Dividends of a Hand Up

Public Benefits of Moving Indigent Adults with Disabilities onto SSI

Prepared in 2011 under the auspices of the
Health Consumer Alliance of California

ECONOMIC ROUNDTABLE
A Nonprofit, Public Policy Research Organization

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Economic Roundtable
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Executive Summary

Counties bear large hidden costs for individuals with disabilities who are indigent or homeless. This includes costs for health care, jails and probation in addition to readily identifiable county costs for public assistance. A large share of this cost is health related – costs that the federal and state governments would pay through Medi-Cal if the individuals were receiving Supplemental Social Security Income (SSI).

This study examines opportunities for counties to avoid costs by moving individuals with disabilities who are General Relief recipients, medically indigent hospital patients, and homeless hospital patients onto SSI and Medi-Cal.

Annual health costs that can be avoided by moving low-income Californians with disabilities onto SSI include:

$504 million in county health care costs for GR recipients

$156 million private hospital costs for GR recipients

A total of $1.4 billion for county indigent patients

California's population of single adults 18-64 years of age who are U.S. citizens and not attending school includes:

- Almost 300,000 indigent individuals with incomes of $4,000 or less in 2009
- Nearly 140,000 individuals receiving General Relief (GR – also called General Assistance or GA) in a typical month, with the annual unduplicated caseload roughly 1.7 times greater
- An estimated 110,000 indigent single people with disabilities who are eligible for SSI but do not receive it
- Over 70,000 indigent individuals who are admitted to California hospitals each year, at an average cost of $40,000 per admission for county indigent programs
- Over 18,000 people identified as homeless who are admitted to California hospitals each year, at an average cost of about $37,000 per admission

Statewide in 2009, an estimated 110,000 low-income single adults with disabilities were eligible for SSI but not enrolled in the program. This represents one potentially eligible person left out of SSI for every person who was covered by the program.

In the typical monthly GR/GA statewide caseload, an estimated 51,000 individuals, have disabilities but are not receiving SSI. Eligibility rates for SSI increase markedly with age, rising from less than 20 percent among recipients 18-25 years of age to half among recipients 46-55 years of age.

Most health care and public assistance costs for GR recipients with disabilities that are currently paid by counties ($831 per month) can be covered by Medi-Cal and SSI. In addition, there is a monthly average of $259 in health care costs at private hospitals that will be covered by Medi-Cal when these individuals move over to SSI.

California counties could save $42 million per month and private hospitals could save another $13 million if eligible General Relief recipients with disabilities in the typical monthly caseload were moved onto SSI. Because recipients cycle on and off of aid, the annual caseload is an estimated 1.7 times greater than the monthly caseload. Therefore, the annual costs avoided by moving the annual caseload of eligible individuals onto SSI are also 1.7 times greater, totaling $71 million for counties and $22 million for private hospitals.

County health costs for indigent residents will be ameliorated when the Medicaid Expansion provisions of the new Federal Health Law take effect in 2014 (and to a lesser extent by the 1115 Medicaid waiver), but the extent and amount of federal offsets is not known at this time. Counties are likely to face some level of continuing costs for these residents, and there are likely to be continuing financial benefits for counties' healthcare and GR budgets when low-income persons with disabilities are enrolled in SSI.

Mental disorders were the cause of hospitalization for three-quarters of homeless patients and half of county indigent patients. Most hospitalizations of these patients are for chronic conditions that are likely to result in return visits to the hospital.

Over half of homeless hospital patients and over a third of county indigent patients have disabilities and are likely to be eligible for SSI. After they move onto SSI, they have ongoing access to outpatient health care through Medi-Cal, which can help stabilize their chronic health problems, reduce the frequency of hospitalization, and provide a federal source of payment for inpatient care when it is necessary. Movement of these patients onto SSI will result in roughly $1.4 billion dollars a year in avoided hospital payments that are currently paid by county indigent programs.

When individuals with disabilities enroll in SSI, the federal government assumes a much larger role in underwriting public costs. Counties no longer have to pay health and welfare costs totaling $831 a month, and hospitals are assured of compensation for health care services. Furthermore, with greater financial stability under SSI and opportunities for permanent housing, county justice system costs may well decline significantly. Justice system costs have been shown to decline 82 percent when homeless individuals with disabilities enter permanent supportive housing.

When individuals move from General Relief to SSI, their income increases because SSI provides significantly higher monthly payments than General Relief. In addition to improving the quality of life for individuals, this increased income has multiplier impacts on the regional economy. Each new dollar that enters a region is spent multiple times, first by the original

recipient, then by providers of goods and services as they in turn buy goods and services from their suppliers to meet increased demand. The net result is that the increased expenditures of SSI recipients create economic impacts that are greater than the amount of SSI funds that are spent.

For the 50,000 GR recipients with disabilities in the statewide monthly caseload, monthly SSI payments are typically $469 more than General Relief payments for single adults.

Another 60,000 low-income Californians with disabilities are estimated to be eligible for SSI but receive no cash aid of any kind in a typical month. The $686 that SSI recipients in the state typically receive each monthly is all new money coming into the local economy when it goes to unaided individuals.

When 110,000 low-income California residents with disabilities move onto SSI, 50,000 from the GR caseload and another 60,000 from the unaided population, the statewide impacts will be:

- $647 million in additional annual economic output
- 4,310 new jobs will be created
- $47 million in additional annual local and state tax revenue will be generated annually
- $50 million in additional federal tax revenue will generated annually

Moving all 110,000 eligible Californians onto SSI will:

- **Increase output in the state economy by $647 million**
- **Create 4,310 new jobs**
- **Increase state and local tax revenue by $47 million**
- **Increase federal tax revenue by $50 million**

Improved access to SSI will enable more individuals with disabilities who are chronically homeless to enter supportive housing, where they will have permanent, affordable rental units with on-site case management and linked supportive services. When these individuals are provided with supportive housing, local public costs for them decrease by about 80 percent. If the operating and capital costs, which are largely paid for by non-local funds, are added to the equation, public costs will decrease by about 44 percent.

Chapter 1

Indigent Adults with Disabilities

Counties bear large hidden costs for individuals with disabilities who are indigent[1] or homeless. This includes costs for health care, jails and probation in addition to readily identifiable county costs for public assistance. A large share of this cost is health related — costs that the state and federal government would pay if the individuals were moved onto Supplemental Security Income (SSI).

This study examines potential county savings from moving individuals with disabilities[2] who are General Relief recipients, medically indigent hospital patients, and homeless hospital patients onto SSI and Medi-Cal.

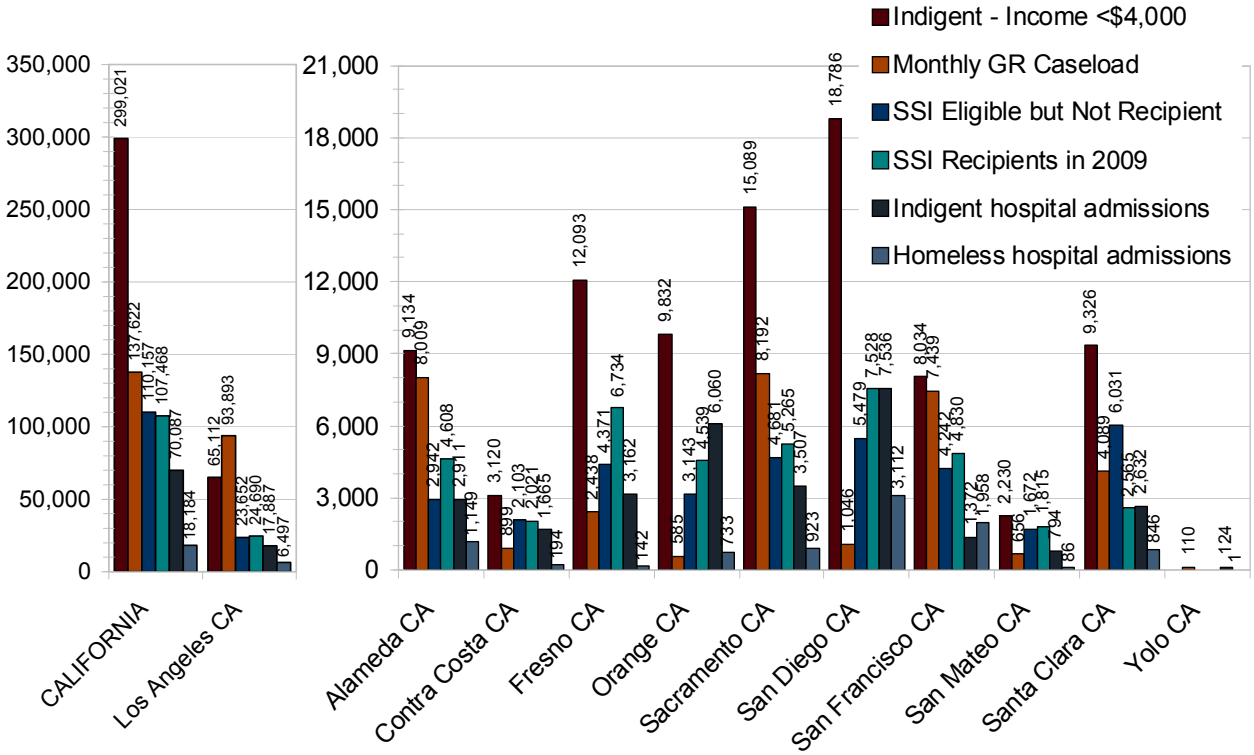
Potential cost savings for counties are broken out for the entire state of California and for 11 counties where efforts are underway to strengthen local capabilities for moving eligible individuals with disabilities onto SSI. These counties are: Alameda, Contra Costa, Fresno, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara, and Yolo.

How Many People are Eligible for SSI?

The number of state and county residents potentially eligible for SSI can be inferred from the size of the indigent population with disabilities, the share receiving General Relief, the share

Figure 1

Number of Residents by County who are Indigent, GR Recipients, Low-income w/Disabilities, & SSI Recipients



Sources: 2009 American Community Survey (ACS) for age, citizenship, school status, income, disabilities, household size, and SSI benefits; California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief population. ACS data for Yolo County is not shown because the small sample size makes it unreliable.

receiving SSI, and the number of indigent patients and patients who were homeless admitted to California hospitals.[3] Using multiple data sources including 2009 census data, and other current data described in the Data Appendix, we find, as shown in Figure 1[4] (with one population scale for California and Los Angeles, and another for the balance of counties; supporting data for the figure is in the endnote), that California's annual population of single adults 18-64 years of age who are U.S. citizens and not attending school includes:

- 300,000 indigent individuals with incomes of $4,000 or less in 2009 who are potential recipients of General Relief (GR)
- 138,000 individuals receiving GR in a typical month
- 110,000 low-income individuals with disabilities who are estimated to be eligible for SSI but not receiving it
- 107,000 individuals with disabilities who received SSI in 2009
- 70,000 hospital patients charged to county indigent programs[5]
- 18,000 hospital patients that are homeless

The largest group, the 300,000 potential GR recipients has been defined to represent the *typical* characteristics of GR recipients, but *under-represents* the actual size of this population. The five filtering criteria used to identify this population were: 1) income under $4,000 in 2009, 2) 18 to 64 years of age, 3) U.S. citizen, 4) not enrolled in school, and 5) 1-person household. The GR caseload includes exceptions to the last three criteria (see endnote for table).[6] GR recipients can be legal immigrants rather than U.S. citizens; dropping the citizenship criteria increases the size of the population by 14 percent. Recipients can be enrolled in school, for example at a community college; dropping the out-of-school criteria increases the size of the population by 51 percent. Recipients can be a spouse or domestic partner; dropping the 1-person household criteria increases the size of the population by 691 percent. These exceptions to the typical profile of GR recipients are the likely explanation of why in Figure 1, Los Angeles County's GR caseload is larger than the narrowly defined population of potential GR recipients.

The under-representation of potential GR recipients is illustrated by information from homeless surveys in Los Angeles indicating that at a given point in time, only slightly over half of single adults who are homeless are GR recipients.[7] Yet, Figure 1 shows the population of actual GR recipients to be larger than the population of potential recipients in Los Angeles.

Three groups that often overlap are particularly important because of the potential to reduce counties' general fund costs if eligible individuals are enrolled in SSI. The first group is General Relief (sometimes called General Assistance or GA) recipients whose cash assistance is paid out of scarce general fund dollars in each county. The second group is individuals with disabilities and incomes under the eligibility ceiling for SSI, which is roughly $9,000 a year, whose medical costs are likely to be paid by county indigent medical funds if they are not enrolled in SSI or Medi-Cal. The third group is indigent and homeless hospital patients who are not covered by private or federally funded health insurance and whose costs are likely to be paid by counties or private hospitals.

Estimated Size and Overlap of Vulnerable Populations

The comparative size and degree of overlap among the six groups of vulnerable California residents shown in Figure 1 is presented in the form of a diagram in Figure 2, where the statewide population of each group is represented.

The largest population is the 300,000 indigent California residents 18 to 64 years of age who are U.S. citizens, not enrolled in school and had incomes of $4,000 or less in 2009. This conservative approximation of the population eligible for GR includes:

- all or most of the 138,000 individuals receiving GR in a typical month
- roughly half of the 110,000 individuals with disabilities and incomes under $9,000 who are not receiving SSI but are likely to be eligible for this benefit
- nearly all of the 70,000 hospital patients charged to county indigent programs
- all or most of the 18,000 patients who hospitals conservatively identify as being homeless[8]

The group that is completely separate from the indigent population with annual incomes under $4,000 is the population of 107,000 state residents with disabilities receiving SSI. In 2009, SSI recipients in California had average annual incomes of $8,227.

County Ratios of Persons in Need to Persons Receiving Aid

The size of the populations aided by SSI and Medi-Cal in each county provide indices of the proportion of vulnerable residents who are left unaided or are inadequately aided. Two key benchmarks of the number of people who are aided are shown in Table 1:

1. Percent of residents with disabilities and annual incomes under $9,000 who are receiving SSI. This shows the relative barriers faced by low-income residents with disabilities trying to obtain SSI. This ratio is an index of the amount of work remaining to move potentially eligible persons onto SSI.
2. Number of homeless hospital patients paid for by Medi-Cal. This shows the effectiveness of programs for enrolling individuals likely to have high public costs in Medi-Cal and SSI. This is an index of the extent of SSI enrollment for high-need, high-cost individuals who are likely to have disabilities.

These ratios are summarized as follows for each county included in this study:

Alameda – average SSI coverage for residents with disabilities; above-average Medi-Cal coverage for high-need homeless residents.

Contra Costa – above-average SSI

Table 1
Percent of Persons in Need Receiving Aid

	Percent of single adults with disabilities 18-64 with incomes ≤$9,000 receiving SSI	Percent of homeless hospital patients paid for by Medi-Cal
CALIFORNIA	49%	31%
Alameda	51%	39%
Contra Costa	61%	43%
Fresno	49%	25%
Los Angeles	61%	34%
Orange	59%	47%
Sacramento	53%	18%
San Diego	58%	23%
San Francisco	53%	40%
San Mateo	52%	26%
Santa Clara	30%	25%

Key to color codes:

Below Average	Average	Above Average

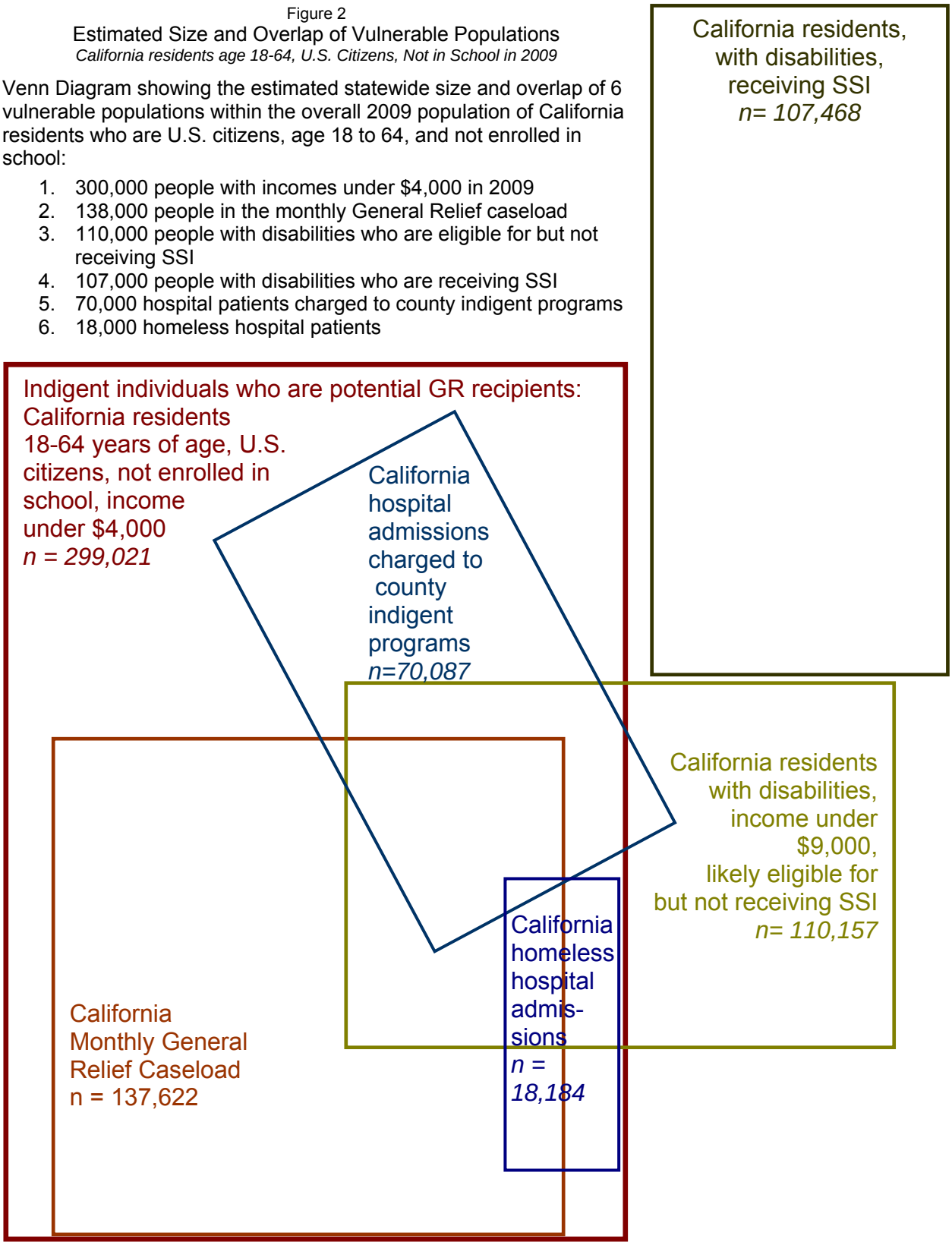
Data is for 2009 from ACS and OSHPD, for California residents age 18-64, who are U.S. Citizens, and not in school

Yolo County data is not shown because it is not available or too small to be reliable.

Figure 2
Estimated Size and Overlap of Vulnerable Populations
California residents age 18-64, U.S. Citizens, Not in School in 2009

Venn Diagram showing the estimated statewide size and overlap of 6 vulnerable populations within the overall 2009 population of California residents who are U.S. citizens, age 18 to 64, and not enrolled in school:

1. 300,000 people with incomes under $4,000 in 2009
2. 138,000 people in the monthly General Relief caseload
3. 110,000 people with disabilities who are eligible for but not receiving SSI
4. 107,000 people with disabilities who are receiving SSI
5. 70,000 hospital patients charged to county indigent programs
6. 18,000 homeless hospital patients



coverage for residents with disabilities and Medi-Cal coverage for high-need homeless residents.

Fresno – average SSI coverage for residents with disabilities; below-average Medi-Cal coverage for high-need homeless residents.

Los Angeles – above-average SSI coverage for residents with disabilities; average Medi-Cal coverage for high-need homeless residents.

Orange –above average SSI coverage for residents with disabilities and Medi-Cal coverage for high-need homeless residents.

Sacramento – average SSI coverage for residents with disabilities; below-average Medi-Cal coverage for high-need homeless residents.

San Diego –above-average SSI coverage for residents with disabilities; below-average Medi-Cal coverage high-need homeless residents.

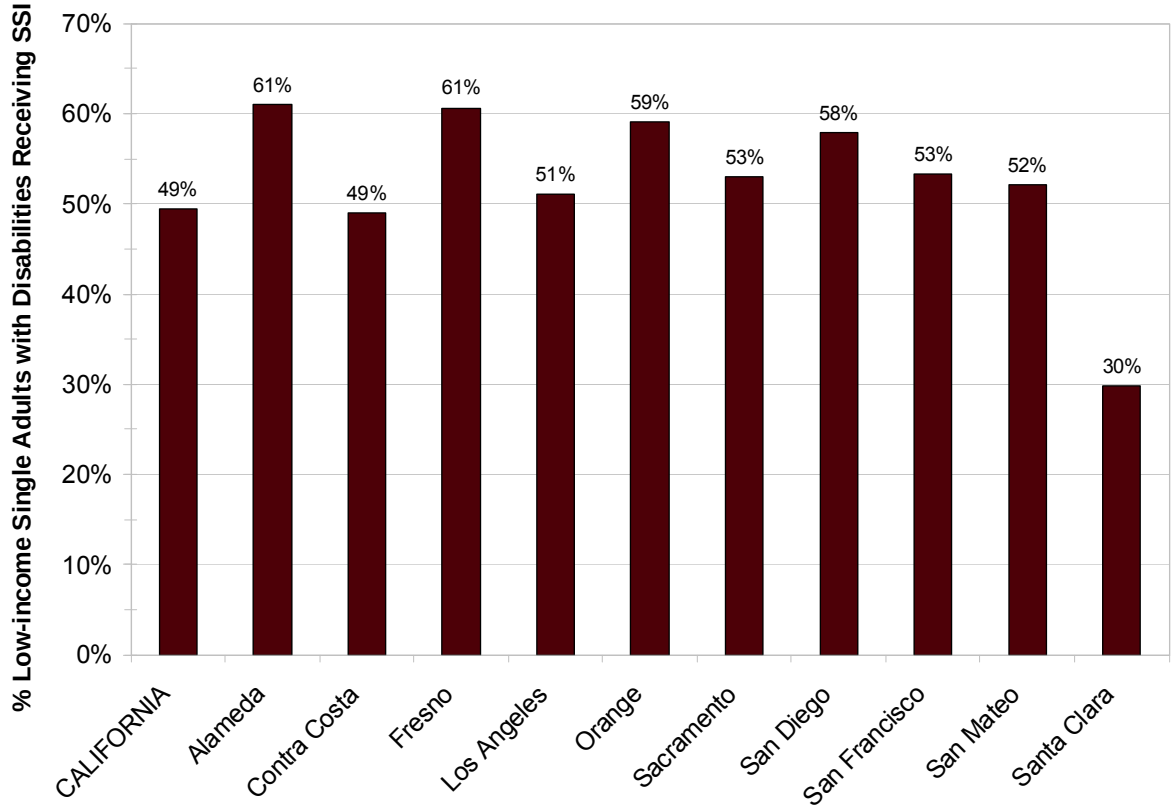
San Francisco – average SSI coverage for residents with disabilities; above-average Medi-Cal coverage for high-need homeless residents.

San Mateo – average SSI coverage for residents with disabilities; below average Medi-Cal coverage high-need homeless residents.

Santa Clara – below-average SSI coverage for residents with disabilities and Medi-Cal coverage high-need homeless residents.

Figure 3

Percent of Single Adults with Disabilities and Incomes of $9,000 or less who Received SSI in 2009



Source: 2009 American Community Survey for disability status, age, citizenship, school status, income, disabilities, household size, and SSI benefits. The population left out of SSI is comprised of single adults with disabilities, 18 to 64 years of age who are U.S. citizens, not enrolled in school, and have annual incomes of $9,000 or less. Data for Yolo County is not shown because the small sample size makes it unreliable.

Coverage of Low-income Single Adults with Disabilities by SSI

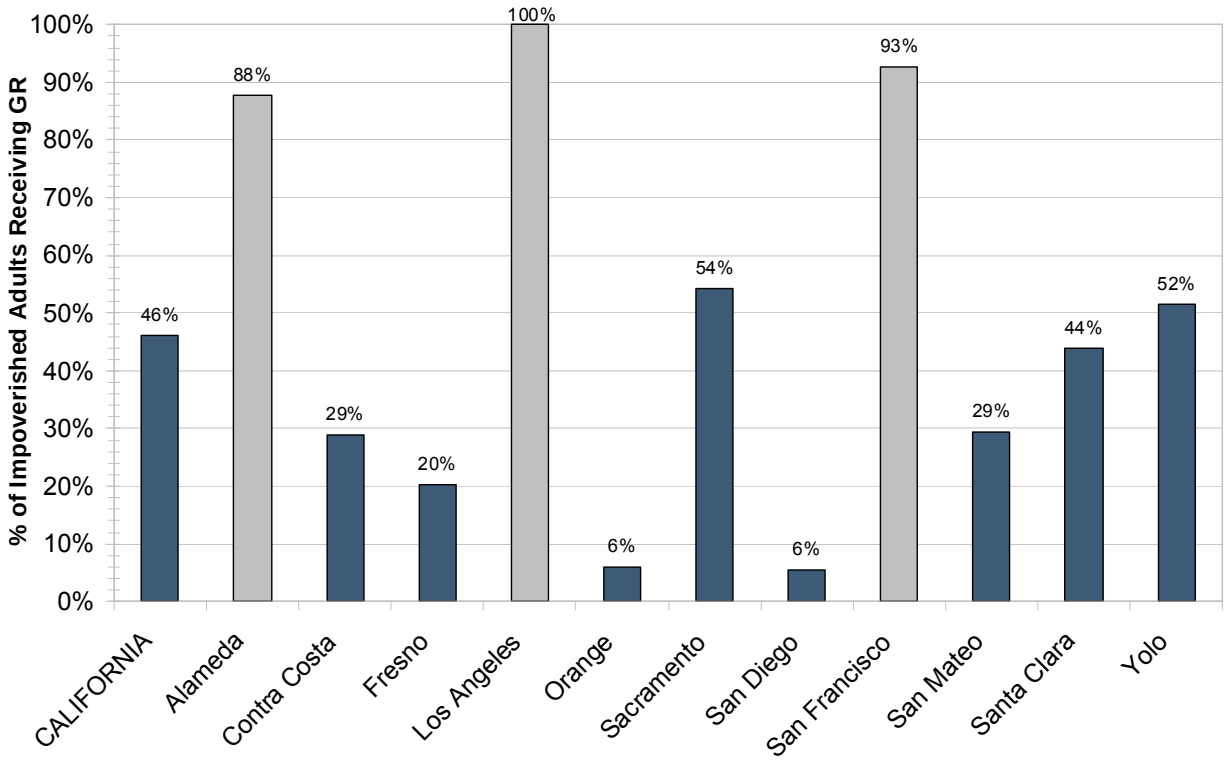
Statewide only half of those likely eligible for SSI receive it. In 2009, there appeared to be one potentially eligible Californian left out of SSI for every person who was covered by the program. This can be seen in Figure 3 – 49 percent of California residents with disabilities who are estimated to be eligible for SSI are SSI recipients. In Alameda, Fresno, Orange and San Diego counties, eligible individuals appeared to be somewhat more successful in obtaining SSI, with roughly 60 percent of eligible residents covered. This may be due in part to county sponsored SSI advocacy programs. On the other hand, in Santa Clara County, eligible individuals appear to face greater barriers, with a particularly low coverage rate of only 30 percent enrolled in SSI.

Because this population has disabilities, many have ongoing costs for chronic medical conditions. In the absence of SSI enrollment and the accompanying Medi-Cal coverage, these costs are likely to be charged to county indigent programs or to non-county hospitals.

Coverage of Indigent Single Adults by County General Relief Programs

There is wide variation in the coverage of indigent single adults by county GR programs.

Figure 4
GR Recipients as a Percent of Single, Out-of School Adults who are U.S. Citizens with Incomes ≤$4,000

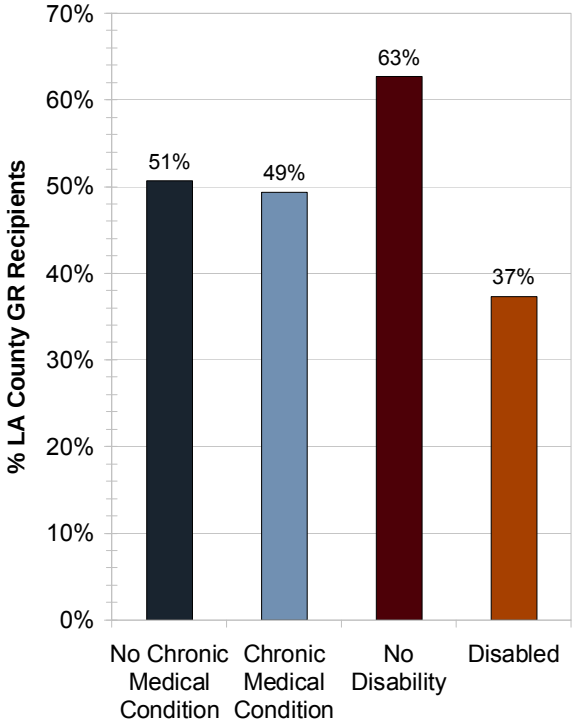


Sources: 2009 American Community Survey for age, citizenship, school status, income, disabilities, household size, and SSI benefits; California Department of Social Services GR 237 report, September 2009 to August 2010 for GR population. The pool of potential GR recipients is arbitrarily defined as single adults, 18 to 64 years of age who are U.S. citizens, not enrolled in school, and have annual incomes of $4,000 or less. This population is smaller than the actual eligible population, as a result, Los Angeles is inaccurately represented as enrolling all, and San Francisco and Alameda nearly all, eligible individuals.

Statewide, in a typical month, GR recipients are equivalent to 46 percent of those potentially eligible – defined here as single adults 18-64 with incomes of $4,000 or less who are U.S. citizens and not enrolled in school, as shown in Figure 4. This conservative estimate of the total statewide population of eligible individuals, substantially understates the size of the actual eligible population, as discussed earlier, but it provides a consistent benchmark for assessing the extent to which counties provide cash aid for destitute adults.

San Diego and Orange counties stand out for having especially low rates of coverage, with 94 percent of indigent individuals left out of the program. The highest rates of coverage are found in Los Angeles, Alameda and San Francisco counties.[9]

Figure 5
Percent of GR Recipients Eligible for SSI



Source: Los Angeles County Adult Linkage Project for a representative sample of 13,176 General Relief recipients

Counties with higher rates of GR coverage have the greatest opportunity for reducing direct expenditures for cash grants when eligible individuals are enrolled in SSI because these grants can be discontinued after SSI payments begin. However, even counties with low GR caseloads have opportunities for reducing county expenditures in the health care, mental health, substance abuse, and justice systems when eligible individuals qualify for SSI. As discussed later, counties with the lowest rates of GR coverage experience the greatest infusion of new revenue into the local economy when eligible individuals begin receiving SSI benefits.

General Relief Recipients who are Eligible for SSI

Drawing on information from the unique database of linked departmental records for General Relief recipients in Los Angeles County that is described in the Data Appendix, we find that 49 percent of GR recipients have a chronic medical condition and 37 percent have a disability. These breakouts are shown in Figure 5. GR recipients with disabilities are likely to be eligible for SSI. This disability rate is applied statewide in this report to estimate the number of GR recipients who are eligible for SSI and the cost savings to counties that result from moving these individuals onto SSI and Medi-Cal.

Age, Disability and Work History

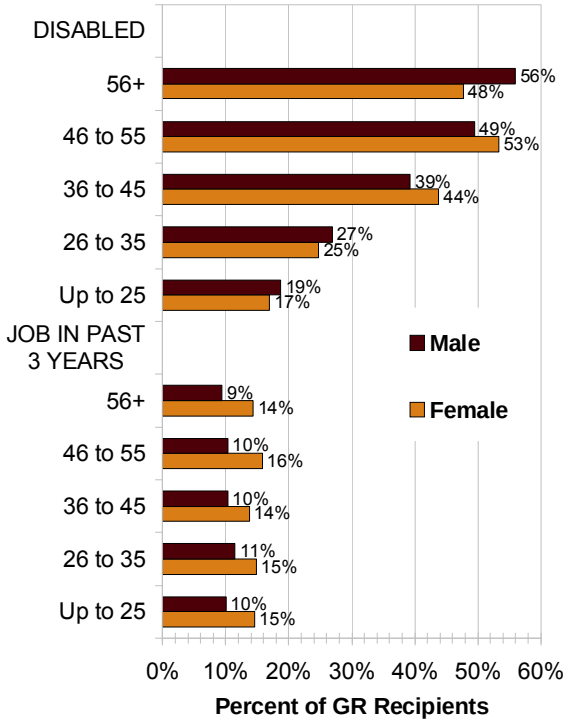
Using the 37 percent overall disability rate among GR recipients as a benchmark, there is a marked increase in the frequency of disabilities as this population ages. A quarter of GR

recipients 26 to 35 years old have disabilities, whereas half of GR recipients older than 45 have disabilities, as shown in Figure 6.

Most GR recipients of all ages are disconnected from work. Only 12 percent of GR recipients have been employed in the past 3 years, meaning that 88 percent are long-term unemployed. Employment rates for women are half again higher than those for men. A possible explanation for this disparity may be that men are more likely to find jobs in the informal economy that do not show up in the state's base wage file.

A majority of GR recipients are not eligible for SSI, which means that their only path to economic sustainability is through employment. An important conclusion from the extremely low employment rate among this population is that there is an urgent need for more effective employment programs for individuals who do not have disabilities.

Figure 6
Age, Sex, Jobs and Disabilities



Source: Los Angeles County Adult Linkage Project for a representative sample of 13,176 General Relief recipients

Summary of Findings about Eligibility for SSI

Key findings about the number of people eligible for SSI include:

1. Statewide in 2009, only half of those who appear to be eligible for SSI were enrolled in the program.
2. 37 percent of GR recipients are estimated to be eligible for SSI.
3. In Alameda, Fresno, Orange and San Diego counties, SSA appears to have the highest success rate in enrolling indigent single adults with disabilities in SSI, while in Santa Clara County SSA appears to have a particularly low success rate.
4. In 2009, there were an estimated 110,000 low-income single adults with disabilities in California who were eligible for SSI but not enrolled in this program.
5. Disability rates increase markedly with age.
6. 88 percent of GR recipients are disconnected from work. Individuals who are employable urgently need effective assistance in obtaining employment.

Chapter 2

County Cost Savings from Moving GR Recipients to SSI

Eligible population

California's typical monthly caseload of GR recipients includes over 51,000 people who are estimated to be eligible for SSI, as shown in Figure 7. This estimate is based on applying the 37.3 percent disability rate among GR recipients to the 137,662 California residents who receive GR benefits in a typical month. Because this is a dynamic population with people cycling into and out of GR each month, the cumulative number of GR recipients who are eligible for SSI is substantially larger than this point-in-time estimate.

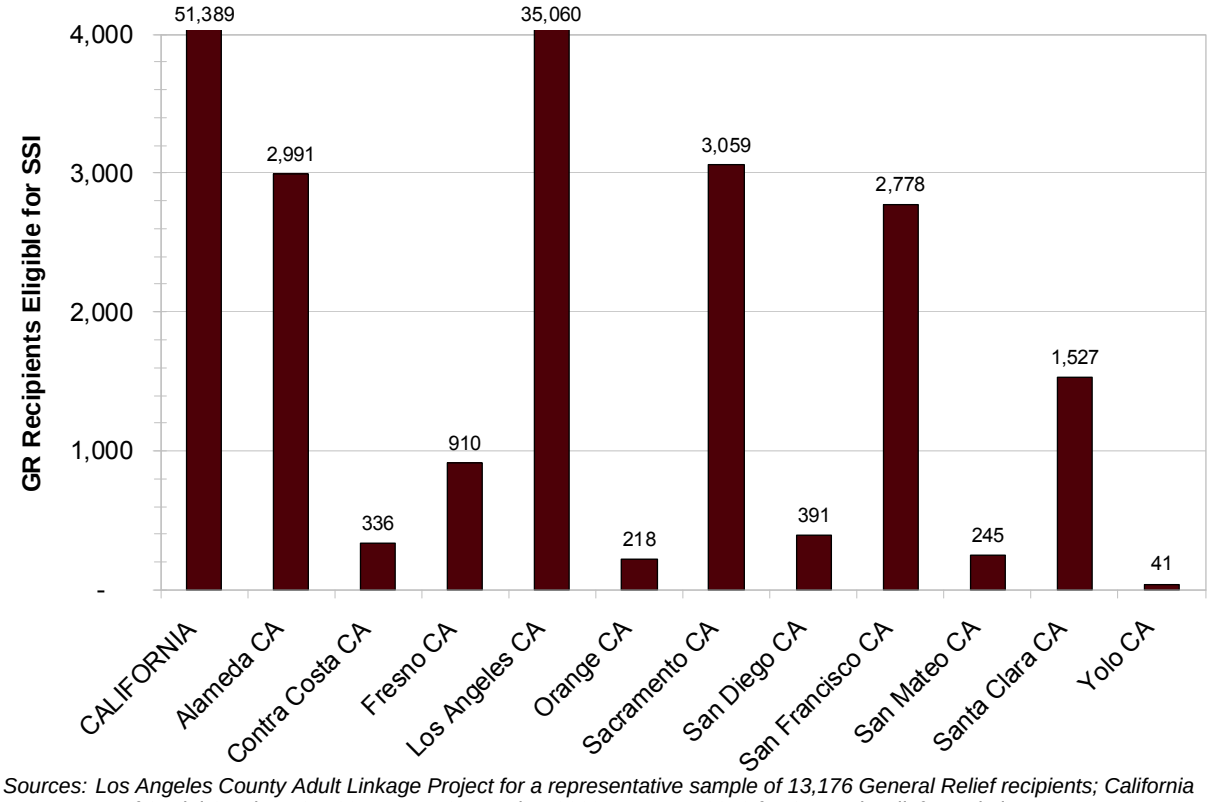
Information about the caseload movement in the General Relief population is scarce. The best available data suggests that the average length of stay in the program is about seven months, which means that the number of people who are in the program annually is about 70 percent greater than the monthly caseload.[10]

Savings per Person

A typical General Relief recipient with a disability has average monthly costs of $1,572

Figure 7

Number of People Estimated to be Eligible for SSI in the Typical Monthly GR Caseload



Sources: Los Angeles County Adult Linkage Project for a representative sample of 13,176 General Relief recipients; California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief population.

that are paid for by counties, private hospitals and modest federal offsets. These costs are broken out in Figure 8.

Counties pay the largest share of these costs, including:

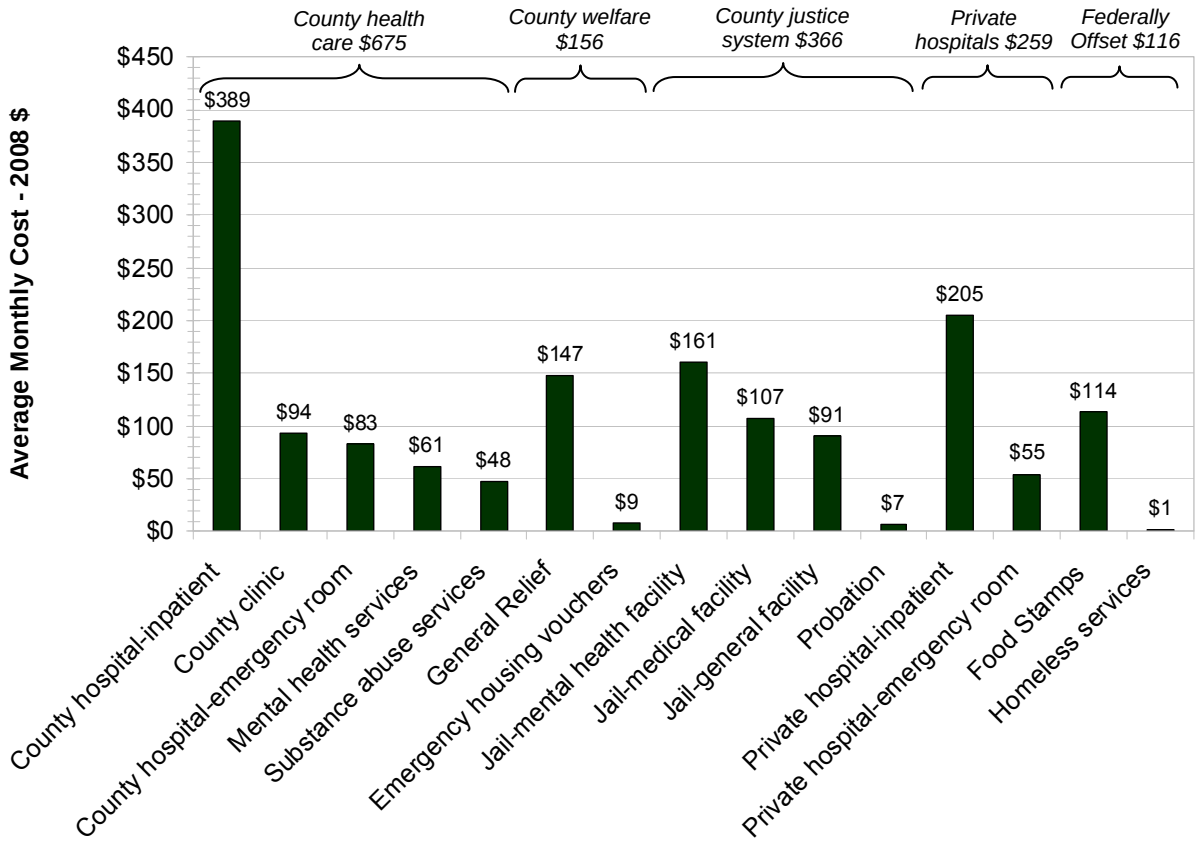
- $675 for health care costs to cover hospital inpatients, clinic visits, emergency room visits, mental health services, and substance abuse services
- $156 a month for welfare costs that cover General Relief cash grants and emergency housing
- $366 in justice system costs that include different types of jail facilities and probation

Private hospitals have an additional estimated $259 in monthly costs for inpatient stays and emergency room visits, which may not be reimbursed.

The federal government offsets a modest $114 a month for Food Stamps and homeless services.

If these individuals are enrolled in SSI, the federal government assumes a much larger role in underwriting public costs. Counties no longer have to pay health care and welfare costs totaling $831 a month, and hospitals are assured of compensation for health care services. Furthermore, with greater financial stability under SSI and opportunities for permanent housing,

Figure 8
Typical Monthly Costs of Disabled GR Recipients for Counties and Private Hospitals



Source: Los Angeles County Adult Linkage Project for a representative sample of 13,176 General Relief recipients.

county justice system costs may well decline significantly. Justice system costs for individuals with disabilities have been shown to decline 82 percent when they enter permanent supportive housing.[11]

Savings from moving eligible GR recipients onto SSI:

California counties: $42 million a month

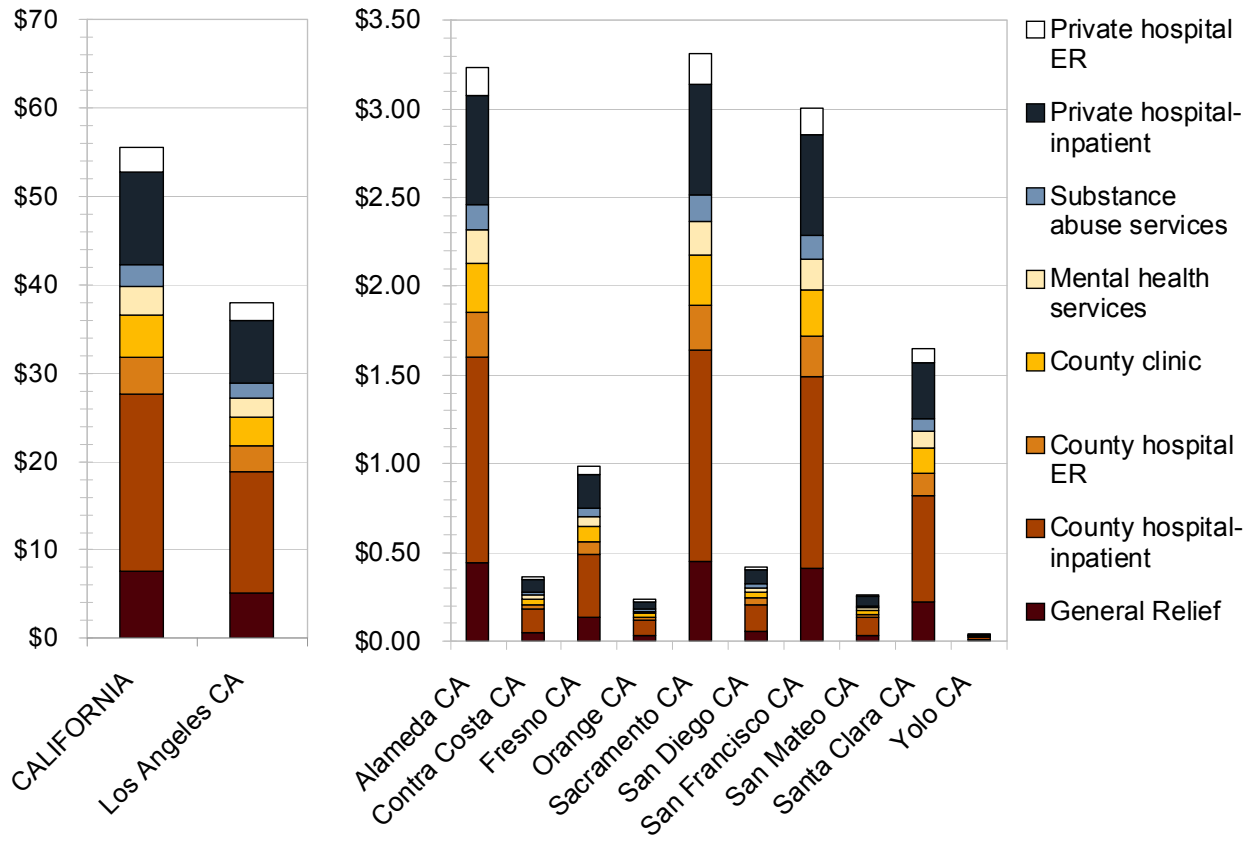
Private hospitals: $13 million a month

Savings per County

California counties would save $42 million per month and private hospitals would save another $13 million if the 51,000 individuals in the typical monthly GR caseload who are estimated to be eligible for SSI are moved onto that program. These savings are broken out by cost category for each county in Figure 9. The projected monthly savings include:

- $7.6 million in discontinued General Relief payments

Figure 9
Millions of Dollars in Monthly Savings if Eligible Individuals in the Monthly GR Caseload Move onto SSI



Sources: Los Angeles County Adult Linkage Project for a representative sample of 13,176 General Relief recipients; California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief population. The distribution of costs between public and private health providers found in Los Angeles County is projected onto other counties and the state. In reality, some counties provide a smaller share, or no share, of health services through county agencies. In those counties, the cost savings shown in this chart would accrue to non-county health providers and through them to county indigent programs.

- $20 million for inpatients at county hospitals
- $4.3 million for emergency room visits to county hospitals
- $4.8 million for outpatients at county clinics
- $3.2 million for mental health services
- $2.5 million for substance abuse services
- $10.1 million for private hospital-inpatients
- $2.8 million for emergency room visits to private hospitals

The breakout in savings for public and private hospitals shown in Figure 9 is based on the division in health care services found in Los Angeles County. In some counties, a larger share of health care for GR recipients is provided by private hospitals, and in those counties, a larger share of cost savings would go to those hospitals, and secondarily, would accrue to county indigent programs.

Because the GR caseload is dynamic, with individuals leaving the program each month, many to cycle back into it later, and new individuals entering each month, the aggregate savings from moving all eligible GR recipients onto SSI would be much greater than the $55 million in monthly savings shown in Figure 9.[12] Based on the earlier estimate that the number of unduplicated individuals in the annual caseload is 1.7 times greater than in the monthly caseload, the savings from moving the annual eligible population onto SSI would be roughly $93 million per month, or $71 million for counties and $22 million for private hospitals.

Summary of Findings about Savings in Expenditures for GR Recipients

1. At any point in time there are roughly 51,000 GR recipients in California who are eligible for SSI
2. Because the GR population is dynamic, the total population that is eligible for SSI is substantially larger than the point-in-time population
3. A typical General Relief recipient with a disability is estimated to have monthly costs of $831 for health care and public assistance that are paid by counties and that are covered by SSI and Medi-Cal when the individual moves onto that program.
4. A typical GR recipient with a disability is estimated to have monthly health care costs of $259 at private hospitals that are covered by Medi-Cal when these individuals are moved onto SSI.
5. California counties would avoid $42 million per month in costs and private hospitals another $13 million if the 51,000 individuals in the typical monthly GR caseload who are estimated to be eligible for SSI were moved onto that program.

Chapter 3

Hospital Costs Avoided by Moving Patients with Disabilities who are Homeless or Indigent onto SSI

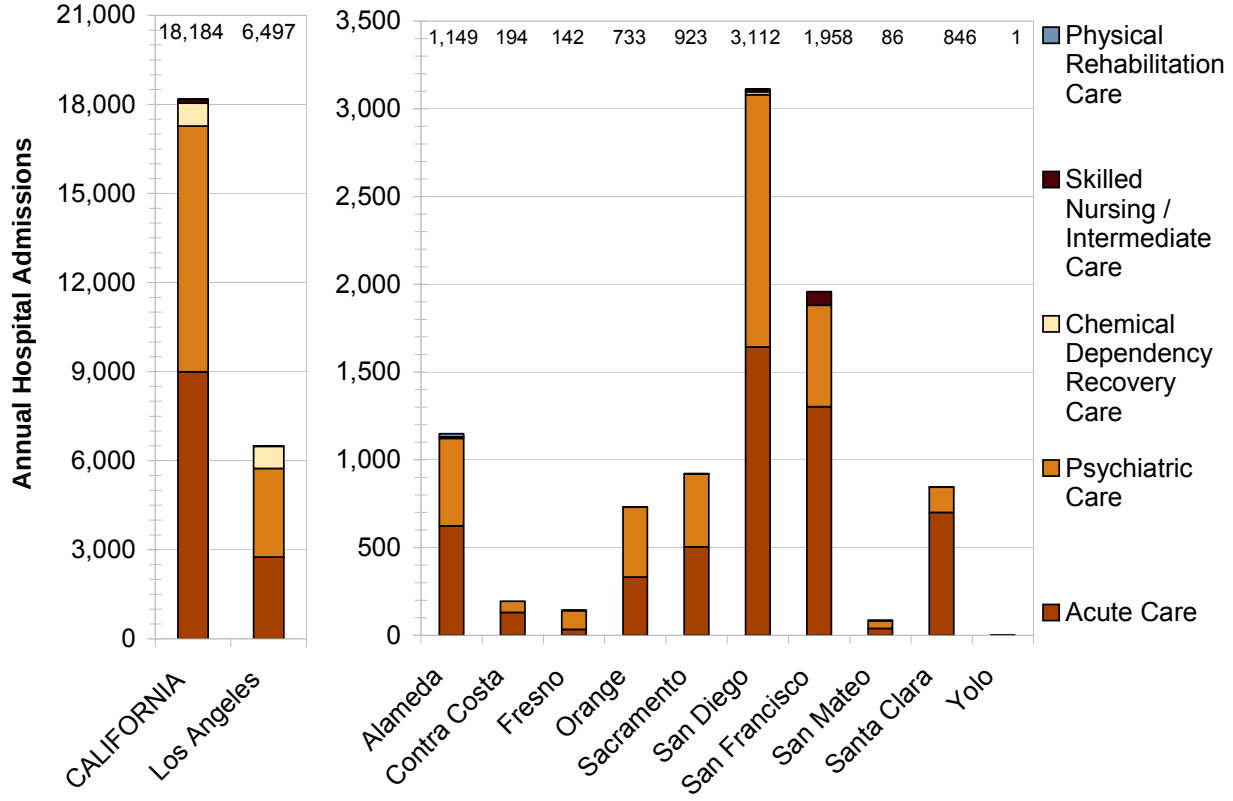
Healthcare outlays account for a large share of the total costs shouldered by county government and are particularly high for homeless and indigent individuals with disabilities. Moving more GR recipients and indigent residents with disabilities onto SSI and Medi-Cal will help reduce unrecoverable healthcare costs incurred by counties.

In this section, we examine costs and potential cost savings for 18,000 homeless inpatients and 70,000 county indigent inpatients who were admitted to California hospitals each year in 2008 and 2009. The average cost accompanying the discharge of each homeless patient from a hospital was almost $37,000; the average cost for each discharge of a patient charged to county indigent programs was $40,500. These populations overlap slightly – 4 percent of county indigent patients were identified by hospitals as being homeless.[13]

The individuals with disabilities within these homeless and indigent populations are likely to be eligible for SSI. If they are moved onto SSI, the cost for their health care will be transferred from counties and private hospitals to state and federal governments, and their quality

Figure 10

Annual Average Admissions of Homeless Persons to Hospitals in 2008 and 2009, by Facility Type



Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 36,367 homeless inpatient admissions 2008-2009.

of life will be improved through monthly SSI payments of up to $845 a month. This income can make it possible to obtain housing and other basic necessities.

To profile the costs of homeless and county indigent hospital patients in this section, we break out the size and cost of these populations in each county, identify the causes of their hospitalizations, and estimate the number of people in both the homeless and indigent populations who have disabilities and therefore are likely to be eligible for SSI.

Homeless: Hospital Admissions

In 2008 and 2009, California hospitals admitted an average of 18,184 patients a year who they identified as being homeless, as shown in Figure 10.[14] Some of these admissions represent multiple hospitalizations of the same individuals, but if we treat them as an unduplicated count of individuals, they represent 0.08 percent of California's population that is 18 to 64 years of age.[15] Despite their comparatively small number, they represent a significant cost for hospitals and counties. It is likely that hospitals under-report the number of homeless patients by a large measure. OSHPD documentation indicates that these individuals were identified as homeless because they lacked an address.[16] This probably results in a significant undercount of patients who are homeless but use the address of a friend, relative, shelter, or service provider.

The types of facilities that patients who are homeless enter vary by county, depending on the types of hospitals that are available. The statewide breakout of admissions is:

- 49 percent into *general acute care hospitals* (the highest share is in Santa Clara County - 83 percent)
- 46 percent into *psychiatric hospitals* (76 percent in Fresno County)
- 4 percent into *chemical dependency recovery facilities* (12 percent in Los Angeles County)
- 1 percent into *skilled nursing/intermediate care facilities* (4 percent in San Francisco County)
- 0.1 percent into *physical rehabilitation facilities* (1.6 percent in Alameda County)

Homeless: Inpatient Days by Facility Type

California hospitals provided 155,336 days of inpatient care each year for persons who they identified as homeless in 2008 and 2009 (Figure 11).[17] Out of this annual statewide total,

- 51 percent of patient days were spent in *psychiatric hospitals* (the highest share is in Fresno County - 73 percent)
- 37 percent were spent in *general acute care hospitals* (71 percent in Santa Clara County)
- 6 percent were spent in *skilled nursing/intermediate care facilities* (27 percent in San Francisco County)
- 6 percent were spent in *chemical dependency recovery facilities* (17 percent in Los Angeles County)
- 0.3 percent were spent in physical rehabilitation facilities (5 percent in Alameda County)

Statewide, a homeless person who was admitted to the hospital typically spent 9 days as an inpatient. The range among counties varied from a high of 14 days in Orange and San Mateo counties to a low 7 days in Alameda, Fresno, San Diego and Santa Clara counties.

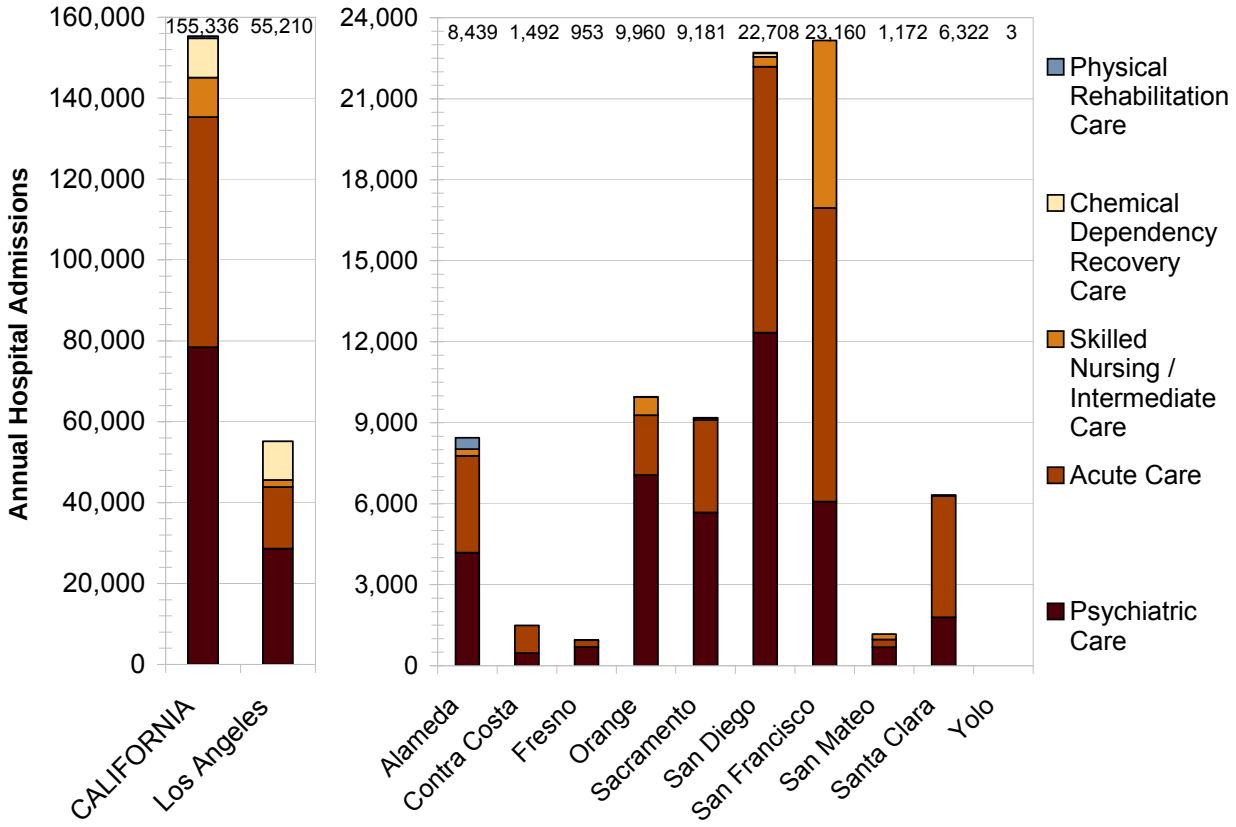
Patients who were homeless had differing lengths of stay in different types of facilities. The statewide averages by type of facility were:

- Acute Care 6 days
- Psychiatric Care 9 days
- Chemical Dependency Recovery Care 13 days
- Physical Rehabilitation Care 21 days
- Skilled Nursing / Intermediate Care 82 days

Homeless: Annual Cost for Inpatients by Payment Source

The yearly cost for patients who were homeless and who were admitted to California hospitals in 2008 and 2009 was $672 million (Figure 12).[18] This is an average of $36,954 per admission. The average cost per admission for different counties reflects the length of stay, the mix of facilities where patients were admitted, and differences in health care costs. From high to low, these averages were:

Figure 11
Average Annual Number of Inpatient Days for Homeless Patients in 2008 and 2009, by Facility Type



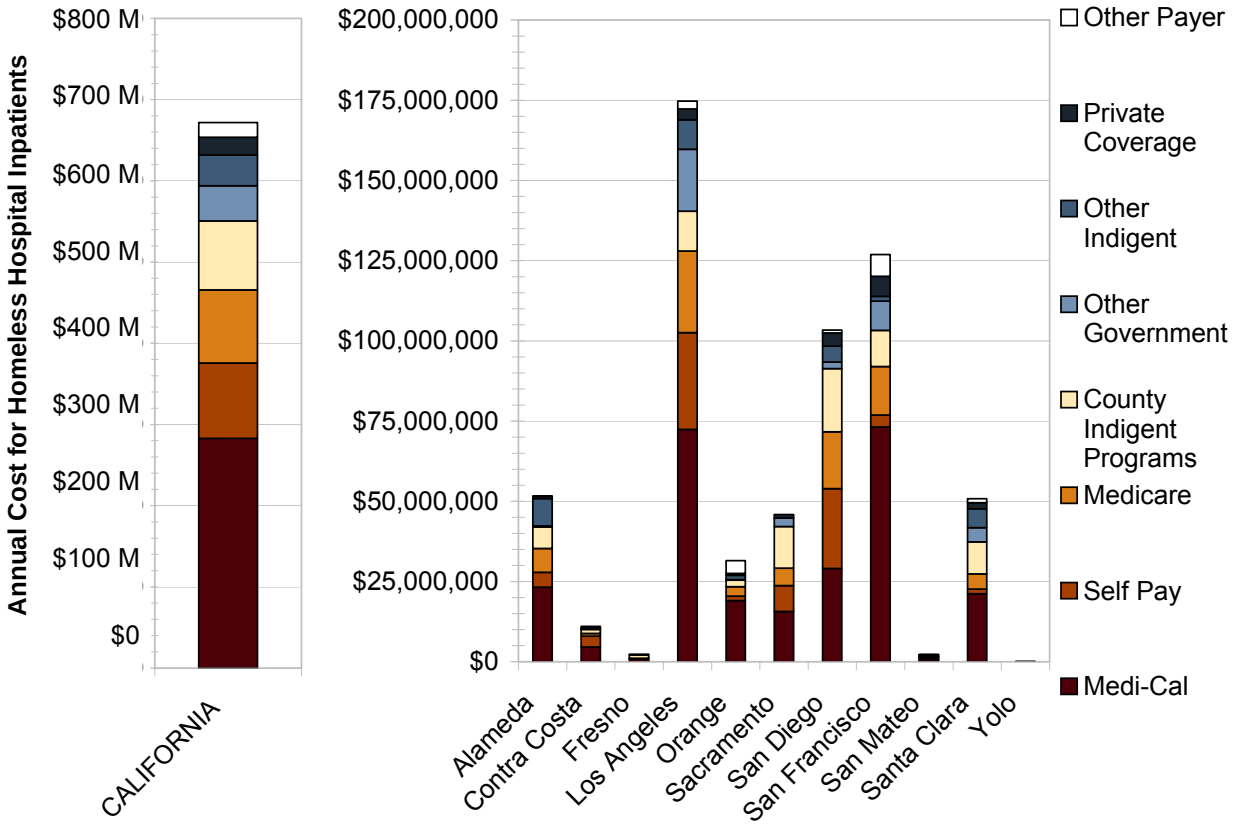
Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 36,367 homeless inpatient admissions 2008-2009.

- San Francisco $64,835
- Santa Clara $60,077
- Contra Costa $56,747
- Sacramento $49,691
- Alameda $44,938
- Orange $43,000
- Yolo $39,834
- San Diego $33,220
- Los Angeles $26,894
- San Mateo $25,973
- Fresno $16,341

The information shown in Figure 12 can be used to determine the share of hospital costs for patients who were homeless that are paid by county indigent programs, as well as the total amount of those costs. Statewide, 13 percent of these hospital costs are paid by county indigent programs, with significant variation among counties. At the high end, Fresno's indigent program pays 42 percent of total hospital costs for homeless patients and Sacramento's pays 28 percent. At the low end, Los Angeles and Orange's indigent programs pay 7 percent and San Francisco's pays 9 percent.

These county costs will be ameliorated when health reform takes effect in 2014 (and to a lesser extent by the 1115 Medicaid waiver) but the extent and amount of federal offsets is unclear at this time.19 This report is being written and distributed before the financial impact of

Figure 12
Average Annual Cost for Homeless Inpatients in 2008 and 2009 by Payer



Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 36,367 homeless inpatient admissions 2008-2009.

the 1115 Waiver or the Affordable Care Act on counties can be ascertained. What can be said is that depending upon the structure of the 1115 Low Income Health Program (LIHP) structure in each County, there will be federal financial participation in the cost of health care provided to eligible low-income county residents between 2011 and 2014.[20]

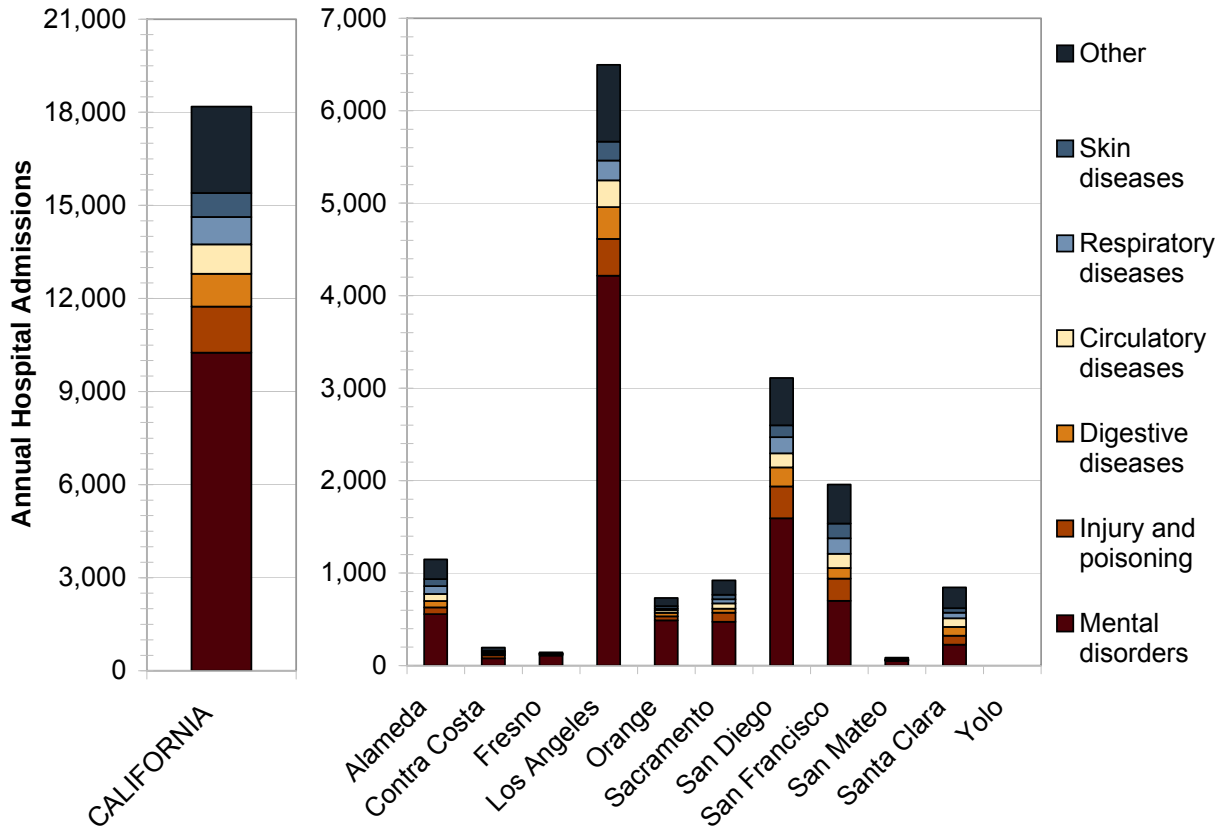
Homeless: Diseases Resulting in Hospitalization

Fifty-six percent of hospital admissions in 2008 and 2009 for patients who were homeless were for mental disorders (Figure 13).[21] The average length of stay for these patients was 9 days. The share of admissions that are for mental disorders and average length of stay for these patients vary as follows among counties:

- Fresno 77 percent, 7 days
- Orange 67 percent, 15 days
- Los Angeles 65 percent, 9 days
- San Mateo 61 percent, 14 days
- Sacramento 51 percent, 13 days
- San Diego 51 percent, 8 days
- Alameda 48 percent, 8 days
- Contra Costa 40 percent, 7 days
- San Francisco 36 percent, 15 days
- Santa Clara 27 percent, 10 days

The highest rate of homeless hospitalizations for mental disorders (77 percent) was in Fresno. The shortest length of stay for these patients (7 days) was in Fresno and Contra Costa.

Figure 13
Types of Diseases Resulting in Hospitalization of Homeless Individuals in 2008 and 2009



Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 36,367 homeless inpatient admissions 2008-2009.

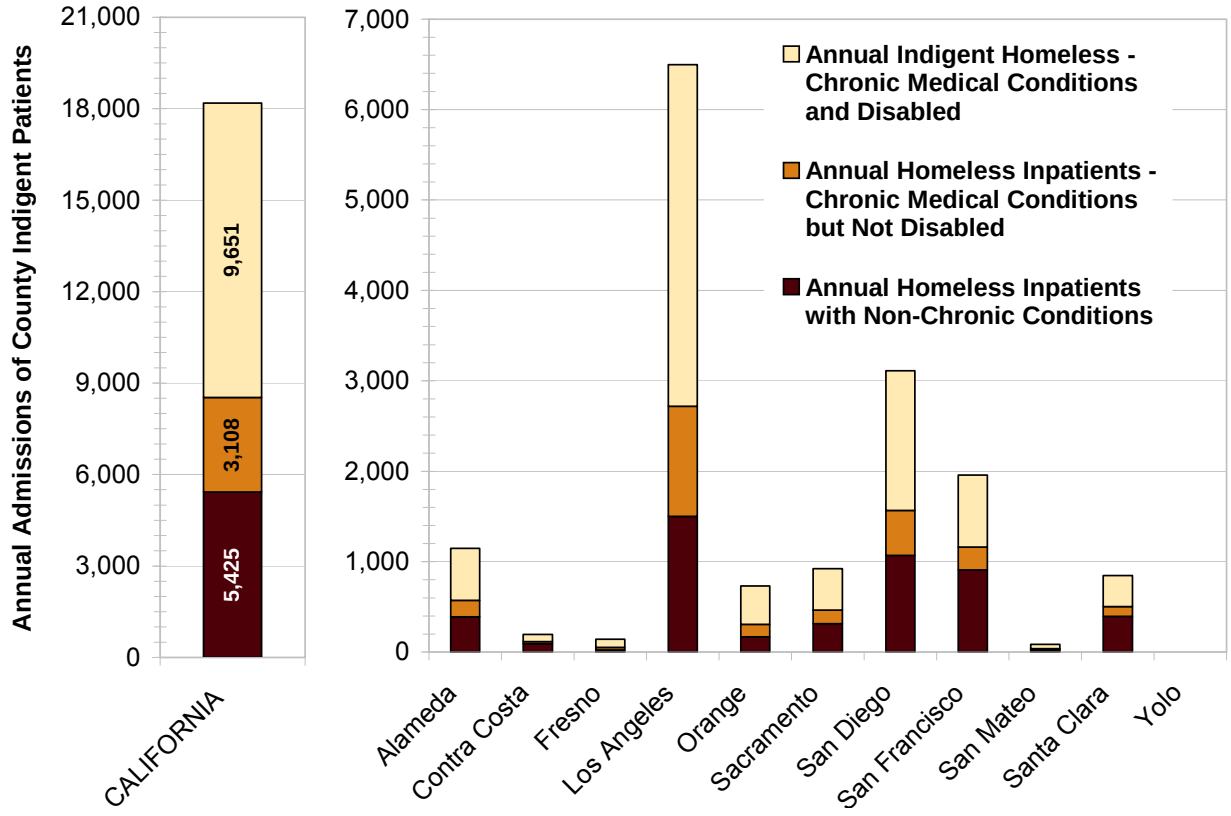
It may be that this high rate of hospitalizations for mental illness is partially a result of acutely ill patients whose problems are inadequately addressed during short hospital stints, and who have recurrent hospitalizations. Moving such patients onto SSI and Medi-Cal would likely make it more feasible to pay for adequate care.

Other frequent reasons why individuals who are homeless are admitted to hospitals include injuries and poisoning (8 percent), digestive diseases (6 percent – often neglected dental problems), circulatory diseases (5 percent – often hypertension or heart failure), respiratory diseases (5 percent – often asthma), and skin diseases (4 percent – often cellulitis).

Homeless: Estimated Disability Rates among Hospital Patients

Combining the two factors that 76 percent of patients with chronic medical conditions have disabilities,[22] and that 70 percent of hospital admissions for people who are homeless are for chronic medical conditions, we arrive at the estimate that *53 percent of the homeless individuals admitted to hospitals have disabilities and are likely to be eligible for SSI*. The likelihood of eligibility for SSI is based on the fact that they are both indigent and persons with disabilities. This represents 9,651 hospital admissions of homeless persons with disabilities each year (Figure 14).[23] The rate of chronic medical conditions, and consequently the estimated rate

Figure 14
Annual Number of Chronic and Disabled Homeless Patients Admitted to Hospitals in 2008 and 2009



Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 36,367 homeless inpatient admissions 2008-2009. Los Angeles County Adult Linkage Project for disability rate data.

of disabilities varies among counties. The estimated disability rates among patients who are homeless in different counties are as follows:

- Fresno 63 percent
- Orange 58 percent
- Los Angeles 58 percent
- San Mateo 54 percent
- Alameda 50 percent
- Sacramento 50 percent
- San Diego 50 percent
- San Francisco 41 percent
- Santa Clara 40 percent
- Contra Costa 40 percent

The highest disability rates among patients who are homeless, and the highest rates of eligibility for SSI, are estimated to be in Fresno (63 percent, Orange 58 percent, and Los Angeles 58 percent).

Homeless: Coverage of Hospital Costs by Medi-Cal vs. County Indigent Programs

The most stable source of health care funding for homeless residents who are sick and have disabilities, with the least financial burden to counties is Medi-Cal. The extent to which the hospital costs of patients who are homeless are covered by Medi-Cal rather than county indigent programs varies widely among counties, as shown in Table 2.[24]

Individuals who are homeless whose health problems require hospitalization often have ongoing high public costs for health care and justice system services. Multiple county agencies have cost savings of up to 80 percent when the individuals with disabilities in this population have improved income maintenance, health care and opportunities for stable housing through SSI enrollment.[25]

Looking just at county indigent programs and Medi-Cal, because these are all-or-nothing financial alternatives for counties, statewide, 69 percent of patients who are homeless are paid for by Medi-Cal rather than county indigent programs. Several counties have particularly low rates of Medi-Cal coverage: Fresno has the lowest rate – 28 percent. The next lowest coverage rates are Santa Clara (45 percent), San Mateo (48 percent) and Sacramento (49 percent).

Table 2

Expected Principal Source of Payment for Homeless Patients Admitted to Hospitals 2008-2009

Two-year admission totals for each county

	County Indigent Programs	Medi-Cal	Percent of Admissions for these Two Programs that are Paid by Medi-Cal
CALIFORNIA	5,005	11,289	69%
Alameda	398	890	69%
Contra Costa	68	166	71%
Fresno	181	70	28%
Los Angeles	903	4,372	83%
Orange	119	694	85%
Sacramento	341	323	49%
San Diego	1,148	1,450	56%
San Francisco	486	1,580	76%
San Mateo	48	44	48%
Santa Clara	507	420	45%

Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 36,367 homeless inpatient admissions 2008-2009. No data is available for Yolo County.

Note: This table does not show the total population of patients identified as being homeless. Costs for 54 percent of patients who are homeless are paid for by other sources, with self pay (17 percent) and Medicare (15 percent) being to the two biggest other sources.

County Indigent: Estimated Disability Rates among Hospital Patients

We shift now from homeless hospital patients to the larger population of 70,000 California patients whose hospital costs were paid by county indigent programs each year in 2008 and 2009. The number of indigent

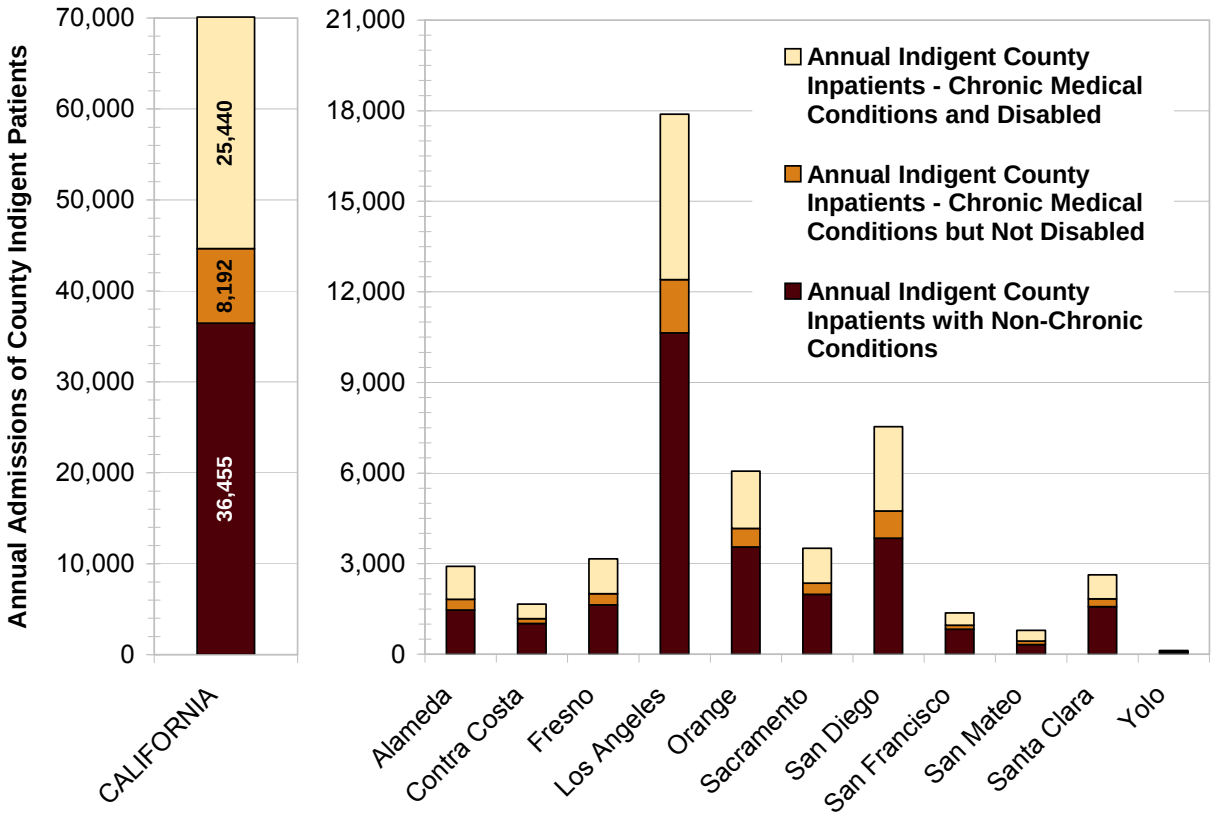
patients, broken out based on medical conditions that are non-chronic, chronic, and chronic with disability are shown in Figure 15.[26]

Combining the two factors that 76 percent of patients with chronic medical conditions have disabilities, and that 48 percent of hospital patients charged to county indigent programs are admitted for chronic medical conditions,[27] we arrive at the statewide estimate that *36 percent of the county indigent patients admitted to hospitals have disabilities and are likely eligible for SSI*.

The estimated percent and annual number of indigent hospital patients that are estimated to have disabilities and be eligible for SSI in each county are broken out below.

- Alameda 38 percent of indigent patients, 1,096 patients annually
- Contra Costa 29 percent of indigent patients, 488 patients annually
- Fresno 37 percent of indigent patients, 1,157 patients annually
- Los Angeles 31 percent of indigent patients, 5,480 patients annually
- Orange 32 percent of indigent patients, 1,899 patients annually
- Sacramento 33 percent of indigent patients, 1,151 patients annually
- San Diego 37 percent of indigent patients, 2,795 patients annually
- San Francisco 30 percent of indigent patients, 409 patients annually
- San Mateo 45 percent of indigent patients, 357 patients annually
- Santa Clara 30 percent of indigent patients, 798 patients annually
- Yolo 45 percent of indigent patients, 56 patients annually

Figure 15
Number of Chronic and Disabled County Indigent Patients Admitted to Hospitals in 2008 and 2009



Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 140,173 hospital admissions charged to county indigent programs in 2008-2009. Los Angeles County Adult Linkage Project for disability rate data.

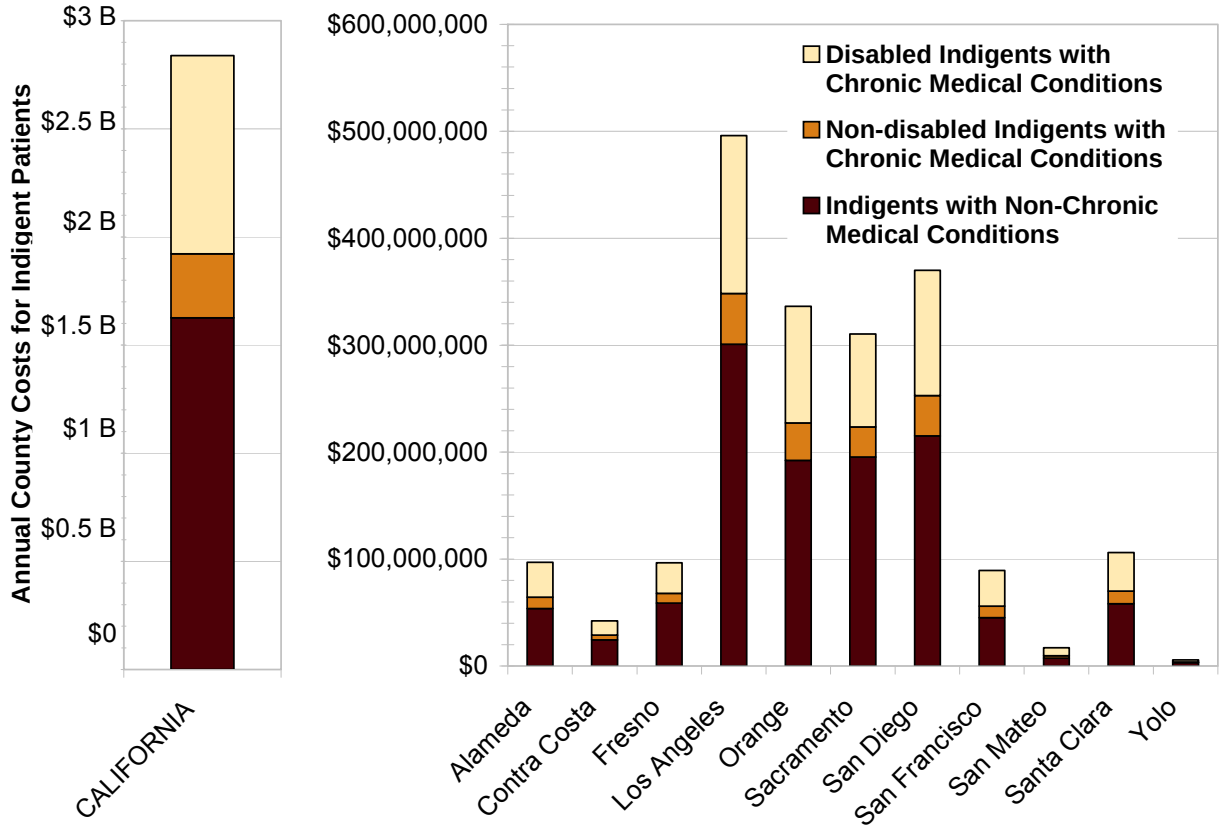
The number of patients estimated to have disabilities is linked to the number admitted to hospitals for chronic medical conditions. The share of these patients is estimated to be highest in San Mateo and Yolo counties; the absolute number is greatest in Los Angeles County.

County Indigent: Annual Cost of Patients Admitted to Hospitals

Each year in 2008 and 2009, counties paid $2.8 billion for patients admitted to hospitals whose costs were charged to county indigent programs (Figure 16).[28] Of this amount, *$917 million is estimated to have been expended annually for patients with disabilities who were eligible for SSI*. Expenditures by county indigent programs for patients eligible for SSI were:

- CALIFORNIA $917,105,914
- Alameda $32,750,584
- Contra Costa $13,394,334
- Fresno $28,639,180
- Los Angeles $147,446,395
- Orange $108,980,760
- Sacramento $87,027,083
- San Diego $117,150,267
- San Francisco $33,404,030
- San Mateo $7,362,790
- Santa Clara $36,112,156
- Yolo $1,872,730

Figure 16
Annual Cost of Chronic and Disabled County Indigent Patients Admitted to Hospitals in 2008 and 2009



Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 140,173 hospital admissions charged to county indigent programs in 2008-2009. Los Angeles County Adult Linkage Project for disability rate data.

County Indigent: Diseases Resulting in Hospitalization of Patients with Chronic Conditions

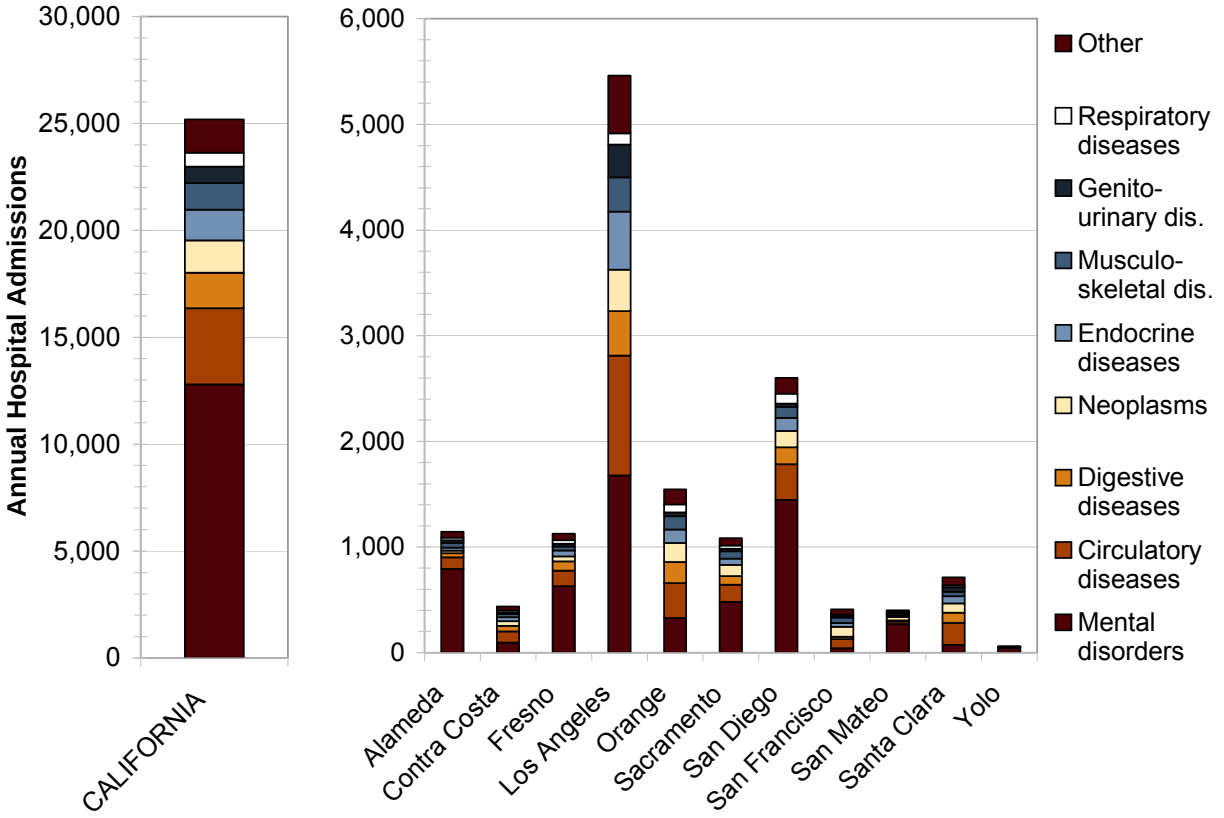
Chronic medical conditions that resulted in hospitalization of 25,189 indigent county patients each year in 2008 and 2009 are shown in Figure 17.[29] Because these conditions are chronic, they are likely to result in return visits to the hospital. Ongoing access to outpatient health care through Medi-Cal can help stabilize these problems, reduce the frequency of hospitalization, and provide a federal source of payment for inpatient care when it is necessary.

A majority of the chronic health problems that lead to hospitalization of indigent patients are related to mental disorders. Statewide, the most frequent causes of hospitalization were mental disorders (often psychoses) 51 percent, circulatory diseases (often hypertension or heart failure) 14 percent, digestive diseases (often dental problems) 7 percent, neoplasms (cancer) 6 percent, or endocrine diseases (often diabetes) 6 percent.

Summary of Findings about Potential Hospital Cost Savings

Each year in 2008 and 2009, 18,000 individuals who were homeless and 70,000 county indigent patients were admitted to California hospitals. The average cost accompanying the discharge of each homeless patient was $37,000; the average cost for each discharge of a patient

Figure 17
Causes of Hospitalization for County Indigent Patients with Chronic Medical Conditions in 2008 and 2009



Source: State of California Office of Statewide Health Planning and Development, Patient Discharge Data, 140,173 hospital admissions charged to county indigent programs in 2008-2009.

charged to county indigent programs was $40,500. These populations overlap slightly – 4 percent of county indigent patients were identified by hospitals as being homeless.

These patients spent over half a million days in hospitals each year – 29 percent of the days were for homeless individuals and 71 percent for county indigent patients. The annual cost was over $3.5 billion – almost $672 million for homeless patients and over $2.8 billion for county indigent patients.

$1.4 Billion

Annual costs avoided by California counties if all low-income patients with disabilities are moved onto SSI

Mental disorders were the cause of most hospitalizations, accounting for the admission 56 percent of patients who were homeless and 51 percent of county indigent patients. Most hospitalizations were for chronic conditions that are likely to result in return visits to the hospital. Ongoing access to outpatient health care through Medi-Cal can help stabilize these problems, reduce the frequency of hospitalization, and provide a federal source of payment for inpatient care when it is necessary.

Fifty-three percent of patients who were homeless and 36 percent of county indigent patients are estimated to be persons with disabilities who are eligible for SSI. If they are moved onto SSI, the cost for their health care will be transferred from counties to the state and federal governments, and their quality of life will be improved through monthly SSI payments of up to $845 a month. This income can make it possible to obtain housing and other basic necessities. Movement of these patients onto SSI will also result in roughly $1.4 billion dollars a year in avoided costs for counties.

Chapter 4

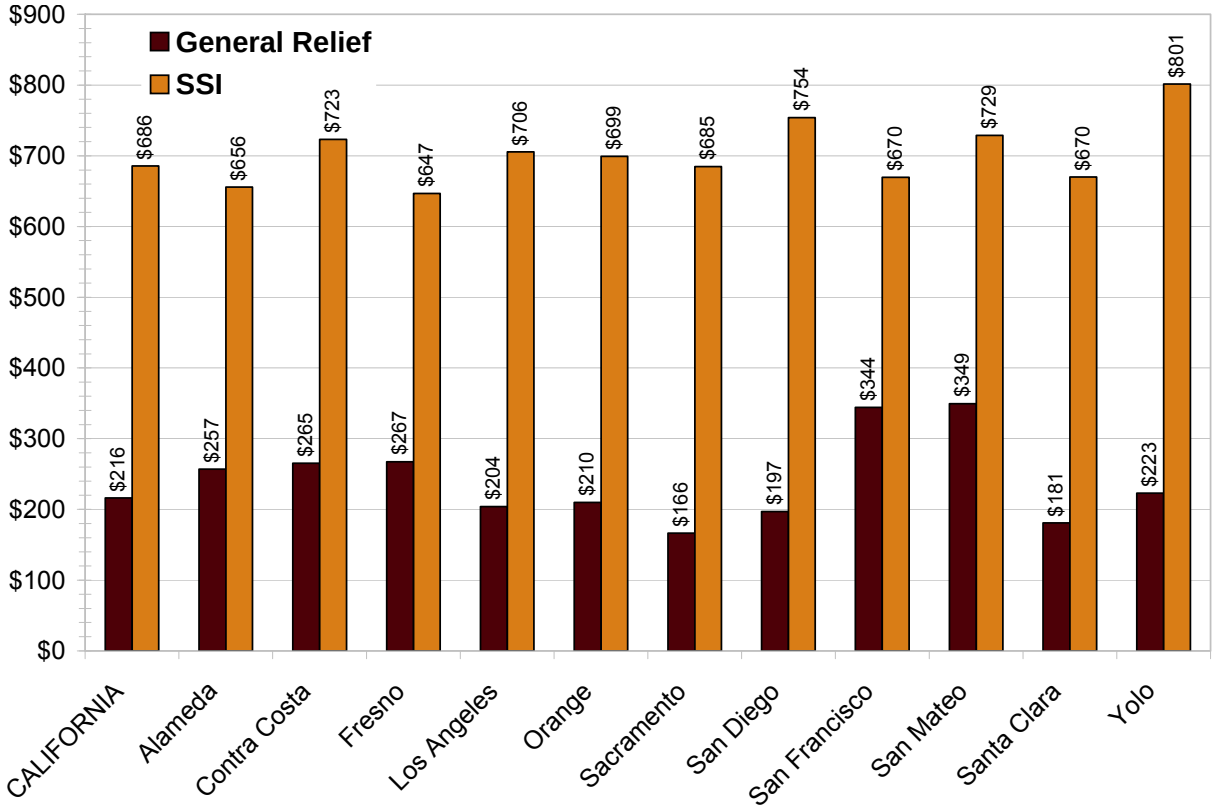
Economic Impacts of Increased Income after Moving onto SSI

When individuals move from General Relief to SSI, their income increases because SSI provides significantly higher monthly payments than General Relief. If they are indigent and receiving no aid at all, for example a person who is homeless but not receiving GR, the increase in income is even greater when they move onto SSI. In addition to improving the quality of life for individuals, this increased income has multiplier impacts on the regional economy. Each new dollar that enters a region is spent multiple times, first by the original recipient, then by their landlord, grocer, and other providers of goods and services as they in turn buy goods and services from their suppliers to meet increased demand. The net result is that the increased expenditures of SSI recipients create economic impacts or "economic multipliers" that are greater than the amount of SSI funds that are spent. These impacts include:

- Increased economic output resulting from consumption of goods as services, including housing, food, and personal necessities by SSI recipients
- Increased employment as new jobs are created to provide additional goods and services
- Increased tax revenue for local, state and federal government

Figure 18

Average Monthly Income for Single Adults from General Relief and SSI



Sources: 2009 American Community Survey for SSI income data, California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief income data.

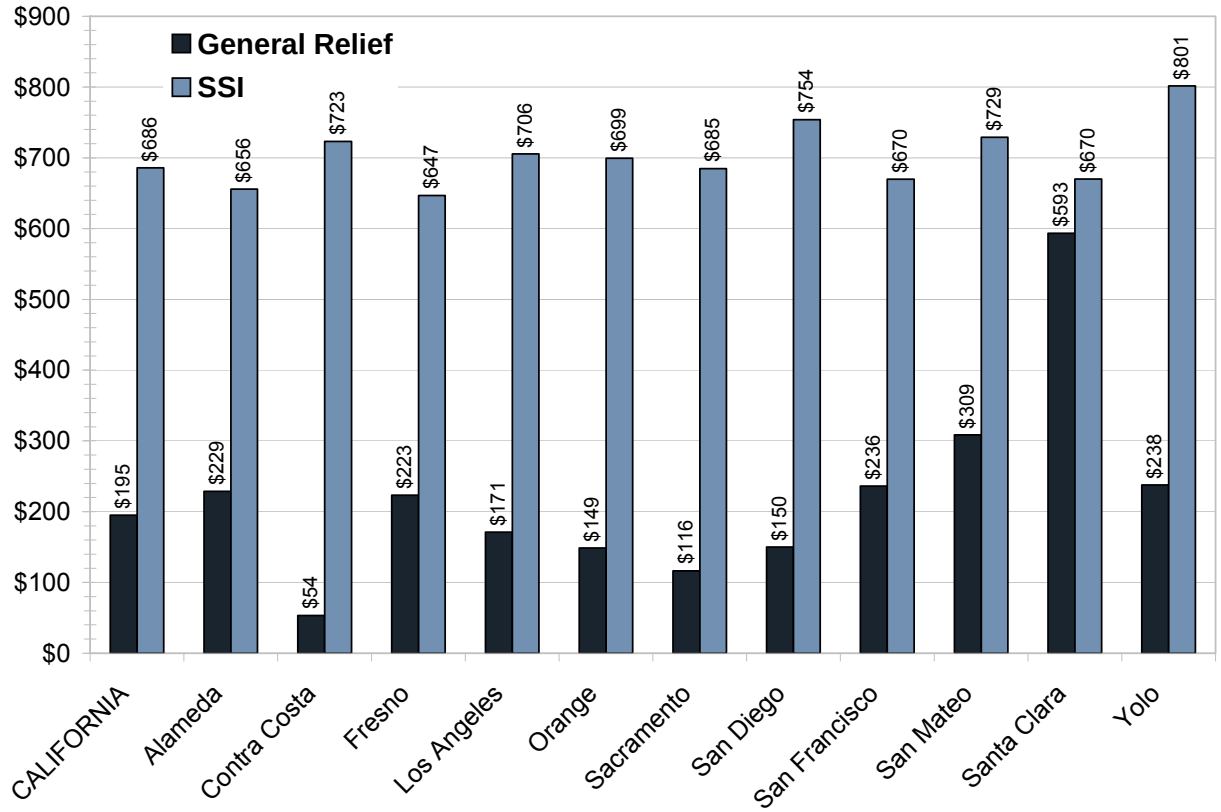
In this section we determine the increase in income for individuals in each county that will result from moving individuals who are single adults and members of families onto SSI; this includes people receiving GR as well as people who are not receiving any cash aid. Then we produce state and county level estimates of the impacts on the economy of each region that are likely to result from spending this increased revenue.

Average Monthly Income from General Relief and SSI

The average monthly income for single adults in California who are SSI recipients is $469 greater than that of General Relief recipients, as shown in Figure 18, with significant variation among counties. Statewide, this is the gap between the $216 typically received by GR recipients and the $686 typically received by SSI recipients in California. Single adults who are not receiving GR or any other cash aid have a $686 increase in monthly income when they move onto SSI. This is the gap between no income and the typical SSI benefit of $686 a month.

Statewide, individuals who are members of families make up 2 percent of the GR caseload. The monthly income from SSI for family members is $490 greater than that of their counterparts who are GR recipients, as shown in Figure 19. This is the gap between the

Figure 19
Average Monthly Income for Family Members from General Relief and SSI



Sources: 2009 American Community Survey for SSI income data, California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief income data.

Table 3
Change in Monthly Income after Moving from GR to SSI, and Estimated Number of Eligible Persons

	Typical Change in Monthly Income for Single Adults who Move from GR to SSI	Typical Change in Monthly Income for Family Members who Move from GR to SSI	Number of Recipients in the Typical Monthly GR Caseload Estimated to be Eligible for SSI
California	$469	$490	51,389
Alameda	$399	$427	2,991
Contra Costa	$458	$669	336
Fresno	$380	$424	910
Los Angeles	$502	$535	35,060
Orange	$489	$550	218
Sacramento	$518	$569	3,059
San Diego	$557	$604	391
San Francisco	$326	$433	2,778
San Mateo	$380	$421	245
Santa Clara	$489	$77	1,527
Yolo	$579	$564	41

$195 typically received by an individual family member receiving GR and the $686 typically received by a SSI recipient in California. For family members who are not receiving any cash aid, moving onto SSI represents a $686 increase in monthly income.

A statewide and county breakout of the change in monthly income for both single adults and family members after they move from GR to SSI, and the number of individuals in the monthly GR caseload who are estimated to be eligible for SSI is shown in Table 3.

Economic Impact of Increased Income from SSI

We used an input-output model of the economy to simulate the overall impacts of increased income from SSI on the economy of each study county and the state. The basic concept of input-output modeling is that production of goods and services occurs through industry networks in which outputs from some industries become inputs for others in a chain of value-added relationships. Input-output modeling produces estimates of the extent to which the ripple effects of an economic activity multiply the impact of an initial event, in this case, increased income from SSI.[30] We modeled the impact that increased expenditures by households with annual incomes under $10,000, based on increased income from SSI, are likely to have on regional economic output.[31]

When households receive additional income, most of the money has multiplier impacts when the providers of local goods and services who receive the money spend it again to buy goods and services from their suppliers, and when the employees of both the original suppliers and their vendors take their wages home and spend them. However, some of the money does not have a local impact because it goes to businesses outside the region, or because it leaves the region in the form of taxes that go to state and federal governments, for example, sales, property, vehicle, payroll, and income taxes.

In short, some of the money creates multipliers that expand its impact, and some of the money leaves the region and has no impact. We estimate that the net outcome from this multiplication and subtraction is that regional economic output increases by 87.3 percent of the amount of increased income that individuals receive when they move onto SSI.[32]

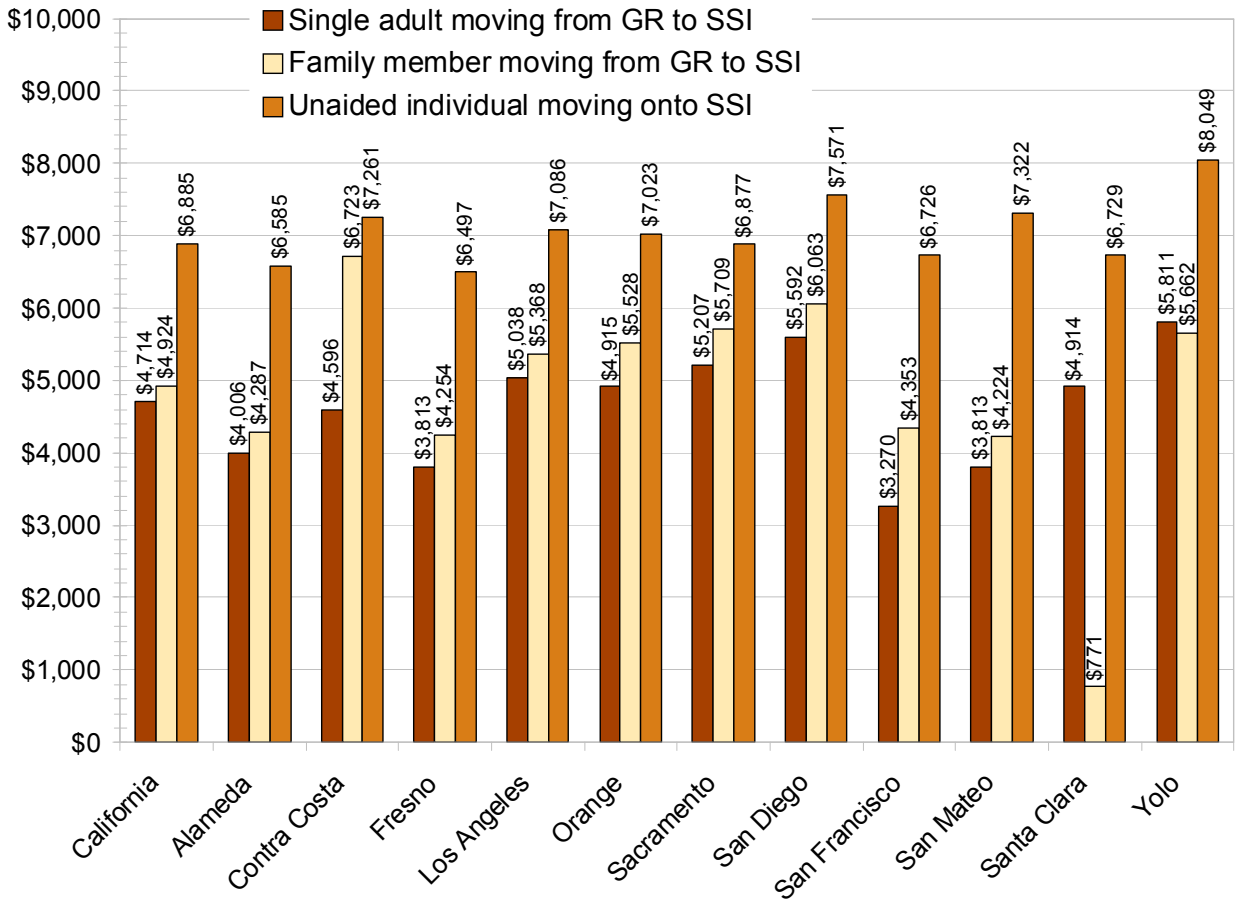
Statewide, yearly economic output in each county is estimated to increase $4,714 for each single adult and $4,924 for each family member who moves from GR to SSI, and $6,885 each individual who moves from not receiving any cash aid to receiving SSI (Figure 20).[33] If all of the individuals with disabilities in the monthly GR caseload were moved onto SSI, economic output in the state would increase by an estimated $242 million, with proportionate increases in each county (Figure 21).

Increased SSI revenue from moving all eligible California residents onto SSI would expand the state's economy by:

$647 Million annually

If all of the individuals who are not receiving any form of cash aid but are estimated to be eligible for SSI were moved onto SSI, economic output in the state would increase by an additional $405 million. The combined impact of moving both groups, that is all eligible individuals who are not currently receiving SSI onto SSI, would be $647 million dollars a year in additional economic output in the state. Counties with very low levels of GR coverage would

Figure 20
Annual Economic Output in the Regional Economy from the Additional Income of Each SSI Recipient



Sources: 2009 American Community Survey for SSI income data, California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief income data. IMPLAN input-output model with 2008 data in 2010 dollars for multiplier effects in the regional economy.

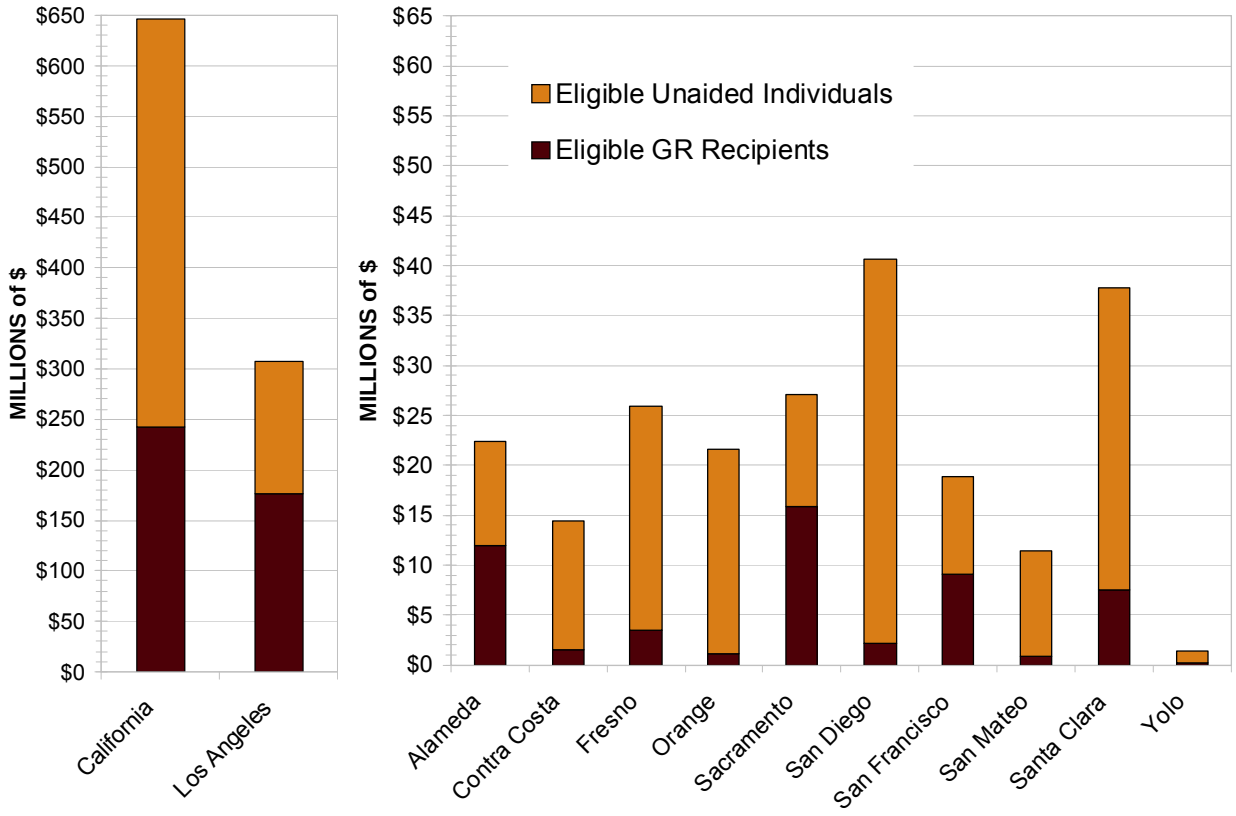
see especially large growth in their economies, for example, San Diego and Santa Clara counties would have $39 million and $30 million, respectively, in additional annual economic output as a result of moving eligible individuals who are not receiving any form of cash aid onto SSI.

Employment Impact of Increased Revenue from SSI

One person-year of employment is created in the regional economy for each $179,356 in SSI income received by households. This means that when 100 individuals move from GR to SSI, 3.3 new jobs are created in the regional economy because of the increased need for labor and materials to fulfill their increased consumption of goods and services. It also means that when 100 individuals who are not receiving any form of cash aid move onto SSI, 4.6 new jobs are created in the regional economy as a result of their increased consumption.

If the 51,389 individuals in the typical monthly General Relief caseload who are estimated to have disabilities and be eligible for SSI were moved onto SSI, 1,614 new jobs would be created in California, as shown in Figure 22. If all of the individuals who are not receiving any form of cash aid but are estimated to eligible for SSI were moved onto SSI, an

Figure 21
Additional Economic Output Generated Each Year by the Potential Additional Income of SSI Recipients



Sources: 2009 American Community Survey for SSI income data, California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief income data. IMPLAN input-output model with 2008 data in 2010 dollars for multiplier effects in the regional economy.

additional 2,700 jobs would be created statewide.[34] The combined impact of moving all eligible individuals who are not currently receiving SSI onto SSI, would be to create over 4,300 new jobs statewide.

Counties with very low levels of GR coverage would see especially large job growth, for example, San Diego and Santa Clara counties would have 277 and 215 new jobs, respectively, as a result of moving eligible individuals who are not receiving any form of cash aid onto SSI. Ongoing, effective efforts to move residents with disabilities onto SSI can produce very significant economic benefits for counties and the state.

Increased household income from moving all eligible individuals onto SSI would create 4,310 new jobs in California

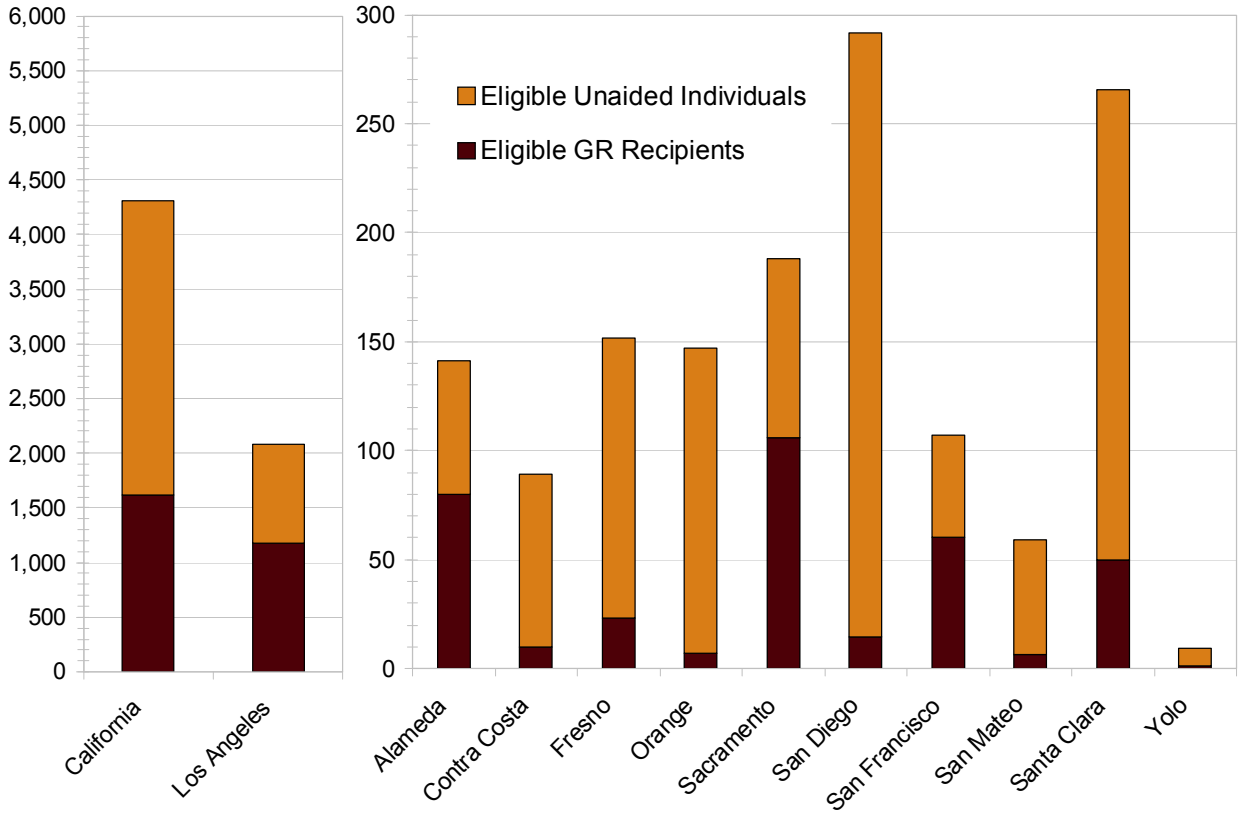
Counties with low levels of GR coverage would see especially large job growth:

San Diego: 227 New Jobs
Santa Clara: 215 New Jobs

Tax Revenue Impacts of Increased Payments from SSI

The additional income that individuals receive after moving from GR to SSI generates many types of tax revenue for local, state and federal

Figure 22
Moving Eligible Residents onto SSI will create over 4,300 New Jobs in California



Sources: 2009 American Community Survey for SSI income data, California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief income data. IMPLAN input-output model with 2008 data in 2010 dollars for multiplier effects in the regional economy. In Alameda and Los Angeles counties, the number of unaided individuals eligible for SSI is estimated to be equivalent to 53 percent of the number of GR recipients who are eligible for SSI.

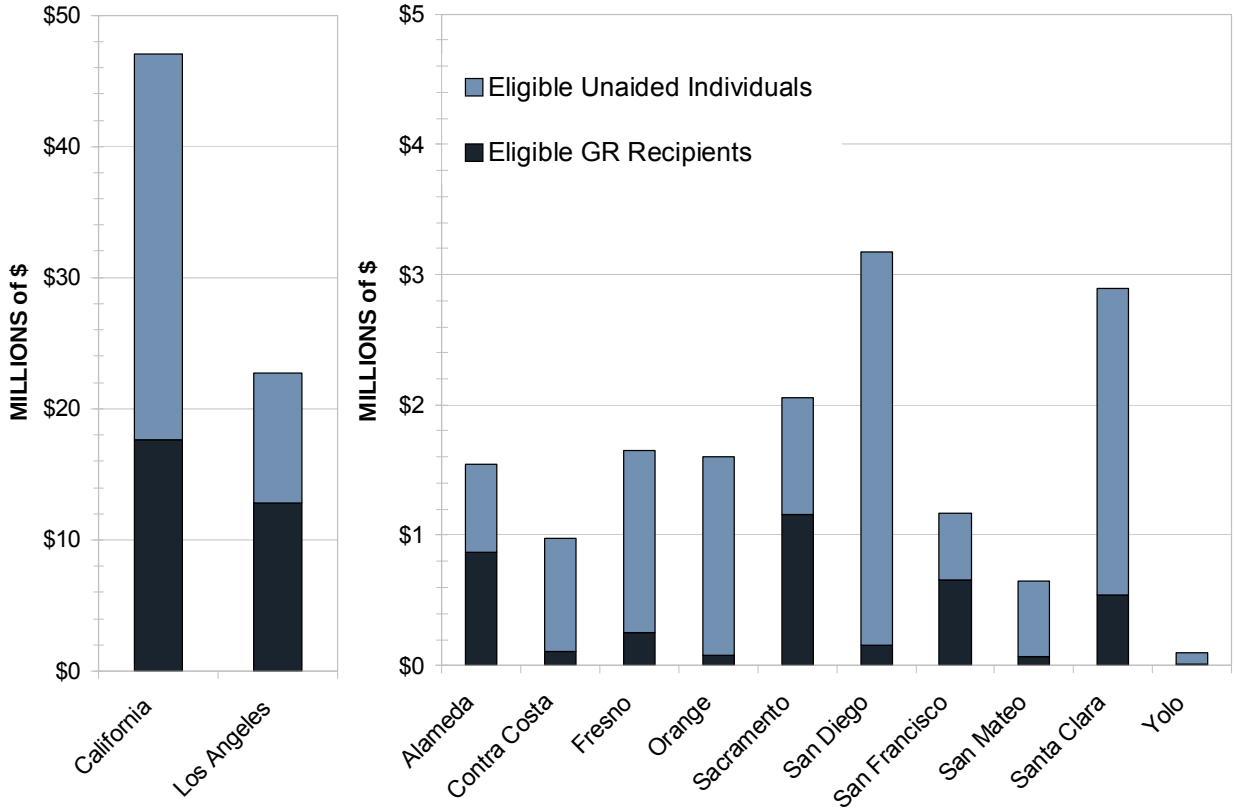
governments as it is spent by recipients, then re-spent multiple times by providers of goods and services who receive those funds, as well as by the suppliers and employees of these establishments. Every dollar in income received by SSI recipients is estimated to generate 6.1 cents in tax revenue for local and state government from dividend tax, unemployment insurance, state disability insurance, sales tax, property tax, motor vehicle license fee, excise tax, corporate profits tax, personal income tax, property tax, and fines and fees. Statewide, moving both eligible GR recipients and eligible individuals not receiving any form of cash aid onto SSI would generate an additional $47 million a year in state and local taxes, as shown in Figure 23.[35]

Every dollar of SSI income is also estimated to generate 6.5 cents in federal tax revenue from Social Security, Medicaid, excise tax, custom duty, corporate profits taxes, and personal income tax. Statewide, moving both eligible GR recipients and eligible individuals not receiving any form of cash aid onto SSI would generate an additional $50 million a year in federal taxes, as shown in Figure 24.

Summary of Findings about Economic Impacts

Monthly SSI benefits are typically $469 more than GR for single adults and $490 more

Figure 23
Local and State Taxes Generated Annually by the Potential Additional Income of SSI Recipients

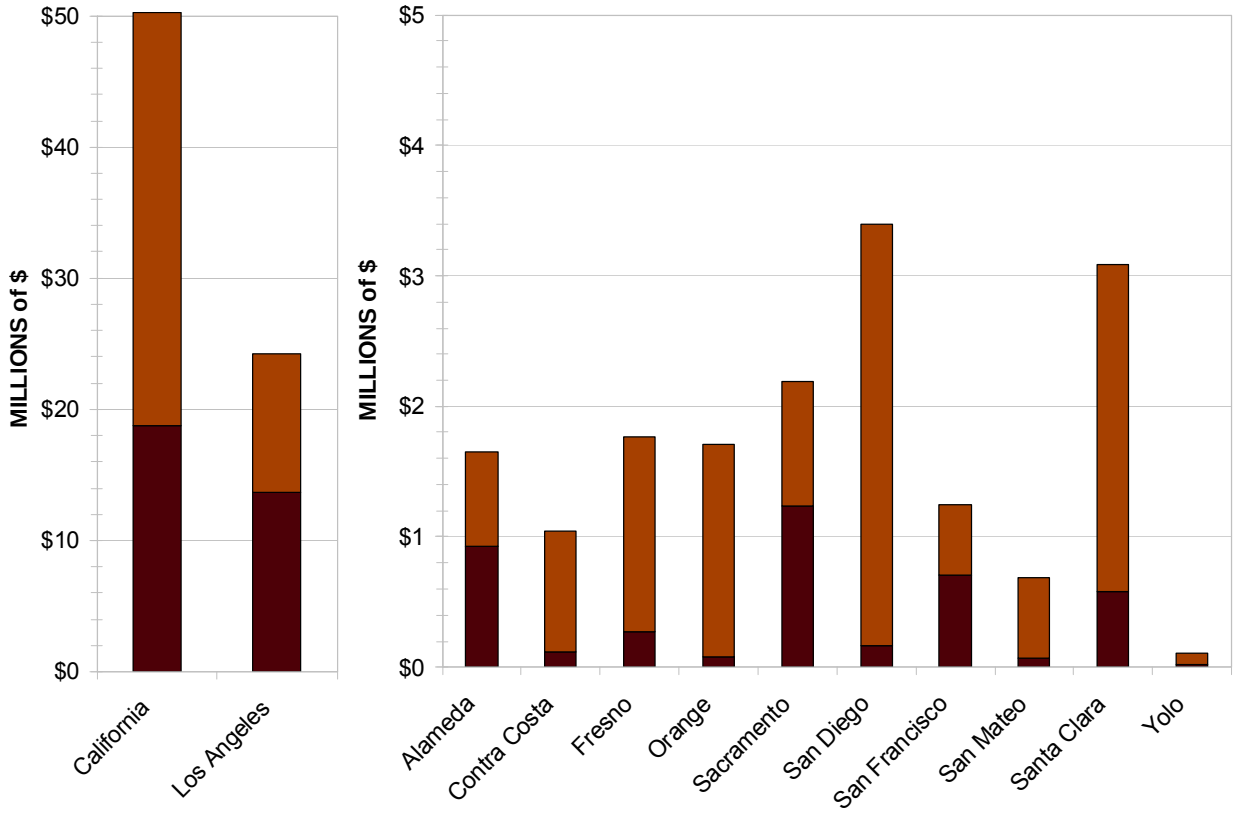


Sources: 2009 American Community Survey for SSI income data, California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief income data. IMPLAN input-output model with 2008 data in 2010 dollars for multiplier effects in the regional economy. In Alameda and Los Angeles counties, the number of unaided individuals eligible for SSI is estimated to be equivalent to 53 percent of the number of GR recipients who are eligible for SSI.

for family members. If individuals are not receiving any form of cash aid, their income typically increases by $686 a month when they move onto SSI. As these funds are spent by recipients, then re-spent by providers of goods and services, and their suppliers and employees, they create multiplier effects in the regional economy. When the 51,389 California residents in the typical monthly General Relief caseload who are estimated to have disabilities and be eligible for SSI, and the 58,768 residents who are not receiving any cash aid but are estimated to be eligible for SSI are moved onto SSI, their increased income and expenditures will have the following statewide impacts:

- $647 million in additional annual economic output will be generated
- 4,300 new jobs will be created
- $47 million in additional annual local and state tax revenue will be generated
- $50 million in additional federal tax revenue will be generated

Figure 24
Federal Taxes Generated Annually by the Potential Additional Income of SSI Recipients



Sources: 2009 American Community Survey for SSI income data, California Department of Social Services GR 237 report, September 2009 to August 2010 for General Relief income data. IMPLAN input-output model with 2008 data in 2010 dollars for multiplier effects in the regional economy.

Chapter 5

Impact of Supportive Housing on Public Costs

High-need individuals with disabilities who are homeless have high public costs that are spread across multiple county agencies including health, social services, and justice system agencies. The Economic Roundtable, in a previous study, has demonstrated the powerful, stabilizing effect of supportive housing and its impact on significantly reducing public costs.[36]

Supportive housing is permanent, affordable housing with on-site case management and linkages to additional supportive services such as health, mental health and substance abuse services. Preferably, but not always, these additional supportive services are provided on-site. Most individuals who enter supportive housing have experienced chronic homelessness, many are mentally ill, and all have disabilities.

The additional income and benefits provided by SSI will enable more individuals with disabilities to enter supportive housing by increasing the amount of income they can contribute towards rent and thereby reducing the amount of operating subsidies that must be provided by supportive housing operators.

Public Costs of Individuals with Disabilities who are Homeless

An analysis of 10,193 homeless, destitute single adults in Los Angeles County – 1,007 of whom exited homelessness by entering supportive housing – was carried out by the Economic Roundtable in 2009, in collaboration with Los Angeles County's Chief Executive Office. The study linked records for these individuals across multiple public agencies, providing crucial information about their characteristics and the public costs for services they used. The homeless population in this study was generally representative of Los Angeles County's overall population of homeless single adults who are U.S. citizens or legal immigrants.[37]

Seventeen types of costs could be determined for all persons in the study, based on data provided by county departments and other agencies:

1. Los Angeles County Department of Health Services hospitals-inpatient[38]
2. Los Angeles County Department of Health Services outpatient clinics
3. Los Angeles County Department of Health Services emergency rooms
4. Private hospitals-inpatient[39]
5. Private hospitals-emergency room[40]
6. Emergency Medical Transportation[41]
7. Los Angeles County Department of Mental Health
8. Los Angeles County Department of Public Health[42]
9. Los Angeles County Department of Public Social Services Food Stamps[43]
10. Los Angeles County Department of Public Social Services General Relief[44]
11. Los Angeles County Department of Public Social Services GR Housing Vouchers[45]
12. Los Angeles Homeless Services Authority services[46]
13. Los Angeles County Probation Department[47]
14. Los Angeles County Sheriff's Department general jail facilities and services[48]
15. Los Angeles County Sheriff's Department medical jail facilities and services[49]

16. Los Angeles County Sheriff's Department mental health jail facilities and services
17. Supportive housing costs

Twelve types of costs could not be determined and were left out of the study:

1. Homeless services not shown in Los Angeles County's Continuum of Care Homeless Management Information System (HMIS). These missing costs included a significant number of agencies funded by LA's Continuum of Care that do not submit data to HMIS, matching costs paid by service providers out of other sources of funds, and all nonprofit homeless service providers not funded by the Continuum of Care, including faith-based missions and food pantries.
2. Non-county outpatient clinics[50]
3. Non-county substance abuse facilities
4. Non-county mental health facilities
5. Veteran's Administrations services
6. State incarceration and parole
7. Federal incarceration
8. Police
9. Courts
10. Business environment impacts
11. Business improvement districts' (BID) costs for addressing homelessness
12. Costs outside of Los Angeles County

These twelve types of costs were unavailable for both housed and homeless individuals in this study, so the absence of this data did not create any asymmetry in cost comparisons. However, this missing data results in understating the amount of public costs for homeless residents, and where there are cost savings from housing individuals who are homeless, in *understating* the amount of those savings.

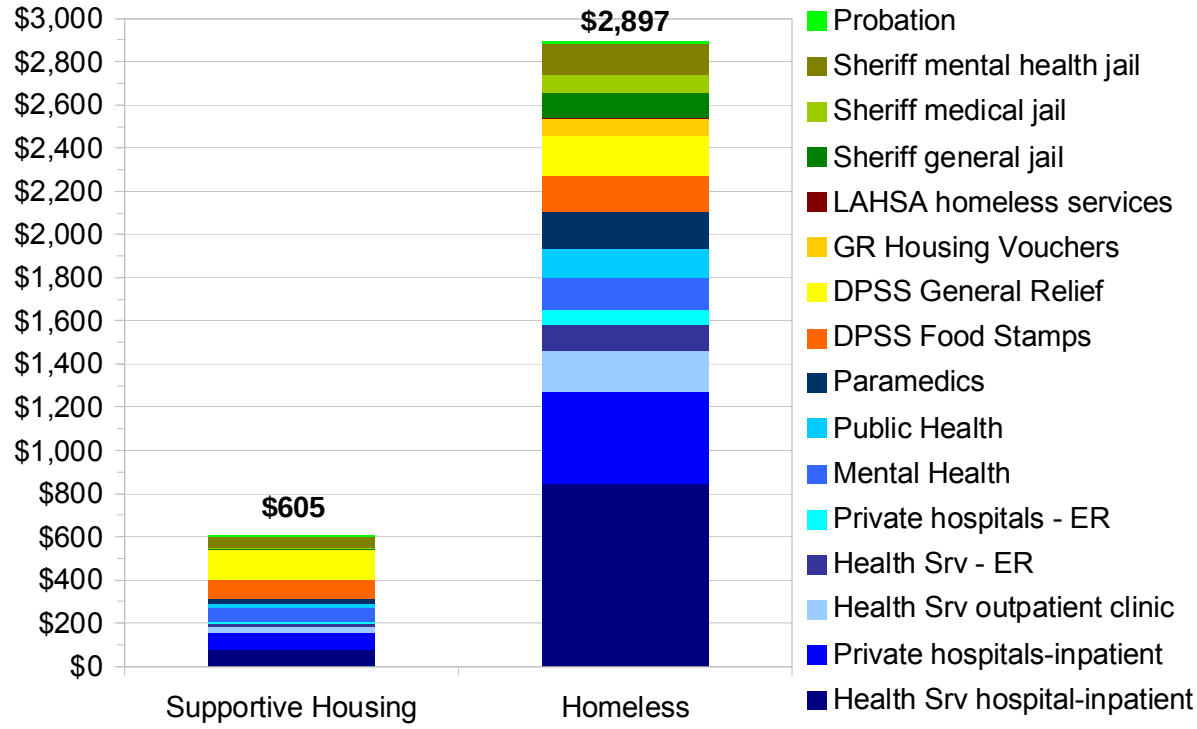
Incomplete cost data has two effects on this analysis:

1. Public costs for un-housed individuals are somewhat understated in comparison to supportive housing costs, which are fully identified.
2. Cost savings are somewhat understated because there are cost savings for most housed individuals, and to the extent that not all public costs are visible, not all savings are visible.

All 1,007 current and former residents in supportive housing were individuals with disabilities, many with histories of mental illness and substance abuse, and most were chronically homeless. The impact of supportive housing on public costs for persons who are homeless was estimated by comparing 279 individuals who were formerly homeless and had lived in supportive housing for at least a year with a matched-pair comparison group of 279 similar persons who remained homeless.[51] These comparison pairs were identified through one-by-one matches based on similar *propensity scores*, that is, similarity in the crucial attributes that characterize the population.[52]

The typical monthly cost for supportive housing residents is $605. The typical public cost for similar homeless persons is $2,897, five-times greater than their counterparts that are housed.[53] This remarkable finding that public costs are reduced by

Figure 25
Average Monthly Costs by Public Agency for Persons in Supportive Housing and Homeless Persons



Source: 279 Matched pairs of SRHT supportive housing residents and homeless General Relief recipients

four-fifths when homeless individuals with disabilities entered supportive housing demonstrates that practical, tangible public benefits result from providing housing and services for vulnerable individuals who are homeless.

Cost Distribution among Public Agencies when Homeless and Housed

Average monthly costs borne by public agencies and health providers for supportive housing residents and comparable homeless persons in this analysis are shown in Figure 25.

The amount of costs and the payer of costs vary greatly between people that are homeless and those that are housed. The $605 average monthly cost for supportive housing residents and the $2,897 average monthly cost for comparable homeless persons are distributed among service providers as shown in Table 4.

Table 4

Public Agency"	Supportive Housing Residents		Homeless Persons	
	Monthly Cost	*% of total*	*Monthly Cost*	*% of total*
Country Health Services hospital-inpatient	$80	13%	$848	29%
County Health Services outpatient clinic	$25	4%	$191	7%
County Health Services – ER	$13	2%	$118	4%
County Mental Health	$65	11%	$146	5%

Table 4, cost distribution among public agencies, continued

Public Agency	Supportive Housing Residents		Homeless Persons	
	Monthly Cost	*% of total*	*Monthly Cost*	*% of total*
County Public Health	$20	3%	$134	5%
County DPSS Food Stamps	$91	15%	$172	6%
County DPSS General Relief	$138	23%	$183	6%
County GR Housing Vouchers	$1	0%	$83	3%
Continuum of care homeless services	$0	0%	$2	0.1%
County Probation	$7	1%	$9	0.3%
County Sheriff general jail	$6	1%	$116	4%
County Sheriff medical jail	$4	1%	$84	3%
County Sheriff mental health jail	$48	8%	$146	5%
Private hospitals-inpatient	$76	13%	$424	15%
Private hospitals-ER	$9	2%	$74	3%
Paramedics	$22	4%	$167	6%
Total	$605	100%	$2,897	100%

Costs for health care services provided by the county departments of Health Services, Mental Health and Public Health, together with private hospitals, account for a majority – 68 percent – of the total cost for the matched-pair comparison group of persons who were homeless. Department of Public Social Service costs and justice system costs account for an additional 15 percent and 12 percent of total costs, respectively, for persons who were homeless.

The distribution of costs by public agency is quite different for supportive housing residents. The major difference is the share of total costs borne by agencies providing health services. Only 48 percent of total costs for supportive housing residents are county Health Services, county Public Health and private hospitals. Food Stamp and General Relief benefits account for an additional 15 and 23 percent, respectively, of the total cost for supportive housing residents.

Cost Savings by Public Agencies

Overall, the public cost for formerly homeless persons with disabilities in supportive housing was found to be 79 percent less than their homeless counterparts. This cost saving is seen across all public agencies, with the largest savings in health care services. Highlights of average monthly cost savings for housed individuals by public agency are as follows:

- $768 or 91 percent savings on county inpatient hospitalizations
- $348 or 82 percent savings on inpatient care at private hospitals
- $165 or 87 percent savings on county outpatient clinics
- $144 or 87 percent savings on paramedics
- $114 or 85 percent savings on county public health substance abuse programs
- $110 or 95 percent savings on incarceration in general jail facilities
- $105 or 89 percent savings on county emergency rooms
- $99 or 67 percent savings on incarceration in mental health jail facilities

- $81 or 56 percent savings on county mental health
- $81 or 47 percent savings on Food Stamps
- $80 or 95 percent savings on incarceration medical jail facilities

Cost Savings after Including the Cost of Supportive Housing

Local government is the primary beneficiary of the cost savings that result from supportive housing, but typically contributes only a small share of the cost for building and operating supportive housing.[54] Still, it is informative to include the operating costs[55] for supportive housing and the capital costs[56] for creating housing units in a final bottom line statement of cost savings.

When we add the capital and operating costs of housing to the public costs of individuals after they are housed, the average monthly savings to the public is $1,190 per person per month, compared to the cost when they were homeless.[57] This is a 44 percent reduction in total costs compared to costs when the residents of supportive housing were on the streets.

Summary of Findings about Cost Savings from Supportive Housing

High-need individuals with disabilities who are homeless have high public costs that are spread across multiple county agencies including health, social services, and justice system agencies. When these individuals are provided with supportive housing, which is permanent, affordable housing with on-site case management and linkages to additional supportive services, local public costs for them decrease by 79 percent. If the operating and capital costs, which are largely paid for by non-local funds, are added to the equation, public costs decrease by 44 percent.

Most individuals who enter supportive housing have been chronically homeless, many are mentally ill, and all have disabilities. The additional income and benefits provided by SSI will enable more individuals with disabilities who are homeless to enter supportive housing by increasing the amount of income that they can contribute towards rent, thereby reducing operating subsidies that must be provided by supportive housing operators.

Chapter 6

Benchmarks for Estimating Costs, Cost Saving and Economic Impacts

Many counties have small General Relief programs, with a large share of the indigent population disconnected from public assistance. The following benchmarks for costs, savings and impacts can be used when public data is not readily available to estimate hidden public costs, the share of the indigent population that has disabilities and is likely to be eligible for SSI, and probable public cost savings from moving low-income individuals with disabilities onto SSI.

Homelessness-linked Ratios

- 53 percent of the individuals admitted to hospitals who are homeless are estimated to also have disabilities and be eligible for SSI
- The annual number of inpatients admitted to hospitals who are homeless is conservatively estimated to be equivalent to 0.08 percent of the population
- 56 percent of hospital admissions for patients who are homeless are for mental disorders
- Among hospital patients who are homeless, 0.4 are paid for by county indigent programs for every patient paid for by Medi-Cal

Disability-linked Ratios

- There are 1.03 individuals with disabilities and incomes below $9,000 who are not receiving SSI for every person who is receiving SSI
- 37 percent of all GR recipients are estimated to be eligible for SSI
    - 18 percent of recipients 18-25 years of age have a disability
    - 26 percent of recipients 26 to 35 years of age have a disability
    - 41 percent of recipients 36 to 45 years of age have a disability
    - 51 percent of recipients 46-55 years of age have a disability
    - 53 percent of recipients 56 years of age or older have a disability
- 53 percent of homeless hospital patients are estimated to have a disability and be eligible for SSI
- 36 percent of county indigent hospital patients are estimated to have a disability and be eligible for SSI
- 76 percent of patients with chronic medical conditions are estimated to have a disability

Benefits-linked Ratios

- 49 percent of GR recipients have chronic medical conditions
- 37 percent of GR recipients have a disability and are eligible for SSI
- 12 percent of GR recipients have been employed in the past 3 years
- 88 percent of GR recipients are long-term unemployed

- For every 2.17 single adults 18-64 years of age with annual incomes of $4,000 or less who are U.S. citizens and not attending school, there is a statewide average of 1 person receiving General Relief in a given month
- The annual caseload of unduplicated GR recipients is 1.7 times greater than the General Relief caseload in a given month
- A typical GR recipient has $831 a month in public costs paid by counties including:
  - $675 for health care
  - $156 for public assistance
- The average monthly cost for inpatient stays and emergency room visits at private hospitals is $259 per GR recipient
- The statewide average monthly benefit payment to GR recipients is $216
- The statewide average monthly benefit payment to SSI recipients is $686

Hospital-linked Ratios

- The average cost per hospital admission of a patient who is homeless is $36,954
- The average cost per hospital admission of a county indigent patient is $40,503
- 51 percent of county indigent hospital inpatient admissions are for mental disorders
- 36 percent of county indigent patients are estimated to have a disability and be eligible for SSI

Economic Impact Ratios

- Annual economic output within each county is estimated to increase $4,714 for each single adult and $4,924 for each family member who moves from GR to SSI
- When 100 individuals move from GR to SSI, 3.1 new jobs are created in the regional economy
- Every dollar of income received by households with incomes under $10,000 per year is estimated to generate $0.064957 in federal tax revenue
- Every dollar of income received by households with incomes under $10,000 per year is estimated to generate $0.060797 in tax revenue for local and state government

Supportive Housing Ratios

- When chronically homeless individuals with disabilities enter supportive housing, local public costs for them decrease by 79 percent
- If the operating and capital costs, which are largely paid for by federal funds, are added to the equation, public costs for supportive housing residents decrease by 44 percent compared to when they were homeless
- Health care costs for supportive housing residents are 86 percent less than when they were homeless

Data Appendix

Five data sets were used in preparing this paper. Each graph has a footnote explaining the sources of data for the graph. Each of the five data sets are described below.

1. *U.S. Census Bureau American Community Survey*
   - Public Use Microdata Sample (PUMS) data for 2009 provides responses to the complete Census Bureau long-form questionnaire for 352,875 California residents. These records are weighted and can be used to represent the entire state population
   - These records can be filtered and cross tabulated based on any combination of variables include in the data. For example, these cross tabulations can provide information about disability rate among indigent adults who live in 1-person households, are 18-64 years of age, are U.S. citizens, and are not attending school.

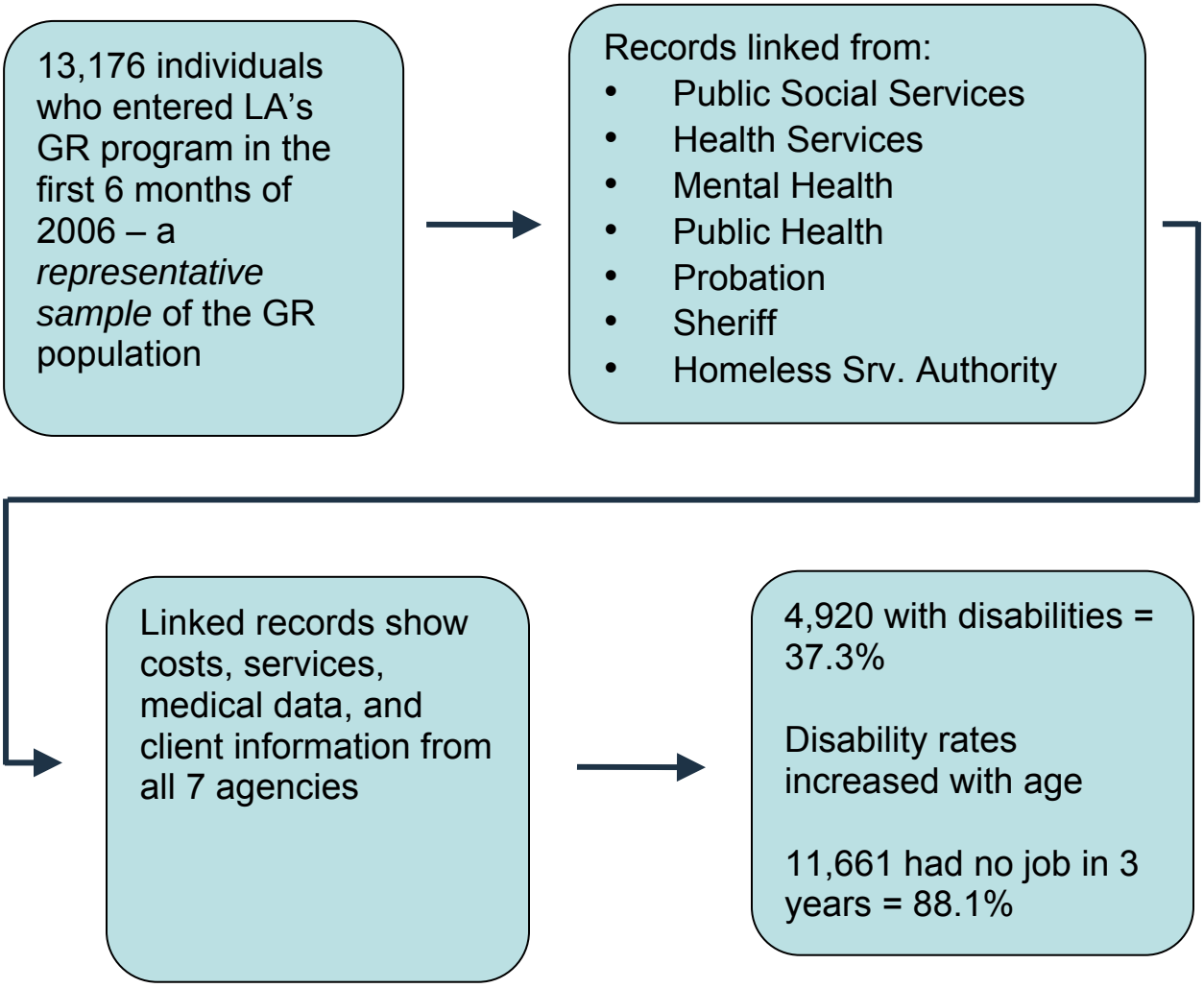
2. *California Office of Statewide Health Planning and Development (OSHPD)*
   - De-identified records for every hospital admission in the state. Includes diagnosis, hospital ID, cost, source of payment, and flag for patients who are homeless
   - Provides information about medical problems and who pays hospital costs
   - Data for 4,017,998 hospital admissions in 2008 and 3,985,166 hospital admissions in 2009. The combined 2008-2009 records include 140,173 patients charged to county indigent programs and 36,367 patients who were homeless.

3. *California Department of Social Services GR 237 - General Relief Report*
   - Monthly reports from each county about the number of family and individual cases, total persons in each type of case, and amount of benefits paid
   - Provides information about GR caseload size and cost in each county

4. *IMPLAN input-output econometric model*
   - The model produces estimates of economic impacts using data about the relationship of every industry to every other industry in the county economy and projects probable economic changes if expenditure levels change.
   - Provides information about the economic, employment and tax impacts that would result from additional revenue for households in different income bands

5. *Los Angeles County Adult Linkage Project*
   - Linked records from 7 county agencies for a representative sample of 13,176 General Relief recipients, with information about services, costs and client characteristics from each agency, including medical diagnoses
   - Provides information about health problems, employment history, disabilities, and homelessness among GR recipients
   - The following flow chart shows the steps in linking records through the Los Angeles County Adult Linkage Project

Los Angeles County Adult Linkage Project



END NOTES

[1] The term indigent is used two ways in this report. First, it refers to California residents who are General Relief/Assistance recipients, or who have annual incomes under $4,000 a year and appear to be eligible for General Relief/Assistance. Second, it refers to hospital patients whose medical costs are paid by county indigent programs. These two populations overlap, but we do not have income data for the second population.

[2] Data in this report for Indices and rates of persons with disabilities comes largely from self declarations of respondents to the U.S. Census Bureau's American Community Survey and from case records linked across departments of a representative sample of General Relief recipients in Los Angeles County. These incidences of disabilities are assumed to meet the standard met by the Social Security Administration. "Disability" under the Social Security Administration is based on a person's inability to work. A person is considered "disabled" under Social Security rules if:

a. He or she cannot do work that they did before;

b. The Social Security Administration decides that the person cannot adjust to other work because of their medical condition(s); and

c. The person's disability has lasted or is expected to last for at least one year or to result in death.

Anecdotal information suggests that the 37 percent rate of disabilities shown in records of General Relief recipients may be lower than actual rates, indicating that this benchmark used throughout this report may be conservative.

[3] Data showing population size by income group and disability status is from Public Use Microdata Sample (PUMS) records from U.S. Census Bureau's 2009 American Community Survey. These records provide responses to the Census long-form questionnaire for a weighted 1 percent sample of the population, with the weights making it possible to expand the sample to represent the entire population. In producing data for this study, these records were filtered to include only single adults 18 to 64 years of age who are U.S. Citizens and not enrolled in school. The resulting sample of indigent and disabled persons in Yolo County was too small to provide reliable information. General relief caseload information is from the California Department of Social Services GR 237 report, September 2009 to August 2010. Data about hospital patients is from the State of California Office of Statewide Health Planning and Development, Patient Discharge Data for 2008-2009. This data set contains a de-identified record for every person discharged from a hospital, including gender, age, ethnicity, ZIP Code of residence, name and address of hospital, diagnostic codes, procedure codes, payment codes, length of stay, and status when discharged. The geographic location of homeless patients is inferred from the location of the hospital, since no address is provided for these patients.

[4] Supporting data for Figure 1, Number of Residents by County who are Indigent, GR Recipients, Low-income and Disabled, and SSI Recipients

	Indigent - Income <$4,000	Monthly GR Caseload	Disabled & SSI Eligible	SSI Recipients in 2009	Indigent hospital admissions	Homeless hospital admissions
CALIFORNIA	299,021	137,622	110,157	107,468	70,087	18,184
Los Angeles	65,112	93,893	23,652	24,690	17,887	6,497
Alameda	9,134	8,009	2,942	4,608	2,911	1,149
Contra Costa	3,120	899	2,103	2,021	1,665	194
Fresno	12,093	2,438	4,371	6,734	3,162	142
Orange	9,832	585	3,143	4,539	6,060	733
Sacramento	15,089	8,192	4,681	5,265	3,507	923
San Diego	18,786	1,046	5,479	7,528	7,536	3,112
San Francisco	8,034	7,439	4,242	4,830	1,372	1,958
San Mateo	2,230	656	1,672	1,815	794	86
Santa Clara	9,326	4,089	6,031	2,565	2,632	846
Yolo	n.a.	110	n.a.	n.a.	124	1

The data cells for Yolo County with n.a. notations represent data from the 2009 American Community Survey (ACS). The sample of ACS records for Yolo County is too small to provide reliable data for these cells.

[5] Data for hospitalization of homeless and county indigent patients is from the State of California Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data for 2008-2009. These records do not include information about school enrollment, citizenship status, or marital status, so these records were not filtered for those factors. The records do include information about age, but since 96.4 percent of homeless patients and 98.0 percent of county indigent patients are 18 to 64 years of age, and since the individuals outside of this age range may well be eligible for SSI, this data was not filtered based on age.

[6] Number of potential GR recipients in California and study counties with incomes of $4,000 or less in 2009, based on different inclusion criteria for population

	All Filtering Criteria Applied	**Citizenship Criteria Dropped**	**School Enrollment Criteria Dropped**	**Household Size Criteria Dropped**
COUNTY	Income ≤$4,000, 18-64 years, U.S. citizen, not enrolled in school, 1-person household	Income ≤$4,000, 18-64 years, not enrolled in school, 1-person household	Income ≤$4,000, 18-64 years, U.S. citizen, 1-person household	Income ≤$4,000, 18-64 years, U.S. citizen, not enrolled in school
Alameda	9,134	9,477	15,351	82,053
Contra Costa	3,120	3,224	4,226	59,135
Fresno	12,093	13,182	14,542	64,570
Los Angeles	65,112	76,610	105,465	587,649
Orange	9,832	11,249	24,524	171,652
Sacramento	15,089	16,696	19,562	97,179
San Diego	18,786	21,154	37,228	185,780
San Francisco	8,034	8,702	11,845	41,462
San Mateo	2,230	2,308	3,389	31,567
Santa Clara	9,326	10,607	18,155	96,302
Yolo	213	213	5,438	7,500
CALIFORNIA	299,021	339,946	452,664	2,364,787
Population increase with criteria dropped		*14%*	*51%*	*691%*

Source: U.S. Census Bureau, 2009 American Community Survey Public Use Microdata Sample

[7] Economic Roundtable (2004): "*Homeless in LA: Final Research Report for the 10-Year Plan to End Homelessness in Los Angeles County*," p.71, www.economicrt.org.

[8] Anecdotal information as well as the quantitative mismatch between the number of California residents identified as homeless and the number of hospital patients identified as homeless in OSHPD data indicate that hospitals are quite cautious about identifying patients as homeless. This appears to result in this population being significantly undercounted in OSHPD data.

[9] These higher coverage rates may be partially explained by the fact that Los Angeles covers employable recipients for 9 out of 12 months a year, San Francisco 12 out of 12 months, and Alameda only recently reduced coverage to 3 months out of 12. Many counties limit coverage to 3 months out of 12.

[10] This is a conservative estimate of the rate of turnover in the GR population. Many counties terminate aid to "employable" recipients after three months, likely resulting in a typical statewide stay on GR that is shorter than the seven months found in Los Angeles County. Data for Los Angeles County is from Moreno, Manuel H., Halil Toros, Max Stevens (2009), "The General Relief Housing Subsidy and Case Management Pilot Project: An Evaluation of Participant Outcomes and Cost Savings," County of Los Angeles Chief Executive Office, Service Integration Branch. p. 8. This data about duration of General Relief enrollment is from a pilot program. The population in this program was similar, but not identical, to the overall GR population in Los Angeles County. The length of stay on GR within this population may differ from the overall population in Los Angeles County as well as the overall population in the state.

[11]Economic Roundtable (2010): "*Tools for Identifying High-Cost, High-Need Homeless Persons*," p. 3, www.economicrt.org.

[12] Supporting data for Figure 9, County Point-in-Time Monthly Cost Savings from Moving GR Recipients to SSI - 2008$

	General Relief	County hospital-inpatient	County hospital ER	County clinic	Mental health services	Substance abuse services	Private hospital-inpatient	Private hospital ER
CALIFORNIA	7,578,164	20,000,115	4,256,094	4,811,419	3,159,817	2,457,088	10,528,360	2,806,974
Los Angeles	5,170,235	13,645,164	2,903,738	3,282,611	2,155,799	1,676,359	7,183,018	1,915,070
Alameda	441,012	1,163,909	247,684	280,001	183,886	142,990	612,699	163,352
Contra Costa	49,504	130,649	27,802	31,430	20,641	16,051	68,775	18,336
Fresno	134,235	354,270	75,390	85,227	55,971	43,523	186,493	49,721
Orange	32,204	84,992	18,087	20,446	13,428	10,442	44,741	11,928
Sacramento	451,116	1,190,576	253,359	286,416	188,099	146,267	626,737	167,095
San Diego	57,612	152,048	32,356	36,578	24,022	18,680	80,040	21,340
San Francisco	409,629	1,081,085	230,059	260,076	170,801	132,815	569,099	151,728
San Mateo	36,136	95,371	20,295	22,943	15,068	11,717	50,205	13,385
Santa Clara	225,170	594,265	126,462	142,962	93,888	73,008	312,830	83,404
Yolo	6,043	15,950	3,394	3,837	2,520	1,959	8,396	2,238

[13] Of the 140,173 California hospital patients charged to county indigent programs in 2008 and 2009, 5,005 were identified by hospitals as being homeless.

[14] Supporting data for Figure 10, Annual Average Admissions of Homeless Persons to Hospitals in 2008 and 2009, by Facility Type

	Acute Care	Psychiatric Care	Chemical Dependency Recovery Care	Skilled Nursing / Intermediate Care	Physical Rehabilitation Care
CALIFORNIA	8,990	8,283	768	120	24
Los Angeles	2,756	2,981	748	12	1
Alameda	624	499	0	8	18
Contra Costa	131	64	0	0	0
Fresno	34	108	0	1	0
Orange	333	398	0	3	1
Sacramento	505	415	0	3	1
San Diego	1,643	1,438	17	13	2
San Francisco	1,302	580	0	77	0
San Mateo	40	43	1	3	0
Santa Clara	701	144	0	0	2
Yolo	1	0	0	0	0

[15] U.S. Census Bureau, 2009 American Community Survey, Table B01001, Sex by Age, Universe: Total Population, shows 23,383,331 California residents 18 to 64 years of age in 2009.

[16] California Office of Statewide Health Planning and Development (OSHPD), "Patient Discharge Data File Documentation," Public File, January-December 2009, p. 8, http://www.oshpd.ca.gov/HID/Products/PatDischargeData/PublicDataSet/Doc/PD09docwapp.pdf.

[17] Supporting data for Figure 11, Average annual number of number of homeless patient days 2008 and 2009 by type of hospital

	Psychiatric Care	Acute Care	Skilled Nursing / Intermediate Care	Chemical Dependency Recovery Care	Physical Rehabilitation Care
CALIFORNIA	78,457	56,883	9,747	9,741	509
Los Angeles	28,666	15,160	1,762	9,610	13
Alameda	4,192	3,578	252	.	418
Contra Costa	472	1,021	.	.	.
Fresno	697	246	10	.	.
Orange	7,064	2,215	675	.	6
Sacramento	5,671	3,434	72	.	6

San Diego	12,336	9,845	376	125	27
San Francisco	6,076	10,878	6,206	.	.
San Mateo	685	284	202	2	.
Santa Clara	1,791	4,505	.	.	27
Yolo	.	3	.	.	.

[18] Supporting data for Figure 12, Average Annual Cost for Homeless Inpatients by Payer

	Medi-Cal	Self Pay	Medicare	County Indigent Programs	Other Government	Other Indigent	Private Coverage	Other Payer
CALIFORNIA	282,826,969	92,833,303	90,076,247	84,897,214	43,325,644	37,791,605	21,859,897	18,338,112
Los Angeles	23,238,702	4,604,756	7,474,882	6,679,090	278,138	8,606,394	651,042	77,746
Alameda	4,542,862	3,426,822	890,703	1,223,734	271,455	48,201	585,813	19,330
Contra Costa	785,011	234,345	90,038	977,366	214,658	0	19,012	0
Fresno	72,407,470	30,156,492	25,467,259	12,423,143	19,262,786	9,203,206	3,397,159	2,413,315
Orange	19,037,400	1,434,894	2,858,750	2,071,425	177,009	1,336,373	602,223	4,001,017
Sacramento	15,643,348	8,083,344	5,413,281	12,934,660	2,689,020	85,314	990,642	21
San Diego	29,060,713	24,879,697	17,718,305	19,683,248	2,025,908	5,061,591	4,072,438	879,675
San Francisco	73,153,648	3,734,727	15,101,739	11,284,611	9,089,880	1,501,410	6,248,634	6,832,505
San Mateo	750,883	439,645	444,584	506,757	27,527	0	51,281	0
Santa Clara	21,189,751	1,407,574	4,762,022	9,962,613	4,473,812	5,875,244	1,872,312	1,253,137
Yolo	0	0	19,415	0	0	0	20,420	0

[19] The estimated cost avoidances here do not account for the effects of the Affordable Care Act (ACA), which was enacted as federal law in March, 2010, and is being implemented in stages over the next several years. Significantly, starting in 2014, the ACA will require all states to expand their Medicaid programs (Medi-Cal in California) to include ***all*** adults who meet immigration and income eligibility requirements. Medi-Cal is a state and federal government funded program; the counties expend little or no general fund dollars on Medi-Cal.
Currently, California limits Medi-Cal enrollment to certain low-income parents, seniors, and persons with disabilities. Most General Relief recipients are not enrolled in Medi-Cal, even if they may be eligible due to their disabilities. The disability standard for Medi-Cal is very similar to that of the SSI program, and SSI recipients automatically receive Medi-Cal. Thus, this study assumes that counties will be able to avoid certain health care costs when GR recipients move onto SSI and Medi-Cal. This assumption stems from the fact that, currently, when someone moves onto Medi-Cal, the state and federal governments will pay for their health care, rather than the county through a county indigent health program.
In 2014, most GR recipients will become eligible for Medi-Cal through the ACA. Thus, the counties will likely expend fewer county general funds on health care for this population, regardless of whether they are on SSI or GR. Moreover, starting in 2011, counties have the option to begin implementing Medi-Cal Expansion (MCE) programs through California's Section 1115 Medicaid Waiver. These programs will provide 50 percent federal reimbursement for county funds spent on health care for certain low-income adults, including much of the General Relief population. The Section 1115 Medicaid Waiver, however, contains a Maintenance of Effort provision that will require counties to maintain 2010 levels of county funding on health care for this population. Counties that implement MCEs, however, will likely be insulated by federal reimbursement funds from increases in health care costs in future years.

[20] All individuals on General Relief are likely eligible for the Medicaid Coverage Expansion under LIHP, which provides county coverage to individuals under 133% of the Federal Poverty Level.
Counties with large General Relief caseloads that successfully link General Relief recipients to the LIHP could realize significant cost avoidance when the federal government provides partial reimbursement for medical services delivered to this population. However, mental health services are limited and substance abuse services are not included in the required 1115 Waiver benefit package. Because 70 percent of General Relief recipients are homeless, it is likely that these two type s of care, which together make up over 15 percent of the county health care costs for the typical General Relief recipient with a disability (see Figure 8), could provide additional cost avoidance to counties if added to the LIHP Medicaid Coverage Expansion.

The further advantage of linking the General Relief population to the Medicaid Coverage Expansion is that by providing medical care to these individuals it is more likely that the County can establish the medical record necessary for successful SSI applications, potentially providing additional cost avoidance for the County. As described more fully in a companion report, "Investing in People to Save Counties Money," providing supportive housing and case management to this population will further assist in stabilizing lives and sustaining the county's cost avoidance.

[21] Supporting data for Figure 13, Number of Homeless hospital Admissions Each Year in 2008 and 2009 by Type of Disease

	Mental disorders	Injury and poisoning	Digestive diseases	Circulatory diseases	Respiratory diseases	Skin diseases	Other	Total
CALIFORNIA	10,249	1,488	1,056	952	883	772	2,785	18,184
Los Angeles	556	74	69	77	86	77	211	1,149
Alameda	78	34	13	11	14	9	36	194
Contra Costa	110	8	5	5	2	3	11	142
Fresno	4,217	397	345	290	213	206	830	6,497
Orange	489	44	38	29	19	25	90	733
Sacramento	472	102	43	56	45	48	158	923
San Diego	1,592	346	208	152	172	129	515	3,112
San Francisco	702	240	114	154	168	159	423	1,958
San Mateo	53	2	3	4	5	4	16	86
Santa Clara	225	99	96	92	63	46	226	846
Yolo	0	1	0	0	0	0	1	1

[22] The 76 percent disability rate among very low-income adults with chronic medical conditions is based on Los Angeles County's Adult Linkage Project which records across agency sectors for a representative sample of 13,176 General Relief recipients. Of the 6,922 individuals with health care encounters in this data set, the number of persons with disabilities represented 75.6 percent of the number with chronic medical conditions.

[23] Supporting data for Figure 14, Number of Chronic and Disabled Homeless Patients Admitted to Hospitals Each Year in 2008 and 2009

	Annual Homeless Inpatients with Non-Chronic Conditions	Annual Homeless Inpatients - Chronic Medical Conditions but Not Disabled	Annual Indigent Homeless - Chronic Medical Conditions and Disabled
CALIFORNIA	5,425	3,108	9,651
Los Angeles	389	185	575
Alameda	91	25	78
Contra Costa	24	29	89
Fresno	1,503	1,217	3,778
Orange	169	137	427
Sacramento	315	148	460
San Diego	1,069	498	1,546
San Francisco	907	256	795
San Mateo	24	15	47
Santa Clara	395	110	341
Yolo	1	0	0

[24] Other statewide sources of payment for homeless patients over this two-year period included: Medicare 5,420 patients, private coverage 1,533, Workers' Compensation 43, other government programs, 4,843, other indigent programs 1,539, self pay 6,047, other payer 646, not reported or reported in error 2.

[25] Public costs in Los Angeles County were found to decrease an average of 79 percent when chronically homeless, individuals with disabilities entered permanent supportive housing. Economic Roundtable (2009), "*Where We Sleep*," pp. 25-30, www.economicrt.org.

[26] Supporting data for Figure 15, Number of Chronic and Disabled County Indigent Patients Admitted to Hospitals Each Year in 2008 and 2009

	Annual Indigent County Inpatients with Non-Chronic Conditions	Annual Indigent County Inpatients - Chronic Medical Conditions but Not Disabled	Annual Indigent County Inpatients - Chronic Medical Conditions and Disabled
CALIFORNIA	36,455	8,192	25,440
Los Angeles	1,462	353	1,096
Alameda	1,020	157	488
Contra Costa	1,633	372	1,157
Fresno	10,643	1,764	5,480
Orange	3,550	611	1,899
Sacramento	1,985	371	1,151
San Diego	3,841	900	2,795
San Francisco	831	132	409
San Mateo	322	115	357
Santa Clara	1,577	257	798
Yolo	50	18	56

[27] California Office of Statewide Health Planning and Development (OSHPD), "Patient Discharge Data," Public File, 2008-2009.

[28] Supporting data for Figure 16, Annual Cost of Chronic and Disabled County Indigent Patients Admitted to Hospitals in 2008 and 2009

	Indigents with Non-Chronic Medical Conditions	Non-disabled Indigents with Chronic Medical Conditions	Disabled Indigents with Chronic Medical Conditions
CALIFORNIA	$1,626,282,301	$295,309,255	$917,105,914
Los Angeles	$53,769,139	$10,545,729	$32,750,584
Alameda	$24,539,362	$4,312,993	$13,394,334
Contra Costa	$58,781,237	$9,221,852	$28,639,180
Fresno	$300,953,393	$47,477,924	$147,446,395
Orange	$192,264,317	$35,091,941	$108,980,760
Sacramento	$195,412,689	$28,022,830	$87,027,083
San Diego	$215,199,957	$37,722,533	$117,150,267
San Francisco	$45,316,041	$10,756,139	$33,404,030
San Mateo	$7,281,709	$2,370,828	$7,362,790
Santa Clara	$58,361,803	$11,628,160	$36,112,156
Yolo	$3,192,471	$603,021	$1,872,730

[29] Note: Includes only indigent patients with chronic medical conditions. Supporting data for Figure 17 Causes of Hospitalization for County Indigent Patients with Chronic Medical Conditions in 2008 and 2009

	Mental disorders	Circulatory diseases	Digestive diseases	Neoplasms	Endocrine diseases	Musculo-skeletal dis.	Genito-urinary dis.	Respiratory diseases	Other
CALIFORNIA	12,799	3,558	1,661	1,509	1,434	1,257	762	648	1,563
Los Angeles	792	110	39	26	28	44	25	24	58
Alameda	96	106	53	44	40	30	16	18	38
Contra Costa	629	147	88	47	58	37	27	32	63
Fresno	1,676	1,135	423	390	550	324	311	106	549
Orange	327	331	199	182	126	127	36	76	143
Sacramento	482	162	83	105	59	71	24	31	70
San Diego	1,447	336	161	156	124	104	31	93	152
San Francisco	43	86	23	93	36	51	19	10	51
San Mateo	272	24	10	33	13	17	10	6	17
Santa Clara	74	210	96	87	68	43	43	20	75
Yolo	45	2	6	3	1	1	0	1	2

[30] The basic concept of input-output modeling is that production of goods and services occurs through industry networks in which outputs from some industries become inputs for others in a chain of value-added relationships. The input-output model replicates this value-added chain in a very large matrix derived from industry reports of

sales and purchases between all sectors of the economy. Input-output analysis is a powerful tool for revealing the total economic impacts of different industries in:

- Creating jobs through direct employment, linked industries, and consumer industries fueled by purchases of directly employed workers.
- Producing output in anchor industries, linked industries, and consumer industries supplying worker needs.
- Generating taxes for local government in the form of property, sales, excise and severance taxes, and business fees and licenses.
- Attracting wealth from outside the region and creating positive trade balances, as reflected by the percent of output made up of imports compared to percent of output that is exported.

Input-output modeling produces estimates of the extent to which the ripple effects of an economic activity multiply the impact of the initial activity. Multipliers are one of the most useful measures of an industry's total economic impacts. Multiplier analysis is used to estimate the regional economic impacts resulting from a specified change in demand for a commodity. Typically, three types of economic "effects" are identified:

- Direct Effects are production changes associated with the immediate effects of final demand changes. For example, if consumer spending on commodity A increases by one million dollars, then the industry producing commodity A must expand output by one million dollars.
- Indirect Effects are production changes in industries that make inputs consumed by sectors experiencing direct effects. For example, if the output of commodity A expands by one million dollars, and if commodities B and C are used as inputs in the production of commodity A, then the output of commodities B and C will also increase with an expansion in demand for commodity A. The production of commodities B and C also consumes inputs that have to be produced, and so this multiplier process continues across many sectors and rounds of production.
- Induced Effects are production changes that result from increased consumer spending throughout the regional economy. Labor is an input in all sectors of the economy. As direct and indirect effects demand greater volumes of output be produced within the economy, so additional labor is used. A portion of the wages received by workers performing this labor is spent within the region, thus stimulating further demand.

Information about economic impacts of income growth through SSI enrollment was produced using IMPLAN input-output software to create a model of the economy of each study county, using 2008 IMPLAN data. IMPLAN is an economic impact assessment software system created by the Minnesota IMPLAN Group. The IMPLAN system serves three functions: 1) data retrieval, 2) data reduction and model development, and 3) impact analysis.
The IMPLAN database consists of two major parts: 1) a national-level technology matrix and 2) estimates of sectorial activity for final demand, final payments, industry output and employment for each county in the U.S. along with state and national totals. Input-output accounting describes commodity flows from producers to intermediate and final consumers. Using county-level data provided by IMPLAN it is possible to estimate each industry's total purchases of commodities and services, employment, compensation to employees and owners, value added, tax payments, and imports. Purchases for final use (final demand) drive the model.

[31] IMPLAN software was used to project the broader economic impacts of the increase in income that would result from moving eligible persons with disabilities in each county onto Supplemental Security Income. The IMPLAN model for Los Angeles County was used to represent impacts that occur within regional economies throughout the state. Industry and employment data used in the model was for 2008, the most recent data available when these projections were produced. Impacts were adjusted to show effects in 2010 dollars.

[32] The estimate that local output increases by 83.7 percent of the amount of increased income received by GR recipients who move onto SSI is conservative because only the amount of the increase is treated as new dollars in coming into the region, rather than the total amount of the SSI grant. Funds counties no longer pay to GR recipients may be reallocated to other uses, such as paving roads or maintaining parks, rather than resulting in an overall reduction in public expenditures. In that case, the entire amount of SSI payments will represent additional cash infusions into the regional economy.

[33] Supporting data for Figure 21, Additional Economic Output Generated Each Year by the Potential Additional Income of SSI Recipients, and Figure 22, Moving Eligible Residents onto SSI will create over 4,300 New Jobs in California:

	GR Recipients Estimated to be Eligible for SSI	Unaided Individuals Estimated to be Eligible for SSI	Economic Output Generated by Moving Eligible GR Recipients onto SSI	Economic Output Generated by Moving Eligible Unaided Individuals onto SSI	Jobs Created by Moving Eligible GR Recipients onto SSI	Jobs Generated by Moving Eligible Unaided Individuals onto SSI
California	51,389	58,768	$242,245,356	$404,607,482	1,614	2,696
Alameda	2,991	1,576	$11,978,885	$10,381,125	80	61
Contra Costa	336	1,767	$1,542,925	$12,831,558	10	79
Fresno	910	3,461	$3,470,955	$22,483,549	23	128
Los Angeles	35,060	18,481	$176,628,145	$130,954,349	1,177	906
Orange	218	2,925	$1,073,425	$20,540,706	7	140
Sacramento	3,059	1,622	$15,927,622	$11,154,277	106	82
San Diego	391	5,088	$2,184,646	$38,522,401	15	277
San Francisco	2,778	1,464	$9,082,046	$9,848,614	61	47
San Mateo	245	1,427	$934,261	$10,447,897	6	53
Santa Clara	1,527	4,504	$7,502,744	$30,308,912	50	215
Yolo	41	136	$238,154	$1,094,791	2	8

[34] The conservative methods used in this study to estimate the size of the indigent population produced anomalous outcomes for Alameda and Los Angeles counties – no unaided individuals were shown to be eligible for SSI. This excessively conservative outcome was the result of our very conservative estimate of the size of the total population that is eligible for GR, combined with higher-than-average effectiveness in these counties in obtaining GR and SSI coverage for eligible individuals. To correct this anomaly, an eligibility ratio from San Francisco, which is another urban county with comparatively generous benefit policies, was applied to Alameda and Los Angeles counties. The share of unaided individuals in San Francisco who are estimated to be eligible for SSI is equivalent to 53 percent of the number of GR recipients who are eligible for SSI. This rate was applied to Alameda and Los Angeles counties to estimate the size of the unaided population that is eligible for SSI in those counties.

[35] Supporting data for Figure 23, Local and State Taxes Generated Annually by the Potential Additional Income of SSI Recipients, and Figure 24, Federal Taxes Generated Annually by the Potential Additional Income of SSI Recipients:

	State and Local Taxes Generated by Moving Eligible GR Recipients onto SSI	State and Local Taxes Generated by Moving Eligible Unaided Individuals onto SSI	Federal Taxes Generated by Moving Eligible GR Recipients onto SSI	Federal Taxes Generated by Moving All Unaided Individuals onto SSI
California	$17,598,707	$29,394,035	$18,802,939	$31,405,390
Alameda	$870,245	$669,978	$929,794	$715,823
Contra Costa	$112,091	$861,879	$119,761	$920,855
Fresno	$252,159	$1,400,156	$269,413	$1,495,965
Los Angeles	$12,831,730	$9,878,797	$13,709,771	$10,554,777
Orange	$77,983	$1,525,310	$83,319	$1,629,683
Sacramento	$1,157,114	$896,009	$1,236,292	$957,320
San Diego	$158,711	$3,019,044	$169,571	$3,225,629
San Francisco	$659,795	$507,958	$704,943	$542,716
San Mateo	$67,872	$577,241	$72,517	$616,740
Santa Clara	$545,061	$2,348,229	$582,359	$2,508,912
Yolo	$17,301	$83,869	$18,485	$89,608

[36] Daniel Flaming, Michael Matsunaga and Patrick Burns (2009): "*Where We Sleep: The Costs of Housing and Homelessness in Los Angeles*," Economic Roundtable, www.economicrt.org.

[37] The complex task of linking client records was carried out by the Service Integration Branch of Los Angeles County's Chief Executive Office through its Adult Linkages Project (ALP). Focusing on indigent adults

participating in Los Angeles County's General Relief Program, the ALP linked administrative records across eight departments to provide information on client needs, service gaps, service costs, and utilization patterns. The ALP used an anonymous record linkage method that addressed the legal obstacles involved in sharing confidential information by de-identifying personal information provided in administrative data. Random project IDs are generated for each participant. These markers do not identify any client personally.

[38] Using information from the LA County CEO-SIB staff as well as from the California Office of Statewide Health Planning and Development (OSHPD), the Economic Roundtable applied per day cost factors to the service records obtained from the LA County Department of Health Services. The per day cost factors were applied based upon the county clinic or hospital providing the service, and the type of health service: inpatient, outpatient or emergency. For DHS *inpatient* service records containing either an ICD-9 procedure code or diagnosis code, the Economic Roundtable *superseded* these cost factors with cost data from another data source: Patient Discharge Data from OSHPD. Inpatient health records from OSHPD were compiled spanning the years 2005-2007 where the patient was determined to be homeless. (OSHPD's Patient Discharge Data contains a variable for the patient's 5-digit ZIP Code of residence, *PAT_ZIP*; homeless patients are assigned a zip code of ZZZZZ.) This homeless-specific data set for Los Angeles County contained over 17,000 inpatient discharge records with ICD-9 procedure and diagnosis codes. The charges recorded in this data set covers all services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates (before contractual adjustments). The Economic Roundtable then created a per day cost factor from this OSHPD data, and calculated average daily costs for all ICD-9 procedure and diagnosis codes. For procedures where there was not cost data from OSHPD records, the Economic Roundtable used the information from Los Angeles County CEO-SIB staff in the table above.

[39] The ratio of visits by downtown Los Angeles homeless residents to private hospitals as compared to county hospitals within a 3-mile radius of downtown Los Angeles was determined using hospital discharge records from the California Office of Statewide Health Planning and Development (OSHPD). The ten hospitals were California Hospital Medical Center - Los Angeles, Pacific Alliance Medical Center, Good Samaritan Hospital-Los Angeles, Promise Hospital of East Los Angeles-East L.A. Campus, Kaiser Foundation Hospital - Mental Health Center, White Memorial Medical Center, USC Kenneth Norris, Jr. Cancer Hospital, Los Angeles County-USC Medical Center, USC University Hospital – Norfolk, USC University Hospital – San Pablo Street. OSHPD records were extracted for inpatient hospitalizations of homeless patients from 2005 through 2007. The ratio of discharges from private hospitals to discharges from county hospitals was found to be 0.6195 to 1. The average cost per discharge of homeless residents from private hospitals was found to be $31,469 in 2008 dollars (the comparable cost for county discharges was $35,284). These hospitalization and cost ratios were applied to county Department of Health Services inpatient hospital discharges of homeless residents in order to estimate the number and cost of homeless discharges for county hospitals. Since only 4.6 percent of the homeless General Relief recipients in this study were hospitalized in a county Department of Health Services hospital during a month when they were homeless within the cost window for this study (and 3.2 percent in a month when they were not homeless), these estimates of private hospitalization costs could not be applied to individuals, but only to groups within the study population - based on the frequency with which members of the group are inpatients in county hospitals. Unless otherwise noted, all cost and cost savings estimates in this study are based on group data that includes estimates of private hospital inpatient and emergency room costs and emergency medical transportation costs.

[40] Homeless visits to private hospital emergency rooms compared to county hospital emergency rooms were assumed to be the same ratio as homeless admissions to private hospitals compared to county hospitals: 0.6195. The cost ratio for private emergency visits compared to county emergency room visits was assumed to be proportionate to the cost differential for homeless discharges from private hospitals compared to county hospitals, which is 0.8919 to 1. Since only 17.3 percent of the homeless General Relief recipients in this study visited a county Department of Health Services hospital emergency room during a month when they were homeless within the cost window for this study (and 11.6 percent in a month when they were not homeless), these estimates of private emergency room visits could only be applied to groups within the study population, not to individuals.

[41] Cost estimates for emergency medical transportation assumed that there was one one-way trip for each hospital admission or emergency room visit. No estimates were made of paramedic services provided to homeless individuals who were not taken to hospitals. The estimated cost was $850 per transport. This figure is based on Daniel Chandler's interview with Captain Douglas of the LA City Fire Department, which provides paramedic services in the Skid Row Area.

[42] The cost factors for the county Department of Public Health were: $8.50 per day for Outpatient Services, $63 per day for Residential Services, $360 per day for Detoxification Services, and $8.50 per day for other services.

[43] Costs for Food Stamp and General Relief (but not emergency housing voucher) benefits provided by the Department of Public Social Services include administrative costs in addition to the amount of benefits provided to recipients. Administrative cost factors were taken from the report, *Spending on County Human Services Programs in California: An Evaluation of Economic Impacts*, Jon Haveman, Beacon Economics, 2009, p. 3. The combined statewide costs for program administration and direct benefits to recipients provided in this report show the overall cost of the Food Stamp program to be 129 percent of the direct benefits provided to recipients.

[44] The ratio of total program costs to direct benefits for recipients is assumed to be the same for General Relief as for CalWORKs. Based on the Beacon Hill report (preceding endnote), the combined statewide costs for program administration and direct benefits to recipients is 168 percent of the direct benefits provided to recipients.

[45] Only the actual voucher amount is included in cost estimates for General Relief emergency housing vouchers. The average voucher amount is $266 per month.

[46] Only a partial inventory of services funded by the Los Angeles Homeless Services Authority (LAHSA) is included in this study. This inventory includes only services rendered by agencies that participate in the Consortium of Care's Homeless Management Information System (HMIS). The cost factors for these services include only the share funded by LAHSA, leaving out matching operational and capital costs. The cost factors that were used are:

	Emergency Shelter (1)	Winter Shelter (1)	Transitional Housing (2)	Permanent Housing (2)
Bed Night w/o meals	15.85	19.46		
Breakfast	1.20	1.62		
Dinner	1.80	2.42		
Total Bed Night Cost	18.85	23.50	32.88	32.88
Case Management (3)	24.88	24.88	24.88	24.88
Vouchers (1)	63.64	63.64	N/A	N/A

(1) Calculated based on the average costs per day of LAHSA's 2008-2009 service providers
(2) Calculated based upon an average annual participant cost of $12,000
(3) Represents the estimated for case management services (1 hour average session)

[47] The cost factors for individuals on probation were $2.63 per day in fiscal year 2007-2008, and $2.76 per day in fiscal year 2008-2009.

[48] Sheriff's Department booking costs for fiscal years 2005-2006, 2006-2007, and 2007-2008 were, respectively $427, $553 and $629. Costs for incarceration in general jail facilities for these three fiscal years were, respectively, $64, $83, and $92 per day.

[49] Sheriff's Department costs for incarceration in medical or mental health jail facilities were $840 per day in fiscal year 2005-2006, and $1,093 per day in fiscal years 2006-2007 and 2007-2008.

[50] Some uninsured visits by General Relief recipients to non-county outpatient clinics that were paid for by the Los Angeles County Department of Health Services (DHS) are included in the study data and shown as costs for DHS outpatient clinics.

[51] Costs for the homeless comparison groups are for months when they were documented in public records as being homeless. The criteria for coding a record as homelessness in a particular month were: 1) a Los Angeles County CEO-SIB flag indicating whether the address for a person's General Relief check that month was a DPSS office or homeless shelter, 2) receipt of a General Relief emergency housing voucher in that month, 3) receipt of services funded by the Los Angeles Homeless Services Authority in that month, or 4) a stint in jail immediately following a month in which one of the first three flags indicated they were homeless.

[52] In examining the effects a particular program has on its participants, a comparison group of non-participants is invaluable. But if selection of participants has not been random, then personal characteristics (e.g., the demographic profile) of participants may vary systematically from those of non-participants in ways that confound (or bias) the measurement of program effects. For example, the prevalence of disability may be higher among program participants. The solution is to assemble a sub-group of non-participants who collectively resemble (i.e., "are balanced with") the participant group with respect to the confounding characteristics, or "covariates".
If these covariate effects can be captured in just three or four variables, then selection of a comparison group of non-participants may be straightforward. Otherwise, it may be useful to use instead a single function of the several covariates. One way of doing this is to create what is called "propensity scores". A propensity score reflects an individual's probability of being selected into the program, given the respective individual's covariate profile. The idea is that if you match a participant and a non-participant who share the same propensity, you in effect have an approximate match with respect to the covariates that are important for measuring program effect. Not only will the treatment and comparison groups resemble, but the one-to-one matching enables matched-pair analysis, which often is statistically more efficient than group comparisons. Briefly,

> *The basic idea of a propensity score is to replace a collection of confounding covariates in any observational study with one function of these covariates. It can be used to balance confounding covariates in treatment group and control group, therefore to reduce election bias in observational studies, where the investigator has no control over the treatment assignment. (Yang, Stemkowski and Saunders)*

Typically, propensity scores are created by applying logistic regression to the combined population of participants and non-participants, with "participation" ("yes" or "no") as the dependent variable, and the covariates as independent variables. Covariates that are categorical can be specified as dummy variable sets. Predicted probabilities are a standard output of logistic regression.

[53] The public costs for supportive housing residents when they were homeless is higher than the average monthly cost of $1,572 for the overall population of disabled General Relief recipients shown in Figure 7. This is because the supportive housing population was more severely disabled, and when homeless was often in less stable circumstances than the overall disabled General Relief population.

[54] For a detailed discussion of funding sources for building and operating supportive housing see, "Where We Sleep," pp. 58-60, www.economicrt.org.

[55] The operating costs for SRHT buildings are covered by monthly rent. Monthly rent is based on the fair market rent for the unit as determined by the Housing Authority of the City of Los Angeles. Monthly rents vary by building, and residents' contribution towards rent also varies. Residents in units for which the Trust has a Shelter Plus Care (SPC) rental subsidy pay 30 percent of their gross income in rent. The remainder of the rent is provided through SPC rental subsidy. On average, persons in the SRHT analysis group had a monthly rent of $499; they paid $147 per month for rent; they received an average rent subsidy of $352 per month; and their average rent subsidy was approximately 70 percent of their monthly rent.

[56] The monthly capital cost per unit was calculated by taking the average cost to develop one supportive housing unit ($270,000) and dividing it by 30 years. The present value of dollars was used in this calculation. Neither financing costs for components of the development budget that incur financing charges nor the offsetting effect of inflation on the future cost for public services provided to homeless residents were included in the calculation.

[57] The breakout of costs for individuals in supportive housing compared to similar individuals who are homeless, with the cost of housing included, is as follows:

Cost Category	Cost Breakout	Supportive Housing	Homeless
Supportive Housing	Capital cost-supportive housing	$750	$0
	Rent subsidy-SSI recipient	$268	$0
	Subtotal	*$1,018*	*$0*
Justice System	Sheriff mental health jail	$48	$146
	Sheriff general jail	$6	$116
	Sheriff medical jail	$4	$84
	Probation	$7	$9
	Subtotal	*$65*	*$356*
Public Assistance	DPSS General Relief	$138	$183
	DPSS Food Stamps	$91	$172
	GR Housing Vouchers	$1	$83
	LAHSA homeless services	$0	$2
	Subtotal	*$229*	*$440*
Health Services	Los Angeles County Health Services hospital-inpatient	$80	$848
	Private hospitals-inpatient	$76	$424
	Los Angeles County Health Services outpatient clinic	$25	$191
	Los Angeles County Health Services – emergency room	$13	$118
	Private hospitals – emergency room	$9	$74
	Los Angeles County Mental Health	$65	$146
	Los Angeles County Public Health	$20	$134
	Los Angeles City Paramedics	$22	$167
	Subtotal	*$311*	*$2,101*
Total Average Monthly Costs		**$1,623**	**$1,623**