PRI
POLICY RESEARCH, INC.

Funding Supportive Housing Services for People with Behavioral Health Needs: Federal Resources

JUNE 2022

HOMELESS & HOUSING RESOURCE CENTER

SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

Disclaimer and Acknowledgments

This resource was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS) under grant 1H79SM083003-01. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, SAMHSA/HHS, or the U.S. Government. The Homeless and Housing Resource Center (HHRC) would like to thank the Technical Assistance Collaborative (TAC) for the contribution of their expertise to the development of this resource. The lead writers were Rachel Post, Sherry Lerch, and Francine Arienti.

Recommended Citation

Homeless and Housing Resource Center, *Funding Supportive Housing Services for People with Behavioral Health Needs: Federal Resources,* 2022, https://hhrctraining.org/knowledge-resources.

Introduction

Supportive housing combines high-quality, affordable housing with supportive services for persons with behavioral health conditions—a serious mental illness (SMI), substance use disorder (SUD), or both—who are experiencing or at risk of homelessness, thereby helping them to live and recover in the community. The success of supportive housing depends partly on the availability of high-quality services and supports to help people access, transition to, and sustain their tenancy in housing. This paper will offer practical information about key federal resources available through the U.S. Department of Health and Human Services (HHS) that can be used to pay for these supportive housing services, also called housing-related services and supports (HRSS). Additionally, this paper outlines considerations for providers that can help maximize these federal resources to ensure the availability of the full array of HRSSs needed in supportive housing.

Housing-Related Services and Supports

Programs across the country have demonstrated efficacy in helping people experiencing homelessness with mental and substance use disorders address barriers to housing access and improve housing retention through supportive housing services.[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S Department of Housing and Urban Development (HUD), as well as many behavioral health and homelessness systems and service providers, are well versed in the benefits of supportive housing. Examples include permanent supportive housing,[2,3] Housing First,[4,5] rapid rehousing,[6] and recovery housing.[7,8] Offering the full range of flexible, participant-driven supportive housing services that people with mental and substance use disorders want and need requires that providers have adequate resources to fund and deliver these services effectively—in the community and on demand.

The Centers for Medicare and Medicaid Services (CMS) has also recognized the role HRSSs can play in assisting Medicaid beneficiaries, including those with behavioral health conditions, to achieve community stability. In January 2021, CMS issued a State Health Official's letter [PDF] outlining the types of HRSS that Medicaid can cover. CMS's list of optional services that Medicaid can cover offers a good framing of HRSSs, which can include the following forms of assistance.

- Pre-tenancy services, which assist individuals in preparing for and transitioning into housing, such as the following:
  - Conducting individualized screening and assessment to highlight an individual's preferences for and barriers to community residence
  - Developing a community integration plan based on the individualized screening

- Assisting with locating housing and area amenities needed to promote sustained tenancy; this can include assisting in completing an application for housing assistance and for the residence and providing support around reviewing and signing a lease or rental agreement
- Determining safety and quality of the housing unit before move-in
- Supporting the move into a housing unit (including securing moving expenses)
- Connecting individuals to community-based resources that can help with parts of the process, such as securing documents and fees needed to apply for housing and making any reasonable accommodation requests related to the individual's disability

→ Tenancy-sustaining supports, which are provided once a person is housed to promote the length of their residency, such as the following:

- Providing services that identify and intervene when there are behaviors that may jeopardize housing (e.g., lease violations)
- Education or training on the role, rights, and responsibilities of the tenant and landlord
- Connecting individuals to community resources to maintain housing stability
- Individualized case management and care coordination that connects an individual with needed service providers and resources

To ensure that these services and supports are effective, programs must be able to individualize them based on an assessment of each person's strengths and interests. Effective programs must be versed in engagement strategies that use evidence-based interventions such as motivational interviewing and trauma-informed care. Such strategies should support people to step into services and the services need to be adjustable to meet tenants' changing needs over time. Working with peer providers or others with lived experience is another effective strategy for gaining voluntary participation in services.

Understanding Funding Needs and Options for HRSSs

Typically, no single funding source covers all the supportive services necessary to promote housing placement, stabilization, tenure, health, and wellness for supportive housing tenants. Instead, the full array of services and supports are funded by combining various resources that state and local systems and providers must bring together. There is variation among states and locales within states in both the resources available and how they are used.

Behavioral health authorities (BHAs) at the state, regional, and local levels are responsible for planning, managing, and monitoring the use of resources to meet the treatment and rehabilitative needs of people with mental and substance use disorders. BHAs can work with providers and state agency partners such as Medicaid authorities to assess HRSS needs among this population, the funding streams currently being utilized to cover these services, and any gaps that remain. Through this assessment, they can maximize federal resources available to reimburse providers for the delivery of HRSSs. BHAs can also help align federal resources with available state and local resources to ensure individuals have access to the full array of HRSSs they need to ensure housing success.

Providers can begin to proactively assess the types of HRSS available to those they serve and any gaps in

services availability and coverage. Providers can then educate themselves about which funding resources could potentially cover these services and their requirements both for supportive housing program participants and providers. With this knowledge, they can begin exploring partnership opportunities with the state and local entities responsible for administering and providing services using these resources to maximize their impact.

Learning the Basics of Key Federal Resources

A variety of funding sources are used to cover HRSSs in different ways from state to state. This paper highlights ways in which federal resources made available through HHS via the Medicaid program and SAMHSA grants can be used within states to cover HRSSs for the target population of people experiencing or at risk of homelessness who have behavioral health needs. While providers don't need to understand all the details regarding these resources and how they may be used to cover HRSSs, this brief outlines a few key areas that will go a long way toward understanding how best to use these resources. Additionally, this brief offers details on using these funding streams in combination with other state and local resources to ensure individuals have access to the full array of HRSSs they may need or desire.

Medicaid

As supportive housing resources have not kept pace with demand, many states have looked to Medicaid to provide coverage for HRSSs, allowing states to dedicate their own funding toward additional housing assistance instead. Medicaid can cover many, but not all, of the services and supports that people with mental and substance use disorders may want and need to live in the community. Medicaid is a unique federal and state program with lots of complexity. Nevertheless, Medicaid is an attractive funding source for HRSSs within states as it leverages federal dollars and is also a sustainable alternative to time-limited grant funding or state general funds, which are subject to the state budget process.

The Affordable Care Act, signed into law in 2010, allows for Medicaid expansion, increasing the number of people eligible for Medicaid coverage. As of February 24, 2022, thirty-nine states (including Washington, D.C.) have adopted the Medicaid expansion.[9] In states that have expanded Medicaid, individuals with very low incomes are eligible for Medicaid coverage, including many individuals who experience homelessness and have mental or substance use disorders but previously were not eligible. Extending Medicaid coverage to more people increases Medicaid coverage for services, allowing states and providers to focus limited state funds on non-Medicaid-eligible people and services.

Service providers need to know whether they are in a Medicaid expansion state and some other basics about the Medicaid program and how it operates within their state. Some key questions to explore include the following.

WHAT'S IN YOUR MEDICAID STATE PLAN?

The Medicaid State Plan describes which populations the state will serve under its Medicaid program, the benefits provided, any limits on coverage, and qualified providers. Most states post their plans online or make them available upon request, but reading the actual plan document can be tedious and may require assistance with interpreting the content. Focusing solely on those sections of the plan that apply to coverage of HRSSs is advised. The names of the services may differ, so it is essential to pay attention to the function of the service. For instance, "navigation" or "coordination" services may be the same or similar things but could be defined differently under different Medicaid authorities.[10]

WHICH MEDICAID AUTHORITIES CAN BE USED TO COVER HRSSS?

Most services covered under a Medicaid State Plan are "entitlements," meaning that the service must be covered when provided by an eligible provider to any eligible Medicaid recipient in the state. However, services covered under a Medicaid waiver authority are not entitlements, which means that services can be limited geographically, to a specific population, or as a "capped" benefit.

Table 1 below gives examples of the Medicaid authorities used to cover HRSSs in some states, but every state's Medicaid plan is different. Service providers should become familiar with their State Medicaid Plan to learn if HRSSs are covered benefits, and in states where this is the case, identify the eligibility criteria for becoming an enrolled provider. If your state does not cover HRSSs, providers can determine which Medicaid services are covered that can be used to provide specific activities within the array of HRSSs. More information about your state plan can be found by searching online for your state Medicaid agency or visiting CMS's "State Profiles" page.

Table 1: Examples of Medicaid Authorities That Can Include HRSSs

Medicaid Authority	Description	Sample HRSSs That Can Be Covered	State Example
Section 1915(i) State Plan Services	Allows states to cover home- and community-based services, including HRSSs, to individuals with mental and/or substance use disorders. Services cannot be "capped"; instead, they are an entitlement for any Medicaid recipient that meets eligibility criteria. Recipients are not required to meet institutional level-of-care criteria. Services must be based on an individualized assessment conducted by an entity not delivering the services prescribed.	Housing assessment; housing search; assistance with applying for benefits, understanding and negotiating a lease, and move-in.	Minnesota is authorized to provide HRSSs under a 1915(i) state plan amendment. Eligible individuals must meet needs-based criteria resulting from the presence of a disability and/or a long-term/ indefinite condition and must be experiencing housing instability, which is evidenced by experiencing or being at risk of homelessness.

Medicaid Authority	Description	Sample HRSSs That Can Be Covered	State Example
Section 1115 Research and Demonstration Waiver	Provides states with maximum flexibility so they can test policy approaches and payment mechanisms to better serve Medicaid recipients. States can extend coverage to additional populations not defined in law, require enrollees to use a specified provider network, or deliver Medicaid long-term services and supports through capitated managed care. This authority is often used as states attempt to address social determinants of health, including helping enrollees to access and live successfully in stable housing.	The full array of pre-tenancy and tenancy-sustaining services listed in "Housing-Related Services and Supports" on page 1.	Washington State is authorized to provide HRSSs under a Medicaid 1115 demonstration waiver. Recipients must be at least 18 years old and eligible for Medicaid, must have a functional impairment resulting from a mental illness or SUD, and must meet the criteria related to individually assessed need for assistance with activities of daily living and/or complex physical health need. Eligible individuals also must have at least one of the following risk factors: chronic homelessness (as defined by HUD); frequent or lengthy institutional contacts; frequent or lengthy residential-care stays; frequent turnover of in-home caregivers; or an elevated Predictive Risk Intelligence System (PRISM) risk score.

HOW IS MEDICAID ORGANIZED IN YOUR STATE?

Is your state using Medicaid managed care organizations (MCOs) or other delivery systems? As of July 2021, 41 states (including Washington, D.C.) contracted with comprehensive, risk-based managed care plans to provide care to at least some of their Medicaid beneficiaries, including individuals with mental illness or SUDs.[11] State Medicaid authorities pay MCOs a set fee for each enrolled "member" to provide necessary treatment and support within the array of a state's Medicaid-covered services. In addition to required services, MCOs can also offer "in-lieu-of services" to members, which are alternative services that are often preferred by members and cost less than required services. MCOs are contractually responsible for determining eligibility for a covered benefit, authorizing initial and ongoing coverage for services, enrolling and credentialing providers, and paying for services. MCOs often provide technical assistance and training to "non-traditional" Medicaid providers, including nonprofits that may be highly skilled in delivering HRSSs, to assist them in enrolling in their provider networks and in supporting their members.

Some states have moved to accountable care organizations or other health care management entities to administer coverage for HRSSs. It may be helpful to consult with health care providers, advocates, and other administrators in your state to learn about these more complex arrangements.

WHAT IS YOUR STATE BEHAVIORAL HEALTH AUTHORITY'S ROLE?

State BHAs may or may not have a role in administering Medicaid, but even if they do not, they can work in partnership with state Medicaid agencies to coordinate reimbursement for HRSSs. Typically, BHAs administer resources to fund services that are not covered by a state's Medicaid program or services provided to individuals not eligible for Medicaid coverage or third-party insurance. These resources may include the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant (both of which are further outlined below), or state or locally obligated funds. Though states are increasingly turning to Medicaid to fund HRSSs, Medicaid does not cover all services, and some people in need of HRSSs are ineligible to enroll in Medicaid, so BHAs can play a role in helping to align non-Medicaid resources to pay for the HRSSs that Medicaid cannot cover.

SAMHSA Grants

SAMHSA administers grants to states and local public and nonprofit organizations that support programs designed to prevent and treat mental illness and SUDs. Some grant programs are specifically designed to meet the treatment and other support needs of persons who have mental illness and SUDs and are experiencing or at risk of homelessness, and several cover many of the HRSSs highlighted above. SAMHSA's Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants are non-competitive grants to state agencies responsible for public mental health and SUD services, which are in turn allocated to regional and local providers. Projects for Assistance in Transition from Homelessness (PATH) and State Opioid Response grants are also noncompetitively awarded to states and territories, and area public or nonprofit organizations receive these grant funds to deliver services at the local level. Table 2 outlines these and other SAMHSA grant programs, including two that competitively award discretionary grant funds to states and local public and nonprofit organizations to address homelessness among people with mental illness and SUDs. Outlined are the types of HRSSs that each program may cover, the state administering agency (if applicable), the general target population eligible to be served, and typical regional and local service providers and partners. Behavioral health and homeless service providers can find more information on the "SAMHSA Grant Awards by State" page. Providers may also consider whether their agency is or could be taking advantage of some of these funding opportunities to fill in gaps or expand the availability of HRSSs to those they serve in supportive housing.

SAMHSA'S HRSS DEFINITION:

- Outreach/engagement/referral services that help identify and refer people experiencing homelessness to coordinated entry in order to access housing assistance provided by the HUD Continuum of Care Program and public housing agencies
- Pre-tenancy services that assist people with housing access, such as housing search assistance, landlord engagement and housing navigation, security deposits, rent/utility arrears, help obtaining documentation to verify eligibility, move-in assistance, and home furnishings
- Housing stabilization services and service coordination to help people stabilize in housing and connect with community-based services
- Ongoing tenancy-sustaining supports and wraparound services (e.g., those offered in permanent supportive housing) that assist people in being successful tenants, such as ongoing individualized case management, help with activities of daily living and maintaining one's home, support to prevent lease violations, and care coordination with health and behavioral health systems

Table 2: SAMHSA Grant Program Support for HRSSs

Program and Agency	Eligible HRSSs	State Administering Agency	General Eligibility	Service Providers/ Local Providers
Community Mental Health Services Block Grant, from SAMHSA's Center for Mental Health Services (CMHS)	• Outreach/ engagement/ referral • Housing stabilization and service coordination • Ongoing tenancy supports and wraparound	State agencies responsible for public mental health services	Adults with SMI and children with serious emotional disturbance	Local/regional mental health authorities, nonprofit community mental health centers, and other behavioral health providers; funds may be used for case management to help obtain housing and train people with SMI/serious emotional disturbance to help them maintain stable housing
Substance Abuse Prevention & Treatment Block Grant, from SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP)	• Outreach/ engagement/ referral • Pre-tenancy • Housing stabilization & service coordination • Ongoing tenancy supports & wraparound	State agencies responsible for public SUD services	Pregnant women and women with dependent children; people who inject drugs; people with SUD and co-occurring disorders; and people who need tuberculosis services, early intervention services for HIV/ AIDS, or primary prevention services	Nonprofit community providers, faith-based organizations, and behavioral health providers who provide SUD treatment, prevention activities, and recovery support services to individuals, families, and communities

Program and Agency	Eligible HRSSs	State Administering Agency	General Eligibility	Service Providers/ Local Providers
Projects for Assistance in Transition from Homelessness, from CMHS	• Outreach/ engagement/ referral	Funds are distributed to states' mental health agencies (find state PATH contacts)	Individuals experiencing or at risk of homelessness who have SMI or co-occurring mental illness and SUD	Local public or nonprofit organizations receive funding from states (find PATH providers)
State Opioid Response, from CSAT	• Outreach/ engagement/ referral • Pre-tenancy • Housing stabilization and service coordination • Ongoing tenancy supports and wraparound	Single-state agencies for SUD services (find recent grant awards)	Individuals with or at risk of opioid use disorder or stimulant use disorder; co-occurring mental illness and SUD	State and county mental health and substance use service agencies; for-profit and nonprofit prevention, treatment, and recovery support providers; community health centers; health systems; courts; public housing agencies; and colleges and universities
Grants for the Benefit of Homeless Individuals, from CSAT	• Outreach/ engagement/ referral • Pre-tenancy • Housing stabilization and service coordination • Ongoing tenancy supports and wraparound	N/A—funds competitively awarded to domestic public and private nonprofit entities	Individuals (including youth and families) experiencing homelessness who have SUD or co-occurring mental illness and SUD	Behavioral health, health, housing, and homeless services providers; health systems; and colleges and universities (find recent awardees)

Program and Agency	Eligible HRSSs	State Administering Agency	General Eligibility	Service Providers/ Local Providers
Treatment for Individuals Experiencing Homelessness, from CMHS	• Outreach/ engagement/ referral • Pre-tenancy • Housing stabilization and service coordination • Ongoing tenancy supports and wraparound	NA—funds competitively awarded to states, territories, tribes, and domestic public and private nonprofit entities	Individuals experiencing homelessness who have SMI, serious emotional disturbance, or co-occurring disorders	State and county mental health and substance use agencies, nonprofit behavioral health and homeless system providers, community health centers, health systems, courts, public housing authorities, and colleges and universities (find recent awardees)

Source: Technical Assistance Collaborative. 2021. "Coordinating HHS Housing-Related Supports and Services with HUD Housing Assistance for People Experiencing Homelessness." *Webinar from Technical Assistance Collaborative, July 14.*

Exploring Partnerships to Maximize Available Resources for HRSSs

Equipped with an understanding of the HRSS needs of those they are serving, gaps in service availability, and funding opportunities to potentially fill these gaps, providers can explore partnerships with entities that either administer or provide services using the key federal and other resources discussed so far.

Understand Levers That Incentivize Collaboration

The systems that administer the resources listed above are responsible for maintaining the health and behavioral health of the total population they serve. These systems are recognizing the role of social determinants of health (SDOH) in effectively improving population health while lowering healthcare costs. SDOHs are conditions in the environment where people are born and live, including access to nutritious food, affordable and accessible housing, transportation, strong social connections, and the availability of quality education and meaningful employment. Provider organizations and payers can reduce spending substantially when they connect people to services that address SDOHs, such as housing,[12] as it is very difficult to prevent or manage complex health conditions when people are experiencing homelessness or unstable housing. When entities responsible for organizing and funding services are interested in reducing the costs of care and improving outcomes related to SDOHs, providers who deliver supportive housing services bring valuable capacities. Such entities need providers with the knowledge, skills, and expertise to effectively deliver HRSSs that assist individuals who have behavioral health needs with accessing and sustaining community-based housing tenancy and avoiding high-cost care, and providers need to be able to get paid to deliver them. In any given state or locale, it is important to examine which state and local

agencies administer which sources of funding. While states are responsible for identifying and/or securing coverage for HRSSs, most states administer but do not directly provide services, relying on various local and regional partners to oversee and directly deliver services and supports.

Define Your Options for Filling Gaps in Service Coverage

Once you have determined whether your state Medicaid plan and SAMHSA grants cover the individuals you serve and the HRSSs they need, there are two pathways to explore. If your Medicaid state plan covers the desired services, the first pathway starts with determining whether there is capacity within the agency to integrate these funds into your supportive housing program. Both Medicaid and SAMHSA funding has administrative requirements that may increase your agency's infrastructure needs. Consult with your state Medicaid and/or BHA to understand what is required to administer supportive services funding through these programs.

It may be that your Medicaid state plan covers the HRSSs needed by those you are serving, but you are not an enrolled provider, which may particularly be the case for homeless service providers delivering supportive housing services to the target population. In such instances, you may need to help Medicaid-enrolled providers and payers to understand the benefits of collaborating with you. Potential partners may include community behavioral health centers and providers or healthcare providers such as federally qualified health centers, including Health Care for the Homeless clinics. Sometimes managed care organizations and other healthcare entities, including hospitals, can help with one-time expenses for infrastructure to administer these funds and they can also assist with ongoing monitoring that may be required to document efficacy. You may need to make a case for why these entities should care about supportive housing services and what these services mean for their bottom line. Draw from your own community's data or the volumes of published studies that document how supportive housing services can reduce costly visits to emergency departments and stays in inpatient units. This will help you persuade potential healthcare partners to utilize Medicaid and other available resources to fully fund HRSSs.

If your state Medicaid plan or SAMHSA block grant funds do not cover the needed supportive services, the second pathway requires that you work with your state Medicaid or BHA to explore using these funding streams to fill service gaps in the future. In the case of SAMHSA block grants, states have flexibility in how to use this funding but are required to submit a block grant application and plans for approval to SAMHSA. The application requires stakeholder input. System partners should learn their state's process for gaining stakeholder input into their block grant applications and ensure that funding for HRSSs is prioritized. When approaching Medicaid as a potential payer for HRSSs, prepare to share how your supportive housing program(s) can help the healthcare system meet the goals of increased access to health care, improved health outcomes, and lower healthcare costs. Define the services for which you are seeking reimbursement, and identify the hard-to-serve populations that would benefit from supportive housing. Make the business case for investment in HRSSs with clearly defined populations and outcomes and reference published evidence, as well as your own data and projections on possible cost savings. For more information on bringing system partners together to advocate for HRSSs with Medicaid and health care systems, consult Using Medicaid to Pay for Services in Permanent Supportive Housing [PDF].

Additionally, providers should consider and pursue partnerships with entities that control other sources of revenue that can be used to pay for non-Medicaid-eligible HRSSs and populations served in supportive

housing. This can include state general funds, county or local funds, and other public and private funding sources to fill gaps in services coverage.

Conclusion

States across the country are working to improve access to the full range of HRSSs required to support those experiencing and at risk of homelessness with mental illness and SUDs in finding and keeping housing. Key federal resources available through the U.S. Department of Health and Human Services are fundamental to funding HRSSs. This paper highlights how behavioral health and homeless service systems can familiarize themselves with these available federal resources and offers considerations for building partnerships with the state and local systems that administer these funding streams. These partnerships are central to supporting access to the array of HRSSs necessary to achieve lower healthcare costs while improving health, wellness, and housing tenure.

Learn More about the Homeless and Housing Resource Center

Providing high-quality, no-cost training for health and housing professionals in evidence-based practices that contributes to housing stability, recovery, and an end to homelessness.

Contact Us:

- hhrctraining.org
- info@hhrctraining.org

Endnotes

1 Debra J. Rog, Tina Marshall, Richard H. Dougherty, Preethy George, Allen S. Daniels, Sushmita Shoma Ghose, and Miriam E. Delphin-Rittmon, "Permanent supportive housing: Assessing the evidence," *Psychiatric Services* 65, no. 3 (March 2014): 287-94. https://doi.org/10.1176/appi.ps.201300261.

2 Substance Abuse and Mental Health Services Administration, ***Permanent Supportive Housing: How to Use the Evidence-Based Practices KITs***, HHS Pub. No. SMA-10-4509 (Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services), 2010. https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509 [PDF].

3 U.S. Department of Housing and Urban Development, Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing [PDF], HUD Office of Community Planning and Development Notice CPD-16-11, (Washington, DC: author), 2016, https://pasadenapartnership.org/wp-content/uploads/2015/10/Notice-CPD-16-11_Prioritizing-Persons-Experiencing-CH.pdf [PDF].

4 U.S. Department of Housing & Urban Development, Housing First in Permanent Supportive Housing Brief (Washington, DC: author), 2014, https://www.hudexchange.info/resource/3892/housing-first-in-permanent-supportive-housing-brief/.

5 U.S. Substance Abuse and Mental Health Services Administration, "Housing First Supports Recovery," Homelessness Programs and Resources, last updated April 6, 2022, https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/housing-first-supports-recovery.

6 U.S. Department of Housing and Urban Development, *Rapid Re-housing Brief* (Washington, DC: author), July 2014, https://www.hudexchange.info/resource/3891/rapid-re-housing-brief/.

7 U.S. Substance Abuse and Mental Health Services Administration, *Recovery Housing: Best Practices and Suggested Guidelines* (Rockville, MD: author), n.d., https://www.samhsa.gov/resource/ebp/recovery-housing-best-practices-suggested-guidelines.

8 U.S. Department of Housing and Urban Development, "Recovery Housing Program," Community Planning and Development, last updated August 4, 2021, https://www.hud.gov/program_offices/comm_planning/rhp.

9 Debra J. Rog, Tina Marshall, Richard H. Dougherty, Preethy George, Allen S. Daniels, Sushmita Shoma Ghose, and Miriam E. Delphin-Rittmon, "Permanent supportive housing: Assessing the evidence," *Psychiatric Services* 65, no. 3 (March 2014): 287-94. https://doi.org/10.1176/appi.ps.201300261.

10 CSH, the National Alliance to End Homelessness, and the Technical Assistance Collaborative, Using Medicaid to Pay for Services in Permanent Supportive Housing: Steps for CoC Leads to Get Started (authors), https://www.tacinc.org/resource/using-medicaid-to-pay-for-services-in-permanent-supportive-housing-steps-for-coc-leads-to-get-started/.

11 E. Hinton and L. Stolyar, "10 Things to Know about Medicaid Managed Care," KFF, February 23, 2022, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

12 Zachary Pruitt, Nnadozie Emechebe, Troy Quast, Pamme Taylor, and Kristopher Bryant, "Expenditure Reductions Associated with a Social Service Referral Program," *Population Health Management* 21, no. 6 (December 1, 2018): 469–76, https://doi.org/10.1089/pop.2017.0199.