January 26, 2016

The Honorable Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
475 Russell Senate Office Building
Washington, DC 20510

Submitted via email to chronic_care@finance.senate.gov

RE: Chronic Care Working Group Policy Options

Dear Senator Isakson and Senator Warner:

The undersigned organizations work extensively with chronically ill Americans on addressing the social determinants of their health. Affordable housing -- including deeply subsidized supportive housing paired with comprehensive wrap-around supportive services and case management, as well as independent housing with services for frail older adults -- is an essential platform for vulnerable, ill, and impoverished people to manage their chronic conditions. One of the defining characteristics of someone who would benefit from supportive housing is the presence of one or more disabling, chronic conditions that contributes to long term poverty and housing need, and the profile of low-income older adults shows that they are more likely to suffer from two or more chronic conditions than the average older adult. We have therefore worked in partnership with state Medicaid offices, managed care organizations, and others to incorporate social determinants of health into their coverage plans. For a summary of how states are integrating housing services into Medicaid for addressing chronic care needs, see http://www.csh.org/wp-content/uploads/2014/04/State_Health_Reform_Summary.pdf.

We want to thank you for putting thought into expanding Medicare's role in chronic care. Many of the supportive service providers we spoke to in preparing these comments told us that they were not well versed in Medicare, simply because it does not pay for the needed supports for the populations they serve. However, supportive housing and service providers have a growing body of knowledge around Medicaid, thanks to Centers for Medicare and Medicaid Services' (CMS) July 2015 bulletin on paying for services related to housing stability, and participation in many innovative state programs.

Mirroring the American population, supportive housing tenants are getting older. Geriatric diseases and chronic care needs show up earlier than age 65 for people with histories of street homelessness. These individuals have the medical and clinical needs of older adults but do not qualify for Medicare based on age (although some may qualify on the basis of receiving SSDI assistance or having a qualifying disability). Approximately 17% of people on Medicare rolls initially qualify by having a disability. In addition, there are frail, older adults and seniors residing in nursing homes, adult homes and long-term rehabilitation who may not need institutional levels of care and could benefit greatly from independent housing with services. However, many of these older adults remain in institutions due to a lack of

community-based housing options where they can access supportive services they need to safely return. Supportive housing and service enriched housing is the ideal solution to address the needs of aging special needs tenants with adaptable housing models and flexible service packages to avoid costly institutionalization. The estimated annual average cost of nursing homes in New York State ranges from $101,184 to $144,408. In contrast, supportive housing costs about $15,000- $25,000 per year.

Nursing home and institutional care are examples of housing and services that have been inappropriately linked to the detriment of the quality of life of people with chronic illnesses or disabilities. Frequently, aging residents of subsidized housing do not come forward to get the adaptations or care they need out of a fear that they will be forced to go to a nursing home and lose their housing. On the other side of the coin, longtime residents of institutions have expressed fears that they will lose access to their services if they go into the community. Case managers play an important role by developing a trusting relationship with their clients, advocating for them, and helping them navigate complicated systems. It is important to put into place the systems to offer flexible, tailored, optional services in the most integrated community settings.

Across the country, many hospital emergency departments are treating individuals who visit hospitals multiple times a year, often because of complex physical, mental, and social needs. These frequent users often experience chronic illness, mental health, and substance abuse disorders and homelessness, all of which can contribute to frequent emergency department visits. Emergency departments are a community resource and are the only provider of health services that by law must serve everyone—but they also provide the most expensive health services in our communities. Frequent users' hospital visits can account for disproportionate costs and time for emergency departments, contribute to emergency department overcrowding, and drain state, county, and federal health care resources. CSH is using supportive housing to address the needs of the frequent health systems users by developing and demonstrating new models that replace a costly and ineffective cycle with ongoing, coordinated and multi-disciplinary care provided in more appropriate settings. Medicare, as an insurance system focused on acute health needs, should be engaged in efforts to reduce expensive emergency room treatment through coordinated care.

Coordination between Medicare and Medicaid is an important issue for addressing America's chronic care needs since Medicaid pays for many chronic care needs that Medicare does not, such as long term supportive services. While HUD does not have comprehensive data on the health insurance status of its residents, a recent LeadingAge study matched HUD/HHS data sets in geographic regions across the country, and found that 68% of HUD tenants who were Medicare recipients were also enrolled in Medicaid, compared to 18% of the general population. Other providers report rates of around 1/3 being dual-eligible. In non-Medicaid expansion states, the numbers of Medicare-only residents of supportive and affordable housing are higher. We urge the Working Group to take into account the lessons, both good and bad, learned in the ongoing state demonstration programs for dual eligible care coordination in order to take such care coordination to scale in the future. Oregon's dual eligible demonstration is a notable success because they allowed coverage of many housing-related services.

In addressing the chronic care needs of its beneficiaries, the Medicaid program has created a number of waiver authorities that allow for coverage of social determinants of health, especially housing stability. Medicaid will now cover services relating to finding housing, funding transition costs, creating a housing support crisis plan for the tenant, assistance with landlords, state-level housing related collaborative

activities, and more. Some waivers even offer coverage for accessibility accommodations. Housing stability services have been recognized as a critical part of successful chronic disease and disability management, and are now rightfully being paid for by Medicaid. We know that Medicare beneficiaries also struggle with maintaining their housing, adapting it to their changing needs, and transitioning out of institutions. We will review several helpful Medicaid programs at the state level that are worthy of wider adoption through Medicare. We urge you to consider adding language that aligns with CMS's June 2015 bulletin on "Coverage of Housing-Related Activities and Services for People with Disabilities" to whatever legislation goes forward on this topic.

HUD is also an active partner in senior health care. The Department recently released a NOFA for a supportive services demonstration grants that will allow senior housing providers to hire resident service coordinators and wellness nurses. The demonstration sites will be subject to rigorous data collection protocols in order to identify interventions and business models that reduce costly emergency room visits for vulnerable seniors in HUD-assisted housing. The Working Group should examine the data generated by this program and apply the lessons learned into any legislation that makes changes to Medicare to better address chronic care. .

Maintaining ACO flexibility to provide supplemental services (page 18)

Accountable Care Organizations are strong partners of housing organizations and the flexibility they have to address social determinants of health that are not typically covered under fee-for-service care. We support any clarification that encourages ACOs to invest in social services. The Working Group should align the Medicare definition of social services with that used in Medicaid. Such authority should be available by right to any ACO rather than requiring participation in a special program. This is particularly important when you consider that ACOs work best when they have the flexibility to meet community health care needs in whatever form they take.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees (page 15)

We strongly support expanding Medicare Advantage supplemental benefits to include non-medical social services such as the housing stability related services discussed above. An exhaustive list of housing services that can now be paid for by Medicaid is available at https://www.usich.gov/resources/uploads/asset_library/A_Quick_Guide_To_Improving_Medicaid_Coverage_For_Supportive_Housing_Services.pdf.

Improving Care Management Services for Individuals with Multiple Chronic Conditions (page 11)

We support the Working Group's proposal to add a new reimbursement code for the extra time physicians spend coordinating care for people with multiple or complex chronic conditions. It may be useful to define the code in alignment with the Vulnerability Index used to prioritize vulnerable chronically homeless individuals. Co-occurring psychiatric, substance abuse, and chronic disease is a key indicator of vulnerability and requires extensive health care coordination. The criteria should include at least one physical and one mental condition since that is the combination most likely to require cross-functional health care teams. We favor a broad definition, at least until more research as to the true cost of complex care management is done. Case managers should be able to bill the new reimbursement code because they definitely fit the description of offering "comprehensive, ongoing care over a

sustained period of time." The Secretary of the Department of Health and Human Services should be given the authority to modify the code based on feedback and information about its effectiveness.

Expanding the Independence at Home Model of Care (page 6)

We support the expansion of the Independence at Home (IAH) demonstration into a permanent program, supported by the findings from 2015 that showed at $25m in savings attributable to this program.[1] Further, we support the identification of eligible individuals through alternative means rather than through non-elective hospitalization. For example, the Vulnerability Index could again be used, or data-matching from past participation in health care, shelter, jail and other public systems. The IAH demonstration allows for coordination across multiple providers, including primary care physicians, home health services, and technology platforms. Coordinating across providers and service entities is critical to the success of addressing the needs of individuals with multiple chronic conditions. This demonstration has the potential to coordinate care and reduce health costs of Medicare beneficiaries with two or more chronic conditions by coordinating across multiple providers, a function that is similar to the work that our partners do on a daily basis as providers of affordable, supportive housing.

Examples of valuable state Medicaid programs

New York

New York's Health Home State Plan Amendment targets individuals with chronic conditions, including mental health or substance abuse disorders. It allows providers to bill Medicaid for comprehensive case management that helps various providers coordinate care for people with complex chronic conditions. Supportive housing providers are required partners in the initiative. Health Homes have struggled because most do not pay for the necessary intensive case management. New York also has an 1115 waiver that helps medical or behavioral health patients transition from institutions to the community. Through the 1115 waiver, New York will reinvest $8 billion of the $17.1 billion in federal savings generated by the State's Medicaid reform efforts, mostly into a Delivery System Reform Incentive Payments (DSRIP) program that includes planning grants, provider incentive payments, administrative costs and DSRIP-related workforce programs. Included in one of the DSRIP projects is an initiative that directs hospitals to partner with housing providers to develop transitional housing for high risk patients who are unable to safely transition from a hospital when the acute medical needs are fully met. This transitional housing would provide short term care management to allow transition to a longer term care management and would allow additional time to support rehabilitation, stabilization, and patient confidence in self-management.

New York is also investing their 'state-only' Medicaid savings dollars into supportive housing. Since 2011, New York has spent nearly $400 million, and they recently approved $222 million more to provide rental subsidies, service funding and capital dollars to create supportive housing for high-cost Medicaid members.

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-18.html

Louisiana

Louisiana's 1915 waivers for Home and Community Based Services pay for support for acquiring and securing housing, budgeting, establishing credit, meeting tenancy obligations, communicating with landlords about necessary accommodations for disability and provides assistance when housing is jeopardized. Individuals with a significant long term disability who also have disabilities related to behavioral health and meet low income requirements are eligible. Supportive housing organizations are partners.

Texas

While most states have a Money Follows the Person demonstration program to help people transition from nursing facilities to the community, the Texas version is notable because a relocation specialist works with the Texas Department of State Health Services to secure housing.

Conclusion

Thank you once again for your excellent ideas for improving America's system of chronic care. Again, we highly encourage you to expand the committee's consideration to include the excellent work happening in the Medicaid system since many chronically ill Americans are either dual eligible or ineligible for Medicare. Coordination between physical and behavioral health care providers, case managers, social service providers, and housing is essential for saving money and improving the quality of care. We urge you to think beyond the existing Medicare programs for chronic care towards filling in the known gaps in care and helping Medicare and Medicaid coordinate care.

If you have further questions about our comments, please contact Cheryl Gladstone at cgladstone@enterprisecommunity.org or Eva Wingren at eva.wingren@csh.org.

Sincerely,

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