living on our streets.

So I'd like to show you, just briefly, one case study of a patient that was in our Fuse pilot. We call him Mr. 280. He was well known to the Phoenix Fire Department, because he hit 911 all the time for transport to local hospitals. And we think between adding all the hospitals up, he had 280 visits. But with the hospital that we worked with, he had been to the emergency room 192 times between 2007 and 2013. We engaged him, brought him to the Circle the City's respite center for three weeks, and then we discharged him to permanent supportive housing. This is Mr. 280's hospital bill, just at St. Joseph's Hospital. Page one, page two, page three, page four, page five, page six, page seven, page eight, page nine, and page ten. During that period of time, he had 192 visits to the emergency department, but not one inpatient admission.

Now, I can tell you that when we actually engaged Mr. 280, we found out he was living almost in the hospital parking lot. Total account charges of \$358,417 at one hospital. This is a graph of his emergency room visits during that period of time. As you can see, there's three places there in '12 and '13 when he wasn't in the emergency room for the month. And we can show you three mugshots that correspond to those months, when he didn't appear in the emergency room. So, since being housed, he has been to the emergency room twice, both appropriate visits. He's never been admitted to the hospital. He's stably housed, and has remained stably housed over that period of time. He's receiving care in the traumatic brain injury clinic at our local Barrow Neurologic Institute. He got his food handlers card, and he's employed part time at a local restaurant.

So, what are our challenges on the ground? I think you've heard talk of care coordination. And you know, we love it when we can get somebody into permanent supportive housing, because we have that opportunity. I'm going to get that diabetic foot ulcer healed, if I've got him in housing. I'm not going to get it healed if he's in a shelter or under the bridge. We need to coordinate the services that we provide. We haven't exactly figured out whose responsibility that's going to be. That's another one of those issues where we have to work together. We have to prioritize the supports in terms of medical needs. I think, if you've not seen the work done out of Boston by Dr. O'Connell about our medically vulnerable are dying on our streets. We have pretty good data to show that persons with chronic illnesses, who are medically vulnerable, will not survive.

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And yet our systems, our electronic systems, our silos if you will, we have to learn how to cross them, to prioritize those limited supportive housing resources that we have, to the persons who need them the most. And then, one thing that we're really interested in is developing new and innovative models for delivering primary healthcare efficiently in permanent supportive housing. So once we get people there, how do we deliver the care in the most efficient way possible? Do we take the services to them? Do we provide the transportation and the follow-up to get to fixed sites? All of those are possibilities. We know that it's important to place people immediately. They'll get sick, for one thing.

The second thing is when we can locate the person that needs the housing, we need to try to put them there. I'd like to [put it in a plug] for medical respite care for the homeless, and the growing of these programs as pivotal points, where patients who are too ill sometimes for direct placement, without the stabilization of that illness, can use medical respite as bridge housing. So, my recommendations. Housing is healthcare. If we could increase availability of those permanent supportive housing units. We need the vouchers and we need the services. And so, anything we can do to incentivize our states to cover those array of the comprehensive services in permanent supportive housing. Medicaid is wonderful, but Medicaid alone can't do it. We need the support from our mental health providers. We need HUD. We need housing.

And you know, when we can get those wraparound services, those positive outcomes that people think aren't possible, I'm here to tell you they're possible. Thank you.

Ed Howard: That's terrific. Thank you, Sister Adele. And let me just -- we now are at a point where we would love to hear your questions, both orally at one of the microphones, with the green card that you can fill out and hold up, and someone will bring forward. Or, you can tweet it and we'll go from there. But let me just start with Sister Adele, if I can. Could you talk -- and I would welcome other panelists chiming in as well -- about the kinds of money, you know, which pockets were you able to pick to put together what looks like an incredibly impressive array of housing, with services, that have allowed you to make such progress?

Sister Adele O'Sullivan: So, as far as the housing is concerned, through our Continuum of Care, also through our Valley of the Sun United Way, we were able to put together some funds from DES, from the Department of Housing, the State Department of Housing. From a couple of the cities in the metropolitan Maricopa County area, and from philanthropy. Those are the vouchers.

Jennifer Ho: Sister Adele, the healthcare folks in the room may be confused by the term continuum of care. And since I want to take credit for that, because it's a HUD program, I'm just going to jump in. HUD Homeless Assistance Programs is delivered in communities through loose community collaborations that we call continuums of care. That's confusing to the healthcare system. I wish we had named it something else,

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especially since we're not actually even advocating for a continuum model of care anymore. But that's something that's aside. But so, when she's saying that she got money, that was probably rent assistance and maybe some capital development costs through the HUD Homeless Assistance Programs, which is exactly the same place in the budget where we're trying to get the funding to do the additional units, exactly like you're saying you need, so that you could end chronic homelessness in Maricopa County. Just a little plug for that.

Sister Adele O'Sullivan: Thanks, Jen.

Ed Howard: Okay. Oh, okay, thank you for your observation of decorum. If you would identify yourself, and keep the question as brief as you can, we'd very much appreciate it.

Al Milliken: Thank you. [Al Milliken, AM Media]. What experience do any of you have with those who have gone on Medicaid, as a result of experiencing a natural disaster, and losing the housing they had before?

Jennifer Ho: I would love to talk about what I've observed down in New Orleans. It's timely with the anniversary of Hurricanes Katrina and Rita. One of the things -- I mean, it was tragic and the number of people who lost their homes was devastating. What happened to that community was devastating. But what they did in the rebuild is amazing. And because there was a lot of flexible disaster recovery money, they got low income housing tax credits, which are the biggest producer of capital dollars for the creation of more affordable housing, as disaster recovery money. They got HUD Community Development block grant money, which is the most flexible money communities have, as disaster recovery. They got housing choice vouchers, which is HUD rental assistance. And they got shelter plus care vouchers, which are HUD's homelessness rental assistance, all as disaster recovery money.

The amazing thing that they did is they used the community development block grant flexible money to pay for services, while they created supportive housing using the low income housing tax credit. They used the housing choice vouchers and the shelter plus care vouchers to deeply subsidize those units for people experiencing homelessness, while they built a Medicaid system, that would pay for the services in supportive housing, and become the triage process for identifying people who had that vulnerability and need, to move them into housing. Now, I say that even in a state, where the Governor has chosen to not expand Medicaid. But it's a great -- it shows what's possible when Medicaid and housing are used strategically together. So, I hope that that reflects some of what you were asking.

Ed Howard: Okay, very good. I should call attention to what's on the screen, and that is an incentive program of ours, along with our friends at Centene, to get you to fill out the blue evaluation form. If you do, in sufficient numbers that we reach a 50 percent participation rate in this exercise, the Alliance will make a contribution to the Community

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of Hope here in town, which actually deals with some of these problems that we've been discussing, including homelessness and healthcare on the ground, here in D.C. So, don't leave without filling out your evaluation form, and making sure that the person next to you fills out the evaluation form as well. Yes, Bob.

Bob Griss: Bob Griss with the Institute of Social Medicine and Community Health. This panel is a great example of social medicine. And yet, I am not hearing a focus on standards of care that we would expect all hospitals and healthcare providers to be aware of. This Mr. 280, that Sister O'Sullivan introduced us to, to me is an example of hospitals taking advantage of the Medicaid program, to extract as much money as they can from it. Rather than identify the sources of this man's needs, and making recommendations for addressing them, whether through the resources of the hospital, or the resources of the generic community.

I think that the Colorado story is interesting, because they want to be the healthiest state. That means not just the healthiest state for homeless people, but the healthiest state for all people. Where are the recommendations on how the healthcare system should be integrated into the social determinants of health, with housing being an example here? Shouldn't we require through regulatory authority, standards of health, when healthcare providers identify, should be forced to identify the social causes of the problems that they're expected to treat? I think this is a great opportunity to raise those issues, so that we can have some generic solutions, and not just be proud of reducing homelessness for a certain segment of the population.

Barbara DiPietro: Well, I'll start with this. I completely agree, and appreciate your passion behind this issue. I think what we are trying to do is get our healthcare system to the place that you have just described. And that's not just for special populations, that's for all of us. And so, what we're all looking for is an outcomes driven, how are we as individual human beings, and in our communities as population health, getting healthier? And how can we demonstrate that, and put the resources of our healthcare system behind that? And when I say a system, I mean an actual integrated system that has informed with it and resources to be able to deliver the kinds of care that we envision in the presentations here. We're trying to build the capacity in our communities to get there.

And a lot of that has to do with the partnerships that have been described, among people who are in charge of the social determinants of health. So not limited to housing, but good nutrition, good education, good jobs, stability in health, as well as stability in life. And so, I think when we talk about investments in housing, and talking about the partnerships we need to have, it's informed by recognizing, this man does not have housing, and that's what's contributing to 280 emergency room visits. So, how does this hospital partner with his outpatient primary care provider in the community, as well as the housing provider to get him into housing?

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But that means identifying the housing resources that are woefully insufficient in just about every community in this country. So I envision, and applaud what you're describing as well, we have to get there. And that also means investments at the federal level, that we just need to be serious and honest about. Does that answer your question?

Bob Griss: It addresses it beautifully, yes.

Barbara DiPietro: Thank you.

Ed Howard: Gretchen.

Gretchen Hammer: I would add, one of the ways we're seeing movement on this issue is, well one, I think there's been a broader recognition of the impact of the social determinants of health, or someone's life circumstances, on their ability to achieve their health potential. But in addition, through our Medicaid delivery system, for our physical health services, are through an accountable care collaborative structure, where we have regional entities that have key performance indicators, that they get additional resources to achieve. And some of those, we picked very strategically to begin, and those were 30 day readmissions to the hospital, inappropriate ED utilization, and the use of high cost imaging, so many of the bills that probably Mr. 280 had experienced.

And we did those for a couple of reasons. One, it's high cost and two, no one likes to have imaging that's not needed, be in a hospital twice if they don't have to be, or be waiting in an ED. So it had both components to it. And I think, very quickly, our healthcare systems who are working towards those key performance indicators recognized, hm, there may be underlying social factors in these individuals' lives, that with some attention, we could meet these key performance indicators. So, those are transforming over time. We now have well-child visits, and visits postpartum. But we've been talking about homelessness in general terms, and certainly there are homeless families as well. And so, we believe all of those indicators can help to continue to broaden the focus on the entire individual or family's needs, beyond just the single engagement with the healthcare system.

Barbara DiPietro: And if I can follow up with a point, that I did not make, which is important. This population largely was ineligible for Medicaid up until the point of the Affordable Care Act extending Medicaid. And so, this population wasn't even part of a system. And so, we are now --

Jennifer Ho: No, they were eligible, but probably not enrolled, because of how hard it is to get a disability determination.

Barbara DiPietro: Correct, right. So right, so only if you had a disability. But the vast majority of people that we saw, just were single non-disabled, non-elderly adults, who were not eligible for Medicaid or any other health insurance. So this is really the first

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time we've even been able to get them into a system, to really be able to comprehensively look at their needs.

Sister Adele O'Sullivan: And actually for Mr. 280, that was before Medicaid expansion, so he had no insurance.

Ed Howard: Very good point. Yes, go right ahead.

Eleanor: Hi. My name is [Eleanor]. I'm with the Infectious Diseases Society, and with the HIV Medicine Association. Thank you so much for the panelists. This has been wonderful. When Barbara and Sister Adele were speaking, you both were speaking of supportive housing. But one distinction I noticed was that Sister Adele kept referring to permanent supportive housing. And so, my question is, are there mechanisms in place with supportive housing to help individuals phase out, so that they can sustain their own housing, and also sustain their own medical needs? And then, are there any metrics put in place, to be able to determine when somebody is able to phase out of supportive housing, if it is meant for them to phase out?

Jennifer Ho: I'm happy to start that one, since housing's in my name. A couple of things. In the world of homelessness, the term of our permanent supportive housing was really created to distinguish it from what had been the paradigm of the day, transitional housing. And what it really meant is that it wasn't a time limited program, and that you could stay as long as you needed to. And the ability to stay in the same home, and not have a clock ticking, is actually supportive of recovery. The stress associated with knowing that you have to have your act together at a certain period of time, and you need to be able to go someplace else, is counterproductive to having long term stability, and working on long term goals. So, it is designed to be housing.

Obviously, we hear stories every day of people who don't need it anymore, and who get a job and want to move out, and make the space available for somebody else. But I think that's also where our aging portfolio is a great example. We do supportive housing for the elderly. And the expectation isn't that when grandma turns 90, she should be ready to move someplace else to independence. And so, I mean the concept that housing is your home, and it's where you live, that idea of home is the idea -- it is the life changing event from hopelessness in the streets, to hope and a future that happens when somebody moves into a home of their own. When somebody moves out of an institution, and into a community, and into an apartment of their own. So while we want to support mobility, we want to support people being able to move off of HUD assistance, whenever that's possible. When we're working with people who are aging, with people who have severe disabilities, and people who have severe disabilities who have been living on the streets for a long time, I think we need to presume that they are going to need support for a long time, and sometimes for the rest of their lives.

We also hear stories every day of people -- and Sister Adele, I'm sure you live this -- of people that you get off the streets, who have been on the streets for 25 years. And what you do is you afford them the dignity of dying in their own home, instead of dying on the streets, because they came to you that frail and that sick.

Sister Adele O'Sullivan: Those things happen very frequently.

Ed Howard: Yes, Laden?

Laden Cluid: I'm [Laden Cluid], George Washington University. So, I've heard a couple of themes that are slightly different among the speakers, and maybe there could be a little bit of dialogue along these questions. One was Medicaid should pay for housing. There's more housing needed. The others, Medicaid doesn't need to pay for housing. Medicaid just needs to pay for housing services, or services related to housing. And another is homelessness is the diagnosis. The other says, we should target things to people who have relatively severe needs. Like, you know, frequent ED users, serious mental illness. So, is there any way to resolve these apparent contradictions and views?

Jennifer Ho: I don't think there's any contradiction in what we're saying at all. I think that when people say, Medicaid should pay for housing. I think what they're really saying is that we need more housing, and the federal government isn't investing in housing through the housing programs. And we need to get it somewhere in, because it has a health impact. You know, maybe Medicaid should be the thing, but Medicaid is statutorily prohibited from paying for housing. So I have found it to be a fairly unproductive loving strategy. So as a result, therefore, I talk about Medicaid could at least pay for the things that Medicaid does pay for, which are the health services, and the home and community based supports that would allow us to move somebody off the street, into a home of their own, and keep that housing. So I don't think that those things are at odds at all. I look to my colleagues to see if they heard --

Gretchen Hammer: I think the other piece that's important is in Colorado, in particular, we have a very population dense front range, so from Fort Collins through Denver, down to Colorado Springs. But then, we've got lots of rural communities that also have individuals who experience homelessness. And so to some extent, some of the flexibility of letting local partnerships figure out what kinds of resources are available in their community, and how to leverage those appropriately, I think is the other piece that doesn't make them in conflict, but rather probably reflects the reality of the diversity of our nation, and the availability of resources in each of our communities.

Sister Adele O'Sullivan: And I think I'm just -- you know, I'm coming from this local perspective, where we really had to pull together, you know? Public, private, faith based, philanthropic. Everybody had to pull together, and it was almost a, "this can't go on in our community, that we are not providing for the most vulnerable on our streets". And I guess that's what we're saying to you, is we just hope that we can all pull together. I'd

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just think I was in Heaven if I had three things: if I had enough supportive housing units, and if everybody was insured, and we had the supportive services to surround the person in the housing. Those three things. So, could you --

Female Voice: [unintelligible 01:12:35]

Female Voice: That's mine, too, yeah.

Ed Howard: If I can, I want to just follow up with a question that got raised by the previous question. And it involves a former administrator of the Health Care Financing Administration who runs Medicare and Medicaid, Bruce Vladeck.

Jennifer Ho: So that's how former it was, it was --

Ed Howard: Yes, that's right. And someone had asked him about the reasons we ought, or ought not, to meld the funding streams between housing and Medicaid more fully. He said, "I think the problem with funding housing, or seeking to fund it through Medicaid is that Medicaid's already under all kinds of political pressure, because of its' expense. If you start to say that anything might benefit a Medicaid beneficiary -- if you start to say that anything that might benefit a Medicaid beneficiary ought to be covered by Medicaid, you're really opening up a bottomless pit, and making the program even more vulnerable to those who want to cut or eliminate it." And I wonder if I could illicit some responses.

Jennifer Ho: I would love to speak to that.

Ed Howard: And also some [real world responses].

Jennifer Ho: I'm really confident that Bruce Vladeck isn't in the room, so I feel safe saying, I couldn't disagree with the shortsighted perspective that represents more, and I think the case studies that are told here say that. But I think the important thing, from our perspective at HUD, and we have this conversation with the folks at CMS all the time, is that Medicaid shouldn't pay for housing, because the whole history of Medicaid is about doing housing in really, really institutional horrible ways. And every time that Medicaid thinks that it's doing it better, 10 years later, it is trying to figure out how to downsize and divest itself of what it thought was a great idea 10, 20, 30, 40 years ago. Medicaid does not know how to pay for, or provide housing. Conveniently, we do.

So, I think it's not a question of, should Medicaid pay for housing? I think it's a question of, should the federal government invest in discretionary side, housing programs, that have enormous human benefit and cost offsets on the mandatory side of the budget, in order to deal with budget deficits issues, you know, globally, to deal with the aging of America, to deal with the institutionalization, to deal with individuals with disabilities who are living on the streets? I don't see that as a slippery slope. I don't see that as a black hole. I actually see that as sound public policy, to go upstream and fix the problems

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that are costing \$328,000 for Mr. 280, when we don't. Sorry, I got a little impassioned there.

Ed Howard: That's all right. But I --

Jennifer Ho: And very un-federal of me.

Ed Howard: But I note that in one of our handouts, there's a chart of some state initiatives in this area. And the State of New York, in fact, did ask for Medicaid money to build housing.

Jennifer Ho: And I went and talked to Jason Helgeson before he submitted it, and I said, why are you asking Medicaid to do the very thing it cannot do? And he submitted it anyways, and Medicaid said, no. And what he didn't do is to include in that same request -- I hope Jason's not here -- everything that Medicaid could have paid for, all of the services. And instead, they're paying for that on a state general operating fund, instead of leveraging the federal match of Medicaid. I don't know why they did that.

Ed Howard: It sounds like some technical assistance is in order here. Yes, you've been very patient.

Yasmin Peled: Hi. Yasmin Peled from Families USA. I appreciate all the focus that you guys have put onto homeless issues in regards to housing and health, but I'd like to broaden that a little bit. Miss Ho, you mentioned that the federal government has -- the collaboration between the different agencies is unprecedented right now. And I'm wondering if there are conversations going on, where you're discussing improving housing conditions, rather than just getting people into housing? For instance, low income children who have a chronic condition like asthma often are increasingly going to the emergency room, because of the mold in their house. So I'm wondering if there's any work going on around that.

Jennifer Ho: Yeah, absolutely. There's a ton that HUD is doing around the intersection of housing and health. And it's everything from the environment in which we live, the way that communities are designed, to what's happening specifically in a home, is there mold? Is there lead? To the production side of the agenda, the stuff I talked about, about we just need more. But when we do more, hopefully, we do it well. We have an Office of Lead Control and Healthy Homes that focuses specifically on, how do we do lead abatement? How do we do a home modification to deal with the causes of asthma? How can we partner with the healthcare system, and the public health system, so that we can do that at scale?

I think one of the challenges, especially with highly mobile families, is that there can be a hesitancy for the healthcare system to go in, and oh, we'll just completely overhaul this unit. And then, you don't live there anymore. I think that'd be great, because it meant that

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we had one more healthy unit in the world. But, who pays for it? You know, we would love to pay for it, if we had the budget dollars to do that, and do it at scale. But I think in the absence of those dollars -- and we do some funding in this area, but we really are trying to figure out how to do partnerships. I can think of, for example, the partnership that we have with John Hopkins University, and really trying to do a very targeted strategy in that community. There's some things that we're doing in California, where we're partnering with the city and the healthcare system, to try to figure out how to do a very concerted effort on that. So, it wasn't a part of my remarks today, but that certainly doesn't mean that it's not an important part of the work that HUD and HHS are doing together.

Yasmin Peled: Thank you.

Gretchen Hammer: And I would just add from a state perspective, that kind of thinking is great thinking, and adds yet another state agency to the mix in our world. So, the Department of Public Health and Environment, as part of the State of Health, has guiding principles around the 10 winnable battles, that include the kinds of things that from a public health perspective, we know if we leaned into, we could win, and childhood asthma and other things, environmental causes of disease. And so, it is an important reminder to us. And again, perhaps we should contemplate adding them to our housing interagency group. But it's a piece that is also from a different perspective, and in a different place in our state government structure. Although again, between us, health sister agencies, we work very closely and it may be another nexus point for us to contemplate.

Ed Howard: Yes, ma'am.

Rhonda Hamilton: Hello. My name is Rhonda Hamilton. I'm actually an ANC Commissioner, a local official. I represent hundreds of low income residents, all of whom receive Medicaid and Medicare. In our area, and other areas, there's a push to break up what is considered concentrated poverty. That's the housing of hundreds of low income families that have, in some cases, many chronic illnesses, mental health issues, a number of factors. But there's a big push to eliminate their housing, to reduce it, to create mixed communities. And so, most of my constituents live in fear, that within the next few years, they will not have housing. That leads them to become sick, to become ill, and then in some cases, they die, because they don't know what is going to happen in the future.

Because a lot of people don't like to see hundreds of low income residents that are concentrated in certain areas throughout the cities, as we push for mixed communities. So my question is, how do we secure housing for those that are already housed in low income housing, particularly public housing units? So that we can work on their health issues and they don't continue to become ill, because they fear that they're going to lose their social ties, and their connections to their communities.

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Jennifer Ho: It's a terrific question, and thank you for asking it. You know, we have learned a lot at HUD about community redevelopment, over the course of the last five decades. And, you know, I think when we did it poorly, we kicked everybody out of the building. We tore it down, and we built mixed income communities. And then, we didn't know where the people were, who had been sent away. I had an opportunity last year to visit a community in Atlanta, created by the community, and a nonprofit called Purpose Built, that just blew me away. And it had been a public housing project, old school. It was in horrible shape. The people who lived there had horrible unemployment rates. The neighboring school was one of the worst schools in Atlanta, if not the State of Georgia. It had one of the highest crime rates. And it had basically, there was almost like a demarcation zone around it, because it had had a downward pull on the single family homes in other communities around it.

But working with the residents -- which I think was probably a three year process at the front end, to do that engagement in a meaningful, sustainable way -- they, building by building, you know, unit by unit, built more, moved people out of the old and into the new, attracted other people to the community. The community is beautiful. They built a school. It is now one of the highest performing schools in the Atlanta area. People of all incomes want to move to this neighborhood, so that their kids can go to that school. They started as a charter school, K through 3, or something. They just built a high school that's just opening now. They have a YWCA. They're dealing with health and fitness. I have never been in a place, where I saw young children of color, in the hallways of school learning with such pride, in a community that is the envy of Atlanta.

We can do this. You know, we can do this. But you know, the old ways, we didn't do it well. And you know, people have a right to be afraid. I wish I could take your community down to see this community in Atlanta, because it is testament to what happens when we do it right.

Rhonda Hamilton: Thank you.

Ed Howard: Thank you very much. Yes, sir.

Darren: In terms of innovation, and up and coming services, Telehealth. I'm not sure if you're familiar with it, but --

Jennifer Ho: Can we just get you to introduce yourself?

Darren: Oh, I'm Darren. I work for Congressman Alcee Hastings. But we're looking at Telehealth right now, for not just providing health over the Internet, or over tablets or over Smartphones, but keeping people from traveling very far if they're in rural areas or underserved areas. This is sort of a new service, to help provide quality care for people. And I guess my question is, do you see this playing a role in housing, Telehealth? And saving a lot of money on like Mr. 280, these several trips. Telehealth usually prevents

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people from actually going to hospitals a lot. Like 70 percent of it is, they don't need to go to the hospital.

Barbara DiPietro: One thing that I can address is Telehealth is absolutely an emerging model that I think has got a lot of promise, and is being implemented in a lot of places. And I think we're seeing more and more opportunities to implement that in rural areas in particular. In a health center setting and from a service provider, I think it gives us some opportunities to access specialty care, where it may not be available always. And so the travel time and often public transportation is not adequate, or even feasible maybe for a really vulnerable population to navigate. So, I think that this is a really intriguing idea on how we can maybe implement this where we can.

But I think we might also be overlooking that, there are lots of reasons why Mr. 280 and a lot of our patients go to the hospital. And it's not always strictly out of medical necessity. No doubt, the clients we see are acutely ill. But because there is a lack of stability -- sometimes, the nurses there know these folks by name, and it's because of a social connection that they're looking for, to be in a care environment where people actually touch you. And I think that we shouldn't overlook the quality of care that our healthcare institutions provide, from a compassion perspective. And I know Sister Adele can speak to the fact that very few of our clients are touched by anyone else, except in violence or anger. And when you have had a healthcare provider put their hands on you in a loving, caring way, and the first time in 25 years, that can be life changing.

And so yes, I'm excited about Telehealth. But I think for our clients, the social connectedness of being together with people is really important. And, I'll look to Sister to maybe add onto that.

Sister Adele O'Sullivan: I agree. I know that for rural areas, and for people who have no access, when what they really need is a specialist, it's wonderful. But I have that same concern that, you know, just to back to Mr. 280. So, we had him for three weeks in the respite center. And I can tell you that he has a traumatic brain injury, and he had poor impulse control, okay. But every time he felt unsafe, he would say to us, I got to go to the hospital. Well no, you're fine. He went there really, because it was safe. It was clean. It was sheltered. And he needed a human contact, to tell him he was all right. Now, can we do that with Telehealth? Well, I would be careful about implementing it, but I think it certainly has its' place.

Ed Howard: Okay.

Barbara DiPietro: Our clients need a group hug, really. And so, the compassion that you're hearing here is really born out of that realization, that that's really an intense human need for all of us.

Ed Howard: I think we've got the last questioner.

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Janet Viveiros: Thank you. I'll try and make it a good one. Janet Viveiros with the National Housing Conference. And I'm curious to get your thoughts on the panel about housing navigation services. Given that Medicaid doesn't pay for housing, and shouldn't pay for housing, is there a role for these housing navigation services in the health system, when you think about how difficult it is for vulnerable low income individuals, particularly homeless and formerly homeless individuals, to even start to think about how to find a home? Whether it's permanent supportive housing or some other kind of affordable unit, and what role you think that plays in some of these comprehensive care coordination services.

Jennifer Ho: Take a look at, you know, what is it that states use their Money Follows the Person dollars to pay for, you know. And, what was the biggest challenge associated with that? What I am so excited about, about the informational bulletin from CMS is that it understands that building a network of landlords, housing navigation, pre-tenancy supports are a package of things. That you can't just write a script for housing, hand it to somebody, boom, done, especially given the affordable market. So I think that Medicaid can pay for so much more than Medicaid has paid for, for all of these populations broad and small. And I really think we're making good headway on that.

I would be remiss if I sat here today and failed to say, but we also need more affordable housing. And in the Senate mark, there is a 93 percent cut to the HUD Home Investment Program, which is the best engine that we have, for the creation of more affordable housing. And if we believe that the connection between housing and health is a matter of achieving the Triple Aim, and that you are going to need housing -- the healthcare system is going to need housing units that are available to the people that they're targeting, we are going to need to create more affordable housing.

Barbara DiPietro: And, can I also make a plug for the National Housing Trust Fund. That is also needs to be, has been authorized but not funded. Again, a vehicle for creating affordable housing. So we need to prevent people from becoming into homelessness, which would be really great at getting ahead of this curve.

Gretchen Hammer: I think the other thing to contemplate, quickly, is if care management for medical conditions and/or you're navigating your eligibility for Medicaid or other public programs, [shouldn't be] located closer to the housing units themselves. And so, that's another -- I think that's the opposite side of the question that you asked, but one that we certainly are thinking through. That for individuals who do have housing available to them, the resident services coordinators or whoever else is in those facilities are often the first people, when they open the mail from our State Department -- which we are working hard to make our mail more understandable, for us who can read things, because even those of us who are sometimes like hm, what does that mean? So, that is the first place they would potentially have the chance to ask a question. I just got this. What does this mean? I think I may have lost my eligibility. How do I get back enrolled? So

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that, at the point of where they're housed, may be an effective mechanism for us to contemplate as well.

Ed Howard: Sister Adele, do you have a quick word? Or, you don't need to take it. That's fine.

Sister Adele O'Sullivan: Is this a wrap up?

Ed Howard: Yes, it is.

Sister Adele O'Sullivan: Oh. So, I would really thank you for coming today, for your attention to this message. And really, for whatever you can do to try to provide the collaborative effort among us to provide services for the vulnerable. Thank you.

Ed Howard: Thank you all. Let me do just a little bit here at the end. First of all, Jennifer's mention of the Senate mark reminds me of something you said earlier, which we would like to endorse heartily, and that is if you're the health LA, talk to the housing LA, and the appropriations LA, and maybe the veterans LA about these issues. And try to make sure that each of you knows what's going on in the other's dominion. You can see that the evaluation form's still up there. The contribution to Community of Hope is still dangling in your hands. So, please fill it out before you leave.

Jennifer Ho: And they're doing really amazing work.

Ed Howard: There you go. First, a point of organizational privilege, if I can take 30 seconds. We have one more slide to show you, and that is the thank you slide to the interns that have done such a great job this summer for us, Molly [Ennis and Katy Lebeck]. I see one here, and I don't know where Molly is, but thank you very much. [applause] It's been great. The selection of materials, largely in Molly's hands in this briefing, so. My apologies to those of you who wrote very good questions, that I was hoping to get to, on cards and wasn't able to, even a tweet or two.

Thanks to you for staying with us. This is not an easy topic. There are lots of good things to be done on a Friday afternoon, in August, in Washington and you stuck with it, and we very much appreciate it. [applause] Thanks to our colleagues at the Centene Corporation for their support of and helping to point us to some good folks for this program of exceptional panelists. Which brings me to my final point, which is to ask you to help me thank this excellent panel, for a discussion of a very multifaceted and important topic. [applause]

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