

Using Medicaid to Pay for Services
in Permanent Supportive Housing:

STEPS FOR COC LEADS TO GET STARTED



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The Alliance, CSH and TAC are national advocacy organizations that seek to promote programs and policies to improve housing and wellbeing for vulnerable persons, including those experiencing homelessness across the U.S.

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INTRODUCTION

Permanent Supportive Housing (PSH) is an effective intervention for ending chronic homelessness. An essential part of the PSH model is a package of health care and supportive services that helps people with disabilities get and stay housed. Those services, however, cost money - money that can be difficult to identify, secure, and sustain. The U.S. Department of Housing and Urban Development (HUD) recommends Medicaid as a potential funding resource for supportive services, but the process to secure this resource can be complex and overwhelming.

To that end, the National Alliance to End Homelessness, the Technical Assistance Collaborative, and CSH have developed this “how to” guide to help Continuum of Care (CoC) and other service system leaders work with health care systems to explore how Medicaid can finance supportive services in permanent supportive housing. While the strategies may be informative to many audiences, including individual supportive housing providers, this guidance is primarily geared toward individuals who have the authority to work on behalf of the entire CoC or state. It is also geared to those focused on securing housing and ending homelessness.

This guide is organized around five steps, each of which includes concrete ways to get started as well as links to additional resources. These five steps will help you build a case for why and how Medicaid can be structured at the state and local levels to pay for services in permanent supportive housing. When building a case you need to know some basics of Medicaid and the types of services you want Medicaid to cover. In order to convince Medicaid administrators and other health care payers to support your efforts, you need to have evidence of need for and impact of supportive housing and you need a coalition of many stakeholders at your side. The five steps are summarized below and do not need to be taken sequentially.

- 1 LEARN THE BASICS OF MEDICAID**
- 2 DETERMINE WHAT SERVICES YOU HAVE, AND WHAT YOU NEED**
- 3 MAKE THE CASE WITH DATA**
- 4 GATHER YOUR ALLIES**
- 5 KNOCK ON THE DOOR**

1. LEARN THE BASICS OF MEDICAID

To get started, it will be helpful for you and your housing allies to be conversant in the basics of health care and Medicaid and to understand your role in working to secure Medicaid as a resource for supportive services. Having this background will also help you develop new or better partnerships with health care payers and providers who can help you through this process.

2. DETERMINE WHAT SERVICES YOU HAVE, AND WHAT YOU NEED

As a system or Continuum of Care leader, you are able to see what services are available across providers in your system, determine what you still need, and investigate what funding can support these activities. While Medicaid can be used to reimburse many types of supportive services, it cannot cover everything. The answers to the following questions are not always the same in each state — who is eligible, what services are covered, when are they covered, who can provide them, and how are they paid for? You will need to know how these are defined in your state.

3. MAKE THE CASE WITH DATA

There are many studies showing that PSH saves communities money and improves the health of those housed. Taking this a step further, if you are able to use your own data to demonstrate these outcomes in your own community the results can be much more powerful and convincing. In order to produce these results you often need to access, share and analyze data across housing and homeless data systems and health care systems at the state and local level.

4. GATHER YOUR ALLIES

It is important for you to be aware of the needs of multiple stakeholders when engaging health care payers. Stakeholders, advocates, state agencies and providers including hospitals and local agencies, are constantly asking state Medicaid agencies, Managed Care Organizations (MCOs), and other payers to consider their target population, organization or service a priority. Even if ending homelessness is a priority in your state, being part of a broader coalition will give homelessness a voice, and build consensus around a specific and targeted strategy.

5. KNOCK ON THE DOOR

You've learned the basics of healthcare, identified the services you want to finance, established a coalition, and set a course of action. Now it's time to figure out whom to approach in the healthcare world: state Medicaid agencies, state/local mental health authorities, substance use and public health agencies, Federally Qualified Health Centers, MCOs, Accountable Care Organizations (ACOs), and Hospital Associations, among others.

WHAT'S YOUR ROLE IN THE PROCESS

Everyone has a role in the process of using Medicaid to support services in PSH. There are three general levels of knowledge about Medicaid: client-, program- and systems-level.

Client-Level Knowledge

Frontline workers and case managers should understand the following to help individuals who are eligible or potentially eligible for Medicaid services:

- Who is eligible for Medicaid.
- How to ensure that those who are eligible are enrolled in Medicaid.
- *How* to enroll those who are eligible.
- What Medicaid funded services are available for PSH tenants – this should be informed by program directors.

Program-Level Knowledge

PSH program management should understand the following in order to integrate Medicaid into programs.

- Whether or not you need to become an eligible provider of Medicaid covered services.
- How to develop capacity to support Medicaid-funded services while maintaining funding for overall operations.
- How to partner with other Medicaid service providers to maximize your capacity to provide services and operate your program.

System-Level Knowledge

System and Continuum of Care leaders should be focused on system-wide supportive service needs and need to understand the following:

- The number of PSH units you have in your system and how many your community and state needs to meet the demand for housing and services.
- The process for developing PSH capacity to meet the need locally.
- The creation of a comprehensive funding strategy to pay for the supportive services for accompanying PSH units.
- How to work with health care payers and providers to finance supportive services with Medicaid and other resources.
- How to educate partners about the importance of integrating housing and health care.

STEP ONE: LEARN THE BASICS OF MEDICAID

This section will address:

- What do you need to know about Medicaid?
- What do you need to know about Medicaid in your state?

1

LEARN THE BASICS OF MEDICAID

2

DETERMINE WHAT SERVICES YOU HAVE, AND WHAT YOU NEED

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KNOCK ON THE DOOR

WHAT DO YOU NEED TO KNOW ABOUT MEDICAID?

Medicaid is a health insurance entitlement program, meaning that it will pay for certain health care-related services for those who are eligible and enrolled in Medicaid. It was established as part of the [Social Security Act of 1965](#).

Federal and state oversight

The federal government and state governments share responsibility over Medicaid. At the federal level, guidance, regulatory and funding responsibilities for Medicaid are managed by the [Centers for Medicare and Medicaid Services \(CMS\)](#). At the state level, states administer the program within federal guidelines and law. Governors designate a single state agency to administer the program; typically this is a health and human services department.

The cost of the program is shared between the federal and state governments. States are required to pay for allowable services, provided by approved providers. States receive matching payments from the federal government for allowable costs of the state's program. The matching rate typically ranges between 50 and 75% depending on a number of factors.

Federal law defines mandatory and optional services and eligibility criteria. States then have the ability to tailor Medicaid to meet their state's needs by selecting various authorities (such as optional services or waivers) to modify who is eligible, what services are available, and the level of services allowed, and who can provide these services. States can restrict eligibility to non-mandatory services so that individuals eligible for Medicaid may not be eligible for all services offered in a state. A state's tailoring of Medicaid is documented in a state's Medicaid plan.

A State's Medicaid plan reflects its policy approach to Medicaid. In order to approve a state Medicaid plan, usually legislative and state budget offices review it to gauge

True or false: I am not a Medicaid expert so I can't help my community increase resources for PSH using Medicaid.

False: Everyone is needed to make Medicaid financing in PSH a reality.

potential cost implications for states which are required to balance their budgets. CMS also reviews states' Medicaid plans to ensure compliance to federal law. State plans cover the following elements:

- **Who is eligible for coverage?** Traditionally, people with low incomes who have certain diagnosed conditions, parents with minor children, pregnant women, and the elderly are entitled to Medicaid coverage. Many states have also expanded coverage to optional groups. Under the Affordable Care Act (ACA) states are able to expand Medicaid coverage to all persons below a certain income (see next section).
- **What services are covered, when and where?** Many medical and health-related services can be covered. Medicaid will NOT pay for rent or housing development, but it can pay for many housing-related services, as set forth in federal guidance. Services have to be medically necessary, provided in specified types of settings for specified duration, and often within limits.
- **How are payments administered?** There are several different ways that providers can be reimbursed for services. Payment models may include fee for service, per diem or monthly case rate approaches, among others. Supportive housing providers will need to have other sources of funds to pay for non-Medicaid eligible services and resources necessary to maintain operations.
- **Who can provide services?** Providers have to meet specific qualified professional or para-professional requirements typically under the supervision of a qualified provider.

Medicaid Expansion

The ACA was signed into law in 2010. It has increased the number of people eligible for Medicaid. This is known as Medicaid expansion.

Medicaid Expansion is not mandatory. It was determined by the Supreme Court that states are not required to expand their Medicaid coverage. Most states have expanded.

Expansion means more people are eligible for Medicaid. In states that have expanded Medicaid, eligibility is no longer based on having a disability, or children, or being a senior. In general, individuals whose income is lower than 138 percent of the federal poverty line can now enroll in Medicaid. This means individuals with very low incomes can get Medicaid coverage including many individuals who experience homelessness but previously were not eligible. For instance, having a substance use disorder is not considered a disability and therefore would not have qualified someone on the basis of their substance use to be eligible for Medicaid prior to expansion. In addition, documenting disabling conditions such as a mental illness for Medicaid eligibility is linked to duration and severity of the illness which does not include all persons with a mental illness. With Medicaid expansion, anyone is eligible for Medicaid based on their income, without having to document having a disability.

Federal reimbursement is higher for the Medicaid expansion group. The federal government will cover 100 percent of allowable costs for the expansion population through FY 2017. States have some options about what benefits they will offer for the expansion population. By 2020 its contribution drops to 90 percent. It is important to note that even a ten percent required state contribution can be a sizable portion of a state's budget and a consideration for states when determining whether to expand. On the other hand, in states not expanding Medicaid, the costs of health care for low-income persons without health insurance who do not otherwise qualify for Medicaid are being paid by the federal (e.g., specialty programs such as Ryan White), state or local government, and/or absorbed by hospitals and passed on to other consumers.

Opportunities exist even in states without Medicaid expansion. There are still opportunities to increase enrollment, even in states without expansion. People may not know they are eligible, may have found the enrollment process difficult and given up, may have lost coverage following incarceration, or for other reasons may not have enrolled even though they are eligible. Efforts to find and enroll people, even in non-expansion states, will help shift the cost burden away from local health and service providers.

True or false: My state has not expanded Medicaid so these options do not apply to me.

False: Most people in PSH are eligible for Medicaid based on a disabling condition. (physical or mental) so public and private options are still available for modifying Medicaid in your state, regardless of expansion.

New Benefits under Medicaid after the ACA

The ACA includes new services options including “[health homes](#)” and community-based services. These options will be discussed later in this series.

Medicaid at its inception had an institutional bias as most services were delivered in hospitals or institutions. Now states can offer services to people in their homes. The ACA expanded opportunities for individuals who do not need institutional care to receive [Home and Community-Based Services \(HCBS\)](#) which can cover non-medical services that [support housing stability](#), excluding rent or housing development costs.

WHAT DO YOU NEED TO KNOW ABOUT MEDICAID IN YOUR STATE?

Each state’s Medicaid Plan is different. Understanding what optional services are covered and how Medicaid is designed and administered will help you understand what options you have for financing services in permanent supportive housing. Here are three important steps for learning about Medicaid in your state.

First, what’s in the state plan?

You need to know the following: how someone gets enrolled, eligibility requirements, covered services and limitations in scope, duration, location, which payment options are used, and the provider requirements of your state’s Medicaid Plan (available on your [state’s Medicaid website](#)). State plans can be cumbersome. Use your health care contacts and try to find easy to understand documents that summarize this information to help you.

Tip: Medicaid is complicated – connect with health care providers, advocates and other administrators in your state who can help you answer these questions.

Second, are you an ACA expansion state?

You need to know [if your state has expanded](#) Medicaid. If it has expanded, look into any [special provisions](#). If it has not expanded, you may want to [advocate for expansion](#) in order to increase your capacity to serve people experiencing chronic homelessness.

Third, how’s Medicaid organized in your state?

Learn how Medicaid is administered and organized in your state, specifically, by which state agency and who are key staff. Is your state using [Medicaid Managed Care \(MCC\)](#) and/or other delivery systems? If so, get to know the Managed Care Organizations (MCOs) and learn about the state’s contracts with MCOs or other healthcare management organizations. This information should also be on your state’s Medicaid website.

STEP 2: DETERMINE WHAT SERVICES YOU HAVE AND WHAT YOU NEED

The best place to start integrating Medicaid financing into supportive housing for the first time is by conducting a needs assessment or “crosswalk.” This process will identify the types of services that are available in your system, what services are needed, and what services are covered by your state’s Medicaid plan or other resources, and under what circumstances.

This section will address:

- What services do PSH programs need to provide to the individuals they serve?
- What services are available in your state’s Medicaid plan, and what are its requirements?
- What are your options for filling any gaps in service coverage?
- Who will need to be persuaded and how?
- Where can you find technical assistance and additional resources?



WHAT SERVICES DO PSH PROGRAMS NEED TO PROVIDE TO THE INDIVIDUALS THEY SERVE?

Start by creating a list of services provided by your PSH programs; to help you, below are some common PSH services. The list only includes supportive services, not basic and specialty health and behavioral health care which should always be a priority for individuals you serve based on their needs. Then add to your list any services that you are NOT providing, but that you would like to include. Next compare these services to what is covered by Medicaid in your state. Not all of these services will be covered or covered under all circumstances. Here is a [template](#) to help you get started.

Common PSH Services

- Outreach / in-reach and engagement / re-engagement
- Assessment and identification of clients’ needs
- Service plan development
- Housing search and negotiation
- Ongoing tenancy supports
- Living skills coaching
- Community support and integration services
- Coordination and linkage with primary care and other medical services
- Services to address problematic substance use / substance use disorders
- Support groups
- Referral, monitoring, and follow-up to health care, behavioral health and personal care services as needed
- Entitlement assistance / benefit counseling
- Assistance with employment services
- Family and children’s services
- Support for victims of domestic violence
- Assistance with legal issues
- Peer support and mentoring

WHAT SERVICES ARE AVAILABLE UNDER YOUR STATE'S MEDICAID PLAN, AND WHAT ARE ITS REQUIREMENTS?

Knowing what is covered or is not covered by Medicaid in your state will help you determine the next steps to take. Reading a Medicaid state plan may not be necessary: they can be difficult to find and even more difficult to follow. Your best bet is to find someone who is well versed in your state's Medicaid plan to help you interpret what it is saying relative to what you need. In addition, there is more to consider than just what services are covered.

You will want to consider the following questions with respect to each of the services you have identified as needed in your PSH programs.

Are the services you have identified covered by your state plan? The names of the services may differ so it is important to pay attention to the function of the service. For instance “navigation” or “coordination” services may be the same thing or similar but defined differently under different Medicaid authorities.

Are all the individuals you serve or plan to serve eligible?

Not all persons who are eligible for PSH are also eligible for Medicaid under a state's Medicaid plan. For instance a person who has a substance use disorder and has experienced long-term homelessness may be considered chronically homeless and therefore a good candidate for PSH; but they might not be considered disabled and eligible for Medicaid in non expansion states. In addition, states that cover various housing-related services with Medicaid may have additional eligibility requirements beyond basic eligibility for Medicaid.

Are they all enrolled?

People can lose their Medicaid benefits if they are in jail or prison, if their incomes are fluctuating, if they are moving often and their re-certification paperwork is sent to the wrong address or if there are irregularities in their eligibility status. Paperwork is required to keep people continuously enrolled in Medicaid.

Are they all eligible for all services at all times?

Services may only be provided when considered medically necessary. Medical necessity is determined by each state. The medical necessity requirement may mean that not all PSH services can be funded by Medicaid at all times, so it's important to have other sources of funding to maintain program financing.

Can clients access services in all locations?

Services are often allowable across a wide variety of community locations including services that are specifically designed to be home and community based. However, there are exceptions. Many specialty services are delivered in clinic or facility based settings, and in some states, services can be “mobile”.

Can all service providers offer these covered services?

Services covered by Medicaid can only be delivered by a qualified provider. Becoming a qualified provider can be difficult. It requires agencies to meet certification, accreditation and/or licensing requirements. Organizations will need to consider the administrative and infrastructure costs associated with direct staff management and complicated service tracking and billing procedures as well as overall indirect costs. There may be one-time costs if you need to add infrastructure, hire new staff, or have a lag in payments related to starting or expanding services.

How do service providers get paid for providing these services? Financing under Medicaid can take different forms and may be feasible or not depending on how PSH programs are financed and operate. For instance, a fee-for-service model means housing service providers must track time spent with clients and bill for reimbursement. Often this means agencies have to have funds up front to cover staff and costs while they wait for reimbursement from Medicaid. On the other hand, a case rate or some other type of payment per episode or daily or monthly rate may be difficult to determine and may create a perverse incentive to serve individuals with the highest and often acute needs.

Do you have the capacity to deliver Medicaid covered services?

Adding new services or expanding services is just the first step. Delivering services in a different funding environment will require creating or retooling your infrastructure, adding staff and training existing staff. It will require internal auditing and managing resources as well as forecasting revenues and new recordkeeping.

WHAT ARE YOUR OPTIONS FOR FILLING ANY GAPS IN SERVICE COVERAGE?

Once you have established whether your state plan covers the persons and services that you need, there are two pathways to consider.

First, if your state plan covers what you need, then you need to make sure there is capacity within supportive housing programs to integrate Medicaid in your system.

Second, if your state plan does not cover specific target populations or services needed in your system, then you should be able to identify and articulate what these are. You should also be cognizant of political climate, budgetary constraints, community need, and provider capacity. Various Medicaid authorities and programs (e.g. 1115, 1915b, 1915c waivers; Health Homes) can provide additional coverage opportunities for high need populations. You will need to work with your Medicaid agency to explore the possibility of using Medicaid to fill gaps and determine which authority would be appropriate to meet your system needs, if any. While a comprehensive list and description of authorities is beyond the scope of this document, you can find a list of authorities [here](#) and [here](#).

Third, the way states administer and manage their Medicaid programs can also create possibilities. While some states continue to utilize traditional fee for service payment models, Managed Care Organizations (MCOs), contracted by states, are using their flexibility to fill gaps through innovative payments and services. Among the managed care models includes Accountable Care Organizations (ACOs), Coordinated Care Organizations (CCOs), and Administrative Services Organizations (ASOs). In addition, these models may allow savings from innovation and efficiencies to be reinvested into services. You should understand how Medicaid and other funding sources are managed in your system and their ability to meet the needs of your target populations.

WHO WILL NEED TO BE PERSUADED AND HOW?

If your state plan covers what you need but you don't have PSH providers who can bill for those services, then you may need to convince health care providers, such as FQHCs or Health Care for the Homeless clinics, to partner with housing providers and vice versa. Hospital administrators, MCOs, or other health care entities may be able to help defray one time or even ongoing costs to assure these services are available. In other cases, you will have to work with your Medicaid agency to seek a waiver or amendment to the Medicaid state plan so that the needed services can be delivered or funded. **Figure 1** includes some considerations for how to select among these options.

In any case, you will need to approach a health care payer and when you do it will be important to consider the following (addressed in later sections).

- Why should these entities care?
- How do you make your issue their issue?
- How should you tailor your approach with each of these entities?

True or false: Medicaid will cover all of my costs.

False: Unfortunately Medicaid may not reimburse for all costs but it will increase the resources available to those in PSH.

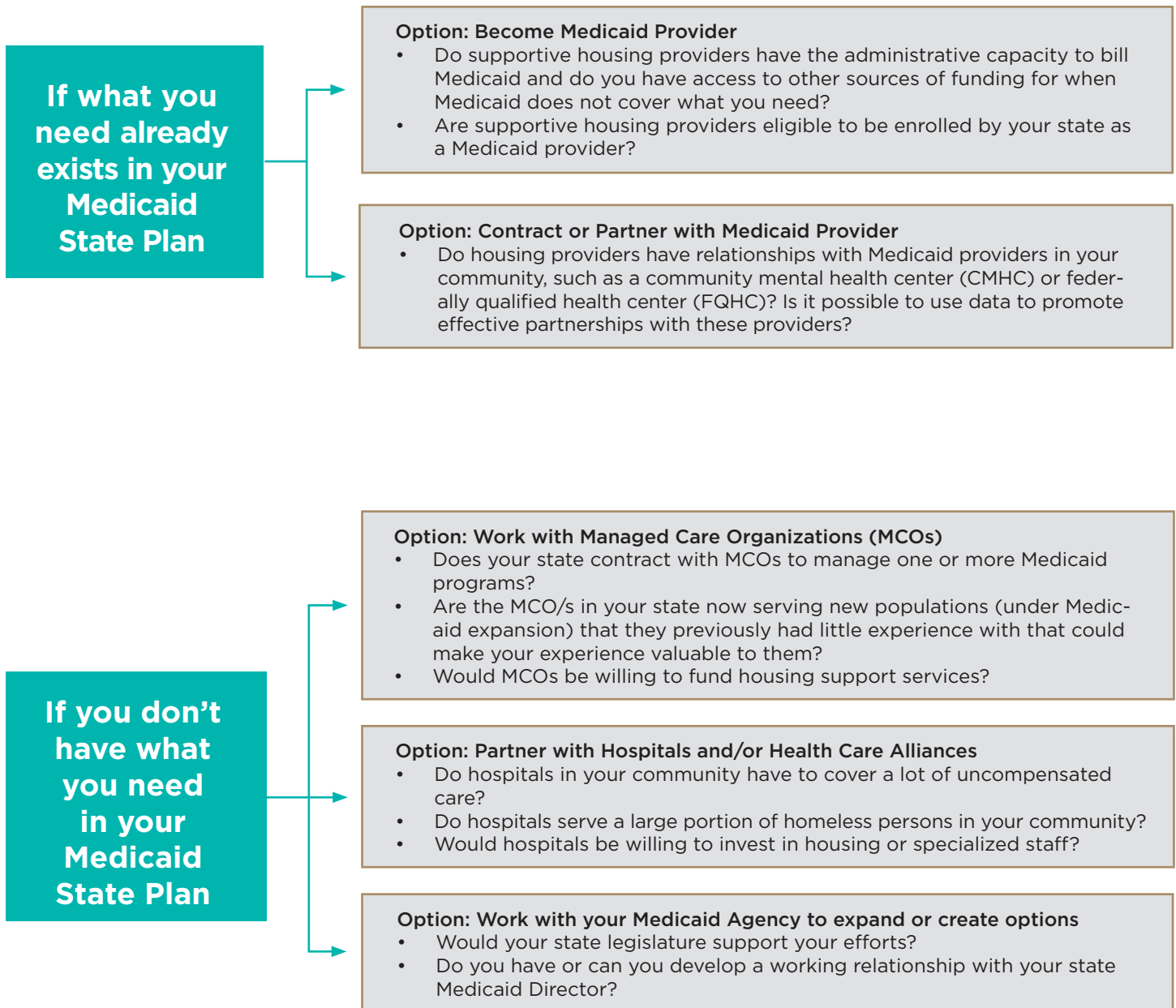
WHERE CAN YOU FIND TECHNICAL ASSISTANCE AND ADDITIONAL RESOURCES?

Below are key resources and technical assistance (TA) providers and opportunities.

- The **Corporation for Supportive Housing** (CSH) and the **Technical Assistance Corporation** (TAC) provide technical assistance to states on Medicaid, PSH and Olmstead compliance. CSH and TAC have worked on crosswalks in several states and has resources available online: [Washington State](#), [Connecticut](#), [Illinois](#), [Texas](#). TAC co-authored a paper with the National Council on Behavioral Health on Medicaid and supportive housing: [Challenges and Opportunities for Community Behavioral Health Organizations and Behavioral Health Authorities](#).
- The **National Healthcare for the Homeless Council** (NHCHC) provides technical assistance primarily to Health Care for the Homeless organizations on how to develop workforce capacity, specifically on how clinic staff can help people enroll in Medicaid to receive the services they need to stay healthy and connect with housing. Additionally, NHCHC published a brief on [Linking the HCH Community and MCO Partners](#).
- State Medicaid directors may have access to additional technical assistance from CMS or other national organizations that focus on states, including the **National Governors Association**. For instance, CMS has technical assistance available through its **Innovation Accelerator Program** to assist states to address two key challenges: increasing the supply and availability of supportive housing stock targeted at low income persons with complex health needs; and determining how to use Medicaid to cover services needed for achieving stable health and housing outcomes.
- The **Department of Housing and Urban Development** (HUD) provided technical assistance to 20 communities, called **Healthcare & Housing or H2**, to support building strong partnerships between health care and housing providers. H2 will be producing case studies, lessons learned, an overall assessment of the progress made in these communities, and information on how this work can be replicated. It will be available on [HUD's website](#).
- The most comprehensive work on Medicaid financing for supportive services was published in two documents by the Department of Health and Human Services, **Office of The Assistant Secretary of Planning and Evaluation** (ASPE). There is a [primer](#) discussing key elements of Medicaid and supportive housing in depth. There is a companion document highlighting emerging practices in the field including [community examples](#). Additionally, two Quick Guides, based on the ASPE documents, are available for [supportive housing providers](#) and [health care centers](#).
- The **Center for Health Care Strategies** (CHCS) has several briefs on Medicaid, health care, and supportive housing.
- CMS released an **Information Bulletin** in June 2015 outlining how Medicaid can cover housing support services.
- For more general information on Medicaid see the [Kaiser Family Foundation](#), [National Academy for State Health Policy](#), and [Families USA](#) websites.

FIGURE 1

CONSIDER THESE OPTIONS



STEP 3: MAKE THE CASE WITH DATA

Data play a critical role when it comes to increasing access to housing and services for high risk populations, developing the capacity of innovative service models, improving outcomes, and saving money across housing and health care systems. As important as data are in communicating efforts to end homelessness, they can be confusing and intimidating to work with and share, especially for those who don't work with data on a daily basis.

This section will address:

- Why are data important to your efforts to end homelessness?
- How do you share data?
- What data should you share and how do you share it?
- How do you know if you have permission to share data?
- How do you get started?

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WHY ARE DATA IMPORTANT TO YOUR EFFORTS TO END HOMELESSNESS?

Better understanding of homeless people's needs, cost reduction, improved outcomes and a more comprehensive system design are just four of the many benefits to be gained by using data, particularly data that link information from different systems.

Understanding population service needs and improving targeting. One of the goals of data sharing is to identify the cohort of people who use both the homeless and other crisis systems, but who may not emerge as a priority when looking at one system alone. People experiencing homelessness often cycle among multiple systems. The interventions they receive often have poor results because their housing needs are not being met. By sharing and analyzing data, communities can identify people with complex health needs and work to rapidly refer them to the right intervention.

Tracking costs. The most costly users of the health care system (so-called frequent users, complex cases or super utilizers) are often homeless. Comparing health and homeless system data can make this apparent. It can also make apparent the savings in health care and other costs once those individuals are housed. This provides a real incentive for health care payers to invest in housing-based services.

Improving outcomes. A data-driven targeting approach can identify what service or combination of services works for what client. This not only improves outcomes, it can promote coordination of services across multiple service providers, as well as lead to new investments in housing solutions.

Identifying system gaps. People experiencing homelessness use services from many mainstream systems. Sharing data can help identify services that are needed but that no system is providing. It can also point out barriers to service. Working across health care, housing, criminal justice and other agencies to identify high utilizers can open up opportunities to create new service delivery systems, financing models, and partnerships that could produce improved outcomes and savings.

HOW DO YOU SHARE DATA?

Sharing data can be done in four ways listed in order of complexity: comparing trends; comparing lists; sharing data among multiple systems; and warehousing data (**Figure 2**). Each method has pros and cons and picking a method will depend on your data capacity and the willingness of agencies to collaborate.

Comparing trends. This method might be used to evaluate a key data element(s) – such as housing status – across the systems you are hoping to work with. As the data are tracked over time, systems will begin to see trends that impact service utilization and cost. If all the systems don't already collect the data you wish to compare (housing or homelessness status, for example), you could ask them to begin doing so and provide the question you use.

Comparing lists. Homeless and health care systems often develop lists of frequent users or super utilizers in order to better target their efforts to those who consume the most resources within their individual system. Under specific agreements, states or managed care organizations, and qualified homeless providers could help break down these lists into categories like long-term shelter occupants or people who are chronically homeless. For health care systems, it could be patients with a high number of emergency room visits. One strategy some community care teams have used is to compare the top 100 utilizers from both systems to see the overlap. Those individuals can then be targeted for more effective interventions to reduce expensive and ineffective utilization of services.

Sharing data among multiple systems. A more precise method is to cross-reference administrative data between two or more systems to identify those who are served by both systems and how they use resources. The number present in more than one of the systems can be aggregated to show to overlap in persons and the costs of services. The information gleaned from the data matches can also be used to assess the nature and degree of the frequent user problem and to define targeting criteria for the CoC's Coordinated Entry process.

Data warehousing. Finally, some communities have implemented data warehouses that permanently link public system use records across agencies. These systems can be queried for different utilization patterns. In some communities, this linked data has been used to develop predictive survey tools that identify high utilizers in hospitals or other community-based settings. While beyond the scope of this document, both developing predictive algorithms and data warehousing are worth noting as more sophisticated methods of using cross-system data for targeted interventions.
ing homelessness.

Example: Data Sharing Between Multiple Systems – Connecticut

Task: Identify the highest cost Medicaid beneficiaries who are also experiencing homelessness.

Method: In 2011, Connecticut uses a quarterly data match between state HMIS and Medicaid to identify those eligible for a super-utilizer program. A collaborative group of regional shelters, outreach workers and supportive housing providers then use that list to locate and place individuals into supportive housing.

Results: More than 4,100 Medicaid beneficiaries who had experienced homelessness the previous year were identified. The top 10 percent accrued more than \$28.5 million in Medicaid costs. The average cost was \$68,000 per person, per year.

Impact: Connecticut was able to use this information along with other data to secure additional state funding for supportive housing.

FIGURE 2
EXAMPLES OF COMPARING DATA

COMPARING TRENDS		COMPARING LISTS		DATA SHARING	DATA WAREHOUSING
35% of people in HMIS reported hospital or other medical facility as prior residence before entering shelter during 2014	65% of people who used ER said they were homeless according to hospital survey during 2014	Homeless Management Information System – List of Chronically Homeless Persons	Highest Utilizers of Emergency Department Services	<p>Frank – 330 shelter nights, 16 ER visits totaling \$25,000</p> <p>Jennifer – 250 shelter nights, 35 ER visits totaling \$54,680</p> <p>Sandra – 26 outreach contacts, 12 ambulance rides totaling \$15,000</p> <p>Vincent – 180 shelter nights, 14 outreach contacts, 20 ER visits totaling \$32,000</p> <p>Michael – 265 shelter nights, 45 ER visits totaling \$170,000</p>	<p>Frank – used 500 shelter nights, had 9 jail stays and 7 ER visits between 1999 and 2014.</p>
		<p>Calendar Year 2014</p> <ul style="list-style-type: none"> •Frank •Paul •Jennifer •Sandra •Dennis •Vincent •Michael 	<p>Calendar Year 2014</p> <ul style="list-style-type: none"> •Frank •Sandra •Jennifer •Howard •Jeffrey •Vincent •Michael 		
FINDING: Homeless people are over-represented among hospital users		FINDING: 5 out of 7 (71%) of ER users are homeless		FINDING: 71% of ER users who are homeless account for 1,025 shelter nights and \$296,680 in health care costs.	FINDING: Homeless clients incur costs in multiple systems over varying time periods.

WHAT DATA SHOULD I SHARE AND HOW DO I SHARE IT?

When deciding which data to share, simplicity is key. There is no need to collect every piece of data from every system. Use simple data sets and minimize what is shared.

Data Sharing Process: Elements to Consider

Identify why you are sharing data. What do you and your partner(s) need to get out of the shared effort.

Identify a timeframe. Decide how many years of data you need. Often HMIS administrators will need to look back multiple years to establish who is chronically homeless or has a longer history of homelessness.

Determine which data elements to share. Without sharing too much information, you will want to identify the key elements that you are looking for from each system, such as services and cost.

Identify how to match records. You will have to decide what fields of data will be required to match records. Typically this includes, at a minimum: last name, first name and middle initial; date of birth; and gender. Social Security Numbers (SSN) can be included as well but is not critical and exposes the organization to risk. There are also ways to create anonymous identifiers based on identifying information in order to share across systems.

Determine how to transfer data. Data files are typically sent via a secure transfer process to a health system analyst or an outside analyst (university, government, etc.) for matching and analysis.

Determine who will match the data. Some general guidelines to remember about engaging with health system partners in a data match are that: they usually have more sophisticated data systems (e.g. electronic health records, or EHRs, or billing systems) than are available in the homeless system; they usually have more capacity to analyze data; and sharing of health information is severely restricted. Therefore, consider having the health partner conduct the match after receiving data from HMIS.

Decide how to share the results. Typically a meeting or series of meetings will be required to review the results and decide if more analysis is necessary.

HOW DO YOU KNOW IF YOU HAVE PERMISSION TO SHARE DATA?

There are several key components to understanding whether you have permission to share person-level data and who is allowed to access and participate in data sharing activity. We cover the broader rules and laws under HIPAA that restrict sharing of identifiable information, however there may be other laws that govern your ability to share client level information. *You should seek legal guidance locally to determine what those may be.* Your HMIS director should be familiar with the restrictions for sharing HMIS data and your state Medicaid administrator should be aware of what permissions are needed on that end. For other entities such as hospitals, managed care organizations, or other health entities, consult with their database administrators.

HIPAA. The body of regulations that governs protection of health data, known as HIPAA (The Health Insurance Portability and Accountability Act of 1996), generally does not apply to CoC entities. HIPAA-covered entities (hospitals, health clinics, managed care plans, etc.) must comply with a long list of technical, physical, and practice security standards that many CoC entities are not prepared to meet. This makes it difficult, but not impossible, for health system partners to share data with homeless and housing system partners. However, it's neither appropriate nor necessary for the housing system to receive detailed health data on potential clients when matching data so it is advisable that the health care entity perform the match and analyze the data when possible.

Written authorizations and protected health information. A written authorization from the clients/patients themselves stating that they give permission to share their information is always the safest way to go when considering sharing data. However it may be unrealistic to obtain authorization directly from all involved clients for a specific data match. There are justifications under HIPAA for sharing “protected health information,” or PHI, without written authorization, including treatment, payment, and health care operations. Health care operations includes “population-based activities relating to improving health or reducing health care costs, and case management and care coordination,” and is therefore closely aligned with the goals of any supportive housing initiative targeted for high utilizers.

While many HMIS administrators are rightly very cautious about sharing data on homeless clients and system utilization, the reality is that most data on homeless persons is NOT PHI, and therefore does not fall under HIPAA. Moreover, most homeless systems have clients sign a general release of some type upon entry into the homeless systems and it should cover sharing their information for the purposes of coordination and service provision. If this language is not in the current release, communities can work with their HMIS steering committees to have it included as they move forward with data sharing efforts.

Business Associate Agreements and Memoranda of Understanding. There are two types of data sharing agreements that organizations can use: Business Associate Agreements (BAAs) or Memoranda of Understanding (MOUs). A BAA requires that an organization become a formal part of another organization in order to share data with them, and therefore take on the responsibilities and legal accountability of the other organization. This allows health entities to provide services for or on behalf of HIPAA covered entities (like a health plan) that involve protected health information. Memoranda of Understanding (MOUs) are more informal, outline the process by which two or more entities will share data within a specified timeframe, and do not require that an organization take on the legal responsibilities of another organization. If the health care provider is performing the match and not sending back individual level information it may be possible to have a more informal agreement or MOU.

HOW DO I GET STARTED?

Data sharing should be treated as a long-term relationship between homeless and health systems. The best way to start is by identifying appropriate partners and start engaging them in a conversation about data.

Target Appropriate Partners

Locally. Sharing data within your own community can help local health providers understand how much the lack of housing impacts people's use of health care services, the nature of those services (emergency, management or preventative), the costs, as well as outcomes. Suggested healthcare partners include:

- Federally Qualified Health Centers
- Hospitals or networks of Hospitals
- Managed Care Organizations or Accountable Care Organizations

State-wide. This level of sharing promotes collaboration and can encompass other state systems. Getting other systems involved allows a better understanding of how people move across state-wide systems. It also works to determine where improvements in programs or coordination can happen.

- Medicaid Management Information System (MMIS) – states have a Medicaid information system to track participants and claims.
- State data warehouse – as mentioned above, some states warehouse data between state agencies.

Engage Data Partners in a Meaningful Way

Start by holding a meeting and invite all decision makers with authority over the data you are hoping to access. Consider the following as you plan that first meeting.

Is there willingness to share?

Accepting a meeting request may be an indication that there is a willingness to share. If you are having trouble getting buy-in, try having the meeting request come from a higher authority, like a governor's office or the head of the hospital association. You could also consider making the case that sharing data will help address each system's programmatic goals, challenges and opportunities. Partnership building will be important.

Is there authority to share?

It helps to understand under what authority each system is allowed to share data. This should be an early part of any data sharing conversation because it will indicate your ability to move forward.

Is there ability to share?

Not every system has personnel with the expertise to share data. Determine early on whether a research analyst is needed to match and analyze the shared data. Often, experts at local universities or colleges can provide data matching and analysis support, and sometimes bring the added benefit of being outside the politics of stakeholders. Also, it is useful to include data analysts from the health source and HMIS (and other systems involved in the work) in early meetings in order to clarify any technical questions for decision makers.

Is there time and money to share?

This can be a time consuming process; even creating and approving data sharing agreements can take a long time, so consider staff time and funding. A working group can be created or the data sharing exercise can be conducted by an existing meeting group in order to shepherd the process.

Is there a process for sharing?

Determine partners, deliverables, and a timeline for the data sharing. It helps to be clear about responsibilities among the partners and be sure to acknowledge some flexibility in terms of time and process. This is often learn-as-you-go.

Is there a future to share?

Have a broader conversation about your overall mission and goals to potentially uncover any other ways in which your systems can work together and be mutually beneficial.

Developing an agreement for data sharing is an important way to get parties "on the same page." The National Center for Medical-Legal Partnership has developed toolkits on how to develop such agreements.

STEP 4: GATHER YOUR ALLIES

State Medicaid agencies, Managed Care Organizations (MCOs), hospitals, and other health care financing entities are hearing from a wide variety of special interest groups and healthcare coalitions about innovative approaches that will save health care dollars and improve health. It is important therefore to build a strong voice by partnering with housing and health care advocates to emphasize the proven impacts of PSH. Coalitions help build consensus around a particular strategy and increase the likelihood of attaining a desired outcome.

This section will address:

- Who should be part of your coalition?
- What are other opportunities to engage with potential partners?
- How do you build an effective coalition?

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WHO SHOULD BE PART OF YOUR COALITION?

Most likely you already have strong homeless services and supportive housing coalitions in your city, county, or state. Health care providers and advocates also have coalitions. The important step now is to integrate these worlds in a meaningful way in order to bring Medicaid and health care resources together with housing resources to create sustainable, quality and scalable supportive housing. This may mean starting a new group or integrating your work into an existing group depending on what you think will help you advance your objectives the most.

Below is a list of potential partners that may be useful to include in your coalition.

Housing

- PSH Providers
- Private funders of PSH
- State, local housing and community development administrators
- Housing advocates
- Homeless providers
- Housing Finance Agencies
- Continuum of Care leaders
- State Interagency Council on Homelessness Members

Health Care

- State Medicaid Agencies
- State/county/local mental health and/or substance use agencies
- State/local Public Health Departments
- Health care policy advocates
- State Medicaid Advisory Committee Members
- Health Finance Agency administrators
- Managed Care Organization executives
- Hospital administrators
- Federally Qualified Health Centers (FQHC)
- Health Care of the Homeless (HCH) Health Clinics

Others

- State/ local elected representatives
- Criminal justice system
- Local business community

Good to Know: Every State Has a Medicaid Advisory Committee

Required by Federal regulation, the role of the **Medicaid Advisory Committee** is to provide the state Medicaid Agency with recommendations on the operation and planning of Medicaid programs. This includes:

- Input in the policy making process and program development
- Oversight of the quality and quantity of services provided under Medicaid
- Improving communication with provider and community stakeholders
- Creating a public understanding and assurance that state services meet the needs of the people served at a reasonable cost to taxpayers
- Planning for future programs, or aiding in decisions to end existing programs when appropriate

The committee membership includes medical professionals familiar with the needs of low- income population groups, consumer stakeholders and state department members.

WHAT ARE OTHER OPPORTUNITIES TO ENGAGE WITH POTENTIAL PARTNERS?

You will want to identify other efforts in your city, county or state where the purpose is to improve individual health outcomes, decrease costs, and house more vulnerable individuals. The following are programs and initiatives that can provide you with opportunities to meet and work with new partners.

Olmstead. Title II of the Americans with Disabilities Act and the subsequent U.S. Supreme Court 1999 Olmstead decision require states to grant persons with disabilities the choice of where to live and to ensure people with disabilities can live in the most integrated settings possible in the community. This means in many cases providing community-based housing and supports to persons with disabling conditions who are institutionalized or at risk of institutionalization. Read [this blog post](#) for more information.

811 Project Based Rental Assistance Program. This HUD housing program for persons with a disability requires partnerships between housing, Medicaid and other service agencies. Here is a [presentation](#) with more information on 811 and Olmstead.

Social Determinants of Health. The U.S. Department of Health and Human Services has developed an agenda called Healthy People 2020 that outlines goals for public health in the U.S. Included in these goals are promoting housing stability as a social determinant of health and eliminating health disparities that result from poverty and discrimination.

Performance. Homeless providers, as part of the local Continuum of Care, are increasingly required to demonstrate strong performance in order to receive federal funding. So are many other service providers such as Community Services Block Grant (CSBG) grantees (Community Action Agencies) and Managed Care Organizations. Such requirements create an opportunity for partnerships that are focused on improved performance.

Innovative collaborations underway. Look for initiatives already taking place, including any efforts in your state to innovate with Medicaid through the [Center for Medicare and Medicaid Innovation \(CMMI\)](#).

Collaborative grant opportunities. Look for grants that promote collaboration. An example is SAMHSA's Cooperative Agreements to Benefit Homeless Individuals (CABHI) grants which offer an opportunity for health and housing systems to make systemic changes that increase the effectiveness of Medicaid, housing, and other public programs in assisting vulnerable homeless people.

Federal guidance. New guidance or research provide a great opportunity to reach out to potential partners. For instance CMS released an [Informational Bulletin](#) directed towards state Medicaid Agencies outlining how Medicaid can pay for housing support services. This is CMS's way of telling Medicaid Directors that housing matters.

HOW DO YOU BUILD AN EFFECTIVE COALITION?

Typically you will not be working from scratch. Try to observe which partnerships or coalitions have been most effective in your community, why, and who was responsible for their success; then build on what has worked. Or add your mission to an existing successful coalition. No matter where you are in the development of your coalition, below are some tips for [effective coalitions](#) and [partnerships](#).

Leadership. Designate an agency or person to lead coalition efforts. Pick a strong leader. These are typically people or organizations that have legitimacy on a particular issue; can wield some power themselves through funding or decision making; and can bring other decision makers to the table.

Organization. Establish a clear objective. Building a coalition will be easier if everyone understands what the coalition is trying to achieve. Make sure your coalition is aware that this will be a long process. It takes time to develop new partnerships and create change. Creating goals and deadlines around budget cycles, stakeholder meetings and other events will help to move the process forward.

Make sure to establish a communication plan to let all members of your group know what you are doing. It is recommended to make regular reports to standing entities such as Interagency Councils on Homelessness, Continuums of Care or Medicaid Advisory Committees in order to keep these groups informed and in the loop. Posting updates on a website is helpful for keeping people apprised of and engaged in your efforts.

Activities like data sharing and developing a crosswalk of services are typically conducted by smaller work groups within the coalition, or contracted out by coalition members.

Education. The members of your coalition will come from different fields and will use different terminology and acronyms even when discussing the same issue. You should encourage partners to explain what they mean to avoid misunderstandings. Having a diverse membership will help you translate policies and programs across health care and housing areas, but it will still be important to learn the basics of Medicaid and health care. In addition, try to learn about the concerns of the health care community in terms of state and federal policy.

Healthcare partners want to learn about housing and homelessness. You can organize some materials that explain what the Continuum of Care is, what it does, how activities are funded, what Housing First and PSH are, and what your goals and needs are for the future. The Corporation for Supportive Housing has a great [synopsis](#) of PSH as well as a detailed description of Health Care for the Homeless organizations, which are Medicaid providers.

STEP 5: KNOCK ON THE DOOR

This last brief in this series describes how to approach health care payers, primarily to integrate Medicaid financing into your system of services for PSH. Whether you have included health care payers as part of your coalition building process as described in the previous brief, or you are reaching out to them for the first time (or the first time with this request) this brief will describe some strategies and tips to help you knock on their door.

This section will address:

- What are the win-wins when housing providers work with health care providers?
- What is the best way to approach health care payers?
- How do you tailor your approach to specific types of health care payers?

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WHAT ARE THE WIN-WINS WHEN HOUSING PROVIDERS WORK WITH HEALTH CARE PROVIDERS?

There are several incentives for health care providers to work with housing providers – and they help housing partners as well. These “win-wins” should be the foundation of relationship-building for you and your new health care partners. The following are ways your efforts complement one another.

Health care providers can help you improve and expand PSH and you can help health care providers achieve the Affordable Care Act (ACA) Triple Aim. The ACA lays out three goals: increase access to health care, improve health outcomes, and lower health care costs. Housing providers can help with these outcomes. You most likely have better access to a group of people who present a challenge for health care systems, and you have access to housing that will improve health outcomes and has been shown in numerous studies to lower emergency health care costs.

You have complementary workforces. Housing and health care providers have different skill sets, including knowledge about how to navigate the larger systems with which they are associated. The more you partner to access each other’s resources the better both your outcomes will be.

Health care providers can help you identify homeless people and you can help health care providers reach hard to serve populations. Health care providers often see people experiencing homelessness who may not access homeless services. On the other hand, you may know people experiencing homelessness who are not enrolled and who could be receiving health care.

Health care providers can help you access Medicaid financing and health services and you can help health care providers leverage more flexible funding and housing services. Funding, even when including Medicaid, can be a patchwork. Partnering may open up new resources or free up existing resources to put to better use.

WHAT IS THE BEST WAY TO APPROACH HEALTH CARE PAYERS?

Partnering with health care payers may already be part of your coalition-building. If they are the target of your request to integrate Medicaid financing or other funds there are a few things to consider.

Tips on Creating a Proposal.

It is helpful to create a business case or proposal outlining your need for Medicaid financing, your capacity to implement a program around new financing, and a strategic plan to target your efforts around particular goals.

Here are some elements for a business case for you to consider.

- **Objective.** Communicate a clear objective that you want to accomplish, including a population target and outcome.
- **Evidence.** Demonstrate the value of partnering by using published evidence from other communities or the results of your own data sharing exercise to illustrate how the populations you both serve overlap, the possible cost savings, and the impact of housing for health and wellbeing outcomes. (Here is a resource on [building a business case.](#))
- **Housing capacity and resources.** Demonstrate that you can deliver housing capacity through working relationships with landlords, public housing authorities, and affordable housing providers – and through opportunities for new housing development.
- **Partnerships.** For any important meeting, take with you someone from the coalition you are working with to demonstrate your capacity and commitment to moving forward. Think about who in your coalition will be regarded by health care as an important new relationship.
- **Budget,** scope and timeline. Sketch out your overall budget for housing support services, the services for which you are seeking financial support, the target population(s), and milestones for achieving health-care coverage in order to be clear about what you are looking for as a starting point for discussions with health care payers.

Tips on Communication

- **Key messages (and things not to mention).** Your key messages will be the win-wins discussed earlier, including:
 - You serve their toughest clients.
 - Housing improves health outcomes.
 - Housing saves money.
 - You have the capacity to partner with them. There are a few things to avoid when proposing a partnership. Medicaid will not pay for rent or housing development, so mentioning these can be a conversation stopper. Also, there are a lot of issues besides homelessness that health care leaders are dealing with so try to speak to their major concerns.
- **Meetings.** Most often meetings will be the vehicle for communication with health care payers. Start with big picture discussions; this is hopefully going to be a long-term relationship. Also, bring your leaders to let them know you are serious.
- **Materials.** Bring examples to help make your case and translate your objectives. Media stories, write-ups, or webinars on other communities can be useful tools. Also helpful are documents written by authorities such as CMS that encourage partnerships between housing and health care entities. An example is CMS's Informational Bulletin on housing services.

Tips on Outreach

- **Make the first contact.** Find a liaison who can broker a meeting. This should be someone who knows the best people to invite.
- **Establish trust.** To show your commitment, bring suggestions rather than just asking for help. Manage the expectations of all parties; don't ask for things they can't deliver, or agree to things you can't deliver. Help them address their needs, as well as advocating for your own.
- **Educate them and yourself.** Research their mission statements, initiatives, positions on issues, and other information on their website. Share similar information about yourself with them. Help create opportunities to learn from one another such as briefings, conference meetings, etc.
- **Create two-way dialogue.** Set up a regular meeting or attend each other's meetings to stay engaged.

HOW DO YOU TAILOR YOUR APPROACH TO SPECIFIC TYPES OF HEALTH CARE PAYERS?

Depending on what options you have settled on to access Medicaid financing there are a few ways to tailor your approach according to the type of health care payer.

Managed Care Organizations (MCOs). State Medicaid Agencies are contracting with MCOs and or ASO (Administrative Services Organizations) in your state. There are a variety of different types of contracts and management arrangements states are using today or are considering using for the future. In the past most home and community based services and services for persons with disabilities were covered through fee-for-services contracts directly with providers. That is changing rapidly and one strategy is for you to become familiar with the provisions and requirements of MCO contracts (most states include a template on the web), and particularly with the specific contract each individual MCO has. This will allow you to discuss with them what funding is flexible and what performance standards are important, and how these will help the MCO to achieve good outcomes. Perhaps you can help them reach their target goals for high performance.

Hospitals and hospital associations. Because of expansion, hospitals are now receiving less money from the federal government for disproportionate share hospital (DSH) payments -- payments received in part to compensate for their care of uninsured patients. You can help them save money by enrolling more people in health insurance and reducing non-billable costs.

Accountable Care Organizations or Coordinated Care Organizations (ACOs/CCOs). An ACO or a CCO is typically a collection of health care and other service providers. ACOs and CCOs have defined roles for how organizations that are part of their networks must operate. Attend their network meetings to determine if this network is a good fit for your needs.

Federally Qualified Health Centers (FQHCs) and Health Care for the Homeless Clinics (HCHs). FQHCs and HCHs have received increased funding since the ACA passed to help them reach out and enroll people without health insurance. They have flexibility and funding and can be a great partner in providing housing support services in PSH.

Mental health agencies. Some public mental health agencies see the benefit of housing for their clients. They have some funds that can be used for housing and other supports. Try to understand the scope of their budgets and the populations they serve.

Medicaid directors and agencies. Medicaid agencies are under pressure due to the magnitude of changes resulting from the ACA. They have a lot of special interest groups reaching out to them for support of health promoting activities. To cut through the noise use the [Informational Bulletin](#) CMS issued emphasizing the importance of housing supports and how those activities can be covered by Medicaid.

HOW CAN HOMELESS/HOUSING PROVIDERS BEST PARTNER WITH HEALTHCARE PROVIDERS?

At a recent New England Housing Network conference, this question was addressed by a panel of people representing agencies responsible for administering Medicaid across New England. Below are some of their responses.

Question: *Housing advocates want to be Medicaid agencies' friends. What should we do to strengthen our relationship with you?*

Answers:

- Our biggest issues are high users. They are very expensive. Help us with this problem.
- Bring us data to demonstrate the impact your programs can have for us.
- We are ignorant about housing. Help educate us, and help us educate you about Medicaid.
- Be at the table when we are planning around the Affordable Care Act (ACA) and amendments and waivers.
- Come to us as a unified voice to avoid boutique programs.
- Get to know us and our goals.
- Help us know how to give Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs) incentives or the flexibility to work with housers.
- Help us get people enrolled in Medicaid through the exchanges.

Question: *When is it most important for “housers” to be present?*

Answers:

- It's never a bad time to work with us.
- Be cognizant of state budget and legislative cycles.
- Give us a heads up if you are working on legislation so we can be your partners.