

Medicaid and Housing Partnerships: A Resource for Local Health Departments

By Matthew Ralls, Kathy Moses, and Rob Houston, Center for Health Care Strategies

IN BRIEF

Local health departments (LHDs) can address housing needs by combining the flexibilities inherent in a managed care environment with their on the ground knowledge of the community. This brief, produced by the Center for Health Care Strategies and the University of North Carolina-Wilmington Center for Healthy Communities, with support from the Kate B. Reynolds Charitable Trust and the Blue Cross and Blue Shield of North Carolina Foundation, outlines opportunities to use Medicaid managed care levers to address homelessness and housing insecurity. Developing a strategy to support housing stability in rural communities can help LHDs and states improve health outcomes for Medicaid enrollees. Although the action steps in this brief are intended to support North Carolina counties, the lessons can inform other states seeking to reduce homelessness among Medicaid populations.

In 2015, the North Carolina Department of Health and Human Services was directed by its state legislature to begin transitioning enrollees in the state's Medicaid program from fee-for-service (FFS) to managed care, a transition that will take place in July 2021 and 2022.¹ With funding from the Kate B. Reynolds Charitable Trust and the Blue Cross and Blue Shield of North Carolina Foundation, the University of North Carolina-Wilmington Center for Healthy Communities partnered with the Center for Health Care Strategies (CHCS) to help prepare three local health departments (LHDs) in rural North Carolina counties — Bladen, Columbus, and Robeson — for the transition from Medicaid FFS to managed care. These contiguous counties are in a rural corner of southeastern North Carolina and regularly score near the bottom of the state's county health rankings.²

In 2020, CHCS conducted in-person interviews with LHD staff to inform opportunities to support the county-based LHDs in transitioning to a managed care environment. A gap analysis and readiness assessment identified key opportunities to use Medicaid managed care to help address homelessness and housing insecurity as a priority need for the three rural North Carolina counties. This brief explores how LHDs in rural communities can combine Medicaid managed care levers with knowledge of their community to address housing issues. Although the action steps outlined in this brief are intended to support North Carolina counties in strengthening housing supports using Medicaid managed care strategies, the lessons can inform other states seeking to reduce homelessness among Medicaid populations.

The Impetus for Medicaid to Address Housing Instability

Medicaid stakeholders have a vested interest in housing. In many states, particularly those that expanded Medicaid, many individuals experiencing homelessness meet the income requirements to be Medicaid-eligible. People experiencing homelessness are more likely to have higher rates of chronic health conditions than the general population, including high blood pressure, heart disease, diabetes, lung diseases like asthma and chronic bronchitis, and HIV. As a result, these individuals have high health care utilization rates and health care costs. People experiencing homelessness also have less access to needed preventive, primary, behavioral health, and specialty health care services.³ Income, health, and housing are all intertwined. Individuals experiencing poverty are more likely to have poor health outcomes. They are also more likely to be unhoused. And, this vicious cycle continues, since people experiencing homelessness face even worse health outcomes.

Funding for any type of housing initiative, whether it is developing public housing, supportive housing, or housing supports, is complex and involves federal, state, and local stakeholders, both public and private. As the consensus that health care and housing are connected grows, Medicaid is an important stakeholder to help address housing issues. Medicaid can partner with key players in the housing arena — Continuum of Care Providers, state housing finance agencies, public housing authorities, local federal field offices for agencies like the Department of Housing and Urban Development, affordable housing developers, and other clinical providers — to help provide needed housing supports in their communities.⁴

Rural and urban homelessness share certain traits. People experiencing homelessness in both environments are more likely to be low-income or facing unemployment. There are also higher rates of behavioral health issues among people experiencing homelessness in both rural and urban communities. Compared to their urban counterparts, however, people experiencing homelessness in rural communities are more likely to be unsheltered.⁵ In rural communities, there are often scant resources to help people experiencing homelessness and fewer housing units available. Rural communities often lack the infrastructure to support the development or management of either single-site or scattered-site housing programs that their urban counterparts may operate. There also may be less incentive for developers to build new (or improve existing) housing stock. During interviews conducted as a part of CHCS' gap analysis, several staff members at LHDs mentioned that housing stock damaged by recent hurricanes was simply never repaired.⁶

Despite all this, rural homelessness is often absent from the broader conversation around homelessness. Rural homelessness is sometimes referred to as a “hidden problem” or “hidden homelessness.”^{7,8} But a third of rural residents say homelessness is an issue in their community. Federal rental assistance supports over 10 million Americans, with 1.5 million of them in rural communities.⁹

Medicaid can be a valuable asset in providing physical, behavioral, and community support services to members who are in need of supportive housing — and can help pay for tenancy support services — in rural communities.¹⁰ This brief provides information on how Medicaid managed care flexibilities can be used to help address homelessness and provide housing supports. It spotlights ways for LHDs or similar stakeholders in rural communities to establish improved housing practices with limited resources.

Medicaid and Housing

What Can Medicaid Do?

Medicaid cannot be used to pay for rent or new housing construction, often referred to as “room and board” and “bricks and sticks” respectively. Broadly speaking, Medicaid funds can be used to help individuals apply for housing and tenancy support, develop individualized support plans, and form partnerships between medical groups and housing agencies at the state and local level.¹¹ States and health plans can use Medicaid dollars to address homelessness, including through:

1. **Individual housing and transition services**, which include one-time payments associated with moving, such as security deposits or moving fees, or conducting a housing needs assessment for a client;
2. **Individual housing and tenancy sustaining services**, which include services such as tenant’s rights presentations, assistance in dealing with landlords, or connecting a client to community-based organizations offering social services that will help keep the tenant housed; and
3. **State-level housing-related collaborative activities**, such as fostering relationships between the health care sector and local housing agencies or housing-related stakeholders.¹² Medicaid can finance the planning process for agreements or partnerships between health care stakeholders and local housing agencies or community partners who can streamline access to housing services.¹³

In some states, Medicaid managed care plans can pay for housing modification services — e.g., installing air conditioning or lead abatement — that can lead to improved health outcomes for enrollees. In North Carolina, for example, Medicaid covers these types of services for people participating in the states’ Healthy Opportunities Pilot.¹⁴ Medicaid can also pay for medical respite, which is defined as “acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital.”¹⁵ There is strong evidence that providing supportive housing can reduce emergency department visits, admissions, and inpatient stays and result in large decreases in health care costs.¹⁶

Exhibit 1 (*next page*) summarizes examples of how different states or managed care organizations (MCOs) have used Medicaid to address housing needs.

Exhibit 1: Examples of Medicaid Strategies to Address Homelessness*

Program and Description	Evidence	Insights
<p>Finger Lakes Performing Provider System¹⁷ A partnership between DePaul Community Services, a community-based organization that provides supportive housing in New York State, and two health centers to provide medical respite services.</p>	<ul style="list-style-type: none"> Over 60% of medical patients and 80% of psychiatric patients transitioned to permanent housing. Significant cost savings to Medicaid, reduced hospitalizations, and improved quality of life and health outcomes for individuals.¹⁸ 	<p>Providing medical respite services is a way for hospitals, housing providers, and medical respite providers to build partnerships with community-based organizations looking to address social determinants of health and a way to better serve high-cost, high-need patients.¹⁹</p>
<p>Louisiana Department of Health and Housing Authority²⁰ In 2005, after Hurricanes Katrina and Rita, Louisiana used recovery resources to develop a supportive housing program for individuals with disabilities. The state was receiving tax credits and block grants — some of which were temporary — to rebuild after the hurricanes. The state recognized that Medicaid funding could help make the supportive housing program sustainable once the recovery funding ceased. Louisiana established a partnership between the Department of Health and Housing Authority. The Department of Health identifies people with disabilities, and the Housing Authority connects the individuals with rental subsidies and housing units that were developed using recovery resources set aside for permanent supportive housing. The state also used a 1915(c) HCBS waiver to make pre-tenancy support services a Medicaid covered benefit to help sustain the program.</p>	<ul style="list-style-type: none"> Over 90% of individuals placed in supportive housing are either still in a unit provided through the program or have moved to another stable housing situation. Generated a decrease in Medicaid spending associated with acute care and an increase in income for housed individuals. 	<p>Housing programs can use funding from a variety of sources, including disaster relief funds. While temporary grants can help start housing initiatives, Medicaid can be an important part of making them sustainable. Establishing partnerships between health and housing agencies can be a good way to provide services to patients and funding to housing programs.</p>
<p>Health Plan of San Mateo²¹ The Health Plan of San Mateo works with two nonprofits to provide supportive housing and transitional case management for patients needing long-term care. The pilot focused on patients who needed long-term care but could return to the community, individuals who needed acute care or rehab who were subsequently recommended for long-term care, and those residing in the community who would eventually need long-term care.</p>	<ul style="list-style-type: none"> Average overall cost of care PMPM dropped 43% (\$10,055 to \$5,721) following the intervention. Over \$6,000 PMPM was saved on long-term care and skilled nursing facility costs alone. A total of \$2.4 million in savings was accrued 6 months post-intervention. When accounting for \$1 million in start-up costs, total net savings was \$1.4 million. Estimated ROI was \$1.57 in savings for every \$1 invested.²² 	<p>By identifying patients who are likely to be high cost, in this case individuals who need (or may soon need) long-term care, significant cost savings can be generated while keeping individuals housed.</p>

*Source: Modified from [Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples](#), January 2017, Kaiser Family Foundation, and [Review of Evidence for Health-Related Social Needs Interventions](#), July 2019, The Commonwealth Fund.

(Continues on next page.)






(Continued from previous page.)

Program and Description	Evidence	Insights
<p>Mercy Maricopa Integrated Care²³</p> <p>Mercy Maricopa — an integrated health system in Phoenix, Arizona — had a long-running permanent supportive housing program for individuals with serious mental illness (SMI). But after a men’s shelter closed in Phoenix, there was a large increase in individuals with substance use disorder and mental illness who did not meet the criteria for SMI, but still needed case management services and access to housing. Mercy Maricopa partnered with United Way and the City of Phoenix Housing Department to create the Comprehensive Community Health Program, which provides services to adult members of the plan, including Medicaid-covered tenancy support services.</p>	<ul style="list-style-type: none"> ▪ Emergency department utilization dropped by 69.5%. ▪ Psychiatric hospitalizations dropped by 43.5%.²⁴ 	<p>Plans and housing agencies can be effective partners, but if they have not worked together before, there needs to be some level-setting between the two partners to make sure that they are “speaking the same language.”</p>
<p>City of Philadelphia Department of Behavioral Health and Intellectual DisAbility Services²⁵</p> <p>Pennsylvania’s Medicaid agency contracts with MCOs to provide physical health services and gives counties the opportunity to receive Medicaid funding to provide behavioral health services for Medicaid enrollees in their jurisdiction. The City of Philadelphia is also a county and is eligible to receive a capitated amount to provide behavioral health services to qualifying residents, 85% of whom are Medicaid eligible.</p> <p>The city has leveraged this Medicaid funding to connect patients identified by the city’s housing agency to permanent supportive housing through a Housing First Program, an inclement weather shelter program, and a resident substance use disorder treatment program.</p>	<p>Since 2017:</p> <ul style="list-style-type: none"> ▪ 89% of patients connected with permanent supportive housing have retained stable housing. ▪ Over \$15 million in Medicaid savings generated for the behavioral health program. ▪ Lower daily costs for behavioral health enrollees. 	<p>Counties or cities interested in using Medicaid and housing to support patients with behavioral health needs should think long-term about savings. In the short-term, cost per day for behavioral health members in Philadelphia upon initial enrollment increased from \$85 per day to \$112. This was due to an increase in service utilization during the engagement period. However, once the patient was stably housed, costs fell to \$18 per day. Generating stakeholder buy-in may require conversations about the spending trends that are likely to occur as patients are engaged in programs like Philadelphia’s.</p>

Foundational Steps for Local Health Departments to Address Community Housing Needs

LHDs may not have the financial resources or flexibility that states or managed care plans possess, but their community connections are extremely valuable. They are aware of local resources that would be unknown to an organization that is not “on the ground.” They also have established ties to their community and can use their role within a community to establish new relationships between health plans and community-based organizations.

The National Governor’s Association developed a “Housing as Health Care” Roadmap for States in 2016.²⁶ The Roadmap contains a “Housing and Services Strategy” that provides a helpful framework for LHDs. The steps include:

-  **1. Build the team and base support;**
-  **2. Develop a data strategy;**
-  **3. Assess the services infrastructure;**
-  **4. Assess the physical housing infrastructure; and**
-  **5. Estimate costs, savings, and cost avoidance.**

These steps offer building blocks to guide how an LHD may engage a managed care plan to address housing. The following guidance builds on this framework to identify potential next steps for LHDs.

1. Building the Team and Base Support

LHDs can take steps to build their team and base support by surveying their resources and advantages as a key stakeholder in rural communities. A key way to build their team is by thinking outside the walls of the health department to identify potential partnerships.



A common hurdle to addressing housing issues is a lack of sustainable capital. Effective partnerships formed around addressing homelessness involve sustainable funding streams. Medicaid dollars can be essential in providing funding for supportive housing programs, especially when time-limited grants for development of new units or disaster relief end. Medicaid can cover services associated with pre-tenancy and tenancy-sustaining support. This includes informing the tenant of their responsibilities as a renter and covering costs included in moving and searching for an apartment. Medicaid can also cover case management services for beneficiaries who are already stably housed. The program can provide a reliable funding stream for supportive housing and other services that help improve health outcomes, serving as a valuable partner to local housing agencies and community-based organizations offering services like medical respite or shelter.

LHDs may be able to identify and connect patients with housing providers by virtue of being the first contact point for Medicaid enrollees. For example, if a patient goes to a local health department to receive physical health services (many LHDs act as a clinic and may be a federally qualified or regional health center), the LHD can conduct a screening that can include housing. In North Carolina, for example, housing status is included as a part of broader SDOH screening requirements.²⁷ A positive screen can result for housing instability can lead the LHD to connect the patient with a local housing agency, ideally with a “warm handoff” to a housing provider, who could even be co-located on site. This “no wrong door” approach can be helpful in rural communities where transportation is a barrier and centralized services can make sure people do not fall through the cracks.

An example of a potential partnership that can meaningfully address housing needs for Medicaid enrollees in rural North Carolina is the Lumbee Tribe of North Carolina’s Housing Department. The Lumbee Tribe provides a variety of services to tribal members in Cumberland, Hoke, Scotland, and Robeson counties in North Carolina. These services include medication assisted treatment; vocational rehabilitation for members with a disability; and Project 3C, an education program and partnership between the Lumbee Tribe, UNC-Pembroke, and Robeson Community College; and the Housing Department. The Housing Department assists tribal members with housing repairs and rehabilitation services for low-income tribal members, as well as rental and mortgage assistance.²⁸ The Robeson County LHD is ideally placed to develop a supportive housing partnership with the Lumbee Tribe. Tribal members who seek services from the health department could be readily screened for housing insecurity and connected with the tribal housing department. Additionally, Project 3C, the educational program, could potentially connect students studying at UNC-Pembroke or Robeson Community College to become providers with the local health department. Tribal members training to become community health workers in the state may be placed to provide services to hard-to-reach Lumbee Medicaid-enrollees.²⁹

2. Develop a Data Strategy

LHDs can work with their managed care plan and housing partners to determine prioritized populations that can benefit from housing support. This prioritization may be based on certain chronic conditions or other programmatic priorities. Some states or plans may specify tools to screen for housing insecurity, or if there are populations that are at a higher emphasis to connect with housing services. In North Carolina, the state developed its own standardized screening tool as a part of its Section 1115 demonstration waiver, which emphasizes housing, food, transportation, and interpersonal violence.³⁰



For states that have not developed their own screening tool, one example of a commonly used tool is the Vulnerability Index - Service Prioritization Decision Assistance Tool, which is used to determine priority for housing based on a “High-Medium-Low” acuity scale.³¹ States and plans have the flexibility to prioritize the results of screening tools to meet their unique needs and work together to integrate assessments to help identify and refer individuals in need of housing. LHDs or other “on the ground” partners are uniquely situated to help states and plans assess housing needs.

3. Assess the Services Infrastructure

When assessing the services infrastructure, LHDs can do a scan to identify currently available Medicaid services they can provide and what are reimbursable in their state. Identifying what existing care coordination or case management services can be provided and reimbursed is a place to start.



Certain populations of Medicaid enrollees may be eligible for care coordination based on chronic conditions. This benefit is often available through a Medicaid health homes program or targeted case management program. (Note: Health homes are federally supported comprehensive care coordination programs for Medicaid enrollees with chronic health conditions. Although North Carolina currently does not have a health homes program, 21 states do.³²) For supportive services related to housing, or tenancy supports, Medicaid can pay for services like landlord engagement, housing respite, obtaining furniture, and eviction prevention as optional services. Not all states allow these options under the appropriate waiver authorities or state plan amendments. North Carolina, for example, operates a supportive housing program, and its Division of Aging and Adult Services provides services like identifying housing and engaging with landlords.³³ North Carolina’s managed care contracts also include provisions for plans to have a housing specialist on staff to help assist people who are experiencing homelessness to find housing.³⁴ Medicaid also often covers supportive services related to physical and behavioral health, or referrals to relevant social services. Medicaid health plans also often cover tenancy services that are considered “in-lieu-of” services for LHDs that operate in a managed care environment. These are services that are not typically covered under a Medicaid fee schedule that have been identified by the state as being cost-effective care options that are included in the plan’s capitation rate. The plan may choose to provide some tenancy support services that are not reimbursed because they are considered effective.

Assessing the service infrastructure will allow LHDs to establish basic referral networks. In the case of North Carolina, the state developed a statewide coordinated social service referral network known as “NCCare 360.” Other states or localities may have their own referral tools or networks. Rural LHDs can develop referral networks of formal and informal housing resources in the county (see next section). For resource-depleted communities, there may be less referrals to make. Developing a system of screening and referring between partners can help form institutional “muscle memory” and help stakeholders who may be new to the housing sector (or health care sector) create a workflow, resource list, establish best practices in trainings, and learn to communicate at the same level. As described in Exhibit 1, when Mercy Maricopa partnered with the Phoenix Department of Housing, there was a growth period as the two partners had to learn to “speak the same language.” In conversations with housing and health care providers, a common refrain is that two fields are often siloed and may use the same terms to describe different things. For example, health care and housing providers both use “Continuum of Care” to mean different things.³⁵ Building a consistent process for referrals can be a first step toward growing a more robust referral network.³⁶

Conducting a Gap Analysis to Assess Housing Needs

States and LHDs can conduct a gap analysis to determine their capacity to respond to the housing needs in their communities. The Medicaid Innovation Accelerator Program developed a *State Medicaid-Housing Agency Partnerships Toolkit*³⁷ that, although focused on partnerships between state agencies, may be helpful for LHDs looking to conduct their own assessment. The toolkit includes questions that LHDs can address after completing a housing-related services crosswalk and housing assessment.

4. Assess the Physical Housing Infrastructure

Many communities have a shortage of rental housing. Without enough homes, there is nowhere to place members who are struggling with housing insecurity or homelessness. Identifying and securing adequate housing stock is a challenge in many rural communities, and an opportunity for partnerships with local housing authorities. State and local housing agencies and authorities have the institutional knowledge to know what affordable housing units exist. They can also be partners in developing new housing. One recommendation from the National Governor's Association is for stakeholders to work with either Housing Finance Authorities at the state-level or even local housing agencies to apply for tax credits or grants that will finance the development or repair of housing units.³⁸ As shown with Louisiana in Exhibit 1, states and localities can use disaster relief funding to support the development of supportive housing. Engaging with developers and securing a portion of rental units to be supportive housing units is something LHDs and their partners can engage in, especially if Medicaid is used to cover pre-tenancy and tenancy support services that make stability and sustain the funding.



LHDs can also think creatively about housing stock. There may not always be the funding or capacity to develop new units, which can encourage interested stakeholders to re-evaluate what units are already established. One example is nursing homes. Nursing homes in many rural communities are facing possible closure as occupancy rates drop.³⁹ One potential solution is to repurpose units in struggling nursing homes as potential supportive housing units. Nursing homes are familiar with providing medical services and billing Medicaid, and may be able to make an easier transition into providing supportive housing.

In April 2020, California launched Project Roomkey to prevent the community spread of COVID-19 and provide isolation and quarantine options for people experiencing homelessness, with an initial goal of securing 15,000 rooms across the state.⁴⁰ The governor's office also provided support to local governments to purchase 1,300 trailers to augment hotel and motel room capacity.⁴¹ By fall 2020, the state had exceeded these goals and began investigating how to turn short-term COVID-19 housing into longer-term, permanent housing options. Mecklenburg County, North Carolina also leveraged federal and local funds to provide short-term housing during COVID-19.⁴² As rural communities look to find unconventional sources of housing stock, hotel and motel rooms may be a potential short-term solution.

5. Estimate Costs, Savings, and Cost Avoidance

MCOs are experienced at recognizing the value of health care institutions — such as hospitals, nursing homes, and primary care practices — and understanding how to work with these institutions to maximize the value. They are often, however, less familiar with LHD partnerships. In addition to providing many health care services, LHDs provide various public health and community services that are not always reimbursable under a Medicaid fee schedule. For this reason, LHDs may seek opportunities to communicate their value to MCOs by showing them how they help to improve health and reduce costs, which can include supporting stable housing for MCO members.



In many rural communities, LHDs may be uniquely suited to address housing concerns due to regular interactions and rapport with community members. LHDs can help engage housing stakeholders in their communities, as well as foster meaningful and effective partnerships with housing agencies that can help identify and connect patients with housing stock. LHDs can demonstrate this value by showing a return on investment for the services they provide by working with an MCO to track claims activities and the health status of members that they connected with housing services, through either a formal or informal pilot. By comparing health care utilization, cost, and health status for members before and after being stably housed, an analysis can show the return on investment of a program, like many of the programs' results profiled in Exhibit 1.

Conclusion

LHDs in rural communities are often the crossroads for many key services in resource-deprived settings. They are frequently the first or only provider of physical or behavioral health services, provide key resources to expecting or new parents, and facilitate health education and outreach programs. LHDs also have an acute sense of the health care needs in their communities. These attributes make them ideal partners to work with stakeholders in addressing housing needs in rural communities, including state and local housing authorities or agencies, managed care plans, and public and private housing developers who are willing to commit new or existing development to affordable, supportive housing. LHDs can use their experience with Medicaid, as well as their deep ties to the community, to position themselves as key facilitators in identifying and connecting individuals with housing instability to the appropriate services.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of people with low-incomes. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ABOUT THE UNIVERSITY OF NORTH CAROLINA-WILMINGTON CENTER FOR HEALTHY COMMUNITIES

The University of North Carolina-Wilmington Center for Healthy Communities, seeks to improve health and well-being by addressing community identified needs through collaborations between campus resources and community agencies. To learn more, visit uncw.edu/chhs/community/chc/.

ENDNOTES

- ¹ North Carolina Medicaid Division of Health Benefits. “North Carolina’s Transformation to Medicaid Managed Care.” Available at: <https://medicaid.ncdhhs.gov/transformation>.
- ² County Health Rankings & Roadmaps: Building a Culture of Health, County by County. “Growing Community Power to Improve Health Equity.” Available at: <https://www.countyhealthrankings.org/>.
- ³ National Health Care for the Homeless Council. “Homelessness and Health: What’s the Connection?” February 2019. Available at: <https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf>.
- ⁴ F. Arabo, S. Wilkniss, S. Malone and F. Isasi, *Housing as Health Care: A Road Map for States*. National Governors Association Center for Best Practices, September 2016. Available at: <http://ngahousingroadmap.cwsit.org/housingroadmap.pdf>.
- ⁵ M. Henry, A. Mahathey, T. Morrill, A. Robinson, A. Shivji and R. Watt. *The 2018 Annual Homeless Assessment Report (AHAR) to Congress: Part 1: Point-In-Time Estimates of Homelessness*. December, 2018. Available at: <https://www.huduser.gov/portal/sites/default/files/pdf/2018-AHAR-Part-1.pdf>.
- ⁶ National Alliance to End Homelessness. “Rural Homelessness.” January 17, 2010. Available at: <https://endhomelessness.org/resource/rural-homelessness>.
- ⁷ Life and Health in Rural America. “Unsheltered And Uncounted: Rural America’s Hidden Homeless.” NPR: Morning Edition. July 4, 2019. Available at: <https://www.npr.org/sections/health-shots/2019/07/04/736240349/in-rural-areas-homeless-people-are-harder-to-find-and-to-help>.
- ⁸ National Alliance to End Homelessness. “Rural Homelessness.” January 17, 2010. Available at: <https://endhomelessness.org/resource/rural-homelessness/>.
- ⁹ Center on Budget and Policy Priorities. “Federal Rental Assistance Fact Sheets.” Updated on: June 1, 2021. Available at: <https://www.cbpp.org/research/housing/federal-rental-assistance-fact-sheets#US>.
- ¹⁰ H. Katch and P. Bailey. *Medicaid Doesn’t Pay for Housing. Here’s What It Can Do to Help Meet Enrollees’ Social Needs*. Health Affairs Blog. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20200110.134351/full/>.
- ¹¹ Ibid.
- ¹² Medicaid and CHIP Payment and Access Commission. “Medicaid’s Role in Housing.” October 2018. Available at: <https://www.macpac.gov/wp-content/uploads/2018/10/Medicaid%E2%80%99s-Role-in-Housing.pdf>.
- ¹³ J. Paradise and D. Cohen-Ross. *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*. Kaiser Family Foundation, January 2017. Available at: <https://www.kff.org/medicaid/issue-brief/linking-medicare-and-supportive-housing-opportunities-and-on-the-ground-examples/view/print/>.
- ¹⁴ North Carolina Department of Health and Human Services. “Healthy Opportunities Pilots Overview Healthy Opportunities Pilots Overview.” Available at: <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots/healthy-0>.
- ¹⁵ National Health Care for Homeless Council. “Medical Respite/Recuperative Care: What Is Medical Respite/Recuperative Care?” Available at: <https://nhchc.org/clinical-practice/medical-respite-care/>.
- ¹⁶ P. Bailey. *Housing and Health Partners Can Work Together to Close the Housing Affordability Gap*. Center on Budget and Policy Priorities, January 17, 2010. Available at: <https://www.cbpp.org/research/housing/housing-and-health-partners-can-work-together-to-close-the-housing-affordability#:~:text=Housing%20Interventions%20Boost%20Health&text=Supportive%20housing%20has%20been%20shown,are%20living%20in%20Institutional%20care>.
- ¹⁷ Finger Lakes Performing Provider System. “Project 2.b.vi – Transitional Supportive Housing Services.” Available at: <https://flpps.org/Projects/Transitional-Supportive-Housing>.
- ¹⁸ New York State Department of Health. Medicaid Redesign Team. “The DSRIP Digest.” May 2017. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/digest/docs/2017-may_issue.pdf.
- ¹⁹ D. Shetler and D. Shepard. *Medical Respite for People Experiencing Homelessness: Financial Impacts with Alternative Levels of Medicaid Coverage*. Journal of Health Care for the Poor and Underserved. 29, 2 (2018):801-813. Available at: <http://people.brandeis.edu/~shepard/Shetler-Shepard-medical-respite-2018b.pdf>.
- ²⁰ J. Paradise and D. Cohen-Ross. *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*. Kaiser Family Foundation, January 2017. Available at: <https://www.kff.org/report-section/linking-medicare-and-supportive-housing-issue-brief/>.
- ²¹ Mercy Housing and The Low Income Investment Fund. “Innovative Models In Health And Housing.” Available at: <https://www.liifund.org/wp-content/uploads/2017/08/Health-and-Housing-LIIF-Mercy-Report-2017.pdf>.
- ²² M. Tsega, C. Lewis, D. McCarthy, T. Shah and K. Coutts. *ROI Calculator for Partnerships to Address the Social Determinants of Health: Review of Evidence for Health-Related Social Needs Interventions*. The Commonwealth Fund, 2019. Available at: <https://www.commonwealthfund.org/sites/default/files/2019-07/ROI-EVIDENCE-REVIEW-FINAL-VERSION.pdf>.
- ²³ Paradise and D. Cohen-Ross. *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*. Kaiser Family Foundation, January 2017. Available at: <https://www.kff.org/report-section/linking-medicare-and-supportive-housing-issue-brief/>.

- ²⁴ M. Kelly. *Reducing Barriers – Mercy Care RBHA Collaboration in our Community*. Arizona Housing Coalition. Available at: https://www.azhousingcoalition.org/uploads/1/2/4/9/124924903/reducing_barriers_-_mercy_care_rbha_collaboration_in_our_community.pdf.
- ²⁵ Paradise and D. Cohen-Ross. *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*. Kaiser Family Foundation, January 2017. Available at: <https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief/>.
- ²⁶ F. Arabo, S. Wilkniss, S. Malone and F. Isasi, *Housing as Health Care: A Road Map for States*. National Governors Association Center for Best Practices, September 2016. Available at: <http://ngahousingroadmap.cwsit.org/housingroadmap.pdf>.
- ²⁷ North Carolina Department of Health and Human Services. “Screening Questions.” Available at: <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions>.
- ²⁸ Lumbee Tribe of North Carolina. Available at: <https://www.lumbeetribe.com/services>.
- ²⁹ Robeson Community College. Available at: <https://www.robeson.edu/health/>.
- ³⁰ D. Crumley, J. Lloyd, M. Pucciarello and B. Stapelfeld. *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations*. Center for Health Care Strategies, December 2018. Available at: <https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf>.
- ³¹ Vulnerability Index -Service Prioritization Decision Assistance Tool (VI-SPDAT). “Prescreen Triage Tool for Single Adults.” American Version 2.0. Available at: <http://pehgc.org/wp-content/uploads/2016/09/VI-SPDAT-v2.01-Single-US-Fillable.pdf>.
- ³² Centers for Medicaid & Medicare Services. “Health Home Information Resource Center.” Available at: <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html>.
- ³³ North Carolina Department of Health and Human Services. “Programs to Find and Maintain Housing.” Available at: <https://www.ncdhhs.gov/assistance/low-income-services/programs-to-find-maintain-housing>.
- ³⁴ State of North Carolina. Revised and Restated Request for Proposal #: 30-190029-DHB, Prepaid Health Plan Services. Available at: <https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf>.
- Department of Health and Human Services. Division of Health Benefits, August 9, 2018. Available at: <https://files.nc.gov/ncdma/Contract--30-190029-DHB-Prepaid-Health-Plan-Services.pdf>.
- ³⁵ K. Moses, A. Hamblin, S. Somers, D. Culhane. “Supportive Housing for Chronically Homeless Medicaid Enrollees: State Strategies.” Center for Health Care Strategies, January 2016. Available at: <https://www.chcs.org/media/Housing-SGC-Brief-Final-022416.pdf>.
- ³⁶ E. Miller, T. Nath, and L. Line. “Health and Human Services: Working Together Toward Better Outcomes.” Nonprofit Finance Fund, June 2017. Available at: <https://nff.org/report/working-together-toward-better-community-health>.
- ³⁷ Centers for Medicaid & Medicare Services. “Medicaid Innovation Accelerator Program State Medicaid-Housing Agency Partnerships Toolkit.” September 2019. Available at: <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/mhap-toolkit.pdf>.
- ³⁸ F. Arabo, S. Wilkniss, S. Malone and F. Isasi, *Housing as Health Care: A Road Map for States*. National Governors Association Center for Best Practices, September 2016. Available at: <http://ngahousingroadmap.cwsit.org/housingroadmap.pdf>.
- ³⁹ A. Kacik. “Rural Nursing Homes Face Closure As Occupancy Wanes.” *Modern Healthcare*, March 14, 2019. Available at: <https://www.modernhealthcare.com/operations/rural-nursing-homes-face-closure-occupancy-wanes>.
- ⁴⁰ Office of Governor Gavin Newsom. “At Newly Converted Motel, Governor Newsom Launches Project Roomkey: A First-in-the-Nation Initiative to Secure Hotel & Motel Rooms to Protect Homeless Individuals from COVID-19.” April 3, 2020. Available at: <https://www.gov.ca.gov/2020/04/03/at-newly-converted-motel-governor-newsom-launches-project-roomkey-a-first-in-the-nation-initiative-to-secure-hotel-motel-rooms-to-protect-homeless-individuals-from-covid-19/>.
- ⁴¹ California Health Care Foundation. “Homelessness and COVID-19: Innovation Snapshot. California’s Project Roomkey.” July 2020. Available at: <https://www.chcf.org/publication/californias-project-roomkey/#background>.
- ⁴² L. Lindstrom and A. Kuznitz. “County leases hotel for homeless people who may have COVID-19. More sites are planned.” *The Charlotte Observer*. March 19, 2020. Available at: <https://www.charlotteobserver.com/news/coronavirus/article241344441.html>.