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Homeless' Healthcare and Mental Health Access:

Medicaid Expansion's Role on the Individual Homeless Experience

By

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On May 2nd, 2023, Carlos Dominguez found the third victim of his rampage throughout Davis, California. The 64 year old homeless woman, who was stabbed more than once through her tent, was taken to the hospital in critical condition.[1] While this event shook the Davis community, it also highlighted the close association between homelessness and healthcare inaccessibility. It imprinted in my mind the questions of "how will she afford the care" and "how will this affect her long term?".

The homeless population's struggles with stable housing often overshadow their difficulties finding accessible healthcare. Data has shown that this population is more than twice as likely to develop medical illnesses, such as diabetes and hypertension, than the housed[2]. However, there have been efforts made to mitigate this - the Affordable Care Act's expansion of Medicaid, a program intended to provide healthcare coverage to various, targeted populations, including the homeless. The program also saw increases to funding for Community Health Centers, a principal aspect of the healthcare sector that provides service to marginalized communities. In 2017, nearly all of the patients in these health centers were low-income (91%) or considered poor (69%).[3] With all of this in mind, however, only 41 states have expanded Medicaid. By comparing the differences between Medicaid expanded versus Non-Medicaid Expanded states and their homeless rates, this research paper aims to analyze the question of "how has Medicaid expansion affected homeless rates?".

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[1] Macht, D. (2023, May 2). *Woman in critical condition after 3rd Davis stabbing in 5 days; search for suspect*. KCRA.
https://www.kcra.com/article/shelter-in-place-ordered-in-downtown-davis-after-reports-of-3rd-stabbing/43766172

[2] *Homelessness & Health: What's the Connection?* (2019).
https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf.

[3] Rosenbaum, S., Sharac, J., Shin, P., Mar 26, J. T. P., & 2019. (2019, March 26). *Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained - Issue Brief*. KFF.
https://www.kff.org/report-section/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained-issue-brief/

Background and Significance

Ever since the passing of the Affordable Care Act, there have been ongoing debates as to whether to expand Medicaid in states that have not done so already. Although Medicaid has covered 86.1 million people, homeless rates between Medicaid expanded and non-Medicaid expanded states vary significantly.[4] However, the root issue and reasoning behind this data is unclear. Questions such as whether this is a result of population size or if it proves Medicaid expansion's effectiveness are often brought up. Adding to the debate, California allocates a large sum of money in its budget for Medicaid, a total of $38.7 billion.[5] In the same light, it costs each expanded state roughly $6,709 per person to cover with Medicaid. As these allotments include a large portion of each state's budget, answering these questions and determining whether there is sufficient evidence that proves Medicaid expansion lowers homeless rates is imperative in the debate for all states to expand.

Focusing on California, it is clear that the state faces a prominent issue when it comes to homelessness. The state has the highest number of homeless with 115,491 and this number accounts for nearly 30% of all the homeless in the nation.[6] Moreover, as mentioned previously, individuals in this population often face severe mental health issues that worsen over time as result of a lack of healthcare. It is clear, then, that the intersection of homelessness and healthcare accessibility exacerbate the lower quality of life for the homeless population. Past research
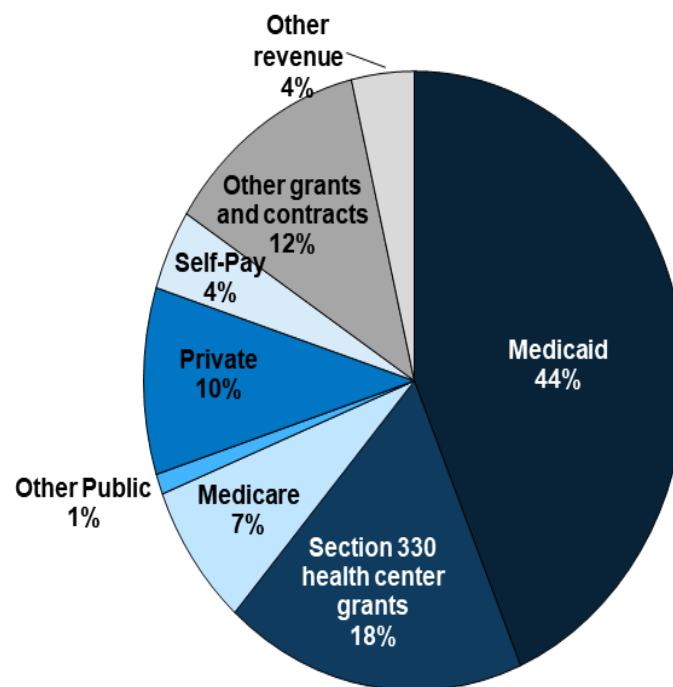
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[4]Medicaid. (2022). *Medicaid*. Medicaid.gov. https://www.medicaid.gov/medicaid/index.html

[5]*The 2023-24 Budget: Analysis of the Medi-Cal Budget*. (n.d.). Lao.ca.gov. Retrieved June 14, 2023, from https://lao.ca.gov/Publications/Report/4675#:~:text=The%20Governor

[6]Paluch, J., & Herrera, J. (2023, February 21). *Homeless Populations Are Rising around California*. Public Policy Institute of California. https://www.ppic.org/blog/homeless-populations-are-rising-around-california/#:~:text=As%20of%202022%2C%2030%25%20of

conducted by the National Healthcare for the Homeless Council uncovered that this population's

life expectancy is twelve years shorter than the general U.S. population.[2] As such, there have

been measures implemented on both the state and federal level to try and address this crisis. One

example is Senate Bill 1019 by Senator Lena Gonzalez (2021-2022), which requires Medical

(the name for Medicaid in California) managed healthcare plans to provide outreach and

education to its enrollees about mental health benefits.[7] While this bill does not directly address

the homeless sector, it represents a step in the right direction by ensuring that Medicaid eligible

individuals understand the mental health services available to them. The hope, then, for Medicaid

and this bill is to alleviate the long-term burden of mental illnesses for these individuals, many of

which are in the homeless population. In fact, this bill was passed unanimously in both the

California Assembly and Senate. This demonstrates that the need to address the mental health

crisis in California specifically is widely recognized. The brilliant individuals making up the

California legislature all view Medicaid as a platform capable of doing so.

      Additional bills beyond the California legislature have recognized the prevalence of this

issue. One example is Senator Dianne Feinstein's Fighting Homelessness Through Services and

Housing Act bill, which authorizes 1 billion dollars annually to fund supportive housing models

that provide mental health, substance abuse, and job training programs to the homeless.[8] In many

ways, this bill has the same intended purpose of funding supportive programs as Medicaid does.

As mentioned previously, Medicaid accounts for 44% of the health center's revenue in 2017

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[7] *Bill Text - SB-1019 Medi-Cal managed care plans: mental health benefits.* (n.d.). Leginfo.legislature.ca.gov.
Retrieved June 15, 2023, from
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1019

[8] *Feinstein Introduces Bill to Address Root Causes of Homelessness.* (n.d.). United States Senator for California.
    https://www.feinstein.senate.gov/public/index.cfm/press-releases?id=2D805876-96D1-4065-8596-B79530
    AF8551

(figure 1). Previous literature has demonstrated that this increase in funding has led to significant

coverage gains among patients from 2013 to 2014.[9] However, there is yet to be substantial

findings that dive deeper into the efficacy of health centers on lowering homeless rates. There is

additionally minimal research on the homeless rate outcomes as a result of Medicaid expansion

in comparison to other states. This paper attempts to fill that gap.

Figure 1. Sources of Health Center Revenue. Community Health Center Financing: The Role of

Medicaid and Section 330 Grant Funding Explained - Issue Brief.[3]

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[9]Warfield, M., DiPietro, B., & 2016. (2016, March 15). *How has the ACA Medicaid Expansion Affected Providers Serving the Homeless Population: Analysis of Coverage, Revenues, and Costs - Issue Brief*. KFF. https://www.kff.org/report-section/how-has-the-aca-medicaid-expansion-affected-providers-serving-the-homeless-population-issue-brief/

Theory and Argument

This research places the focal lens of Medicaid Expansion and homeless rate outcomes on healthcare and mental health accessibility. Simply put, this research attempts to cement or dismantle the argument that as a result of Medicaid, individuals have an increased availability to both healthcare and mental health services, and thus homeless rates within those states will decrease over time. The independent variables in my study are whether a state has expanded Medicaid, the amount of healthcare premiums per capita, and the total amount of Community Health centers per capita. The dependent variable of this study is the rates of homelessness over time.

The Medicaid program policy is designed to provide healthcare coverage to those that would otherwise be uninsured. As such, an element of its intention is to decrease annual healthcare costs for these individuals. Furthermore, Community Health Centers (CHCs) are another aspect of Medicaid expansion that provides mental health services to the homeless population. In a cross-sectional study conducted by various doctors and physicians, they concluded that 43.6% of CHC patients had experienced housing insecurities.[10] Therefore, it is clear that these two factors intersect with the homeless population. As such, my causal mechanism is that the cheapened costs of healthcare premiums per capita as well as the increased availability of Community Health Centers lead to an overall increased availability to services for this homeless population. As a result, homeless rates decrease as this population can utilize the care now available to them. My hypothesis, then, is that states that have expanded Medicaid will have a lower rate of homelessness over time than those states that have not.

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[10] *JAMA*, *319*(7), 717–719. https://doi.org/10.1001/jama.2017.19869

While I anticipate that a decrease and increase of these variables respectively will lead to lower homeless rates over time, other explanations are plausible. For example, homeless rates may decrease as a result of Housing First programs. This approach attempts to thwart homelessness by viewing housing as the fundamental foundation for quality of life improvement. The program aims to provide permanent housing for individuals and families that may have become homeless as a result of a financial or personal crisis.[11] However, one aspect of this program is that it is not targeted to those chronically homeless. While there is some evidence that suggests that the Housing First approach does have benefits for the higher need populations, most of the tailored audience of these programs are homeless individuals or families that need lesser services and care. Therefore, it is difficult to decipher whether the Housing First program eliminated the root issues of increasing homeless rates throughout the nation, or simply addressed the symptoms and helped these individuals rehabilitate. Instead, this paper hopes to display Medicaid expansion - and specifically the widespread increase in healthcare and mental health accessibility - as the root solutions for decreases in homeless rates.

Research Design and Data

This research is a large-n, time-study analysis that quantifies nationwide data including all fifty states from 2014 till 2020. I began this time frame in 2014 as the year when California expanded. As mentioned earlier, there has been substantial research that dives into the before and after outcomes of Medicaid. In other words, their time frame included data gathered before 2014 and after. However, this research differs in its aim to analyze the trend post 2014. I hope to see whether Medicaid expansion has continued to decrease homeless rates, not if its implementation

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[11] *THE CASE FOR HOUSING FIRST -1.* (n.d.). https://nlihc.org/sites/default/files/Housing-First-Research.pdf

had an immediate impact. The choice to end the data gathering in 2020 was a result of

COVID-19. I believe extending the time frame would have introduced the pandemic as another

variable and thus made homeless rate changes after 2020 difficult to analyze with my

independent variables.

As my research included multiple independent variables, I analyzed each individually and

then collectively applied them to the dependent variable of homeless rates. Beginning first with

Medicaid expansion, I collected data on which states have expanded Medicaid and when[12]. The

purpose was to demonstrate that there was a link between homelessness rate changes and

Medicaid expansion. By first illustrating the disparity, I aimed to further investigate whether

increased healthcare and mental health service accessibility were the contributing and causing

factors.

Healthcare accessibility is a broad subject that is often targeted as one of the underlying

causes of homeless rate increases. I measured this variable by first gathering data on the amount

of healthcare cost premiums per capita over each state. With this in mind, however, there were

many variables to account for. In particular, healthcare premiums differ vastly based on multiple

factors, such as age, marital status, income, employment status, etc. In order to account for this, I

ensured that healthcare costs I collected accurately calculated for the same individual with the

same factors. Concretely, I searched for the average cost of healthcare for a single, forty year old

man who purchases a silver tier plan. I began first by collecting the average costs of healthcare

per capita for the Non-Medicaid expanded states. These states included Alabama, Florida,

Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming. This

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[12] Kaiser Family Foundation. (2023). *Status of State Medicaid Expansion Decisions: Interactive Map*. The Henry J. Kaiser Family Foundation.
https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

data was sourced mainly from the Kaiser Family Foundation, an independent source of

healthcare policy that provided information completely necessary for this research. They

gathered data over the years and provided the means to complete the operationalization of this

data.[13]

      Mental Health service accessibility is another subject often discussed in the conversation

regarding homelessness. Data illustrates that 30-35% of the homeless population struggles with

some form of mental illness, with 20-25% struggling with severe mental illness or addiction.[14]

Past literature has demonstrated that homelessness amplifies mental health. However, through

the operationalization of this independent variable, this paper attempts to answer whether this

relationship is a two-way street. This paper operationalizes mental health service accessibility by

creating an index rating displaying the amount of community health centers per capita. This

rating took into account the amount of community health centers as well as the total visits to

CHCs in that state and was calculated by dividing the total number of CHC's in that given year

to the population per 100,000 multiplied by the total number of visits[15]. Through this, I

generalized the data regarding my independent variable to take into account population

differences between states. I again used the Kaiser Family Foundation as the main source of my

data.

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[13] *Health Care Expenditures per Capita by State of Residence*. (2022, September 13). KFF.
https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=6&sortModel=%7B%22col
Id%22:%22Location%22

[14]Homeless Hub. (2014). *Mental Health | The Homeless Hub*. Homelesshub.ca.
      https://www.homelesshub.ca/about-homelessness/topics/mental-health
[15] *Community Health Center Delivery Sites and Patient Visits*. (2022, December 5). KFF.
https://www.kff.org/other/state-indicator/community-health-center-sites-and-visits/?currentTimef
rame=6&sortModel=%7B%22colId%22:%22Location%22

My dependent variable, homeless rates, was difficult to specify. With multiple factors coming into play, I chose to measure homelessness as the amount of homeless per 10,000 people per state. This way, each state has the same variables and does not take into account the amount of emergency shelters, housing programs, etc. that are offered. I gathered data on homeless rates through analyzing the State of Homelessness reports for each year.[16] Therefore, the data collected was from a credible source - the National Alliance to End Homelessness - and maximizes the validity of the variable. With strong reliability, this measure attempts to ensure that homeless rates are generalized and allows for comparison between the states.

I analyzed a simple correlation between my independent and dependent variables in order to evaluate the relationship between them. I created four scatterplots and displayed the trends further through lines. Two of these scatterplots compared the trends of homeless rates with the trends of each measure grouped by Medicaid expanded versus Non-Medicaid expanded states. For these graphs, my x-axis consisted of the healthcare costs in thousands of dollars and my y-axis was homeless rates per 10,000 people. Each point on my scatterplots, then, represented the healthcare costs and respective homeless rate in that year. Furthermore, although my analysis and data collection included all fifty states, I only displayed four states for each group on the graphs. This decision prioritized readability, as displaying data for all fifty states would have overcrowded the graph. For the Medicaid expanded states, I chose four states which expanded every two years. For example, for my independent variable of healthcare accessibility, I chose Michigan, Montana, Virginia, and Nebraska. Each of these states expanded Medicaid in 2014, 2016, 2018, and 2020 respectively. By doing so, I can simultaneously compare the homeless rate

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[16]*The State of Homelessness in America 2013-2016 - National Alliance to End Homelessness.* (2013). National
        Alliance to End Homelessness. https://endhomelessness.org/resource/archived-state-of-homelessness/

trends of Non-Medicaid vs. Medicaid expanded states while also determine if homeless trends decreased directly as a result of Medicaid expansion. This is done through comparing the homeless rates before and after that point in which Medicaid was expanded in that state. I repeated the same process for my second independent variable, mental health service accessibility.

Additionally, my analysis included two other scatterplots which focused specifically on California's homeless rate trends as a result of health care and mental health service accessibility changes. I first took the average of all the Non-Medicaid expanded state data for each independent variable individually. After this, I created homeless rates as my y-axis and each independent variable as my x-axis. I then placed points on my graph that represent the independent variable and the respective homeless rates for that year. Through my analysis and graphs, I hope to display not only a correlation in decreases of homelessness for the Medicaid expanded states, but also how the decrease and increases of healthcare costs and community health centers respectively correlate to the decreases in homelessness.

There are, of course, strengths and weaknesses to my research method. As a large-scale study that captures data for all fifty states, the research methodology allows for broad comparison throughout the nation. Furthermore, as mentioned previously, the specific focus on 2014-2020 not only enables a more concise examination of post-expansion homeless trends, but also ensures a more accurate analysis of my independent variables. Lastly, the use of data from reputable sources, mainly the Kaiser Family Foundation, cements the reliability of the research method.

One way I wish I could have furthered my research method was through the use of qualitative data. I had originally planned on listening to and including individual case studies,

through interviews and observational studies, that would provide deeper insight into the individual homeless experience. While this data collection would have been difficult to incorporate into my scatterplots, I believe that it would have enhanced the scene I set in demonstrating the need for this research. Regardless, the previous literature listed as well as the significant background information displays this need.

Additionally, my research methodology avoided the exploration of confounding variables. This was noted in the deliberate choice of using the timeframe from 2014-2020. While there are benefits to this, as mentioned previously, this specific timeframe makes it more difficult to generalize causation and correlation of my variables. If I were to continue this research further, I would expand into including post COVID-19 data. My analysis, however, would differ in that I would want to explore how the various COVID-19 policies influenced healthcare costs and total CHC amounts. In other words, I would indirectly measure the effect the pandemic had on homeless rates by using the same independent variables, only switching the focus towards how the various policies influenced their trends. However, accumulating data that corresponds to COVID-19 policies to both healthcare and mental health accessibility would be extremely difficult, as even if I were to find data on both, it is difficult to link and correlate the two.

Findings

The analysis concluded that there were slight differences in the homeless rates of Medicaid versus Non-Medicaid expanded states. I chose to display this finding two ways, by a box and whisker chart (figure 2) and a time-series line chart that displays the average homeless rate per year for each group (figure 3). Through this, I displayed first the distribution of homeless rates for Medicaid versus Non-Medicaid expanded states and secondly whether these trends differed over time for each group. As shown in figure 2, there are stark differences in the

homeless rates of Medicaid versus Non-Medicaid expanded states. For Non-Medicaid expanded states, their minimum and maximum homeless rates were 8.76 (2020) and 12.43 (2014) with a median rate of 9.91 (2016). On the other hand, the homeless rate distribution for Medicaid expanded states was much higher. The minimum and maximum values were 14.16 in 2018 and 16.24 in 2014, with a median value of 15.51 in 2019. These collective distributions clearly indicate that the states which expanded Medicaid had significantly higher average rates of homelessness compared to Non-Medicaid expanded states.
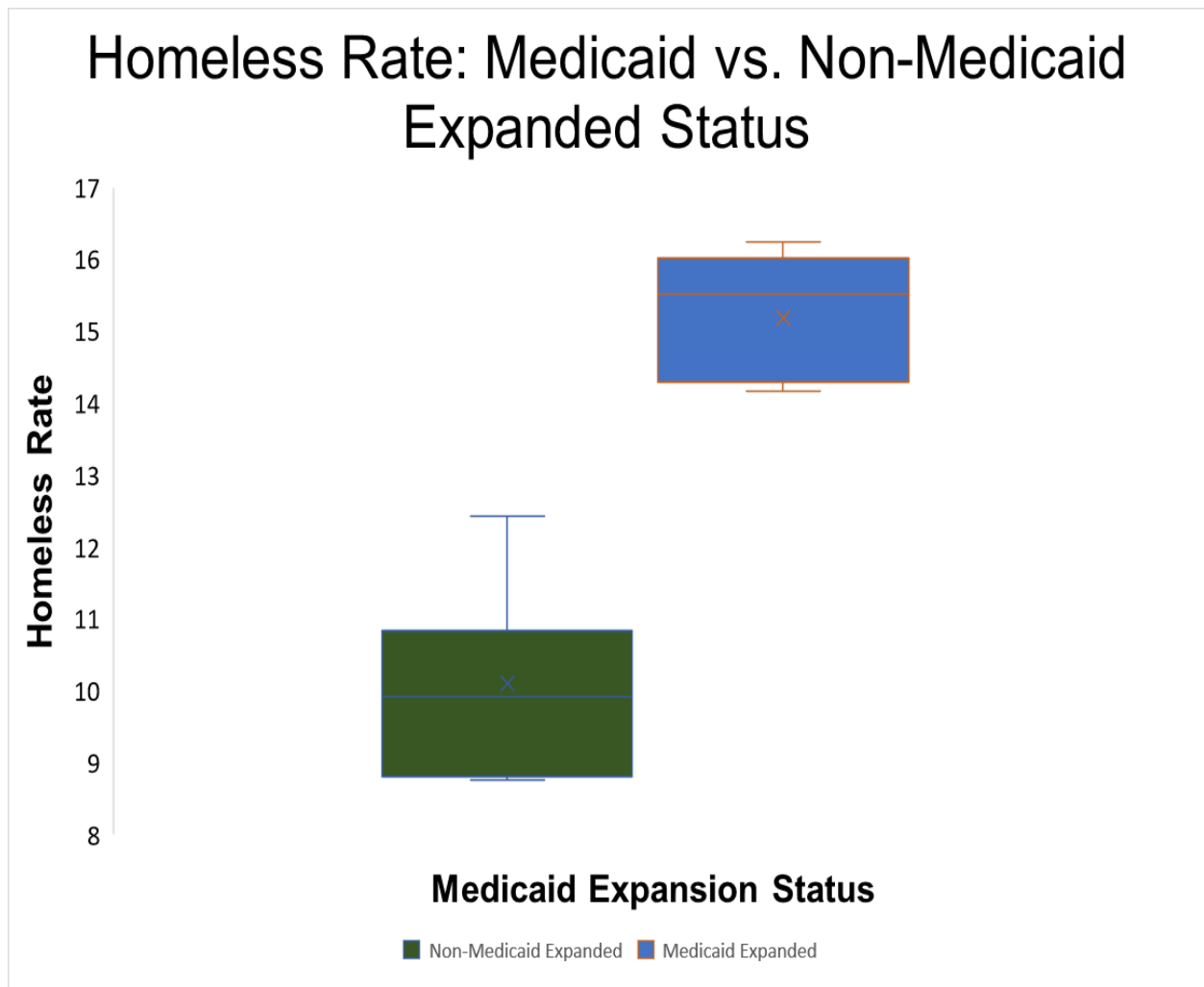
Figure 2: Homeless Rate: Medicaid vs. Non-Medicaid Expanded Status[10]

The time-series chart, then, is critical in determining if the homeless rate trends over time were similar or different between the groups. Figure 3 highlights that the trend of homeless rates over time for both Medicaid and Non-Medicaid expanded groups was negative sloping. In other words, as the years progressed from 2014 to 2020, both groups saw decreases in their homeless rates. Calculating the slope of each group, I determined that slopes for the Non-Medicaid expanded and Medicaid expanded group respectively had a slope of –0.60 and -0.27. This suggests that the rate at which homelessness is decreasing is significantly steeper, more than twice as fast, for the Non-Medicaid states than the Medicaid expanded group. While this alone is not enough information to disprove my hypothesis, it does imply a more rapid improvement in Non-Medicaid expanded states. However, there are many variables that could have influenced this large difference. This time-series graph did not take into account population size, but rather was just a quantitative general summary of the homeless rate trends.
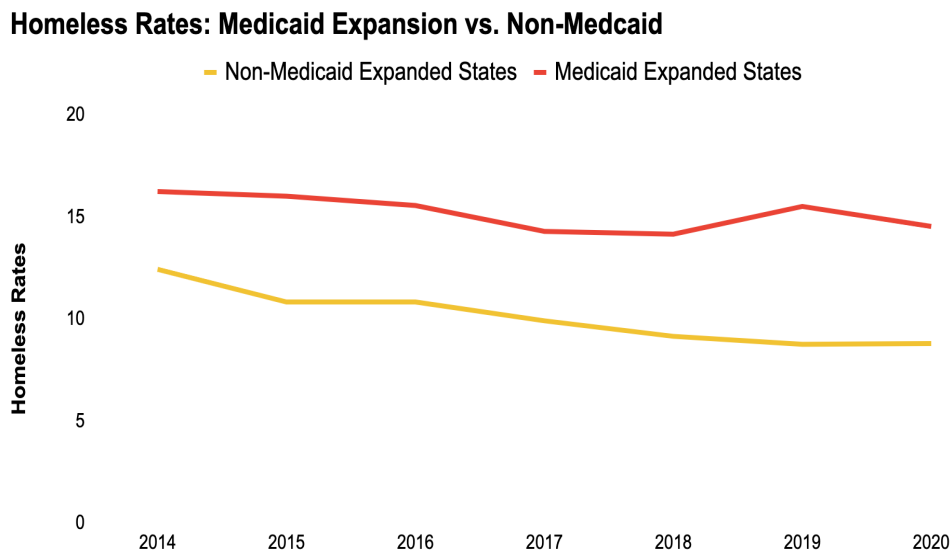
Figure 3: 2014-2020 Homeless Rates: Medicaid Expansion vs. Non-Medicaid Expansion[10]

Instead, my analysis continued through a deeper dive first into the role healthcare accessibility plays in lowering homeless rates. Figure 4 highlights the changes in homeless rate over time for each non-expanded state. As highlighted in the figure, all of the non-expanded states had negative slopes for homeless rates over time. This figure correlated the changes in healthcare costs to the changes in homeless rates. I calculated the changes in slope for each state and measured Florida as having the largest decreases per healthcare cost increase. In 2014, Florida's healthcare cost per person was $7,965 with a homeless rate of 21.3 per 10,000 people. Six years later, however, and in 2020 Florida's health care cost increased drastically to $9,865 while its homeless rate decreased to 12.8 per 10,000 people. With this in mind, figure 4 demonstrates an inverse relationship between healthcare costs and homeless rates for Non-Medicaid groups. Simply put, as healthcare costs increased, homeless rates continued to decrease. This finding is directly contrary to the causal mechanism behind my hypothesis. I argued for a direct relationship between healthcare costs and homeless rates, meaning that as healthcare costs increased, homeless rates would continue to increase. Yet, while this finding is contradictory, I further examined this independent variable and its relationship through comparing Medicaid expanded and Non-medicaid expanded states with a focus on healthcare cost changes.
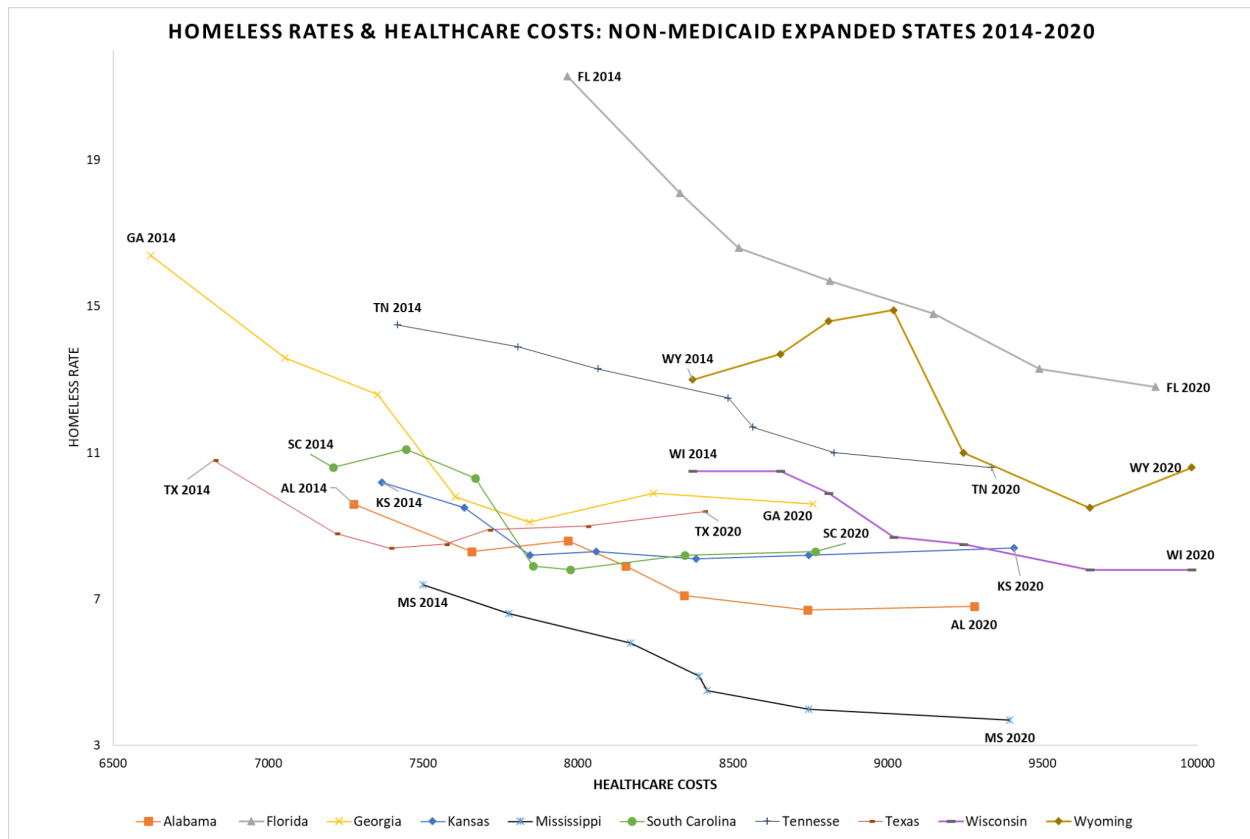
Figure 4: Homeless Rates & Healthcare Costs: Non-Medicaid Expanded States 2014-2020[11]

My analysis concluded that Medicaid expanded states also had an inverse relationship between homeless rates and healthcare costs. With these findings in mind, I plotted both Medicaid and Non-Medicaid expanded groups on the same graph, differentiated by color (figure 4). This illustrated that both groups held the same correlations between my independent and dependent variables. Furthermore, I imputed my data set into a correlation coefficient calculator.[17] The outcome was that for Medicaid expanded states, their r was -0.1 while Non-Medicaid expanded states had an r equal to -0.09. Both of these correlation coefficients point towards a weak relationship between healthcare costs and homeless rates. With these

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[17]Stangroom, J. (2019). *Pearson Correlation Coefficient Calculator*. Socscistatistics.com.
        https://www.socscistatistics.com/tests/pearson/Default2.aspx

findings in mind, the causal mechanism behind my hypothesis - that homeless rates will decrease

as healthcare costs decrease - is contradicted. However, there is another independent variable

stemming from Medicaid expansion that plays a role in homeless rate changes - mental health
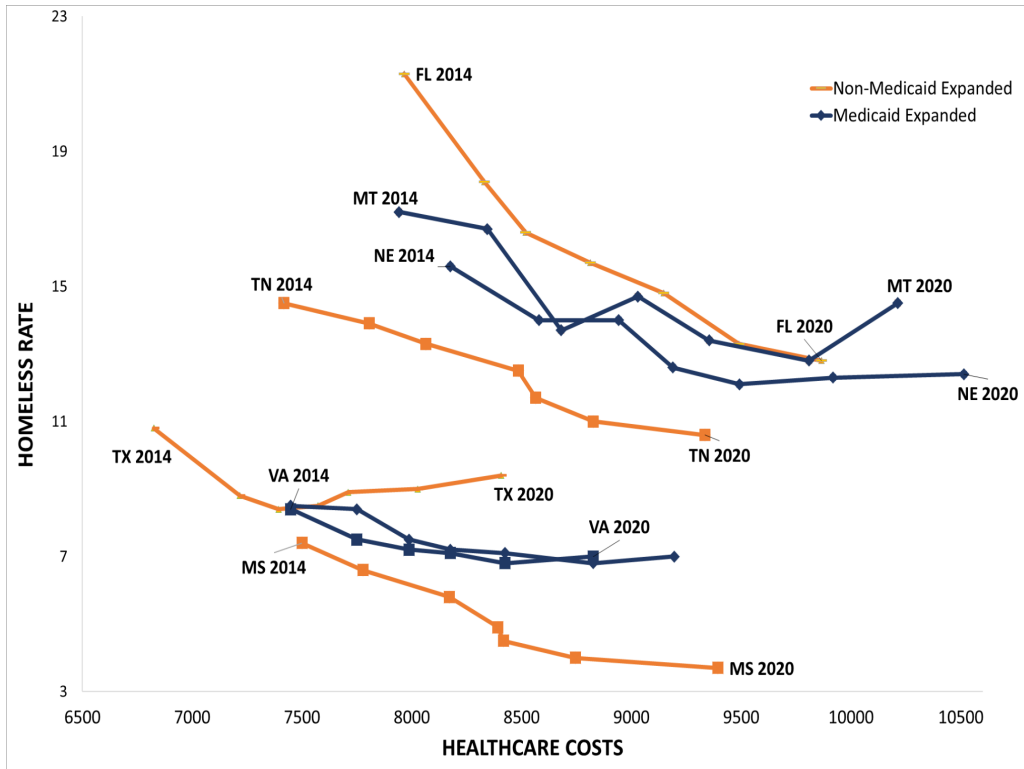
accessibility.

Figure 4: Homeless Rate & Healthcare Costs: Medicaid Expanded vs. Non-Medicaid Expanded States 2014-2020

As mentioned previously, I measured mental health accessibility by creating an index that

calculated the amount of Community Health Centers per capita. I gathered data on this per state

over the years and displayed my data set on a scatterplot comparing Medicaid and Non-Medicaid

expanded states. My analysis found that both groups had negative correlations. The correlation

coefficient for Medicaid equated to -0.425, while the correlation coefficient for Non-medicaid

expanded came out to -0.319. These correlation coefficients display a relatively strong

correlation between my two variables. This meant that for Medicaid expanded states, there was a

stronger negative relationship between the amount of Community Health Centers per capita and homeless rates. In other words, my analysis concluded that mental health service accessibility increased, homeless rates decreased. With this in mind, it can be inferred that the second part of my causal mechanism behind my hypothesis has been supported.
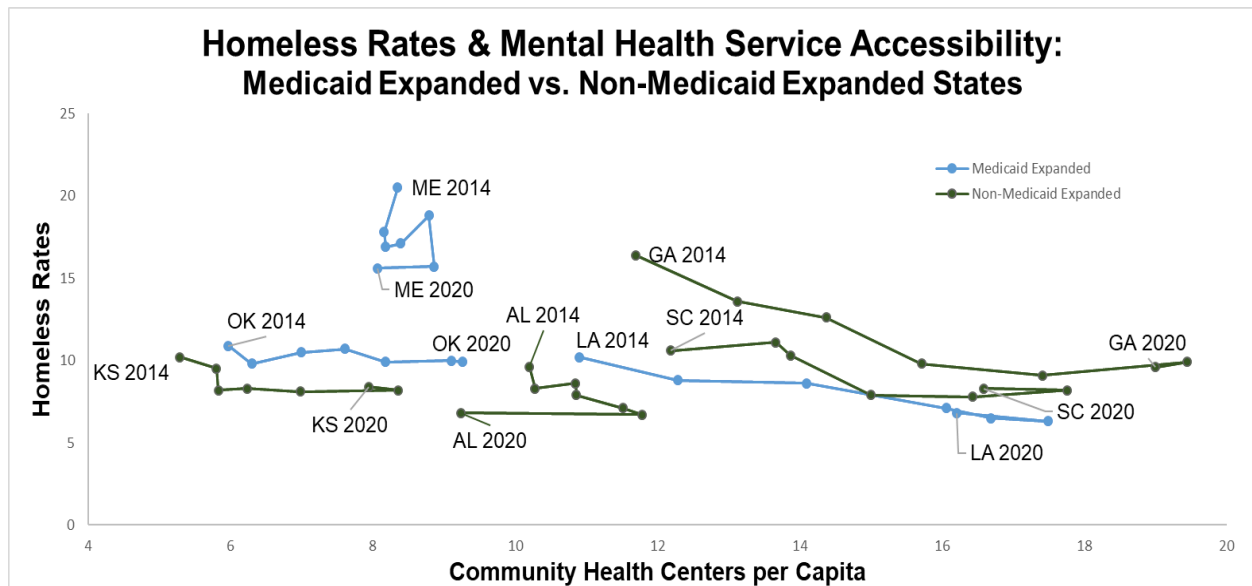

Figure 5: Homeless Rates & Mental Health Service Accessibility: Medicaid Expanded vs. Non-Medicaid Expanded States[13]

Interestingly enough, however, California's trends are vastly different from the other two findings in this analysis. California was the only state in the entire analysis to have a positive correlation for both healthcare and mental health access on homeless rates. As displayed in figure 6, homeless rates in California continued to rise steeply even with the implementation of Medical (California's name for Medicaid). My analysis found that as healthcare costs increased, homeless rates also continued to increase. California in 2014 had an average healthcare cost per capita of $7,472 and a homeless rate of 29.8 per 10,000 people. In 2020, those numbers rose to $10,299 and 40.9 respectively. Calculating the correlation coefficient, the r-value equated to 0.95 - indicating a strong relationship between the two variables. While these numbers are staggering,

previous findings had already inferred that healthcare costs had minimal correlation with

homeless rates in my analysis. On the flipside, California's homeless rates continued to increase

even with increased mental health awareness - the aspect of my causal mechanism that has been
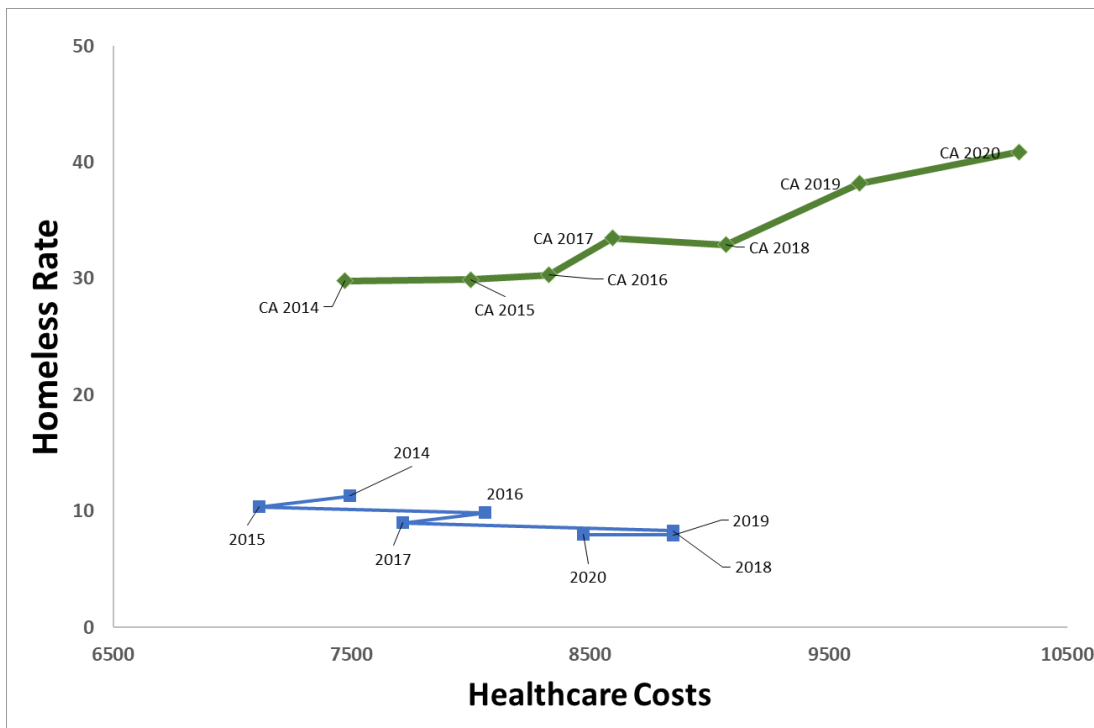
supported.

Figure 6: Homeless Rates & Healthcare Costs: California vs. Non-Medicaid States[11]

California saw the biggest increase in CHCs from 2014 to 2020. This number rose from

162.43 CHCs per capita to 244.37. With the previous analysis in mind, it can be reasonably

inferred that this large increase in CHCs would correlate to a sharp decrease in homeless rates.

However, the opposite is found. Even as California created more CHCs, homeless rates

continued to increase dramatically. The R-value for this measure turned out to be 0.85, again

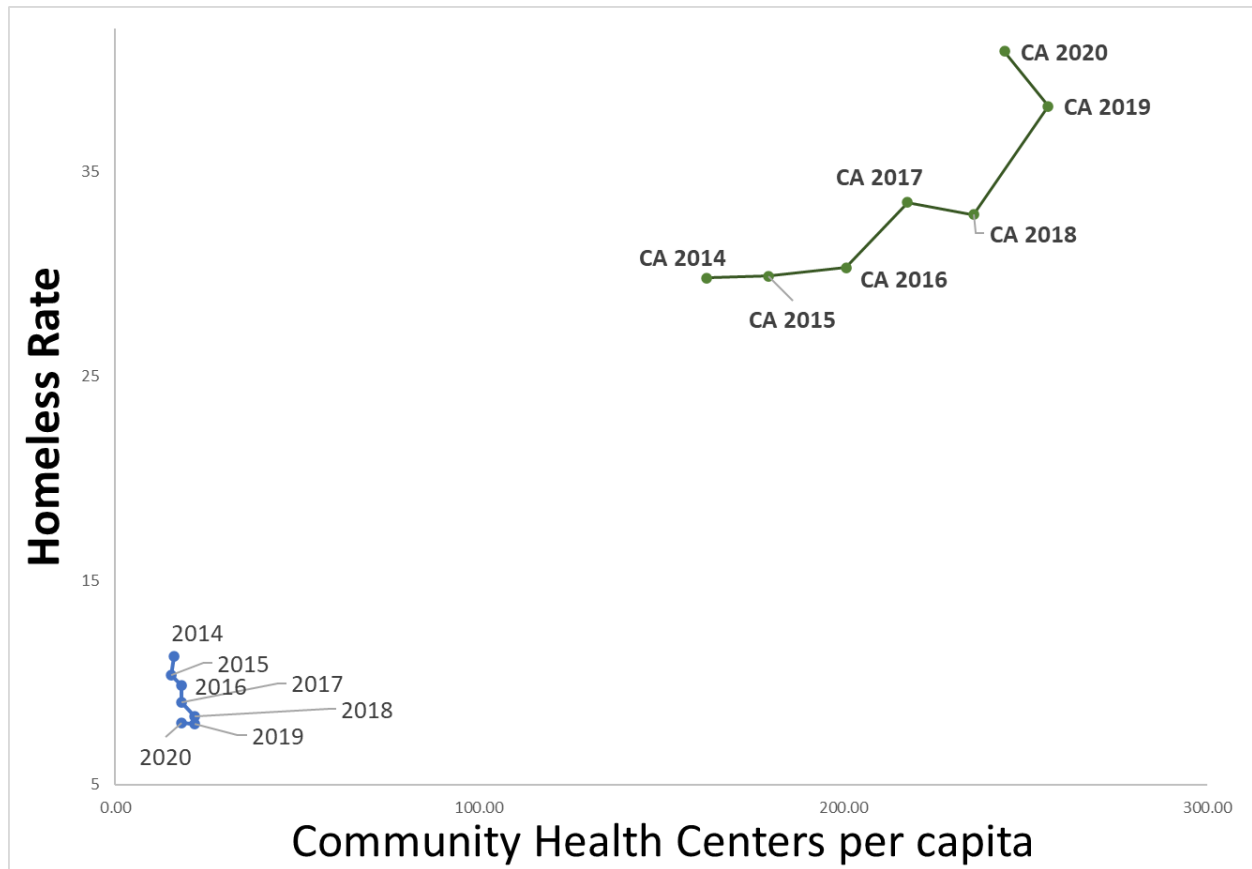implying a strong correlation between the two variables.

Figure 7: Homeless Rates & Mental Health Service Accessibility: California vs.

Non-Medicaid Expanded States[13]

My findings have demonstrated that Medicaid expansions' decrease in healthcare costs
has not led to significant homeless rate decreases. In fact, there is little significant differences
between Medicaid and Non-Medicaid expanded states' homeless rates at all. On the other hand,
my analysis did highlight that mental health awareness holds a relatively strong, negative inverse
relationship with homeless rates. With all of these findings in mind, there is little evidence to
support my hypothesis that Medicaid expanded states will have lower homeless rates over time
due to increased healthcare and mental health service accessibility. Meanwhile, California's data
and correlations display that these two variables may not play a significant enough role in
lowering homeless rates as needed. California, having the highest amount of homeless, may have

been other confounding variables not explored in this research. Thus, while healthcare costs may

not play as large of a role in decreasing homeless rates as I hypothesized, I nonetheless argue that

my research is the stepping stone towards conducting a more in depth study as to how

Community Health Centers decrease homeless rates.

Implications

After conducting a thorough analysis of my research question, it is difficult to pinpoint

one specific variable as the causation for homeless rate decreases. Though my analysis definitely

encourages further analysis on Community Health Centers, it more importantly illustrates the

argument that Medicaid Expansion is not sufficiently lowering homeless rates on its own -

especially not in California.

Three years past the beginning of the pandemic, further research could dive into the role

COVID-19 policies played in lowering homeless rates post-2020. Potential research questions

could include whether the pandemics increased healthcare awareness lead to more utilization of

Community Health Centers and thus less homeless. Another interesting, though convoluted,

research topic could discuss COVID-19's impact on youth social media activity and attempt to

correlate that with increased awareness for homelessness. Although COVID-19 is itself a large,

confounding variable, the policies enacted to counter its effects could have had external impacts

on healthcare costs, Community Health Center engagement, and ultimately homeless rates.

Furthermore, my analysis has displayed that California's homeless rates continue to

increase regardless of healthcare and mental health accessibility. While outside of the state,

increased CHCs have shown positive results in lowering homeless rates (figure 5), simply

increasing the funding or the number of health centers may not be enough for California. With

the state having the highest amount of homeless, I argue - and hope to explore in further research

- that the root issue is rather in insufficient medical staffing. Specifically, a nursing shortage

crisis has left California homeless and even children with inadequate care. It is clear that these

health centers rely on healthcare workers, nurses, and doctors to provide the care to patients.

However, many of them are leaving the field post-pandemic due primarily to financial burdens.

Nurses are paid significantly lower wages by those insured by Medicaid than private insurance.[18]

Therefore, one policy suggestion would be to look beyond increasing funding for these health

centers and look internally at supporting the nurses and healthcare workers running them.

Specifically, Senate Bill 525 by Senator Durazo sets a $25 minimum wage for healthcare

workers. Existing law states that the minimum wage be set at $10. Additionally, the Nurses

Association is calling for Governor Gavin Newsom to include an increase in Medi-Cal

reimbursement rates by 40% in the next fiscal budget. The hidden purpose behind these pieces is

to attract healthcare workers back into the field. Reflecting back on this research, I envision these

two pieces could help provide both support to the healthcare workforce and ensure enough

nurses and workers are available to facilitate care to the ever-growing homeless population in

California.

In conclusion despite the lack of significant correlation between healthcare costs and

homeless rates, I argue that it pointed to the right direction - Community Health Centers. These

health centers are playing a crucial role in addressing the mental health needs of the homeless

population. But their role has not come to fruition. Instead, the healthcare workforce shortage is

threatening the integrity and fortitude of these centers. It is imperative, through SB 525 and the

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[18]

calhealthreport.org/2023/02/21/nursing-shortage-puts-medically-fragile-children-at-risk-spurs-calls-for-change/

increase in Medi-Cal reimbursement rates, to provide support to the healthcare workers that run the foundation of California's system.

California, as an outlier, has demonstrated that decreasing homeless rates is multifaceted and convoluted.The homeless population in California is continuing to rise despite Medicaid expansion. Thus, there must be outside factors, such as affordable housing, community engagement, and economic situations, that intersect with Medicaid expansion and homeless rates. I encourage further research and discussion to be done on the intersection of these confounding variables. Hopefully, then, Medicaid expansion - though not alone - can fully mitigate homelessness and care for the overall well-being of all, especially the Golden State

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