HOUSING AS HEALTH CARE

A Road Map for States

Leveraging Housing Interventions that Improve Health Outcomes and Reduce Costs

Acknowledgements

Housing as Health Care: A Road Map for States was written by Flora Arabo, Sandra Wilkniss, Sally Malone and Frederick Isasi.

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Housing as Health Care: A Road Map For States

The Challenge

Increasing Medicaid and other health care expenditures are a significant driver of budgetary pressure on states. Care for about 5 percent of Medicaid enrollees nationwide accounts for more than 50 percent of all Medicaid spending. Those high-need, high-cost enrollees also have a range of challenges in the social determinants of health.

The Role of Housing

Among the most important interventions for this group is addressing homelessness and housing instability. Housing First is an evidence-based, permanent, supportive housing intervention for chronically homeless individuals that has the potential to improve health outcomes and reduce costs to health care and other public safety net programs.

The Road Map

This road map provides states with a step-by-step guide to creating greater access to housing solutions for high-need, high-cost Medicaid enrollees in order to improve health care outcomes and reduce overall spending on health care and public safety net programs.

Phase 1:
Develop Housing and Services Strategy

State teams work with key stakeholders to develop their housing strategy, including:

- Scanning the environment;
- Developing a housing and health care strategy for the complex care population;
- Incorporating key elements of behavioral health services integral to a housing intervention;
- Assessing bridge solutions for individuals with complex care needs;
- Defining the services in supportive housing; and
- Building capacity for capital and operating resources

Phase 2:
Plan and Build Capacity

State teams and stakeholder partners iteratively plan and obtain buy-in for an overarching health and housing strategy, including:

- Developing Medicaid waiver and state plan amendment options for services; and
- Communicating the plan and engaging leadership

Phase 3:
Implement and Evaluate

State teams and stakeholder partners implement housing solutions, evaluate and communicate outcomes and reinvest a portion of savings. This includes:

- Implementing permanent supportive housing (PSH) and bridge housing solutions;
- Evaluating short- and long-term programmatic outcomes, including health outcomes and cost savings; and
- Deciding on a savings versus reinvestment strategy to support additional housing solutions that will deliver return on investment

What Can Governors Do?

Act as a convener of key groups that may be partnering for the first time, such as: federal field offices, local agencies, state cabinet officials, state budget officers, local government officials, Continuae of Care, clinical and social services providers, the housing developer community, housing finance agencies (HFAs), public housing authorities, the Medicaid director, behavioral health officials, managed care organizations (MCOs), administrative service organizations (ASOs) and other stakeholders.

Direct Medicaid leadership to pursue authorities to cover supportive services, including tenancy support, and ensure that the most vulnerable populations have access to this resource. Prioritize high-need, high-cost populations and reinvest savings into the broader plan.

Direct Medicaid leadership to work with MCOs or through their fee-for-service program to leverage contracts for provision and payment of supportive housing services.

Consider a "no wrong door" policy for streamlined eligibility determination for public programs, including permanent supportive housing.

Leverage state-funded subsidy programs that can support "no wrong door" supportive housing policies.

Create a universal waiting list for affordable housing units to help prioritize the neediest populations.

Encourage public-private partnerships with the state's HFA or cabinet-level housing agency to create financial incentives for the development of supportive housing units and use tax credit set-asides to dedicate affordable rental units for vulnerable populations.

Encourage state programs to incentivize and implement best practices such as Housing First.

To most effectively centralize resources and discussions, create an interagency council on homelessness (ICH). Ensure that ICH governance structure is modeled after best practices.

Support capacity-building opportunities for supportive housing programs, including improving services and administrative capacity to bill Medicaid or partner with Medicaid providers.

HOUSING ROADMAP ACRONYMS

202: Section 202 Supportive Housing for the Elderly Program
811: Section 811 Supportive Housing for Persons with Disabilities Program
AMI: Area median income
ASO: Administrative Service Organization
BH: Behavioral health
BHO: Behavioral health organization
CDBG: Community Development Block Grant program
CDC: Centers for Disease Control and Prevention
CDFI: Community development financial institutions
CMH: Community mental health center
CMS: Centers for Medicare & Medicaid Services
CoC: Continuum of Care
EBP: Evidence-based practice
ED: Emergency department
FQHC: Federally qualified health center
GDP: Gross domestic product
HCBS: Home and Community-Based Services
HFA: Housing finance agency
HHS: The United States Department of Health and Human Services
HOME: HOME Investment Partnerships Program
HMIS: Homeless Management Information System
HOPWA: Housing Opportunities for Persons with AIDS
HRSA: Health Resources and Services Administration
HUD: The United States Department of Housing and Urban Development
IT: Information technology
LCSW: Licensed clinical social worker
MCO: Managed care organization
MH: Mental health
NGA: National Governors Association
PHA: Public housing authority
PSH: Permanent supportive housing
QAP: Qualified Allocation Plan
ROI: Return on investment
RFP: Request for proposals
SAMHSA: Substance Abuse and Mental Health Services Administration
SHP: Supportive Housing Program
SIB: Social Impact Bond
SIM: State Innovation Models Initiative
SPA: State plan amendment
SSDI: Social Security Disability Insurance program
SSI: Supplemental Security Income
SUD: Substance use disorder
USDA: The United States Department of Agriculture
USICH: The United States Interagency Council on Homelessness

Evidence suggests that providing housing to certain high-need, high-cost patients can transform lives and have a very meaningful return on investment. This road map provides governors with a step-by-step guide to creating greater access to housing solutions for high-need, high-cost Medicaid enrollees.

Governors are uniquely positioned to take advantage of innovations in health system transformation to achieve the three-part aim of improving the health of state residents, improving the quality of care residents receive and reducing health costs for families and the government. Increasingly, Medicaid and other health care expenditures are a significant driver of budgetary pressure on states and accelerate momentum to find sustainable health care solutions.[1] For example, a disproportionately large portion of states' Medicaid budgets are used for a small segment of the Medicaid population's care: About 5 percent of Medicaid enrollees nationwide account for more than 50 percent of all Medicaid spending.[2] Those high-need, high-cost enrollees (commonly referred to as "super utilizers") also have complex health and social needs.[3] Eighty percent have three or more chronic health conditions, and 60 percent have more than five.[4] A majority have mental health or substance use challenges or both but have limited access to outpatient behavioral health (BH) services (and virtually no access to evidence-based practices [EBP] in those domains).[5]

This population also has a range of challenges in social determinants of health, such as safe and affordable housing, food security, employment, social connectedness and transportation.[6] When these basic human needs go un- or under-addressed, illness self-management and routinely accessing primary care is secondary. The result is often an overreliance on more costly sites of care, such as emergency department (EDs) and inpatient hospital services, for non-emergent issues.[7] Redirecting state funds to effectively address the social service needs of this population can improve health and functional outcomes of high-risk Medicaid enrollees, break down the barriers that segment the continuum of services required by this complex population and rein in escalating health care costs.

Evidence shows that programs that have been successful in breaking the cycle of avoidable acute care utilization and time in other public institutions (e.g., corrections) invest in well-coordinated transitions to and among outpatient primary and BH care, evidence-based pharmacotherapy and social services interventions.[8] Among the most important interventions for this group is addressing homelessness and housing instability.[9] Some estimates show that as many as one-third to almost half of high-need, high-cost individuals are homeless.[10] Both pioneering and emerging programs are prioritizing housing interventions as a means of cost-effectively intervening with this subset.[11]

Housing as Health Care

Housing First is an evidence-based, permanent, supportive housing intervention for chronically homeless individuals that has the potential to improve health outcomes and reduce costs to health care and other public safety net programs.[12] It is a person-centered approach that focuses on immediate access to permanent, safe and affordable housing without contingencies. Community-based treatment, rehabilitation and support services are available and voluntary. Housing First is especially cost-effective for the high-need, high-cost population because it may reduce ED and hospital inpatient utilization, shelter use and cost to the criminal justice system.[13] Originally designed for homeless individuals who have serious mental illness and substance abuse disorder, the model is relevant to a large subset of the high-need, high-cost population and is a key component of emerging models.[14]

When access to permanent supportive housing programs is insufficient, some health systems have developed short-term solutions to provide shelter for homeless high-need, high-cost individuals who, although no longer in need of acute care, require more frequent contact with health providers to recover from injury or illness. These respite care programs, such as that in Seattle-King County, Washington, provide 24-hour shelter as well as health care and psychosocial interventions during the stabilization period.[15] Housing First is the more effective option in the long-term, but medical respite is a cost-effective component of a continuum of care for homeless high-need, high-cost individuals who cannot immediately be placed in supportive housing and are too sick to return to the street or a shelter. Significant reductions in inpatient days and readmissions, as well as increases in primary care visits, have been observed in the respite programs.[16]

State health leaders are actively pursuing solutions for homelessness as part of health system transformation efforts, working with their housing counterparts to build linkages and use resources effectively. Recognizing the value for these individuals and the Medicaid program, many are taking advantage of clarification from the Centers for Medicare & Medicaid Services (CMS) on coverage of housing-related activities and services for individuals with disabilities to maximize payment for services through Medicaid.[17]

The National Governors Association's Work on Housing as Health Care: Development of the Road Map

Over the past three years, National Governors Association's (NGA) Health Division has engaged in comprehensive technical assistance to 10 states and one territory—**Alaska, Colorado, Connecticut, Kentucky, Michigan, New Mexico, Puerto Rico, Rhode Island, West Virginia, Wisconsin** and **Wyoming**—to develop statewide plans to establish or advance programs to improve outcomes and reduce cost of care for high-need, high-cost Medicaid enrollees. Over the course of this work, states have become increasingly cognizant of the need for housing solutions to cost-effectively address the needs of a subset of these populations—a subset that tends to be unstably housed. As a result, a parallel project with 5 states has focused on specific housing solutions for this population and the intersection of housing and health care.

The road map was developed for both the immediate need to support those state planning efforts and broad use by all governors interested in the promise of housing as an essential element of improved health and reduced utilization of costly health care services. Extensive research and consultation with senior state officials, federal agencies, local providers and national experts in health and in housing informed the road map.

The core elements of the housing for health approach include:

- Building partnerships with key housing and health stakeholders;
- Using a data-driven approach to identify the target population and systems-level gaps and opportunities and inform resource allocation and program evaluation;
- Incentivizing and implementing EBPs, including Housing First;
- Leveraging the state's role as purchaser and administrator;
- Enhancing Medicaid's role in scaling up supportive housing approaches and realizing improved health outcomes and cost savings;
- Increasing access to safe, decent and affordable housing; and
- Demonstrating improved health outcomes and a reduction in health care expenditures.

PRIMER

1. What is supportive housing
2. How is it financed
3. Case studies

Part 1: What Is Supportive Housing?

Core Principles

Housing Principles

- Considered "permanent;"
- Integrated into the community;
- Tenant is offered choices;
- Heavily subsidized;
- Targets chronically homeless adults; and
- Tenants are likely to have substance use disorders (SUDs), chronic health conditions or behavioral health (BH) needs.

+

Services Principles

- Voluntary participation (Housing First approach);
- Comprehensive: Includes medical and BH, tenancy support and social services;
- Community-based or provided on site;
- Tailored to each tenant's needs so that he or she can live independently in the community;
- Care teams consist of case workers, housing specialists, clinicians; and
- May be provided through a partnership with a federally qualified health center (FQHC) or other community-based provider.

Services Provided to Tenants of Supportive Housing*

Supportive Services Housing [18]

Tenancy Support

- Intake;
- Income eligibility;
- Health insurance eligibility;
- Needs assessment;
- Development of housing plan;
- Housing search;
- Housing applications;
- Landlord engagement;
- Deposits;
- Eviction prevention;
- Obtaining furniture, household items;
- Case management/care coordination;
- On-site monitoring; and
- Housing respite.

Supportive Services Health, Well-Being and Community [19]

Health Care

- Medical respite
- Referrals to or provision of:
  - Primary care;
  - BH;
  - Substance use services;
  - Medication management;
  - Vision; and
  - Dental.
- Documentation and application for:
  - Disability; and
  - Health insurance.
- Accompanying tenant to appointments:
  - Transportation to medical appointments;
  - Pain management; and
  - Palliative care.
- Case management/care coordination.

Behavioral Health

- Assertive Community Treatment for high mental health MH/SUD-needs populations;
- Intensive case management for mild to moderate MH/SUD needs populations;
- Mobile crisis services including peer-based crisis;
- Peer support services;
- Psychosocial rehabilitative services (e.g.,supported employment, skill building interventions, community supports);
- Nonemergency medical transportation;
- Medication services including medication management and reconciliation;
- SUD services (e.g., medication-assisted treatment for opioid dependence);
- Individual and group therapies (e.g. integrated dual disorders treatment, illness management and recovery); and
- Case management/care coordination.

Referrals to Social Support

- Employment supports;
- Apprenticeships;
- Education supports;
- Nutrition education, including grocery shopping;
- Legal services;
- Budgeting and finances;
- Documentation and application for food stamps;
- Family counseling, mediation;
- Crisis management;
- Transportation (job-related);
- Access to child care;
- Activities of daily living; and
- Case management/care coordination.

Medicaid can pay for tenancy support but most states have not currently exercised those options.

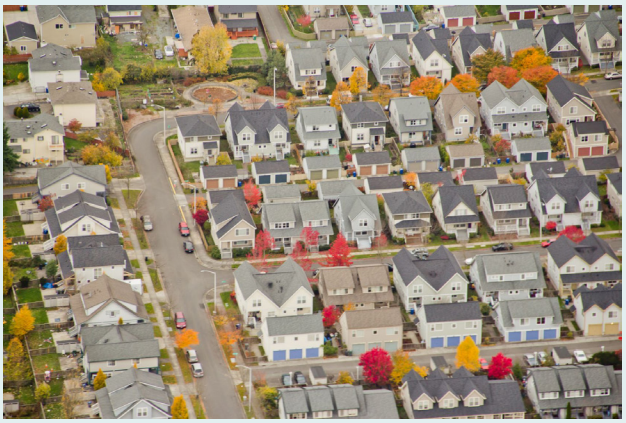
Many Medicaid programs pay for supportive services related to physical health and BH as well as referrals to community-based services, but most do not reimburse for tenancy support.

*Note: This list is not exhaustive but rather intended to serve as an example of the most commonly offered services.
For more information on supportive housing, see: https://www.usich.gov/solutions/housing/supportive-housing

Two Models of Supportive Housing

Scattered Site

- Rental units located throughout the community;
- Apartments or single-family homes;
- Case managers may be mobile and provide services in the home, or patients can receive care at FQHCs or other partner facilities;
- Patients also referred to providers in their community;
- Little or no up-front capital investment; and
- Works well in communities well supplied with MH, BH and other service providers needed to effectively treat this population.



Availability of Units:

- Lease existing units immediately from landlords willing to participate, or identify tax-credit units about to come online.
- Most federally sponsored subsidies require that units meet Fair Market Rent guidelines and Section 8 inspection standards.

Single Site or Mixed Single Site

- Units located in a single building;
- Many services provided onsite by hired staff, through partnerships with providers or onsite at a provider facility;
- Depending on financing:
  - 100% units reserved as supportive housing
  - Percentage of units set aside as supportive housing, remainder reserved as market-rate housing for the general population
- Good option for cities with a shortage of affordable rental units to meet Fair Market Rent guidelines.

Availability of Units:

- Existing units are likely to be filled, with a low turnover rate.
- New units will need to be created through construction or rehabilitation.
- For this reason, scattered site complements single site nicely.

Part 2: How is it Financed?[20]

The Elements of Supportive Housing

Capital
- Land Aquisition
- Demolition
- Construction ("bricks and sticks")
- Rehabilitation

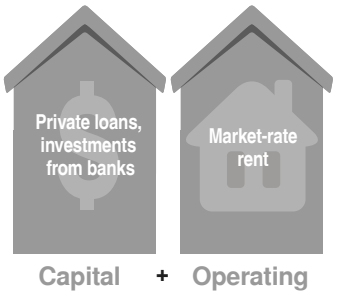
Note: Capital costs only apply to single-site supportive housing.

Operating
- Lights, water, heat
- Landlord services
- Building maintenance
- Debt service payments

Services
- Case management, tenancy support
- Substance use counseling
- Primary care and BH, and
- Workforce training and career services

The Challenge of Supportive Housing: Unlike Other Housing Models, Supportive Housing Must Encompass Services

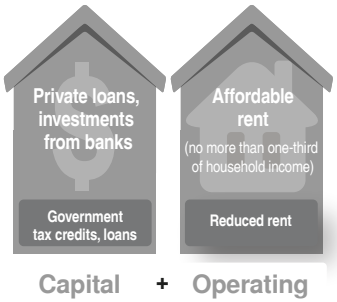
Three Housing Models:



Market Rate Housing

*Target: Those at or Above AMI**

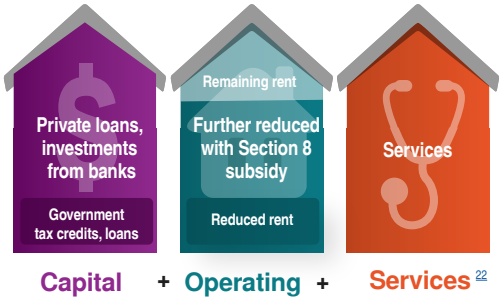
Market-rate housing is reflected in the types of units for which rent is the going market rate or higher. The developer raises capital through bank loans and other investments. Rents are set at a rate that allows the developer to at least meet the debt requirements of the loans used to construct the units and maintain the upkeep and operations of the building.



Affordable Housing[21]

Target: Low Income (below 60 percent AMI)

Affordable housing targets households making 60 percent or less of AMI. "Affordable" means that rents are set at a rate that equals 30 percent of household income. To make the units "affordable", governments may infuse low-interest grants, loans and tax credits into the construction costs which allows the tenant to pay below-market rent. Renters of affordable housing may also have rental subsidies. Not all projects are able to receive tax credits or rental subsidies because of high demand.



Supportive Housing

Target: Extremely Low Income (below 30 percent AMI) with service needs, such as individuals transitioning out of nursing facilities, chronically homeless adults and the high-need, high-cost population.

"Supportive housing" is affordable housing that targets extremely low-income households (30 percent or less of AMI) and provides services that this vulnerable population needs. Similar to affordable housing, households pay roughly one-third of their income toward rent, with the remainder government subsidized. Some services provided in supportive housing are not funded, however, and with no stable revenue source to pay for those services, particularly pretenancy and tenancy support, supportive housing providers often have to cobble together short-term or one-time grants to cover services, a solution that is not sustainable long term.

*AMI: Area Median Income

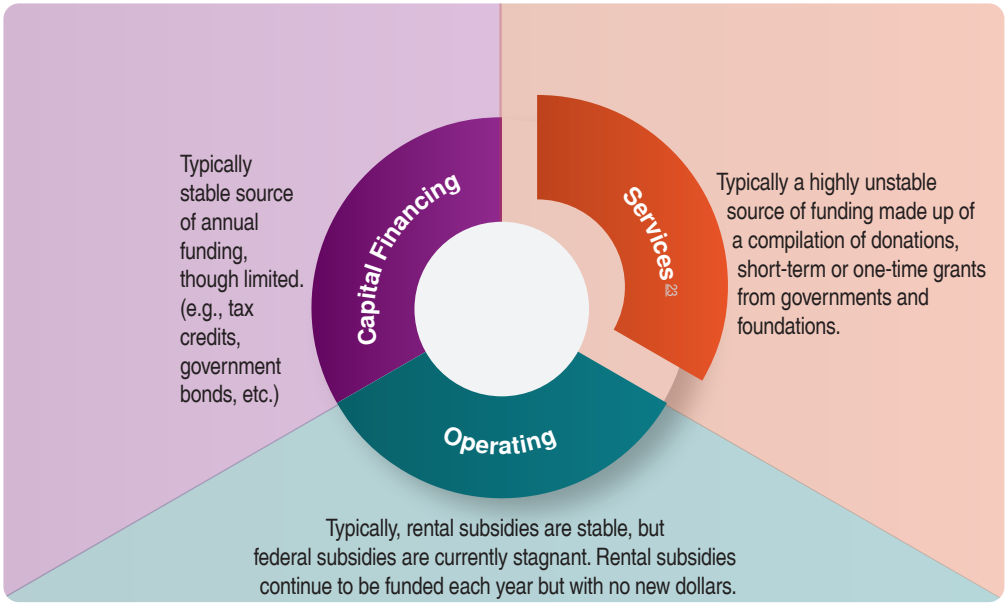
Note: Capital costs only apply to single-site supportive housing.

Stabilizing Funding for Support Services

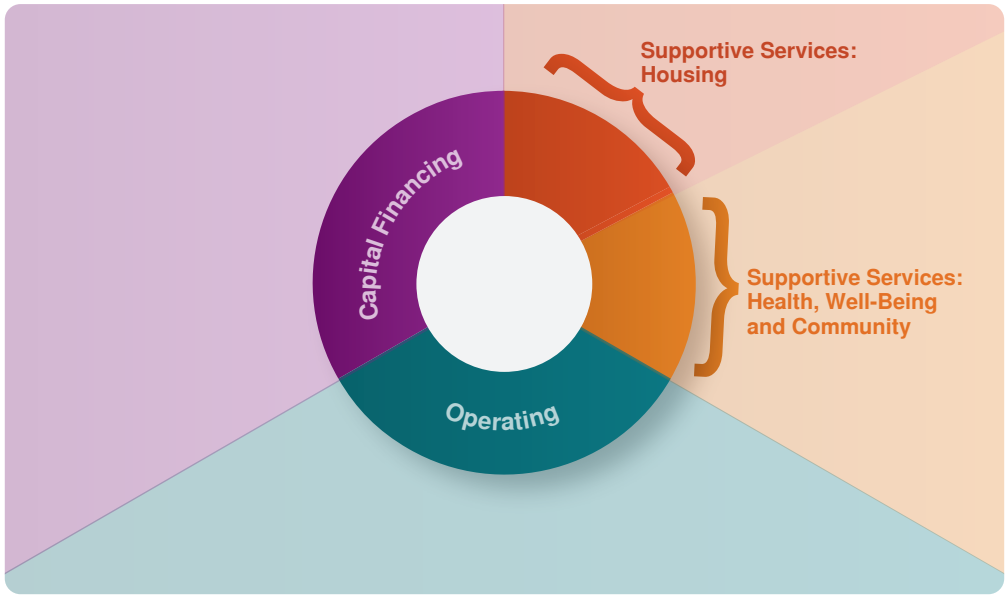
Supportive housing is a financially challenging proposition for many providers.

Although the services are a critical component of the supportive housing model, stable and long-term funding for services is scarce. Most supportive housing providers blend services funding through an array of annual or discretionary federal, state and local grants; foundation grants; and small donations. In particular, there are few funding sources for the pretenancy and tenancy support portion of the services provided to tenants, making the model's financial sustainability even more unstable. State Medicaid programs, however, can reimburse providers for the pretenancy and tenancy support critical to keeping tenants stably housed and healthy, thus providing a steady revenue source for tenancy services that keep residents of supportive housing in their homes.

Supportive Housing Without Medicaid



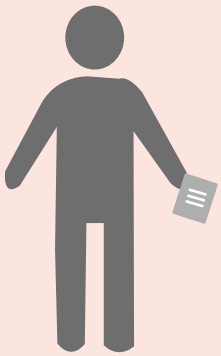
Supportive Housing With Medicaid



Three Models of Rental Subsidies

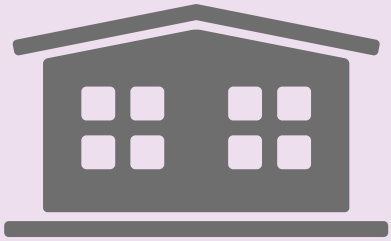
Project-Based[24]

The subsidy is tied to the physical unit, or "project." People living in such units pay a reduced rent. Project-based subsidies are not portable: They stay with the unit. The subsidy covers the remaining cost of that unit.



Tenant-Based[25]

The subsidy is tied to the tenant. Qualified tenants can rent their unit of choice from landlords willing to accept the voucher. Tenants pay a reduced rent, and the remainder of the rent is subsidized directly to the landlord by the voucher program. Tenant-based vouchers are portable, meaning that tenants can take their voucher with them when they move.

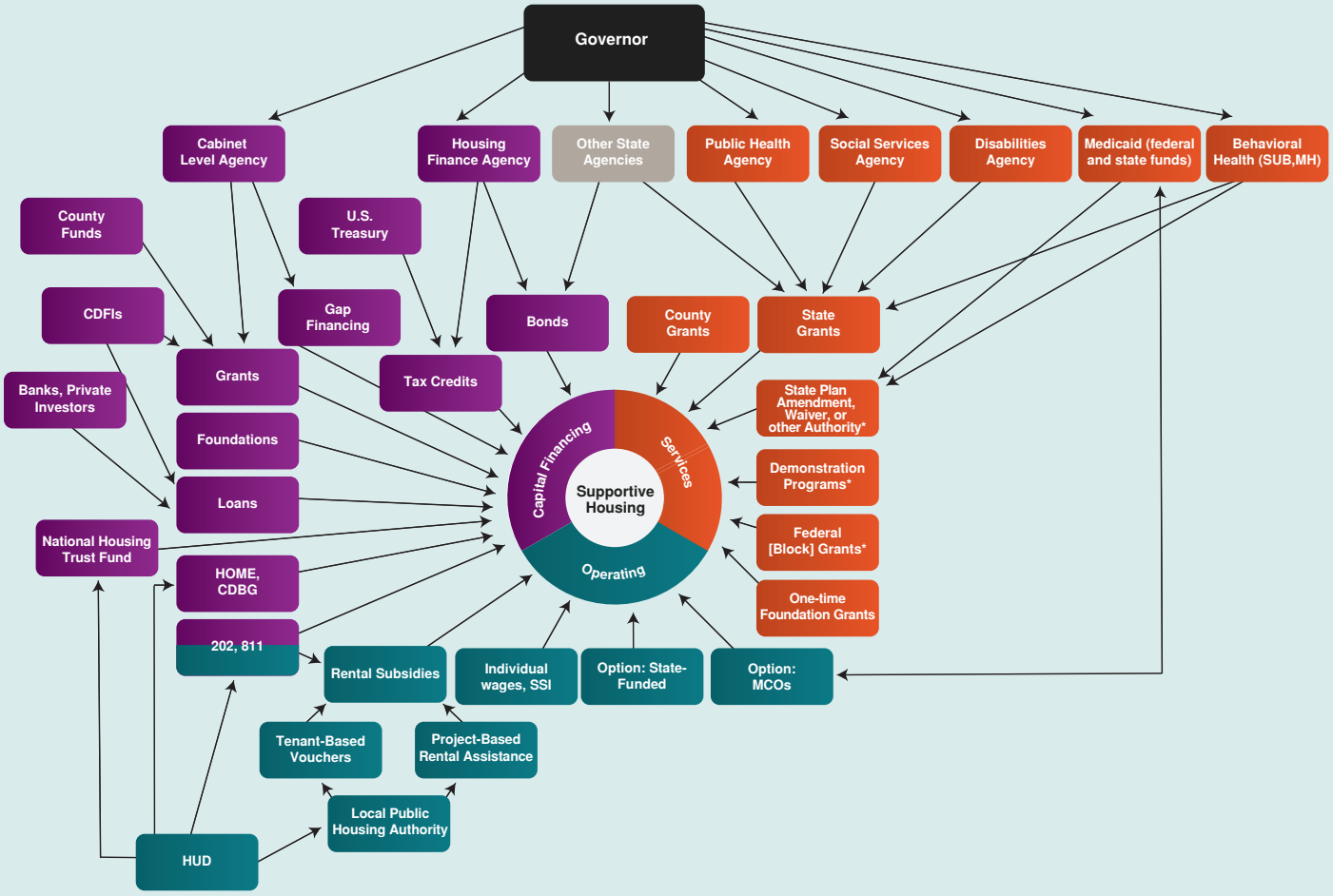


Sponsor-Based

The subsidy is typically provided by a nonprofit that has received funds to buy or lease units, which are then made available to clients. The subsidies stay with the nonprofit sponsor.

The housing and health care sectors can be key collaborators in achieving the common goal of designing, constructing and operating a financially sustainable supportive housing project that can provide a meaningful return on investment.

Creating new supportive housing units involves coordination with players in the public and private sectors to fold in a variety of funds. Developers responsible for the construction of these units work with federal, state and local officials, banks, private investors and foundations to secure capital funding. Developers, along with landlords and property owners, secure rental subsidies to help keep the units affordable. Service providers work with a variety of private foundations as well as federal, state and local agencies to cover the costs of providing supportive services.



*Note that federal funding for supportive housing services may be provided by HHS through programs such as Medicaid and CHIP, as well as federal block grants and demonstration programs.

Governors may choose to play a central role in moving this work forward.

Ultimately, all the partners report to the governor, receive state funding, are run by a board of directors partially appointed by the governor, or have a vested interest in aligning their goals and efforts with those of the state. The most important roles governors play are bringing together many public and private-sector organizations that may be working together for the first time and setting a state-led vision for housing as health care.

Part 3: Case Studies

Case Study 1—Thresholds of Chicago[26]

THRESHOLDS
HOME | HEALTH | HOPE

Thresholds is one of the oldest and largest providers of recovery services for people with mental illness in Illinois, using evidence-based practices and a range of support services to treat the comprehensive needs of clients. Thresholds operates 30 evidence-based programs at more than 100 locations throughout Chicago, its suburbs, and nine surrounding counties. Services include assertive outreach, case management, housing, employment, education, psychiatry, primary care, substance abuse treatment and research. The organization manages more than 75 residential developments in the Chicago metropolitan area. Residents are encouraged to develop basic living skills, including diet, money management, wellness and community integration.

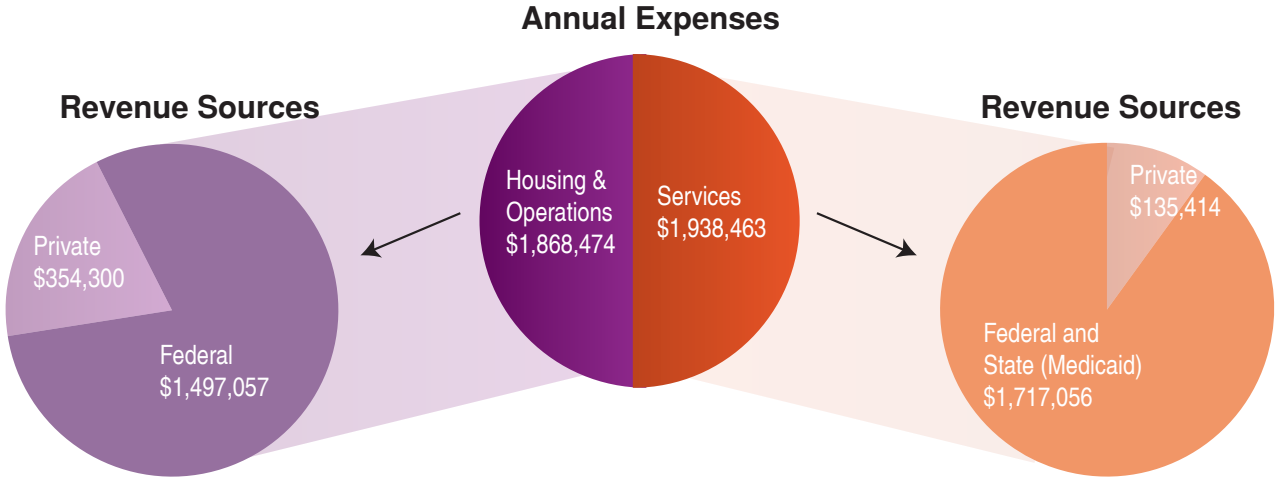
Thresholds provides the following services:

- Assertive Community Treatment
- Community support
- Housing support
- Follow up after hospitalization for mental illness
- Supported education
- Supported employment
- Integrated health care
- Psychiatric services
- Substance use treatment

Thresholds also provides tailored programming for specific populations:

- Veterans
- Young mothers
- Young adults (ages 16 to 21)
- Emerging adults (ages 18 to 28)
- People who are homeless
- Deaf/hearing impaired

Thresholds Breakdown of Financing for Scattered-Site Supportive Housing



Housing and Operations

Average annual expenses:

Debt service	$0
Salaries/benefits	$60,342
Building rents	$1,774,561
Other	$16,103
Indirect costs	$17,468
Total expenses	$1,868,474

Funding Sources:

HUD* McKinney-Vento	$1,497,057
Tenant rent contribution	$354,300
Total revenue	$1,851,357

Total $-17,117

Services

Average annual expenses:

Services	$1,938,463
Other	$0
Total expenses	$1,938,463

Funding Sources:

Medicaid FFS*	$1,717,056
Federal grants	$0
State grants	$0
Foundation grants	$0
Program participant fees	$135,414
Total revenue	$1,852,470

Total $-85,993

Total: $-103,110

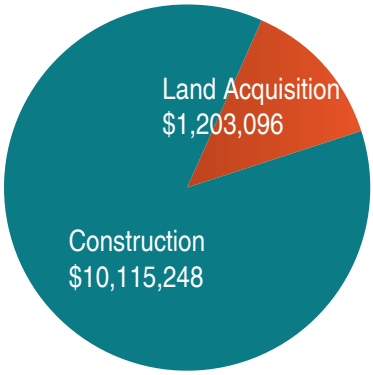
* HUD: U.S. Department of Housing and Urban Development; FFS: fee-for-service

Case Study 2—Howard County, Maryland

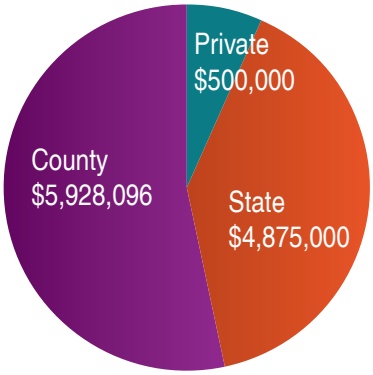
This 35-unit permanent supportive housing project in Howard County, Maryland, is currently under construction. It was financed without Low-Income Housing Tax Credits but with heavy investments from the state and county.

Maryland Financing of Single-Site Supportive Housing

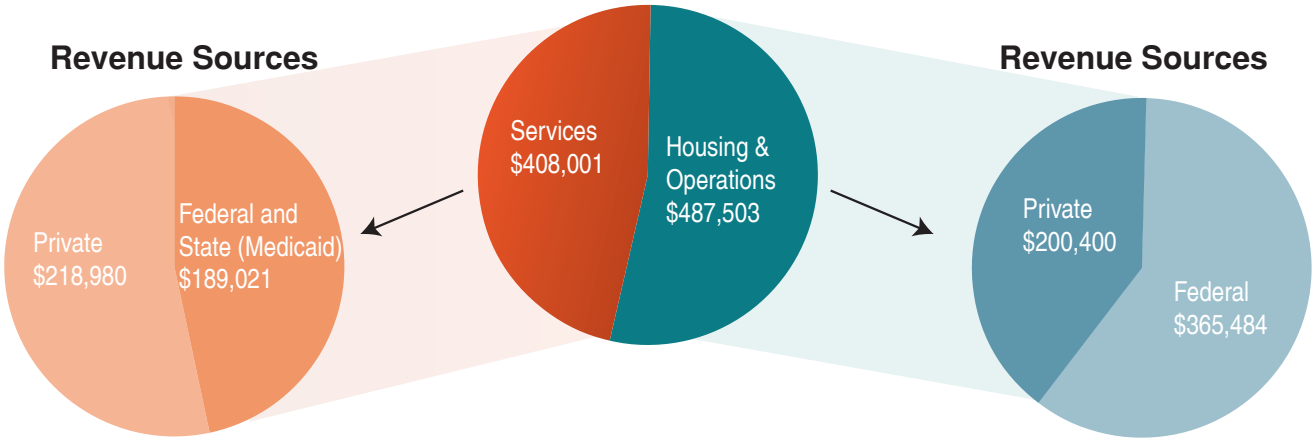
Capital Costs



Capital Sources



Annual Expenses



Capital Costs:

Land acquisition	$1,203,096
Demolition	$0
Rehab/construction	$10,115,248
Other	$0
Total:	***$11,318,344***

Capital Sources:

State loan:	$2,625,000
State grants	$2,000,000
State bonds	$250,000
County bond	$4,250,000
County grants	$1,678,096
Other FHLB****	$500,000
Deferred dev. fee	$15,248
Total:	***$11,318,344***

Housing and Operations

Average annual expenses:

Debt service	$0
Salaries/benefits	$124,423
Building maintenance	$287,636
Other	$75,444
Total expenses	$487,503

Funding sources:

Section 8 subsidies	$365,484
Tenant rent contribution	$0
Medicaid	$0
Other**	$200,400
Total revenue	$565,884
Total	$78,381

Services

Average annual expenses:

Salaries/benefits	$408,001
Other	$0
Total expenses	$408,001

Funding sources:

Medicaid (anticipated*)	$189,021
Federal grants	$0
State grants	$0
Foundation grants	$0
Other***	$218,980
Total revenue	$408,001
Total	$0

Total: $78,381

* Note: Maryland Medicaid has applied for a section 1115 waiver demonstration that would provide capped grant dollars to local jurisdications to offer housing support services funded by Medicaid. This is an estimate of potential funding that, if the waiver is approved and the county receives funding under this initiative, could be dedicated to this effort.

** County Funds

*** In-kind services, medical treatment, food, etc., valued at $218,980

**** FHLB: Federal Home Loan Bank

ROADMAP

1. Develop housing and services strategy
2. Plan and build capacity
3. Implement and evaluate

State Road Map – Housing as Health: Complex Care Solutions

Phase 1: *Develop Housing and Services Strategy*

State teams work with key stakeholders to develop their housing strategy, including:

- Scanning the environment;
- Developing a housing and health care strategy for the complex care population;
- Incorporating key elements of behavioral health services integral to a housing intervention;
- Assessing bridge solutions for individuals with complex care needs;
- Defining the services in supportive housing; and
- Building capacity for capital and operating resources

Phase 2: *Plan and Build Capacity*

State teams and stakeholder partners iteratively plan and obtain buy-in for an overarching health and housing strategy, including:

- Developing Medicaid waiver and state plan amendment options for services; and
- Communicating the plan and engaging leadership

Phase 3: *Implement and Evaluate*

State teams implement housing solutions, evaluate and communicate outcomes and reinvest a portion of savings. This includes:

- Implementing permanent supportive housing (PSH) and bridge housing solutions;
- Evaluating short- and long-term programmatic outcomes, including health outcomes and cost savings; and
- Deciding on a savings versus reinvestment strategy to support additional housing solutions that will deliver return on investment

Phase 1: Develop Housing and Services Strategy

Scan the Environment

Conduct a scan of data sources, funding, services and housing stock to help inform state strategy to ensure housing and services can meet the target population needs.

Build the Team and Base Support

Build a core team:
Create a team to conduct an environmental scan and shape interagency efforts on housing solutions for high-need, high-cost populations;

Identify staff from state health and human services agencies including: mental health (MH), substance use, aging and disabilities, Social Security, departments of labor, housing, corrections[27], IT, quality, and others that play a role in housing special populations to advise the team, develop an action plan based on the environmental scan and champion and lead implementation; and

Engage the budget office early to secure buy-in.

Develop robust stakeholder process:
Engage key stateholders to help tell the story and later champion the efforts. Stakeholders can provide critical data to complete the scan and identify opportunities and geographic mismatches.

Develop Data Strategy

Link Medicaid beneficiaries to housing status:
Consider all data sources including Homeless Management Information System, Medicaid claims data and encounter data.

Define the target population:
Use data to decide on "complex care" target population, then match with homelessness status.

Consider a broad definition of "homelessness" that includes institutionalized, underhoused and imminent risk for homelessness.

Develop evaluation strategy:
Decide on core metrics (include health outcomes, cost, utilization) and establish a means to collect reliable data and track program improvement and rapid cycle evaluation.

Identify who will conduct the evaluation and the frequency of measurement.

Assess the Services Infrastructure

Engage provider and payer partners to assess the full continuum of health care services, bridge housing, tenancy support and housing support services available to the target population. Also assess provider capacity and opportunities to build capacity; and

Evaluate financing strategy, including Medicaid, to inform services and provider strategy to meet population need while creating value (consider role of managed care organizations [MCOs] and behavioral health organizations [BHOs]).

Assess the Physical Housing Infrastructure

Estimate Units Available:
Assess supportive housing capacity: Take inventory of available capital and operating resources. Also, inventory the number of supportive housing units currently available in the state;

Assess state shortage or surplus of affordable rental housing; and

Assess bridge housing capacity and untapped resources.

Map resources:
Assess the implication of the connect/disconnect between location of services and units; and

Estimate total number of units needed to serve the population.

Estimate Costs, Savings, and Cost Avoidance

Estimate costs and impact on state budget for years 1 through 5;

Estimate projected savings of investment, recognizing the impact on various state programs; and

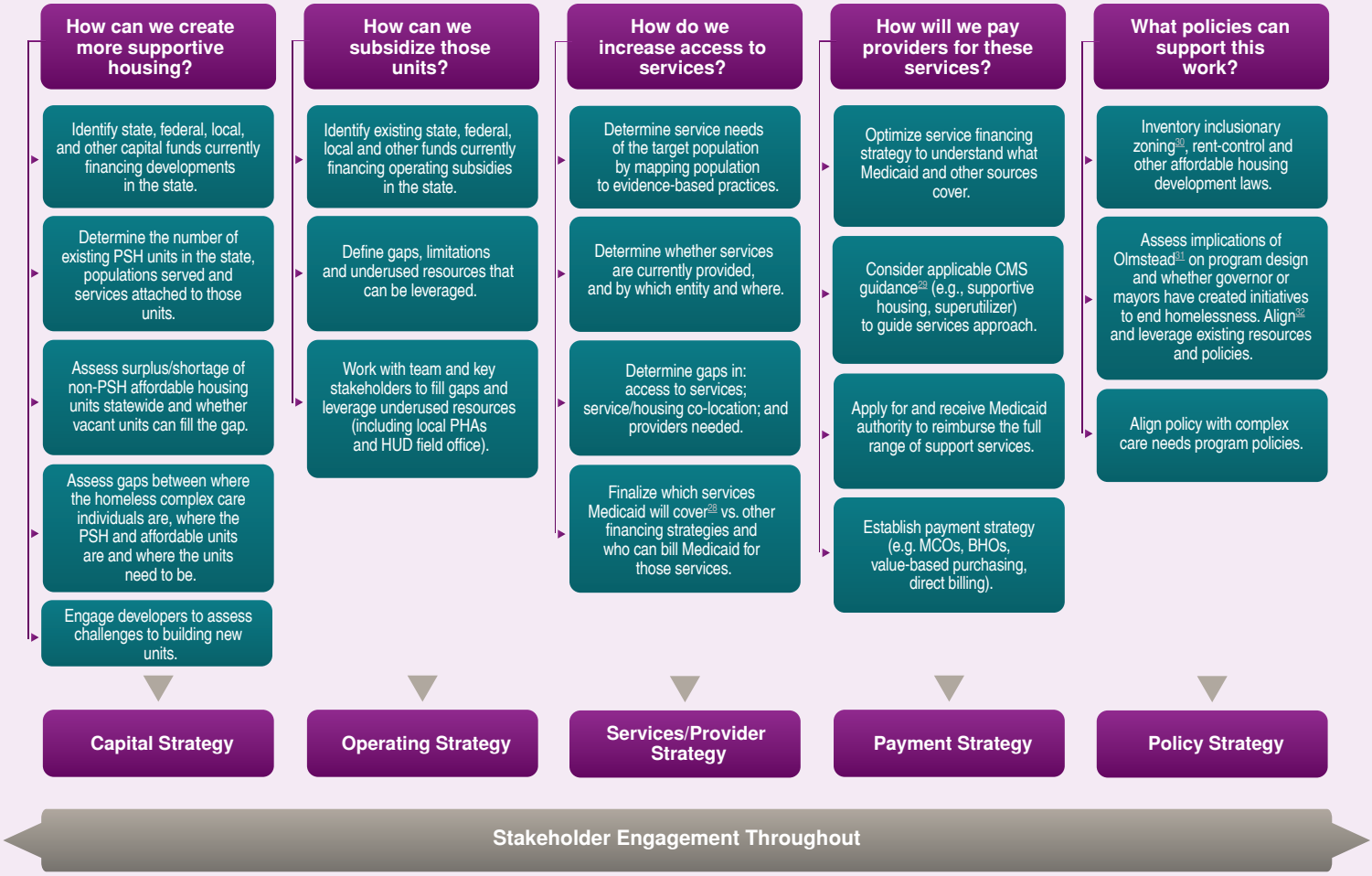
Develop a reinvestment and savings strategy to balance savings with reinvestments to bring more permanent supportive housing (PSH) units online as appropriate.

Obtain Early Buy-in From Key State Leadership:

Tell the story: Include discussion of dollars poorly spent on unnecessary inpatient and emergency department (ED) use (or other institutional settings) and value created by shifting dollars to housing solutions. Include system inefficiencies and implications for other state health system transformation efforts.

Develop a Housing and Health Care Strategy for Complex Care Population

These key considerations help build the foundational elements of an overall housing as health care strategy.



Key Considerations

- Are the housing and services application and eligibility process streamlined?[33]
- Does my plan fully comply with Fair Housing laws?
- Do I have a robust stakeholder engagement process in my state for other initiatives, such as the State Innovation Model?
- What is the level of political support in my state?
- How much support is there to increase Medicaid expenditures?
- Is there initiative fatigue?
- Does my state have a cabinet-level agency on housing? Do I know the executive director of my state's housing finance agency?

Key Decision and Outcomes

- Establishment of capital, operating, services, provider and policy strategies
- Thorough identification of financial resources and physical infrastructure
- Understanding of the geographic connect or disconnect among the homeless, housing units and services

Incorporate Key Elements of Behavioral Health Services Integral to Housing Intervention[34]

These are the key elements of a robust, evidence-based behavioral health system. Considering the availability of these elements supports the needs of the target population.

Housing First was developed to meet the needs of homeless individuals with serious mental illness and substance use challenges. The overlap with the top one percent of individuals using a costly site of health care but whose needs are better met in the community is significant. As many as 70 percent of these individuals have a mental illness, 50 percent have a SUD, as many as one-third are dealing with opioid dependence and close to half are homeless. Housing First approaches that target this high-need, high-cost population are among the most cost-effective.[35,36,37,38,39]

Case Study: 1811 Eastlake in Seattle

This single-site Housing First program provides on-site services for chronically homeless people who have alcohol addiction without requiring abstinence or treatment. A 2009 study found that the program saved taxpayers over $4 million in the first year and $2,449 per person per month in health and social services in the first six months while reducing alcohol use by almost one-third. The study also found a correlation between the length of housing stability and reduction in both cost and alcohol consumption.[40]

Assess Bridge Solutions for Individuals With Complex Care Needs

Health care providers can implement programs that are important for moving the health care system from higher cost and lower efficiency to lower cost and greater efficiency.

Higher Cost, Lower Efficiency

Homelessness

Individual may be ready for discharge from inpatient or ED, living on the street, awaiting release from incarceration or other.

Respite Care[41]

As needed for patients who are discharged from inpatient care[42] but require ongoing management of conditions.[43]

Bridge Housing[44]

Temporary housing solution to immediately shelter homeless individuals who have agreed to be housed until their permanent unit or subsidy becomes available.

Permanently Housed

Individual is stably housed in PSH with necessary wrap-around services.

Lower Cost, Higher Efficiency

Key Considerations

- Does a subset of the population require respite services?
- Are there providers in my state with respite or bridge programs? If so, how are they financed?
- What is the gap between need and existing respite care?
- Are best practices in transitional care management and care coordination employed and incentivized?

Define the Services in Supportive Housing*

Understanding the evidence-based services included in a successful supportive housing models can guide state strategies for covering the full range of pretenancy and tenancy support.

Supportive Services[45] Housing

Tenancy Support[46]

- Intake;
- Income eligibility;
- Health insurance eligibility;
- Needs assessment;
- Development of housing plan;
- Housing search;
- Housing applications;
- Landlord engagement;
- Deposits;
- Eviction prevention;
- Obtaining furniture, household items;
- Case management/care coordination;
- On-site monitoring; and
- Housing respite.

Supportive Services Health, Well-Being and Community

Health Care

- Medical respite
- Referrals to or provision of:
  - Primary care;
  - BH;
  - Substance use services;
  - Medication management;
  - Vision; and
  - Dental.
- Documentation and application for:
  - Disability[47]; and
  - Health insurance.
- Accompanying tenant to appointments:
  - Transportation to medical appointments;
  - Pain management; and
  - Palliative care.
- Case management/care coordination.

Behavioral Health

- Assertive Community Treatment for high mental health MH/SUD-needs populations;
- Intensive case management for mild to moderate MH/SUD needs populations;
- Mobile crisis services including peer-based crisis;
- Peer support services;
- Psychosocial rehabilitative services (e.g.,supported employment, skill building interventions, community supports);
- Nonemergency medical transportation;
- Medication services including medication management and reconciliation;
- SUD services (e.g., medication-assisted treatment for opioid dependence);
- Individual and group therapies (e.g. integrated dual disorders treatment, illness management and recovery); and
- Case management/care coordination.

Referrals to Social Support

- Employment supports;
- Apprenticeships;
- Education supports;
- Nutrition education, including grocery shopping;
- Legal services;
- Budgeting and finances;
- Documentation and application for food stamps;
- Family counseling, mediation;
- Crisis management;
- Transportation (job-related);
- Access to child care;
- Activities of daily living; and
- Case management/care coordination.

*Note: This list is not exhaustive but rather intended to serve as an example of the most commonly offered services.

Key Considerations

- Would any of these services not be reimbursable under the proposed Medicaid waiver or state plan amendment?
- If requiring MCOs to provide these services, which services would be considered an administrative versus direct medical expense?
- In order for states to more clearly define the full range of pretenancy and tenancy support services covered through the Medicaid program, consider listing them as their own services within the Medicaid waiver or state plan amendment.[48]

Build Capacity for Capital and Operating Resources

This is a critical step prior to implementation to ensure an effective supportive housing strategy to inform the Medicaid authority to be established.

Build Up Capital Fund Sources

Low-Income Housing Tax Credit:

- Determine whether current Qualified Allocation Plan (QAP) incentivizes this work. If so, engage developers and provide education and technical assistance;
- If not, revamp the QAP and allocate points to the designated population; and
- Consider a consolidated RFP for supportive housing, such as those in Connecticut, Louisiana and New York.

Explore Availability of Additional Capital Resources

- Determine feasibility of using federal Housing Trust Fund, Social Innovation Funds, social impact bonds (SIBs), multifamily bonds, HUD (Section 202, 811, HOPWA, HOME, CDBG, SHP)*, New Market Tax Credits, tax-increment financing and public-private partnerships.

Encourage Scattered Site and Single Site

- Accelerate the availability of new units by enabling scattered-site housing, which may require little or no capital.

*Housing Opportunities for Persons with AIDS, HOME Investment Partnerships Program, Community Development Block Grants, Supportive Housing Program

Build Up Operating Fund Sources

Maximize Public Housing Authority (PHA) Participation

- Engage the local HUD field office;
- Implement PSH limited preference;
- Tap into unused special-purpose vouchers;
- Project-base existing tenant-based vouchers; and
- Revamp the PHA's system of preferences.

Pursue State Funds to Support Efforts

- Determine if the state has any existing rental subsidy dollars;
- Use projected savings to fund rental subsidies;
- States may be willing to match such investments; and
- Consider repurposing MH and substance use treatment dollars.

Additional Resources

- HUD Section 811, Section 202;
- Money Follows the Person; and
- SIBs/Pay for Success.

Phase 2: Plan and Build Capacity

Develop Waiver and State Plan Amendment Options*

These Medicaid authorities may be considered by states interested in using Medicaid to pay for supportive housing services.

	Managed Care Contracts**	1115 Waiver	1915(c) Waivers
Eligible/Covered Populations	• Most individuals eligible under the Medicaid state plan	• State can define qualifying criteria	• Aged, disabled individuals or those with MH diagnoses who require institutional-level care
Support Services[49]: Health, Well-Being and Community; Health Care, Behavioral Health (BH), Referrals to Social Support	• Managed care plans must cover state plan or waiver services, if applicable • Managed care plans may also cover cost-effective alternative services not included in the state plan	• States can define the benefit package • The Centers for Medicare & Medicaid Services (CMS) have not approved capital expenses — only short-term operating expenses	• Case management services, community transition services, home health aide services, habilitation services, respite care services, environmental modifications for accessibility
	Note that traditional health care services integral to a supportive housing intervention would be covered under states' existing Medicaid authorities.		

Support Services: — Housing: Tenancy Supports[50]	• States can require managed care plans to cover tenancy services if services are covered under the state plan or waivers
	• If tenancy supports are not covered under the state plan or waivers, managed care organizations (MCOs) may still elect to cover the services as "in lieu of" services (included as part of the capitation rate) or may cover those services outside the capitation rate (as part of administrative costs)
		• Most flexibility: States may cover a broad array of tenancy support services as a defined service in the waiver
		• Note that CMS does not currently allow states to cover capital costs
			• Broad flexibility: States may cover a broad array of tenancy support services — for example:
			  • Case management services may include completion of housing applications, tenant training and communication with landlords; and
			  • Community transition services may include security deposits, setup fees for utilities and essential household furnishings

Considerations	• For in-lieu-of services, the state must determine that the services are medically appropriate, cost-effective substitutes and authorize coverage by identifying the services in the MCO contract • States may encourage MCOs to cover non-covered tenancy support services by establishing performance metrics linked to health outcomes for populations with housing instability	• Provides the greatest flexibility to define covered populations, benefits and geographic areas • Requires budget neutrality and extensive negotiations with CMS	• States can target specific populations in certain geographic areas and cap the number of eligible individuals • Covered population will need to meet the state's criteria for institutional care • Must be cost-effective, which is not difficult because all individuals would receive institutional care but for the provision of home and community-based services • Tenancy support can be defined as separate and discrete services under the waiver

*Not exhaustive; these are the most relevant Medicaid authorities for "housing as health" interventions. For example, states can also use 1915(k) or other Medicaid authorities as approved by CMS. This information was gathered through an analysis of federal statutes, regulations and policy guidance as well as conversations with CMS.
** States can implement managed care programs through three authorities – Section 1115 demonstrations, 1915(b) waivers and Section 1932 State Plan Amendments.

Develop Waiver and State Plan Amendment Options (Continued)

	1915(i) Home and Community-Based Services (HCBS) State Plan Option	Health Homes State Plan Option	1905(a) Targeted Case Management

Eligible/Covered Populations	• Aged or disabled individuals who have income at or below 150 percent of the Federal Poverty Level	• Medicaid-eligible individuals who:
		  • Have two or more chronic conditions;
		  • Have one chronic condition and are at risk for a second; or
		  • Have one serious and persistent MH condition
			• Most individuals eligible under the Medicaid state plan can qualify for targeted case management. However, states must target certain populations or individuals living in certain geographic areas

Support Services: Health, Well-Being and Community: Health Care, Behavioral Health (BH), Referrals to Social Support	• Case management services, community transition services, home health aide services, habilitation services, respite care services, environmental modifications for accessibility	• Comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow up, patient and family support, referral to community and social support services	• Case management services
	Note that traditional health care services integral to a supportive housing intervention would be covered under states' existing Medicaid authorities.		

Support Services: — Housing: Tenancy Supports	• Broad flexibility: States may cover a broad array of tenancy support services — for example:
	  • Case management services may include completion of housing applications, tenant training and communication with landlords; and
	  • Community transition services may include security deposits, setup fees for utilities and essential household furnishings
		• Broad flexibility: States may cover a broad range of tenancy support services by incorporating those services into the payment methodology for the health home network
		• States should define the tenancy support services that will be covered under payments to health homes in their state plan amendment
			• Limited flexibility: Targeted case management does not authorize coverage of tenancy support services, only the identification of and linkage to the services — for example:
			  • Case management services may include identifying housing resources and linking individuals to those resources; and
			  • States cannot cover community transition services such as security deposits, setup fees for utilities or essential household furnishings

Considerations	• States must offer benefits statewide but can target certain populations. • States cannot cap the number of eligible individuals • No cost-effective requirement	• States can target specific populations in certain geographic areas • Enhanced federal match (90:10) is available only for the first eight quarters	• Coverage is limited to case management services • States must offer the benefit statewide, but they must define eligible populations

Key Considerations:

- Does the target population for this initiative line up with the eligible population under each option?
- How do the covered services[51] in each option align with the services the state wants to cover?
- Can the state accomplish this under managed care?
  - If so, is the target population already enrolled in managed care? If not, can they be enrolled?
  - How would the state build the services into the Medicaid managed care contract?

Waiver and State Plan Amendment Options – State Examples

These three states are highlighted as examples of different models for carrying out housing as health care programs using Medicaid.

	Example 1: Massachusetts Community Support Program for People Experiencing Chronic Homelessness[52] Implemented in 2005	Example 2: Louisiana Permanent Supportive Housing[53] Implemented in 2011
Target Population	Chronically homeless individuals (U.S. Department of Housing and Urban Development [HUD] definition) with a diagnosis of a MH or SUD	People with substantial long-term disability (includes physical, BH, SUD, developmental disability or disability related to chronic health conditions); prioritizes chronically homeless and institutionalized individuals or households with disabilities
Medicaid Authority	1115 waiver	Multiple 1915(c) waivers, Mental Health Rehabilitation under 1915(i) replaced with Mental Health Rehabilitation under state plan effective Dec. 1, 2015
Services Covered	**Housing Supports** • Identify and triage potential participants • Assist individuals with housing search • Assist individuals in obtaining permanent housing • Assist individuals in enhancing daily living skills: may include tenancy skills support (bill payment, housekeeping, lease observance, etc.) • Provide crisis planning, prevention, intervention **Health Services** • Coordinate service and linkage to BH and physical health • Link/refer to recovery supports • Schedule, transport, and accompany clients to medical appointments **Social Supports** • Link/refer to social supports • Assist with obtaining entitlement benefits • Assist in enhancing daily living skills, which may include nutrition and time management skills building and support	**Pretenancy and Tenancy Supports** • Provide pretenancy assistance in viewing and selecting units, obtaining necessary documents to complete housing and voucher applications, seeking reasonable accommodation when needed and entering into lease agreements • Assist with apartment setup and move in, identify transportation resources and routes, orient to neighborhood • Provide tenancy skills support (bill payment, housekeeping, lease observance, getting along with neighbors) • Provide tenancy preservation and maintenance including assistance in obtaining entitlement benefits, building social connections, accessing primary and other health care, and support for voluntary compliance with treatments • Assist in crisis planning/eviction prevention **Other** • Transition services • Environmental accessibility adaptations • Personal care attendant • Skilled maintenance therapies (physical therapy, occupational therapy, etc.) • Nursing • Support coordination • Home delivered meals • Caregiver respite • Employment support and training • BH services, including for SUD, by licensed practitioners • Adult day health care • Transportation • Personal emergency response systems • Assistive technology, specialized medical equipment and supplies
Outcomes	• In an analysis of 137 members of the Community Support Program for People Experiencing Chronic Homelessness (CSPECH), there was a net savings of $10,249 per person annually, and a total estimated annual savings of $1,404,113[54] • Examining the top 10 emergency department (ED) users in fiscal year (FY) 2009, nine out of 10 had a decrease in ED use after enrolling in CSPECH; these extreme high users of the ED decreased their ED use by 73 percent, from 300 visits in FY 2009 to 166 ED visits in FY 2010 and 80 ED visits in FY 2011[55]	• 24 percent reduction in Medicaid acute care costs (2011–2012)[56] • 96 percent housing retention rate[57] • 61 percent increase in household income[58]

State Examples (Continued)

	Example 3: California Health Homes and Housing[59] Scheduled Implementation of July, 2017	Example 4: California Medi-Cal 2020[60] Scheduled Implementation of November, 2016	Example 5:California Community Transitions Implemented in 2007
Target Population	High-cost Medi-Cal members with chronic conditions and those experiencing homelessness	High utilizers, nursing facility discharges, those who are homeless or at risk of homelessness	Nursing facility discharges, recipients of long-term inpatient care and those who are homeless or at risk of homelessness
Medicaid Authority	Health Homes State Plan Option (pending approval)	1115 Waiver	Money Follows the Person
Services Covered	• Provide comprehensive care management • Provide care coordination • Assist the member in navigating health, BH and social services systems, including housing • Engage in health promotion • Provide comprehensive transitional care • Assist in planning appropriate care/place to stay post-discharge, including temporary housing or stable housing and social services • Provide transition support to permanent housing • Link/refer to individual and family support services • Link/refer to community and social supports • Link to individual housing transition services, including services that support an individual's ability to prepare for and transition to housing • Link to individual housing and tenancy sustaining services, including services that support the individual in being a successful tenant in their housing arrangement and sustaining tenancy	• Provide housing-based care management • Provide tenancy supports, including outreach/engagement, housing search assistance, crisis intervention, application assistance for housing and other benefits • Allows health plans flexibility to provide non-traditional services such as care coordination, discharge planning • Allows health plans and other participants to contribute to shared savings pool with county partners that can be used to fund other housing-related supports and services, and to form regional integrated care partnership pilot programs to more effectively leverage state, federal and local dollars	• Arrange for the transition to home- and community-based services • Encourage local care coordination organizations work directly with willing and eligible individuals to transition them back home or to the community • Combines with HUD Section 811 grants to create more affordable rental units for the disabled population
Outcomes	TBD	TBD	TBD

Local Innovation: Los Angeles Department of Health Services

The Los Angeles Department of Health Services (DHS) recently launched the Housing for Health[61] program to house homeless DHS patients who have complex physical and BH conditions. Notably, they have successfully done so without additional county dollars. The county approved a reallocation of $4 million in existing DHS funds from services to housing, allowing DHS to pay the rent for formerly homeless individuals. DHS secured the reallocation of funds by demonstrating that they would be offset by significant reductions in ED and inpatient utilization. In addition to rent subsidies, DHS provides individuals with intensive case management that includes tenancy support services. Initial results of the program include a 77 percent decrease in ED visits, 77 percent decrease in inpatient admissions and 85 percent reduction in inpatient days.[62]

Communicate the Plan and Engage Leadership

When communicating a housing as health care strategy to key leadership, these elements can help drive the most salient points.

Communicate your five-part housing strategy to the governor and key leadership

1. Capital Strategy
2. Operating Strategy
3. Services/Provider Strategy
4. Payment Strategy
5. Policy Strategy

Key Communication Points:

Estimate Costs

- Determine the state's share of funding for capital, operating and services.
- Create a plan to cover the nonfederal share of Medicaid, including new or existing resources.

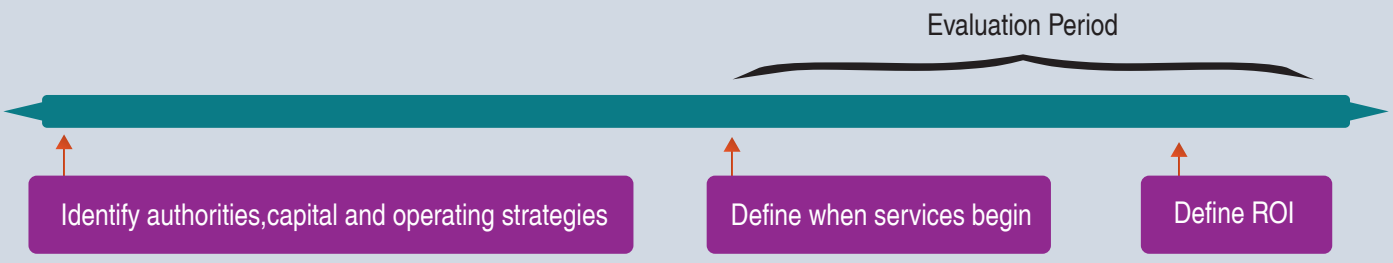
Expected Return on Investment (ROI)

- Include outcomes, quality and cost.
- What are the short-term versus long-term ROI expectations?

Policy Implications

- New laws, regulations or policies that may be needed.
- Alignment with other policy priorities in the state.

Include Timeline



Phase 3: Implement and Evaluate

An evaluation and savings strategy can be designed early on to help inform the future of the program.

Implementation

Evaluate

1. Use measures identified in Phase 1 to implement rapid cycle performance monitoring, reporting and quality improvement strategies.
2. Make programmatic adjustments based on evaluation.
3. Focus short-term ROI on reducing ED visits, inpatient admissions and overall utilizations. Long-term ROI will also include health outcomes.
4. Evaluate impact and cost savings to other public services such as unemployment, corrections, law enforcement and foster care.
5. Evaluate outcomes such as housing stability, employment, reduced incarceration or recidivism to hightlight budget-neutral achievements.

Savings Strategy

1. Develop a savings strategy—determine funds to be reinvested and funds that will generate a savings to the state.
2. Consider scalability and creation of new units as a core component of the review process.
3. Protect prior funding sources such as grants and state MH funds that can be used to further this work.
4. Make the business case, which includes the creation of jobs through investments in housing construction, the revitalization of blighted communities and savings to other state agencies.

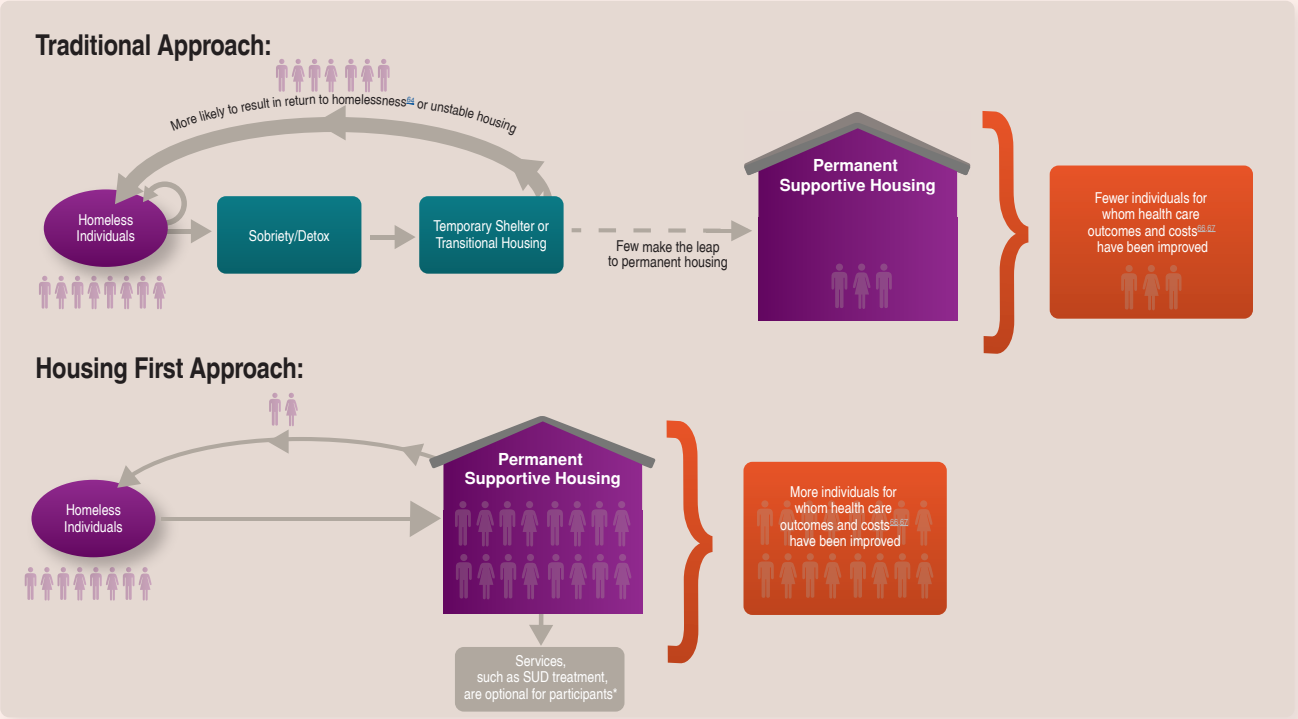
KEY ELEMENTS TO GET STARTED

1. Housing first
2. Build the team
3. Common challenges and solutions

Part 1: Housing First

What is Housing First?

Understanding Housing First approaches can help states as they gather evidence-based practices that yield positive health outcomes and cost savings.



*Note: In a study of 250 chronically homeless individuals with severe mental illness, of whom 90 percent had a drug or alcohol problem, over half of those assigned to Housing First opted to utilize voluntary substance use services in the 24 months the study followed the tenants.[68]

Housing First is a proven approach to chronic homelessness that provides individuals and families stable, permanent housing.[63] The Housing First approach is an evidence-based model for ending chronic homelessness, keeping homeless individuals and families stably housed, improving health outcomes and reducing the costs associated with avoidable emergency department (ED) visits. The approach does not require sobriety, employment or other stipulations as a condition of their housing, but makes substance use treatment and other services available for individuals if they choose. Numerous studies have demonstrated that Housing First is associated with superior housing retention, decreased substance use, longer engagement in treatment, improved quality of life, lower health system costs and decreased involvement in the justice system compared with treatment as usual.[65]

Return on Investment

A study of chronically homeless individuals in central Florida found a total of cost of $31,065 per person per year in inpatient hospitalizations, ED visits, incarceration and other system costs compared with $10,051 per person per year to provide individuals with supportive housing.[69]

Case Study: Oregon

A 2016 study of Housing First for formerly homeless, high-need individuals in Portland, Oregon, found that one year after housing, residents had improved access to care, stronger primary care connections and improved self-reported health outcomes. Evaluation of Medicaid claims data showed that higher quality care was accompanied by reduced expenditures, primarily in ED and inpatient care. After one year of housing, those with Medicaid showed an average annual reduction in costs of $8,724 per person. Reduced expenditures were maintained in year two of the program.[70]

Case Study: Chicago

A 2009 study showed that housing and case management for the homeless with chronic medical illness reduced hospital days and ED visits compared to usual care.[71]

Part 2: Build the Team

Key Partners

States can get to know the key players in their communities who are already connected with the homeless population.

Continuum of Care Providers[72]

A continuum of care is a network of homelessness assistance providers in a defined community responsible to HUD for providing services to this population. CoCs are required to:

- Submit a single funding application to HUD for the entire community of service providers;
- Allocate that funding to their providers in a way that maximizes resources to the local homeless population and helps reduce homelessness; and
- Work together to end homelessness in the community.

State Housing Finance Agency (HFA)[73]

HFAs are state entities responsible for the development of affordable housing to serve low- and moderate-income individuals. Most are independent entities, although some are embedded in state government. In some states, the HFA is also a public housing authority (PHA) or a cabinet-level office. HFA roles include:

- Administering the federal Low-Income Housing Tax Credit program;
- Allocating tax-exempt bonds for single-family and multifamily programs; and
- Administering federal funds such as the HOME program.

Public Housing Authorities (PHA)[74]

PHAs are (usually local) government entities that provide housing assistance and administer federal public housing programs. They may also administer housing assistance programs such as:

- Housing Choice Voucher Program;
- HUD-financed public housing developments; and
- The Family Self-Sufficiency Program.

Local Federal Field Offices[75,76]

Federal agencies maintain local field offices to help state and local agencies administer federal funds and carry out other duties as authorized by the federal government. Such agencies include HUD, the Centers for Medicare & Medicaid Services, the U.S. Department of Health and Human Services, and the Federal Bureau of Investigation. Field offices:

- Provide states with guidance and clarification on the use of federal funds;
- Deliver program assistance, services and resources; and
- Carry out federal functions locally, such as compliance audits.

Affordable Housing Developers[77,78,79]

Developers of affordable housing are typically nonprofit organizations that build multifamily developments with a portion of units set aside for low- to moderate-income individuals. The affordable housing development community can maximize HFA and PHA resources to finance the construction or rehabilitation of affordable rental housing. Developers:

- Are the builders of single-site permanent supportive housing; and
- Can create rental units that meet the needs of this population.

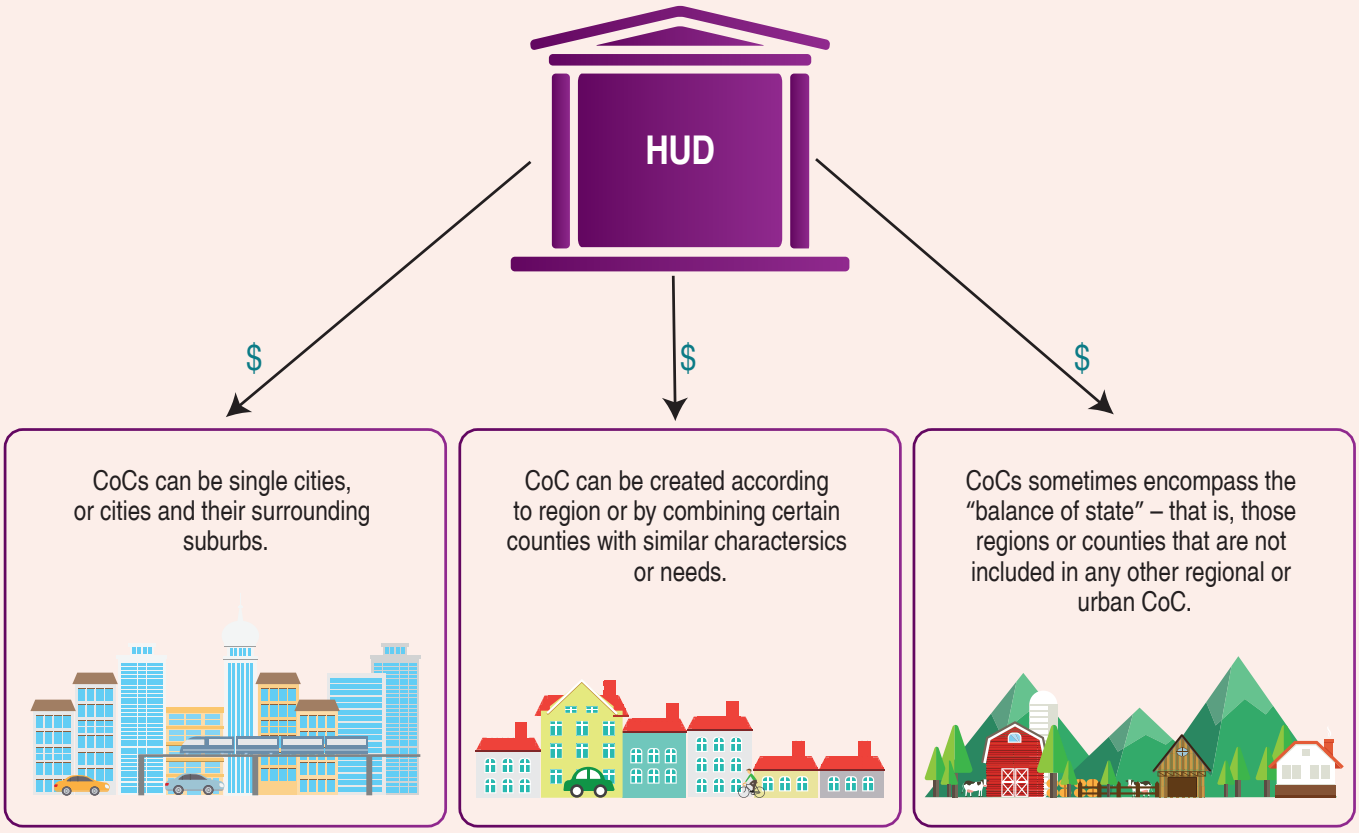
Clinical and Social Services Providers

A range of health care and social services providers cares for the same population that other partners — hospitals, physicians, federally qualified health centers and community MH centers — may serve. They affect individuals' physical health and MH and may provide case management services. These providers:

- Refer individuals to housing;
- Provide services to keep tenants stably housed;
- Provide community-based or in-home health care support and services; and
- Serve the same population as CoC providers but do not receive CoC funds.

The Continuum of Care (CoC)

CoCs are critical stakeholders because they work with the homeless population regularly and best understand the population's most pressing needs.[80]



Funding flows from HUD to each CoC. Each CoC has a designated lead agency which then distributes funding among its providers in accordance with a plan approved by HUD. Each CoC is different and made up of various homelessness services providers such as rapid re-housing, transitional housing, and permanent supportive housing providers in the CoC's designated region. The providers within each CoC are often those agencies that have the most contact with the homeless population and intimately understand their needs, gaps in services, and where to find them. CoCs may be organized at a number of geographic levels, including a single city, a city and surrounding county, a region or an entire state.

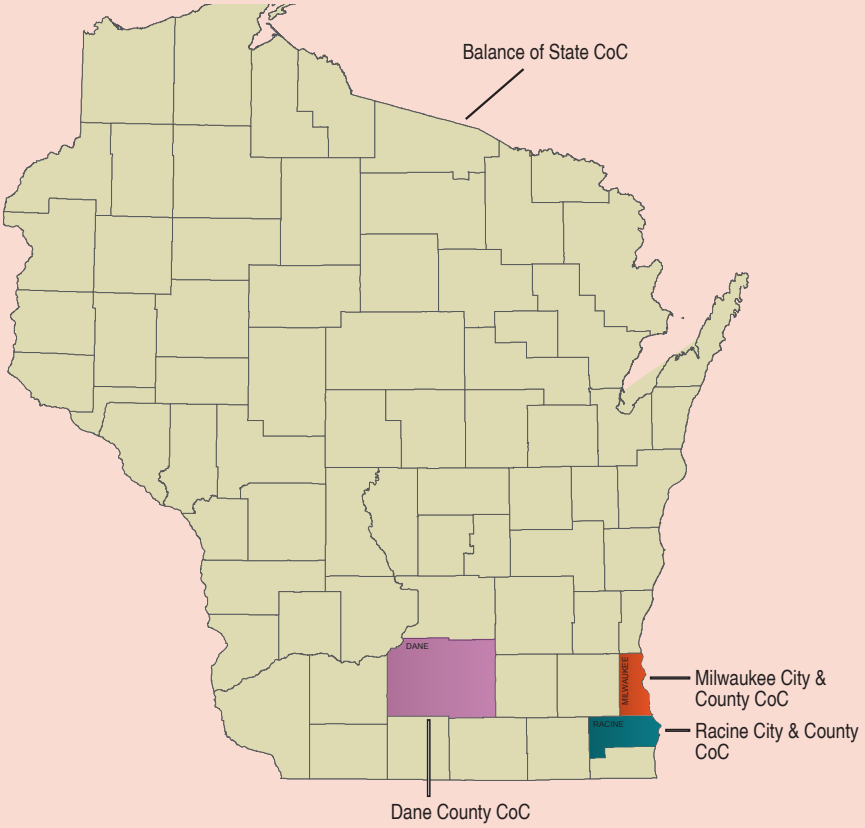
- HUD created CoCs to hold entire communities accountable for addressing homelessness together in a coordinated, planned way.[81]
- HUD requires CoCs to submit a single, consolidated funding application whereby each community can prioritize its needs and services to ensure alignment, effectiveness and strategic use of resources.
- Each state has at least one CoC, as required by HUD. Some states have multiple CoCs arranged around urban centers or by region.
- CoC providers are boots-on-the-ground service providers that interact with this population frequently—for example, by providing crisis services.
- In 2015, CoCs throughout the country received roughly $1.9 billion in homelessness services assistance[82] from HUD and collectively housed approximately 216,000 individuals[83] in emergency, safe haven or transitional shelters.

Continuum of Care (CoC) Examples

These two state examples show how the CoC structure can vary from state to state.

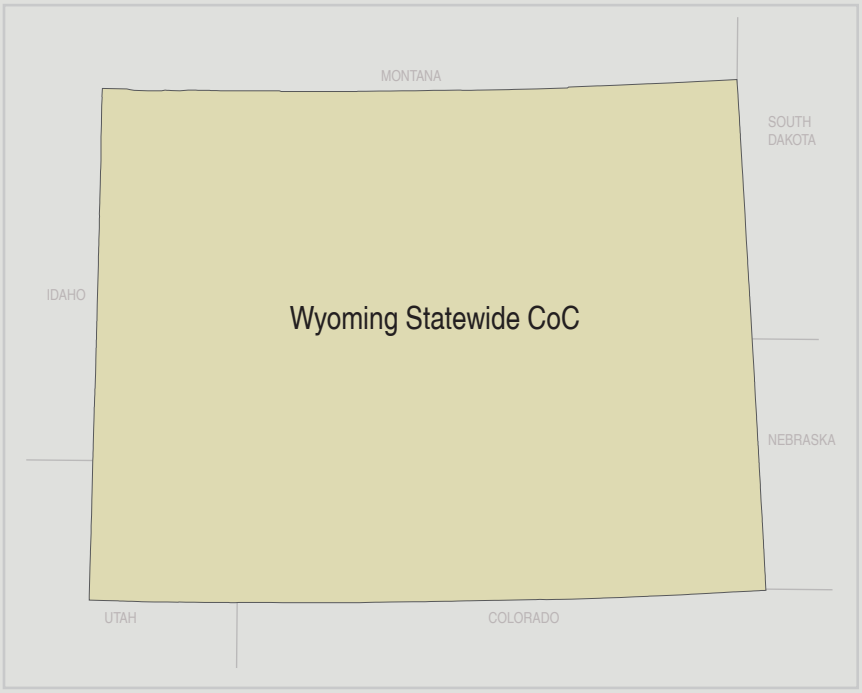
Wisconsin CoC Map

There are four CoCs in Wisconsin, of which three are in high-population regions: Milwaukee, Racine and Dane counties. The fourth is a "balance of state" CoC, meaning the remaining regions of the state are all part of a single CoC.



Wyoming CoC Map

By contrast, there is one, statewide CoC in Wyoming.



Landlord Engagement

Landlord Partnership[84] Is Essential

- In scattered site supportive housing, landlords are often key in providing an adequate supply of affordable housing.[85] Landlords choose whether to participate in government subsidized programs, such as the federal Section 8 Housing Choice Voucher Program. Landlords may hesitate to participate particularly when the tenant is a formerly homeless individual with significant challenges related to MH, SUD or chronic conditions.
- Although there can be financial risk to landlords if tenants are unable to pay their share of the rent, there are also benefits to renting to this population. Frequent case worker visits, for example, can quickly resolve any issues a landlord may face, and the subsidy portion of the rent is guaranteed.
- Some localities run **centralized landlord engagement programs** designed to find and retain landlords who own affordable rental units and are willing to accept subsidies and serve this population. Program features can include:
  - A centralized phone number for landlords to call if a unit is vacant or a tenant needs help;
  - Dedicated staff to conduct outreach and build relationships with landlords;
  - A neutral party to aid in disputes between tenants and landlords;
  - Funds for tenants to cover the incidentals of move-in or briefly pay rent if the tenant is unable; and
  - Education for landlords and tenants on rights and responsibilities.
- Public Housing Authorities (PHAs) are experienced and well versed in landlord engagement because it is critical to getting Housing Choice Voucher Program recipients leased up quickly and efficiently.
- In supportive housing, the service providers, such as case workers and treatment facilities, are also experienced in working with landlords on behalf of tenants.
  - They may have access to a "bank" of landlords who accept homeless tenants.

Risk Mitigation Fund[86]

- State and local housing agencies or state housing finance agencies (HFAs) can share financial risk with landlords to encourage their participation. Government agencies may place funds in a reserve or risk mitigation fund to reimburse landlords for any damage to their units and ensure timely rent payment if tenants are unable to pay their share.
- The fund may be tapped for reimbursement for excessive damage to the unit, lost rent or legal fees beyond the security deposit, up to a predetermined limit.
- This is a powerful landlord engagement tool because it creates assurances and financial guarantees that participating landlords will not incur significant losses. In exchange for those assurances, landlords may be more willing to rent to formerly homeless individuals who have extremely limited income, poor credit, poor rental history or other barriers.

Louisiana HFA's Risk Mitigation Strategy:

Louisiana's HFA requires its local lead agencies to set aside a portion of each tenant's rent subsidy. Those funds are to be used in the event that a landlord's unit is held vacant for a month or as short-term or emergency rental assistance if the tenant is unable to pay his or her portion of the rent.

Part 3: Common Challenges and Solutions

Maximizing PHA Partnerships:

Challenge:	*Why It Matters:*	*Potential Solutions:*
PHAs are often independent or quasi-governmental entities that do not always report to the state and therefore may not be in alignment with the state's objectives. PHAs are also overwhelmed with requests to prioritize various populations within limited resources.	PHAs own and administer the vast majority of federal subsidies for low-income housing. The tenant- and project-based vouchers may be used to house the target population if the PHA is able and willing to make changes.	• **Determine the PHA's board structure. Board members may be appointed by the governor;** • **Determine whether the PHA is part of a government agency. Sometimes state or city housing agencies also function as PHAs, in which case their work may be more closely aligned with the governor's or mayor's objectives;** • **Determine the dynamics among the governor, the PHA board and the mayor or county council; and** • **A statewide PHA may be able to rapidly implement changes, and some HFAs also function as a PHA.**

Subsidizing Rents

Challenge:	*Why It Matters:*	*Potential Solutions:*
Federal funding for rental assistance programs has been dwindling in recent years. Most PHAs have waiting lists that are several years long. Therefore, many PHAs rely on turnover to get wait-listed people housed. In addition, to meet budget cuts, some PHAs have had to reduce costs related to property management and maintenance to keep tenants housed.	Vouchers to pay the rent on the units provided—whether for a single-site or scattered-site project—are essential to funding supportive housing. Supportive housing cannot be created without rental subsidies. In addition, the federal government provides PHAs with flexibility to prioritize certain populations based on the community's needs. The case management that Medicaid can offer helps landlords to keep tenants stably housed.	• **Engage the local HUD field office;** • **Implement PSH limited preference;** • **Tap into unused special-purpose vouchers;** • **Project-base existing tenant-based vouchers;** • **Revamp the PHA's system of preferences; and** • **Create a state-funded rental subsidy program or leverage an existing one.**

Common Challenges and Solutions

Finding Housing Stock

Challenge:	*Why It Matters:*	*Potential Solutions:*
Most communities in the United States are facing a shortage of affordable rental housing[87] for low-income individuals and families.[88]	Access to a sufficient stock of affordable housing is critical to the success of the scattered-site model of permanent supported housing (PSH), without which there are no units to house this population.	• **Engage the state HFA to identify tax credit unit set-asides for low-income individuals;** • **Engage landlords to encourage participation in tenant-based rental subsidy programs; and** • **Use creative state, HFA and local financing to build more affordable housing or convert existing units to affordable housing. For example, work with a local foundation that provides a grant to the HFA for capital housing expenditures. This grant would be provided by the HFA to a local developer. In exchange for the grant, the local developer would agree to provide a portion of the rental units (e.g., 10 percent) at below-market rates (e.g., subsidized) as part of a supportive housing program.**

Community Engagement

Challenge:	*Why It Matters:*	*Potential Solutions:*
In the past, some emergency shelters created a highly visible presence of homeless individuals on nearby streets and sidewalks, leading many communities to believe that PSH may have the same impact on their streets.	Without community buy-in, most projects are not financially or politically viable.	• **Engage communities early, and include them in the process so that they have a say in the final development; and** • **Communicate details to stakeholders and educate residents on this population's needs.**

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