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The Corporation for Supportive Housing is a non-profit with a mission of using housing and services solutions to improve the lives of the most vulnerable people in communities across the country, so I'll be focusing on Californians with complex health needs vulnerable to poor health.

Traditional medical homes work for many with chronic conditions, people like my mother who has COPD. But medical homes don't have their intended impact on a gentleman I recently met who also has COPD and was homeless for decades. He was a college athlete who became addicted to drugs after an injury. His health deteriorated on Skid Row, and he dragged an oxygen tank while wandering the streets. His long-term exposure to the sun left his face and head scarred from skin cancer. If he had stayed on the streets, he would have died young; chronically homeless people die 30 years younger than average. But he was connected to housing and intensive face-to-face case management. He was diagnosed with a mental illness and was able to get treatment. He stopped using drugs, stopped using the emergency department, and stopped getting hospitalized. He got healthier.

He had been one of the fewer than 4% of Medicaid beneficiaries who drive nearly 50% of Medicaid costs. The majority are people with disabilities with multiple physical, behavioral health, and social needs.

Our health system has viewed solutions to improving outcomes and reducing costs with a medical orientation, and so has failed to address other determinants of health, despite what evidence tells us. Evidence shows, for example, just one behavioral health condition doubles hospital admission rates. We know providing medical homes to people without a home will not improve their health outcomes and that they will, in fact, *increase* the number of inpatient days over time because they cannot rest, follow a healthy diet, store medications, or regularly attend appointments. We know, in essence, housing *is healthcare*. We know most high-cost beneficiaries are socially isolated, and frequently unable to comply with treatment.

Managed medical homes often translate to one coordinator for hundreds of patients, with little connection to beneficiaries; coordinators who are located in physician offices, with little sense of how beneficiaries live; coordination that is provided telephonically, with little opportunity to reach beneficiaries who don't have phones, and little responsiveness from beneficiaries who aren't compliant.

Multiple studies of Medicare beneficiaries found care coordination models, particularly those offered telephonically, fail to reduce costs or improve outcomes among high-cost or high-need populations. Targeting populations based on medical condition alone means potentially reaching only those who don't experience negative health determinants or complex health.

Programs that significantly reduce costs and reverse beneficiary outcomes target people who are or are likely to become high-cost users, then provide "*health* homes" to these beneficiaries. As one example, a New York pilot used a predictive modeling algorithm to identify future high-cost Medicaid beneficiaries. Care coordinators conducted in-depth interviews of participants, and then planned for hospital discharge, worked to link participants to housing, provided transportation to and advocacy during appointments, connected beneficiaries to mental

health and substance use treatment, and expedited appointments. The pilot resulted in a 37.5% reduction in hospital admissions, and over $5.000 in reduced Medicaid costs in the first year above and beyond program and outpatient costs. The pilot study confirmed many others:

- Medi-Cal beneficiaries participating in frequent user programs reduced Medi-Cal hospital costs by $7,519 per beneficiary per year after two years above the program's costs.
- A Washington study showed homeless chronic inebriates connected to intensive case management incurred $2,449 less in Medicaid costs per person, per month than control group participants.
- Two randomized Chicago studies of frequent hospital users showed participants decreased hospital inpatient days by 46% after 18 months, and nursing home days by over 60% within a year, compared to groups receiving usual care.

The Affordable Care Act (ACA) includes several opportunities to fund these types of "*health* home" services. The most promising is through the "Health Homes" option. It would provide 90% federal funding for two years, and 50% funding thereafter for comprehensive care coordination, discharge planning, and connection to housing and other community-based services. Beneficiaries with two chronic conditions or a single mental illness are eligible. Philanthropic and county partners are interested in helping the state pay for the non-federal match, and the option would provide incentives for managed care organizations to create health homes for high-need populations. Last year, Assemblymember Mitchell introduced legislation authorizing the state to apply for the option, and to ensure chronically homeless and frequent hospital users are included in the target population. She plans to reintroduce the bill in 2013.

The ACA also bolstered existing programs to allow states opportunities to fund "health home" type services. Home- and community-based services waivers can now be done through state

plan amendments, and can fund comprehensive care coordination targeted to specific populations, even to people not at risk of institutionalization. A state can extend full Medicaid benefits to targeted populations.

The ACA includes funding for programs promising innovations to improve outcomes. California is participating in a five-year demonstration for people eligible for both Medicare and Medicaid as part of the Coordinated Care Initiative. The demonstration is a chance to address the whole needs of dual-eligible beneficiaries with complex health needs.

The ACA offers grants to help hospitals establish community-based multi-disciplinary teams linking participants to primary care, and grants from the Center for Medicare and Medicaid Innovation, or CMMI, are funding hundreds of programs testing care coordination models, including several in California, like LifeLong Medical Care, an FQHC in Alameda County, which is partnering with Alameda Alliance for Health and Berkeley's Center for Independent Living.

Other CCMI grants are creating accountable care organizations, which are patient-centered teams of providers, hospitals, and mental health professionals coordinating a beneficiary's care. The Camden, New Jersey, ACO has been highlighted for targeting "hot spotters" of high costs and poor health, and then using care managers to address comprehensively needs of those health "hot spots."

Finally, the ACA includes state demonstrations for pioneering discharge planning models.

Given the expansion of Medi-Cal to indigent adults, as well as DMH and ADP reorganization, now is a critical moment for California to review all options to use Medi-Cal to fund services that comprehensively coordinate the medical, behavioral health, and social needs of

beneficiaries with significant vulnerability to institutionalization, to worsening health, to high costs, and to early mortality.

We further recommend the state risk-adjust rates to managed care organizations by beneficiary need. Risk-adjusted rates offer appropriate incentives to target and provide care to our most vulnerable Medi-Cal beneficiaries. Other states, like Washington and Minnesota, do so now with good results.

For these approaches to have any meaning, the state must break down barriers and, more importantly, mindsets, to realize health care is more than medical care, and addressing behavioral and social services needs is critical to the health of many Californians.

Thank you.