



Health and Housing: Introduction to Cross- Sector Collaboration

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Introduction

For the past decade or more, state leaders have worked across health and housing sectors to strengthen comprehensive services for individuals experiencing homelessness and housing instability. However, challenges remain for successful, person-centered coordination, cross-agency work and implementation. A significant restricting factor that limits coordination is the fragmentation of the health and housing sectors, with persons or households with multiple needs having to navigate multiple systems to address these needs.

The COVID-19 pandemic and related economic and social crises have further exacerbated long-standing needs for coordinated health and housing services. Structural and institutional racism has created segregated communities and limited access to resources, furthering the need to center equity in states' health and housing work.

Successful health and housing partnerships operate with an understanding of available programs and resources for capital and operating costs and supportive services. Federal affordable housing resources exist across a variety of programs, including the Low-Income Housing Tax Credit (LIHTC), and are operated at the state and local levels. States can implement supportive housing programs by complementing affordable housing with services reimbursable through Medicaid and supported through federal grants (e.g., block grants from the Substance Abuse and Mental Health Services Administration). State Medicaid programs have a variety of federal authorities available to cover the cost of services such as tenancy support.

While models of successful cross-agency partnerships exist, additional learning and collaboration remains necessary if health and housing sectors are to achieve their joint goals of healthy, equitable, and thriving communities. State officials may benefit from opportunities such as the National Academy for State Health Policy's Health and Housing Institute and technical assistance from the Corporation for Supportive Housing to develop a shared health and housing agenda and advance their priorities. This paper aims to provide a background on the health and housing sector, including common language and core programs, as well as current opportunities for cross-sector collaboration for state leaders.

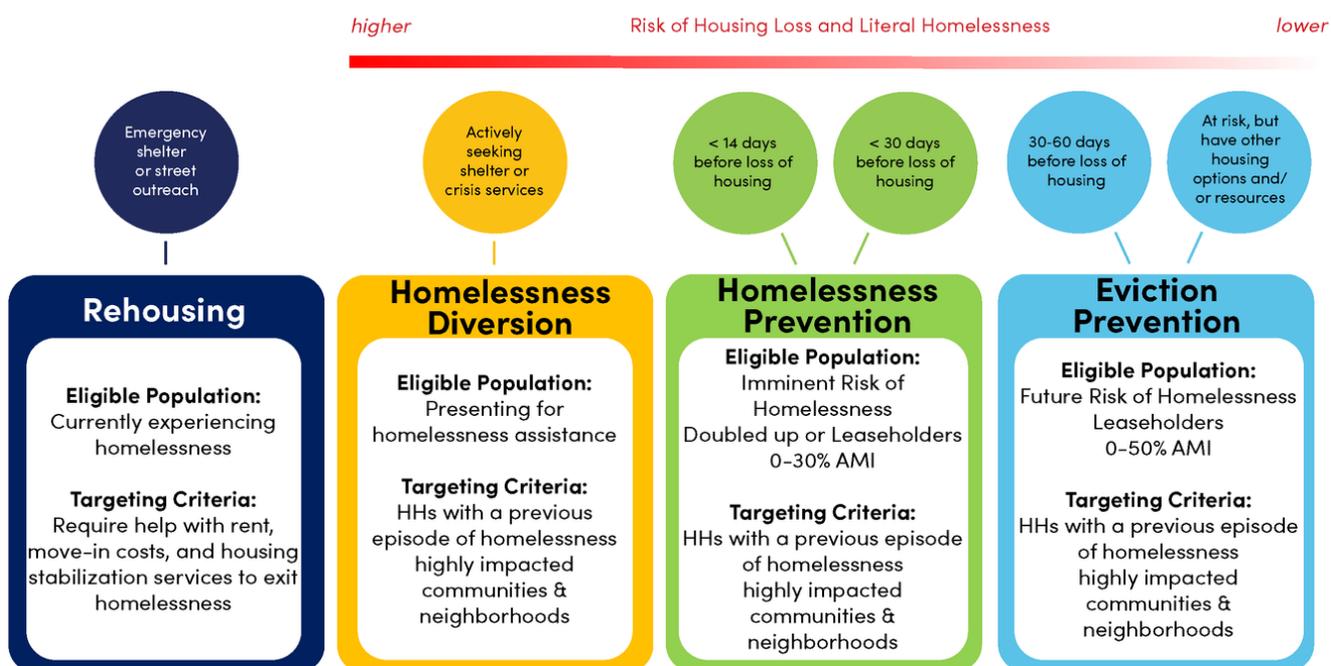
Background

Housing as a Social Determinant of Health

A [Public Health 3.0 approach](#) aims to move beyond traditional clinical interventions and toward population health management where multiple sectors are engaged to improve social, environmental, and economic conditions that affect health. Housing is an essential social determinant of health as there is a [strong association](#) between access to safe, affordable, and stable housing and positive health outcomes. The housing sector has historically engaged the health sector to address the needs of individuals experiencing homelessness or housing instability and significant health care needs. Many states have started to make these linkages by investing in models of housing and health care for people with complex health and social needs by shifting investments from episodic emergency and institutional care into more sustainable community and supportive housing.

For those households experiencing homelessness or at risk of homelessness, a continuum of interventions is potentially available in communities to address those needs. Many people experiencing homelessness and aging or who are living with significant disabilities will need supportive housing. Other households may be successful with less intense or more time-limited interventions. Figure 1 outlines the array of interventions a community may offer around homelessness and housing instability. It is important to note, however, that no community has sufficient capacity in its housing or homelessness sector to address the magnitude of need. Therefore, difficult choices in these systems and their policies continue to be made every day.

Figure 1: Interventions Used to Prevent and End Homelessness



Source: [Framework for an Equitable COVID-19 Homelessness Response](#)

Affordable Housing and Homelessness Landscape

Housing costs differ significantly across regions, states, and communities. Increasingly, communities with high demand for housing are seeing fewer property owners who are willing to rent to low-income persons or persons with public subsidies. [Fifteen states](#) have implemented "income discrimination" laws, meaning property owners cannot discriminate against tenants based on source of income, including housing subsidies. The COVID-19 pandemic, with its loss of income, lack of housing construction, and uneven response to the Centers for Disease Control and Prevention's eviction moratorium, has only exacerbated these challenges for families and individuals.

The National Alliance to End Homelessness' annual "State of Homelessness in America" [report](#) finds over 500,000 Americans are literally homeless, with trends indicating rising numbers in the coming years. In addition, many low-income households [cannot afford the cost of housing](#) (referred to as being "cost burdened" in the housing sector), thereby putting them at risk for homelessness or being unstably housed. The U.S. Department of Housing and Urban Development (HUD) [defines housing affordability](#) as no more than 30% of a household's income being allocated to housing-related costs, including rent and utilities.

Both the supply and cost of housing contribute to housing instability. The National Low Income Housing Coalition's annual "[Out of Reach](#)" [report](#) estimated that \$23.96 an hour wage is necessary to afford a modest two-bedroom apartment, while the national minimum wage remains at \$7.25 an hour. The Technical Assistance Collaborative's "[Priced Out](#)" [report](#) identified that the average Supplemental Security Income (SSI) for individuals with a disability and limited work history is \$794 monthly, while the average cost of a one-bedroom apartment is \$1,063.



HUD [defines](#) homelessness very stringently (see Box 1), limiting eligibility for financial assistance and potentially constraining systems from assisting people before they experience homelessness. While the definition can be frustrating in some cases, the homeless sector is already vastly overburdened even when using such a limiting definition. People who are considered “housing unstable” are those who are “doubled up” with family or friends or are moving repeatedly between other community placements such as hospitals, nursing homes, jails, congregate care or recovery housing, and sober homes. While they may not meet the strict definition of “homeless,” their housing instability makes managing health care needs much more difficult than for persons with stable, supportive housing.

Box 1: HUD Definition of Homeless

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

**Category 1:
Literally
Homeless**

- a. Has a primary nighttime residence that is a public or private place not meant for human habitation;
- b. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, and local government programs); or
- c. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

**Category 2:
Imminent Risk of
Homelessness**

Individual or family who will imminently lose their primary nighttime residence, provided that:

- a. Residence will be lost within 14 days of the date of application for homeless assistance;
- b. No subsequent residence has been identified; and
- c. The individual or family lacks the resources or support networks needed to obtain other permanent housing.

**Category 3:
Homeless Under
Other Federal
Statutes**

Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

- a. Are defined as homeless under the other listed federal statutes;
- b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
- c. Have experienced persistent instability as measured by two moves or more in the preceding 60 days; and
- d. Can be expected to continue in such status for an extended period due to special needs or barriers.

**Category 4:
Fleeing/
Attempting to
Flee Domestic
Violence**

Any individual or family who:

- a. Is fleeing, or is attempting to flee, domestic violence;
- b. Has no other residence; and
- c. Lacks the resources or support networks to obtain other permanent housing.

Longstanding Impacts of Systemic Racism

The history of the United States includes [innumerable policy and practice examples](#) of systemic, structural, and institutional racism that have resulted in segregated communities and limited access to health, housing, and resources to positively influence social determinants of health.

Early colonists forced segregation, seizure of land, and restrictions on land ownership for Native populations – policies that continue to influence access to housing and real estate development for Native Americans. European colonists and Americans primarily forced the enslavement of Africans and implemented laws barring freed Black individuals from owning property. During the Great Depression, the federal government used color-coded maps, or “redlining,” to identify neighborhoods where home loans could be offered, systematically denying access to individuals living in Black neighborhoods. Redlining [continues to leave an imprint](#) on the housing landscape today. Asian immigrants in the mid-19th century were also commonly barred from residing in desirable neighborhoods and forced to live in ethnic enclaves.

The 1968 Fair Housing Act was meant to address these historical wrongs, but weak enforcement built upon past inequities failed to undo the centuries of structural racism or address the core issue of the racial wealth gap. In 2015, the Obama administration attempted to address the disparities in housing across the U.S. by implementing the Fair Housing Act via the [Affirmatively Furthering Fair Housing \(AFFH\) rule](#). The AFFH requires communities that receive federal housing funds to examine barriers to fair housing and/or housing practices that promote bias and segregation. When housing disparity patterns are found, localities are required to create a plan to address these barriers. In response to these analyses, communities are developing Housing Equity Plans to acknowledge their history and work toward redressing systemic inequities – but these plans are in nascent stages. The Biden Administration [recently recommitted](#) to implementation of the rule.



Barriers and Opportunities for Health and Housing Cross-Agency Collaboration

A significant factor that limits collaborations is the fragmentation of the health and housing sectors, with persons or households with multiple needs having to navigate multiple systems to address these needs. Persons who need housing assistance must connect with the local public housing authority, homelessness assistance system, or multiple local providers of affordable housing options. Persons who need services must connect with their local providers, home health agencies, social services, or managed care organization to receive those services. Due to the complexity of navigating these systems, many sectors have professional system navigators, such as service coordinators or housing navigators.

Despite these challenges, there are many opportunities for states to work together on a shared health and housing agenda for people in need of housing assistance. To date, there have been several efforts to provide states with technical assistance in this area. The [Medicaid Innovation Accelerator Program](#) (IAP), launched in 2014, provided technical assistance to states on payment and delivery reform.

The National Governors Association developed a [Health and Housing Road Map](#) and the National Academy for State Health Policy maintains a [resource hub](#) for health and housing partnerships. Corporation for Supportive Housing tracks [state strategies](#) on developing housing support services.

As a part of the IAP, state Medicaid agencies developed partnerships with housing agencies and worked on detailed action plans to meet the needs of Medicaid enrollees. Centers for Medicare and Medicaid Services (CMS), as directed by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, recently convened 10 states in a [learning collaborative](#) to build state health and housing partnerships focused on the needs of persons experiencing homelessness and substance use disorders. In addition to these efforts, national nonprofits, including the Corporation for Supportive Housing, National Governors Association, and National Academy for State Health Policy, provide technical assistance to states for their health and housing partnerships.

The COVID-19 pandemic exacerbated existing housing and homelessness challenges and compelled states to ramp up their health and housing work to mitigate the spread of the virus and [rising rates of homelessness](#). States worked quickly to implement eviction moratoria and policies such as emergency rental assistance and non-congregate shelter. The Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan (ARPA) also provide states with [funding and flexibilities to address housing instability](#).

Housing Support Models and Key Terminology

States and communities are looking to invest in models of housing that link housing and support services for high-need populations. High-need individuals can be persons with complex care needs, behavioral health-related needs, housing instability, homelessness, or a combination of these. Many states are also focused on moving individuals from institutions to community-based settings, a process known as “de-institutionalization,” through agreements with the Department of Justice as a result of [*Olmstead, Commissioner, Georgia Department of Human Resources et al. v. L.C.*](#)

The models described below work to upend the paradigm of siloed institutions and ensure that the burden for negotiating multiple systems is borne by the systems, rather than by people who are experiencing housing instability. While terms vary among different communities within the affordable housing sector, there is a consistent goal to align a diverse group of services with affordable housing and address the needs of populations that face multiple challenges to thriving in the community.

The housing sector uses the generic term “services” to indicate any non-financial assistance a staff person or professional offers to a household to help them address their needs, including stability in housing. These services can be health care-related or broader social services. The homelessness sector uses the term “case management” to describe hands-on assertive support to households in the community, while the health care sector commonly uses “case management” to describe an administrative role. Transportation is a common challenge as affordable housing may be located outside transportation corridors. Other service needs common among residents of affordable housing include child care, educational supports, and employment services.

"Place-based approach"

"Attached to housing"

"Service-enriched"

"Supportive housing"

“Place-based approach” describes when funding for services is broadly attached to housing and provides ongoing supports with no time limits.

“Attached to housing” means services are delivered on-site, by the housing entity or a community partner that has committed to supporting the residents of the property. The services funding may be part of the housing funding or other braided funding. This model is significantly different from most of the health care sector services that attach services to the individual, rather than to where the person lives or to the population as a whole. Affordable housing developments may have an on-site service coordinator who connects residents to community services. Public housing authorities (PHAs) have historically had on-site services, especially for residents 62 and older; however, examples of this model have become less common nationally as funding has decreased.

A **“service-enriched”** housing model has a resident service coordinator who engages residents in health care-related challenges as well as broader social service needs. Common examples of service-enriched housing are programs funded by the [HUD 202 program](#), which finances, develops, and operates affordable housing for those 62 and older. In 2021, HUD requested submission for [new potential Section 202 housing developments](#), a place-based approach that offers “service-enriched housing.” These housing developments commonly have resident services coordinators who connect residents to services in the community, including health-related services. There may be other services available on-site, such as wellness services, meals, transportation, and other social services. Some services are offered by the housing agencies, while others are provided by community partners with long histories of delivering these services in the community.

Other types of HUD developments may also include supportive services. For example, the [HUD IWISH](#) demonstration is piloting a strategy to add an on-site services coordinator with a wellness nurse to help residents address their comprehensive health and social needs. LeadingAge has a [health and housing](#) toolkit to help guide the HUD 202 community to create effective partnerships with local health care sector partners.

Supportive Housing is an evidenced-based best practice for ending housing instability by aligning affordable housing with supportive services. [Supportive housing](#) is defined as “very affordable rental housing forming a platform of stability for vulnerable people who do not have a home or are leaving institutions or hospitals. The model has historic roots in the homelessness sector, but has been adopted by aging, behavioral health, HIV/AIDS, and other health care sectors as well. It is linked to intensive and voluntary, life-improving services like health care, workforce development and child welfare.” Supportive housing services are voluntary for residents, but assertive engagement of residents by staff is a central aspect of the model. Supportive housing services are housing focused, doing whatever is needed to assist the individual to maintain stable housing in the community.

Models of Supportive Housing: Supportive housing projects may be single site, meaning all units in the building are deeply affordable and all residents are engaged for services. Single-site projects are generally financed by a variety of state and federal sources, with a primary source of financing through the federal Low Income Housing Tax Credit (LIHTC) Program. Additionally, a source of ongoing rental assistance or operating subsidy is required and is typically provided through PHAs or state and local governments. A project may be “integrated,” meaning a portion of the units in the property are

What Is [Housing First](#)?

“Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.”

supportive housing units. For communities with higher rental vacancy rates, supportive housing programs align operating subsidies with existing housing in a “scattered site” model. Property owners may lease directly with the individual or may “master lease” the unit with the agency operating the program, which in turn will lease with the individual tenant. Supportive housing funded by HUD’s Homelessness Assistance grants are generally required to follow a “[housing first](#)” model and reduce barriers to program entrance and retention.

Services models in Supportive Housing. Comprehensive service planning in supportive housing examines the type of services to meet resident needs and the service delivery model (on-site, direct services, coordination with community providers). Corporation for Supportive Housing’s (CSH) [Supportive Housing Services Budget Tool](#) outlines the four most common models for services and creates fiscally sustainable rates based upon agencies’ costs. The tool can be used at the program or population level. The tool’s underlying staffing and fiscal assumptions for each services model make the same assumptions as high-fidelity models based on the original research. Those four models are:

Assertive Community Treatment (or ACT):

A Substance Abuse and Mental Health Services Administration (SAMHSA) evidenced-based practice. ACT level services are hands-on, are offered primarily in the community, and are behavioral health-related services that are designed to be comprehensive from a behavioral health treatment and services perspective.

Intensive Case Management (or ICM):

ICM services are common in behavioral health practice and offer hands-on assistance to connect with community services.

Tenancy Support Services

Similar to ICM services, tenancy support services are a brokerage model, connecting people to community-based services and ensuring housing stability by providing whatever is needed to achieve that stability.

Critical Time Intervention (CTI)

CTI is a nine-month hands-on case management model that offers intense assistance over the “critical time,” such as during community transition from an institutional setting to a community-based setting.

Each model can be implemented differently across communities. Housing providers face key considerations when looking at service models, including:

1. **Service participant to staffing ratios:** Staffing ratios that are too high can mean that services participants do not receive the staff time and attention needed to maintain community living.
2. **Assertive versus passive services:** Passive services are when the service recipient contacts the provider, whereas assertive services providers use a strengths-based approach to continuously engage clients until the service need is met. Supportive housing providers consider active engagement in services a part of the process.
3. **Cultural awareness and cultural humility of services providers:** People of color are overrepresented among people experiencing homelessness and those needing supportive housing. Providers of supportive housing should be able to demonstrate cultural awareness and cultural humility and strive toward an anti-racist agency culture to offer quality supportive housing in a community. In the future, development of these and other services models will need to be informed by active engagement of Persons with Lived Expertise (PLE) to ensure the services models are effective and equitable, as experienced by participants.

How Health and Housing Efforts Are Structured and Funded

As health and housing sectors collaborate more frequently, it is important to understand how funding flows and the various systems and structures in place to implement federal, state, and local priorities. HUD offers a variety of programs to address affordable housing needs within communities. These programs are funneled through a variety of governmental and quasi-governmental entities, including:

- State housing finance agencies;
- State housing departments;
- Housing authorities (statewide, regional, county, or city-based); and
- County/city housing departments.

Health and housing efforts require coordination among federal, state, and local entities and funding mechanisms. [Housing sector financing](#) includes funding for development, capital, and operating subsidies. Development is the first stage and includes developing a vision for the project, financing model development, land acquisition, architectural renderings, and development of plans for building and costs for those plans. Box 2 describes financing for supportive housing.

Box 2: Supportive Housing Financing

Capital	Funds used to build or repurpose housing. Often referred to as “brick and mortar.”
Operating	Costs of operating and/or maintaining housing (e.g., property management, utilities, maintenance, insurance, security, debt services)
Supportive services	Cost of providing tenants with needed support to sustain housing stability and meet life goals (e.g., tenancy supports, case management, employment services, behavioral health services, eviction prevention)

Source: [CSH Supportive Housing Quality Toolkit](#)

While housing programs are administered by HUD with funding to states and localities, states operate Medicaid programs that may fund [housing-related services](#). The following describes supportive housing stakeholders:

State Housing Finance Agencies. Unlike health care funding, much of housing funding flows directly from the federal government to local communities, with some exceptions. States have agencies that administer grant programs, such as allocations through federal HOME, Community Development Block Grant (CDBG), and National Housing Trust Fund (HTF) programs; administer the LIHTC program; and operate as statewide public housing authorities. Structures at the state level vary but include these functions carried out by state departments of housing and housing finance agencies (HFAs). In some states, these programs are administered separately, and in others these entities are combined under one larger agency. Many state HFAs operate a website that lists affordable housing opportunities throughout the state. HFAs are often independent entities, led by a board appointed by the governor.

Each state is required to develop a Qualified Allocation Plan (QAP) and update it annually. The QAP defines states’ priorities, state requirements, and the process for competing for an LIHTC award. CSH annually analyzes each state’s QAP to rank states on their strategies to encourage supportive housing developments and identify best practices across states.

The programs administered through state HFAs provide capital and operating support and function to increase access to affordable housing units. The following are examples of these programs:

Health and housing stakeholders are represented by associations including:

- [Council of Large Public Housing Authorities](#)
- [National Council of State Housing Agencies](#)
- [National Association of Housing and Redevelopment Officials](#)

HOME: The [HOME](#) program is a block grant to states and local housing departments to fund a variety of activities to assist low-income renters and homeowners.

CDBG: The Community Development Block Grant ([CDBG](#)) program allocates funds to state and local housing departments to develop urban communities, including housing, business corridors, and other local community needs.

National HTF: The [National Housing Trust Fund](#) is administered as a block grant and supports the creation and preservation of housing units, targeting individuals earning no more than 50% of area median income (AMI). Ninety percent of HTF funds must be used for production, preservation, or operation of affordable rental units, but up to 10% may be spent on homeownership support activities.

LIHTC: The Low Income Housing Tax Credit program is the primary production program to develop and rehabilitate affordable housing nationwide. Households that are able to access affordable housing options are less likely to be cost-burdened, and the LIHTC program provides a mechanism for projects to receive capital, in the form of equity, by “selling” the tax credits to private investors. The program offers affordable housing developers capital and financing to develop low-income housing options at [60% AMI](#). LIHTCs are allocated by the states to local housing developers that apply to the [state HFA](#). States have allocations of 9% credits, which subsidize approximately 70% of costs, and 4% credits that subsidize 30% of costs. People who rely on SSI for housing often struggle to afford housing in a LIHTC development without an operating subsidy, which covers the difference between what the household can afford and the cost of operating the property.

HUD funding also is allocated to PHAs, which manage and operate public housing in local communities and across states. PHAs operate the Housing Choice Voucher ([HCV](#)) program, through which households receive a voucher or rental subsidy to use on the open rental market. PHAs also increasingly develop affordable housing using LIHTC and other capital sources and are in an ideal position to address the unaffordability of LIHTC for people with disabilities because the most frequently used operating subsidy is an HCV. States may also have a statewide housing authority, or an HFA and a statewide housing authority may be combined into one agency that administers HCVs.

HUD may offer grants that are open only to PHAs. Like HFAs, PHAs are quasi-governmental agencies led by a board that may be chosen by state or local elected officials. PHA boards also commonly have at least one “resident” on the board. Public housing developments commonly have a resident council that is organized to represent the voice of residents to the PHA.

Continuum of Care. In the past 15 years, HUD has required that local grantees develop a Continuum of Care (CoC) program that organizes a community’s response to homelessness systemically. CoCs have a local governing board that is commonly a mix of stakeholders, including local government, service providers, and persons with lived experience of homelessness.

Medicaid. While Medicaid funding cannot be used to directly fund room and board or housing development, Medicaid can pay for a range of services to support case management, eviction prevention, and tenant rights training and education and can facilitate partnerships and cross-sector data sharing.

- **1115 Demonstration Waiver:** Section 1115 demonstration waivers allow for “experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.” 1115 waivers give states flexibility to test innovative programs and address the health and social needs of specific populations. The waivers must be budget neutral to the federal government and are approved by CMS for five years with opportunities for renewal. States such as [Hawaii](#), [Maryland](#), [Massachusetts](#), [Oregon](#), [Virginia](#), and [Washington](#) offer, or will offer, housing support services via an 1115 Medicaid waiver as part of their efforts to improve health outcomes and increase supportive housing capacity in their states.
- **1915(b) Managed Care Authority:** 1915(b) waivers give states the flexibility to waive federal requirements for comparability, statewide access, and freedom of choice and require that Medicaid patients participate in managed care for some of their benefits.
- **1915(c) Home and Community-Based Services (HCBS) Waivers:** Section 1915(c) HCBS waivers allow states to provide services in community-based, rather than institutional, settings and define programs for specific populations, such as people with disabilities. HCBS waivers can cover housing, pre-tenancy support services, and tenancy-sustaining services.
- **1915(i) State Plan Home and Community-Based Services:** 1915i authorities allow states to provide home- and community-based services through a State Plan Amendment (SPA), rather than a waiver. States such as [Connecticut](#), [Minnesota](#) and [North Dakota](#) are offering housing support services as part of their HCBS programs via the 1915(i) State Plan Amendment Medicaid Authority. [Connecticut](#), [Illinois](#), and [New Hampshire](#) have developed state plan requests for CMS that are in various stages of discussion. Washington state, with perhaps the longest running program, has data demonstrating that people were successful in transitioning out of homelessness, including [promising reductions in emergency department visits and hospitalizations](#) within the first nine months of program implementation.
- **1915(k) Community First Choice (CFC) Option:** The 1915(k) CFC Option was created through the Affordable Care Act and gives states a 6% bump in their Federal Medical Assistance Percentage (FMAP) to provide home- and community-based services and supports.
- **Health Homes:** Finally, states can create Health Home programs by amending their state plan. Health home services may be provided to Medicaid beneficiaries with chronic conditions and include these six core services:
 - Comprehensive case management,
 - Care coordination,
 - Health promotion,
 - Comprehensive transitional care and follow-up,
 - Individual and family support, and
 - Referral to community and social services.

Other Sources of Federal Funding. The federal government, states, and localities have had a number of other programs that were either developed as, or evolved into, cross-sector programs.

- **Money Follows the Person:** The CMS Money Follows the Person ([MFP](#)) program was designed to assist states to transition people from institutions into community-living settings with incentives for states to enhance their [HCBS](#) programs. The program was extremely successful, but the availability of affordable housing has limited the program's reach.
- **SAMHSA Grants:** SAMHSA's Grants for the Benefits of Homeless Individuals ([GBHI](#)) program prioritized states and local grantees that were able to partner with local housing resources, but those partnerships were challenging to execute.
- **Section 811 funding:** HUD's [Section 811 Supportive Housing for Persons with Disabilities Program](#) required state-level collaboration between state housing finance agencies and state Medicaid offices but experienced significant delays in creating the required cross-sector referral systems.

HUD also funds Fair Housing Resource Centers, lead abatement programs, and a variety of other programs designed to address the housing and community needs of low-income Americans. Housing assistance for rural communities is offered via several programs administered by the U.S. Department of Agriculture.

Federal COVID-19 Funding. In 2020 and 2021, several programs were either allocated additional funds or were created to address needs that were brought on, or exacerbated, by the COVID-19 pandemic.

- **CDGB-CV:** CDBG grantees received additional funds as part of the March 2020 CARES Act and the Coronavirus Relief Funds. Those funds are designated as the [CDBG-CV](#) funds.
- **Emergency Rental Assistance:** The federal FY2021 Omnibus bill provides up to \$25 billion to offer emergency rental assistance ([ERA](#)) to state, local, territories, and tribal governments to assist in keeping people in their homes.
- **Emergency Housing Vouchers:** Nationwide, PHAs are receiving funds for an additional 70,000 Emergency Housing Vouchers ([EHVs](#)) to support collaboration with their local CoCs to address rising homelessness. EHV grantees are required to collaborate with service funders and payers to ensure that those households receiving EHV have the supportive services necessary to be successful in their communities.
- **HOME-ARP:** HUD's HOME program will administer [significant additional funds](#) from the [American Rescue Plan allocations](#). New funding creates the potential for new opportunities, with housing partners needing to collaborate with health care and other service partners to address needs in their communities. The take-home message for service funders and providers is to network and collaborate with their state or community housing partners to ensure aligned, coordinated, or integrated systems and build toward success together.

The president's proposed fiscal year 2022 budget includes requests for housing resources not seen in decades. If funded as written, the [HUD budget](#) would include 200,000 additional vouchers for communities, an additional \$500 million to address homelessness, and full funding for Housing for the Elderly (Section 202) and Housing for Persons with Disabilities (Section 811). The amount of this funding is more than HUD has seen in a generation, and it opens up the possibility of cross-sector partnerships with health care systems and providers to address the need in a coordinated manner.

Successful Strategies

Establish a shared purpose

The Robert Wood Johnson Foundation Aligning Systems for Health offers a [framework](#) for aligning across sectors. Successful work begins with shared purpose. In health and housing work, states have developed these cross-sectors partnerships as part of efforts to reduce homelessness (Hawaii, Minnesota, New Hampshire); as part of a behavioral health systems transformation to reduce reliance on institutions (Illinois, North Dakota, and Oregon); or as part of a larger systems effort to address the need for health care system transformation and to better address the social determinants of health (Massachusetts, Washington). The work requires strong leadership committed to ensuring partners stay at the table until the systems are coordinated and integrated at the person level to ensure goals are achieved. Once the shared purpose is agreed upon, the sharing of governance, data, and financing can be considered. Data-sharing can also be an initial step to define diverse stakeholders' shared purpose. Consistent communication between stakeholders has been prioritized in successful states. The work is ongoing and will be measured in years and decades, rather than weeks or months.

Successful health and housing partnerships align investments from each sector to braid funding for both the Medicaid benefit and new affordable housing resources to increase supportive housing capacity and quality across states. Alignment needs to happen at the population level so the same potential residents can be served by both funding streams and at the services level so that services match what people need to participate successfully in their communities. States must also consider timing so that providers can braid the funding streams effectively. For example, if housing funding is available today and services funding is not available for two years, the programs will not have the desired effect. Finally, alignment on reporting can help to decrease burden on community providers.

In the wake of Hurricane Katrina, Louisiana successfully implemented a braided funding model to support Medicaid members with complex health needs. To learn more about their work, read [NASHP's case study](#).

New Jersey's Housing Finance Agency partnered with the statewide [Hospital Association](#) to develop affordable/workforce housing and supportive housing, addressing priority goals for each agency.

Capacity building and training for implementation

Capacity building at multiple levels is common among states that have successfully undertaken this work. Communication is essential for working across agencies and sectors toward shared goals. More work and financial support is needed to build health and housing partnerships at the system and program levels. Data integration is fundamental but takes time, unique skills, and partners at the system level. Capacity building for the housing, health care, and home- and community-based services sectors is critical to bring solutions to scale. The affordable and supportive housing industries have operated on a grants-based model, while health care commonly operates on a financing model in which services are delivered first and then paid for via medical billing. The challenge to the housing industry to overhaul its administrative structures to make this adjustment cannot be understated. Programs operate on small margins and cannot make these changes without dedicated support, technical assistance, and funding.

Minnesota's Housing and Stabilization Services program rollout has been supported by a Technical Assistance Team focused on assisting grants based agencies to make the transition to Medicaid Funding.

HCBS providers are necessary for supportive housing efforts and require training to best deliver evidenced-based services. CSH is proposing a [Supportive Services Transformation Fund](#) at the federal level to address these gaps and take advantage of the opportunity of new housing-related resources in communities.

Conclusion

States are increasingly aware of the potential to advance equity, improve population health, and address homelessness and housing instability. To be successful, the health and housing sectors need to collaborate more effectively. Communities and health and housing systems will benefit when a shared purpose is agreed upon and key stakeholders work together to ensure dedicated alignment of resources to achieve that shared purpose.

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