Policy Brief: Using Medicaid's Housing Related Services (HRS) to Create New Supportive Housing

Updated Spring 2025

INTRODUCTION

Supportive housing is the solution to a variety of challenges our communities face. Those challenges include the need to end homelessness, the need for an aging population to remain in the community with integrated housing and services, the need for persons to transition successfully from institutions, and the need to stabilize families involved in child welfare. Additional populations who experience poor health and need supportive housing include families involved with the child welfare system[1], those impacted by mass incarceration[2] and those forced to live in congregate care settings.

No community has enough affordable and supportive housing. CSH estimates that an additional 1.1 million households nationwide need access to supportive housing to live successfully in our communities.[3] States wishing to create more supportive housing units have developed Medicaid-financed **Housing Related Services (HRS)** to support these efforts. **Housing Related Services** are the services that help people obtain and maintain housing in a community.

[1] https://www.childwelfare.gov/topics/systemwide/cultural/disproportionality/
[2] https://newjimcrow.com/
[3] https://cshorg.wpengine.com/supportive-housing-101/data/#Need

However, these services will not lead to more supportive housing without additional efforts on the part of state health and housing system leaders.

CSH has found during our work with states that there are six important strategies to adopt in concert with the development of Medicaid financed **Housing Related Services** that can lead to the creation of additional supportive housing capacity.

These six strategies are:

1. Integrate Medicaid Services and Housing Systems
2. Align Eligibility Criteria between Housing and Services
3. Meaningful Inclusion of People with Lived Expertise (PLE) in Systems Integration
4. Easing the Transition to Medicaid Billing
5. Building Medicaid Capacity for Housing and Homeless Agencies
6. Aligning Quality Standards Across Sectors

Medicaid offices execute some of these strategies alone, while other strategies are collaborative efforts between Medicaid offices, various housing systems and provider networks across sectors. CSH has found that strong cross-sector partnerships are essential to address the complex needs of our communities and to create more supportive housing**.**

FIGURE 1

TYPES OF PRE-TENANCY SERVICES

- Help attending a voucher issuance session
- Assistance locating an apartment/unit
- Assistance in applying for an apartment/unit and paying for application fees
- Guidance on understanding and signing a lease
- Establishing a personal budget to pay rent on time
- Assist with additional needs
- Help with lease-up (if applicable)
- Guidance on identifying community resources for move-in assistance

TYPES OF TENANCY-SUSTAINING SERVICES

- Budgeting
- Eviction prevention
- Relationship support with landlords and neighbors
- Education regarding lease compliance
- Help with housing assistance redetermination processes

What Are Housing Related Services (HRS)?

Housing Related Services are the services that support individuals to obtain and maintain housing in a community-integrated manner. Housing Related Services or supportive housing services are one part of an evidenced based approach to helping people with disabilities and other challenges stay housed.[4] Supportive housing takes an assertive engagement approach to ensure that people receive the services they need to maintain their life in the community. Historically, supportive housing developments and services could be funded via the federal Department of Housing and Urban Development (HUD), but new Medicaid financing opportunities are growing in many states. HUD has been walking back from funding services over the last decade or more and encouraging supportive housing operators to access other mainstream services funding opportunities.

[4] https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509

Federal leadership on Medicaid has provided clear direction that these services can be covered as part of a state's Home and Community Based Services (HCBS) program.[5] HCBS is an optional benefit package for states, which may or may not include **Housing Related Services**. The fundamental **Housing Related Services** package includes **pre-tenancy services** and **tenancy sustaining services**. Pre-tenancy services include outreach and engagement, gathering identification, learning what housing or rental subsidy program a person or household qualifies for, and assistance navigating affordable housing or homeless system processes. When a housing program or resource has been identified, pre-tenancy services help a person navigate all the requirements for that program in a timely manner. Once a tenant has moved in, tenancy sustaining services help people maintain housing as long as the tenant needs assistance. See Figure 1 for types of pre-tenancy and tenancy-sustaining services.

Supportive housing services commonly include care coordination and referrals to community providers for other healthcare and social services as lack of access to these services often negatively impacts housing stability.

For persons with disabilities and more significant service needs, supportive housing may also offer in-home assistance such as personal care, home health services or medication management services.

This could include in-home clinical services such as an Assertive Community Treatment (ACT) team, connection to social services such as income and benefits supports, childcare, and supportive employment or supportive education supports or recovery supports.

These services have great value in helping people but are not part of states' **Housing Related Services** package. Most commonly, these services are found in a different Medicaid authority or benefit or are funded via another sector or philanthropy.

[5] https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

Some states use Medicaid to cover **Housing Related Services.** Here is a list of states and year of implementation:

- 2005- Massachusetts, both via their Flexible Services Program[6] and their Community Supports for People Experiencing Homelessness[7]
- 2008- Louisiana's statewide Permanent Supportive Housing program[8]
- 2016- Washington's Foundational Community Supports program[9]
- 2017- Maryland's Assistance in Community Integration Services program[10]
- 2021- Washington DC's Housing Supportive Services Program[11]
- 2021- California via the CALAIM program[12]

[6] https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program
[7] https://mhsa.net/partnerships/cspech/
[8] https://ldh.la.gov/page/1732
[9] https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/initiative-3-foundational-community-supports-fcs
[10] https://health.maryland.gov/mmcp/Pages/Assistance-in-Community-Integration-Services-Pilot.aspx
[11] https://dhs.dc.gov/service/housing-supportive-services%C2%A0
[12] https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

Supportive Housing Services Frequently Operate as Whole Person Care Coordination

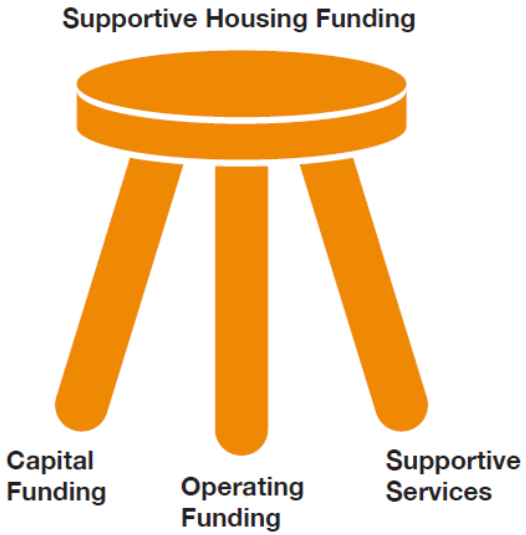
Supportive housing frequently includes services that could be categorized as Whole Person Care coordination. The services that are part of supportive housing programs commonly work to address housing, health and other tenant needs. Tenants receive assistance in accessing primary care, behavioral healthcare, specialty care, but also may receive non-healthcare services such as employment supports, childcare, educational supports or whatever needs the household identifies.

A Whole Person Care approach is challenging for any sector because of the siloes that exist within public systems. A traditional health focused care coordination approach will consider the health-related services but not non-medical needs assistance. Any one geography contains health centers and other primary care providers, affordable and supportive housing, homeless systems, behavioral health systems, public health and income and benefits supports.

Typically, the burden for coordination between all these systems lies with the individual and their available support system. Navigation becomes exponentially harder with each additional system a person needs to engage. Low income communities and families have even fewer resources and often additional barriers to navigating these administratively complex systems. Supportive housing services work at the individual level with residents to ensure that they are accessing the benefits to which they are entitled and the services they need to be thriving members of their community. A cross sector response is needed to achieve population level results.

The Three-Legged Stool of Supportive Housing Financing and Upcoming Opportunities

Figure 2



Financing supportive housing appropriately can be illustrated by a three-legged stool, with **capital** funds to build the building, **operating** funds to keep the rent affordable to persons with extremely low incomes and **services** funds to cover the **Housing Related Services**. Each of these financing streams are required to provide supportive housing built on the evidenced-based model.

Affordable housing will have the first two legs of the stool (capital and operating) but not the third (services). Since supportive housing has been historically funded primarily by the U.S. Department of Housing and Urban Development (HUD), it has been concentrated in the homelessness sector with homeless program requirements in place. Over the last few years, communities have received an influx of new housing funding that prioritizes new supportive housing creation.

The HUD HOME American Rescue Plan (ARP) Act funding allocated $5 billion nationwide. A primary allowable use for HOME ARP is to develop new supportive housing and increase their state's permanent supportive housing (PSH) capacity and quality.[13] The first units funded via HOME ARP are expected to come online in 2026. Communities also have a variety of new Special Purpose Vouchers (SPVs) such as Mainstream vouchers, NED or Non Elderly Disabled vouchers and Veteran's Administration Supportive Housing Vouchers (VASH).[14] All are programs that offer affordable housing options to persons who are aging or with disabilities. Only the VASH program comes with its own dedicated funding source for **Housing Related Services**.

[13] https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Introduction-to-HOME-ARP-for-CoCs.pdf
[14] https://www.hudexchange.info/trainings/courses/special-purpose-vouchers-working-collaboratively-to-achieve-community-goals-to-end-homelessness/

Six Strategies to Ensure that Medicaid Housing Related Services Creates New Supportive Housing

Figure 3

Through our work in multiple states, CSH has found the following six strategies (Figure 3) lead to the creation of new supportive housing. Some strategies have developing examples while others are just beginning. Each state has their own unique Medicaid delivery systems and are at different points in this process. For states whose Medicaid plans do not include Housing Related Services, creating a mechanism within the Medicaid program to fund these services is a fundamental first step in the process. However, no state has exactly the same housing and services ecosystem. Most, if not all, states rely on Managed Care for their healthcare delivery system. Some states offer limited direction to the Managed Care sector, while other states are more directive with their Managed Care contract requirements. Provider capacity across sectors will also create challenges. Some states have new affordable housing funding and opportunities, while others may not. Some communities have very low rental property vacancy rates and housing stock is the most challenging issue, while other communities just need new rental subsidy options.

No state has all of these strategies in place. But many states that use these strategies and understand the 'on the ground challenges,' are well along the path to using these new services to create needed supportive housing opportunities.

1. Integrate Medicaid Services and Housing Systems

Housing Related Services programs require structurally aligning affordable housing options to create new supportive housing. The evidenced based model of PSH requires ease of access to braided housing AND services funding. The Centers for Medicare and Medicaid Services' (CMS) recent approvals of short-term housing assistance also required system level connections to HUD assisted housing systems to ensure that these new services supplement, but do not supplant existing programs. Affordable housing is scarce and **Housing Related Services** alone will not ensure housing access. Hence the need to align the process of how a beneficiary accesses actual housing and **Housing Related Services**.

When systems are made more complicated (two non-coordinated assessments for example), more people fall out of the system. States need to integrate the service recipients' process both for accessing **Housing Related Services** and affordable housing**.** The process needs to be seamless from the perspective of the beneficiary. State offices can reach out to state and local housing partners and housing trade organizations to determine their priority populations and processes and align both the Housing Related Services and housing resources eligibility and assessment processes.

Understanding the impact of aligning these systems means that the **Housing Related Services** program should be tracking housing stability and housing access for those enrolled in the program. Being able to report on benchmarks regarding new supportive housing options and housing stability should be an explicit metric for these new benefits.

Best Practice Example - Washington, D.C.

In relation to the Medicaid program, Washington DC operates as a state Medicaid office via their Department of Health Care Finance. The Department of Human Services leads the city's PSH program and the coordinated entry process for homelessness assessment and referral. DC has used the new Medicaid benefit to expand supportive housing capacity by requiring and assisting the city's supportive housing providers to become Medicaid billers for the 2022 approved 1915(i) State Plan Amendment benefit for Housing Supportive Services.

With these new tools, DC has created an integrated system in which people are seamlessly assessed for supportive housing and the new HSS benefit. Post assessment individuals and families who qualify for supportive housing, they are referred to providers who offer supportive housing with braided funds from HUD, the City and Medicaid. From the beneficiary's perspective, they have one assessment and the administrative burdens are minimized.

Where do I start?

- Identify Key Housing Partners - Know your potential housing system partners and what priorities they have for managing scarce housing resources. That knowledge should influence the service and benefit design and referral process. Those partners may include State Housing Finance Agencies, Public Housing Authorities; Continuums of state or local housing departments. State housing agencies can help their Medicaid offices understand this network and the resources each manages. Determine what housing resources and partnerships are needed to create a seamless system.

- Map Referral Processes between sectors - Consider how a cross-sector referral system would work from a beneficiary perspective. The goal is to have a process of accessing supportive housing that is seamless between the Medicaid system and the housing systems. Work with health and housing partners to create these integrated systems. Consider the process also from a direct service provider perspective.

2. Align Eligibility Criteria Between Housing and Services

Housing and services will only allow blended or braided funding when the same people qualify for each. System leaders must work together to align who is eligible for the Medicaid **Housing Related Services** with who is eligible for affordable or supportive housing units or subsidies. CMS has been clear, that homelessness alone cannot be the primary criteria for eligibility for Medicaid funded **Housing Related Services**.

Many approved services have included 'homelessness and at risk of homelessness' as a risk factor. Alignment between systems includes high-level definitions such as persons with behavioral health challenges, those with multiple complex chronic health conditions or those with unexpectedly high costs to the healthcare system. Definitions between systems need to be standardized. Coordinated messaging across systems needs to be clearly communicated to agencies in both the housing and health care networks.

Best Practice Example - Washington's Apple Health and Home[15]

Washington State established Foundational Community Supports, the state's **Housing Related Services** (HRS) program in 2016. In 2022, the state legislature passed the Apple Health and Home law that required that new funding for affordable and supportive housing have the same eligibility criteria as **Housing Related Services**. A unit of state government was created whose role was both to align systems and administer new housing funding, to increase the supply of supportive housing.

[15] https://www.commerce.wa.gov/building-infrastructure/housing/ahah-psh/ahah-program/

Where do I start?

Where to start depends upon where your state is in the process of developing and implementing Medicaid financed **Housing Related Services**.

If your state is developing a **Housing Related Services** program, you are looking to define the population eligible for these services, similarly to your current or potential housing system priority eligibility populations.

If your state already has a Housing Related Services program with a defined population, you are looking for housing partners most likely to serve the same population. Your policy team may need to crosswalk eligibility for **Housing Related Services** against who is eligible for housing resources. If there is overlap in populations, there is potential to create new supportive housing. If there is limited overlap in populations, a discussion needs to occur about how to create more overlap and what eligibility criteria can be adjusted. If similar eligibility criteria do not exist, an amendment to your **Housing Related Services** program may be necessary.
If your state is creating new housing assistance to match with a **Housing Related Services** program, you are looking to ensure that the eligibility definitions for both systems are the same, so that someone can be eligible for both housing AND services.

Your goal is to create similar eligibility criteria, between both the housing and the services sector, for ease of systems integration. The goal is to identify people who are eligible for services who are also eligible for housing so that systems integration can take place at either ideally at the system level or at least more easily at the provider level.

3. Include People with Lived Expertise, particularly in the Design of the Systems Integration Process

The experts in our communities on managing between these systems are those people who have engaged with these systems to meet basic needs. Those persons are now commonly called people with lived expertise. If these resources are to meet the needs of the community, then the community must define those needs and design systems accordingly. Systems are frequently administratively complex and meaningfully engaging lived expertise in systems design can help reduce those complexities wherever possible. The goal is to make resources available to those who have historically been shut out of access for housing, services and supportive housing. Recruiting and engaging people with lived expertise should be consistent throughout planning, implementation and reporting as housing and services system integration work occurs. Policies should be developed in partnership with people with lived experience to ensure access for all communities.

Where do I start?

Wherever your state or systems are in the process, people with lived experience should be part of your planning team, advisory board and decision-making. There may be groups designed to engage lived experience already in place, such as a Medicaid Managed Care Advisory committee,[16] or new groups and processes may have to be created to work across the services and housing sectors. However your state or team decides to implement, including lived experience at all steps of the process will build invested partners and inform successful planning.

[16] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/List-of-Past-Articles-Items/CMS1191862

4. Reduce Complexities for Medicaid Reimbursement

The agencies in our communities that offer healthcare versus those that offer housing and housing related services are seldom the same agencies. Each sector has its own network of agencies that share common geographies and common service recipients, but seldom share little else. As state Medicaid and health related offices offer these new **Housing Related Services**, simplifying administrative complexity wherever possible is crucial to engage non-health sector agencies. Medicaid leaders and delivery systems should engage in intentional efforts to communicate with and listen to partners in housing-related sectors. Only then can states leverage the knowledge, capacity and access of these networks. States can review their administrative processes and procedures and work to communicate them in a way that is easy to understand for non-healthcare sector partners. States can consider the administrative complexity of their systems and work to ease that burden.

The role of Managed Care will be important to consider. Managed care decisions, training and support will also impact outcomes if housing and homeless systems providers are attempting to join their networks. For most states, Managed Care is a key system partner in this process. Housing and homeless providers do not have experience billing Managed care or even tracking healthcare coverage or Managed Care plans at the individual level. These providers have no experience of how someone's healthcare coverage status impacts their ability to access or be paid for services. States creating and assuring that Managed care creates the most administratively simple process possible will be crucial for a state that seeks to leverage the capacity, expertise and housing access of this sector. Managed Care will need dedicated efforts to on board nontraditional health sector agencies.

Best Practice Example - Washington State's Third-Party Administrator

When Washington State rolled out their **Housing Related Services**, the Health Care Authority created a request for proposals for a third-party administrator to operate statewide and provide all basic Managed Care functions, including onboarding providers, authorizing care and paying claims. Amerigroup was selected as the state's first

third party administrator in 2017.[17] The Health Care Authority contract with Amerigroup explicitly included supporting and on boarding community-based organizations with no experience of healthcare or internal healthcare infrastructure.

These efforts have included state grants, capacity building activities, and technical assistance to agencies who wish to become Medicaid billers for the state's program. The state, Amerigroup and the provider network are building a shared understanding of each other's language, processes and strengths as they each work to address health, homelessness and housing instability.

Where do I start?

A few potential activities or projects can jump start this process including:

- Process map your state's healthcare delivery system for your **Housing Related Services** and use what you learn to lessen the administrative complexity wherever possible. CMS views these services and benefits as part of state's Home and Community Based Services systems, so states that map that system in a process co-led by people with lived expertise would be a valuable process at the benefit design stage.
- Medicaid and health offices increasingly work with housing systems partners to learn what is challenging to their respective networks of agencies and the people they each serve. If your Medicaid or health offices does not already work with your housing partners, develop a cross-sector planning team to develop and implement the program. Include lived expertise in the leadership of this team to ensure their voice and experience is heard, valued and acted upon.
- Create communication links and pathways by which both sectors can learn about and inform developing policy and implementation. Research messaging and communications across sectors and see how Medicaid's information, priorities and resources can be pushed out across the housing and homelessness networks. Use plain language that non-healthcare experts can understand.
- Have members from each sector attend conferences and events from the other sector and exchange

[17] https://provider.amerigroup.com/washington-provider/patient-care/foundational-community-supports

learning, knowledge, and the potential opportunities of these new services programs. Health professionals will learn from the housing sector professionals and housing will learn from the health sector. Key learnings include understanding the other sector's values, priorities, pain points and potential for engagement.

5. Build Capacity for Housing and Homeless Agencies to deliver HRS

As described above, the agencies who are most skilled at addressing homelessness and housing in our communities are seldom healthcare providers. These agencies are also respected partners in their communities and states need to leverage those community networks. However, these agencies will need two types of assistance in order to evolve into an agency that can bill Medicaid for their services.

1) They will need capacity-building funds. These agencies are commonly small and mission-driven with very small operating margins. They do not have the budgets required to start up a new program that requires upfront investment in new staff, new information systems and new workflows. These agencies will need infrastructure support to participate in Medicaid. The agencies will also need technical assistance and training to learn the administrative aspects of Medicaid, build new workflows and new internal systems to meet Medicaid program requirements.

2) Finally, to create a long-term fiscally sustainable program, agencies will need reimbursement rates that cover their total cost of care.

Best Practice Example - CalAIM Capacity Infrastructure Transition Expansion and Development (CITED) funding[18]

As part of California's groundbreaking new CalAIM program[19], the state's Medicaid office, Department of Health Care Services has offered new funding to help community-based organizations develop the infrastructure to bill Medicaid. The Capacity, Infrastructure, Transition, Expansion and Development (CITED) program highlights the vital and potential role of community-based organizations in Managed Care Plan networks. The Department of

[18] https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM-PATH.aspx
[19] https://www.dhcs.ca.gov/calaim

Health Care Services awarded the first round of funding in February 2023, with additional rounds to follow. CSH is providing training and technical assistance to providers of Housing Related Services via our MediCal Academy[20]. In 2023, 38 agencies across the state are participating with 26 of them agencies receiving hands on TA to assist them in building an agency wide workplan that will take agencies through the 12-18 months of startup needed for standard Medicaid billing.[21]

Best Practice Example - Maryland

Maryland recently approved a waiver that includes a policy of cost-based rate development for agencies offering the **Housing Related Services** program, called Assistance for Community Integration Services.[22] In this program, the Maryland Department of Health contracts with county-based Lead Entities (LE) who work with providers to develop cost-based rates. The below quote is from the CMS approved Maryland 1115 waiver and shows how Maryland is handling the differences in costs across the state in a fiscally responsible and flexible manner:

"The monthly ACIS cost-based rate shall be the average cost of the total of a minimum of three ACIS tenancy-based care management/tenancy support services, and housing case management direct services and provided per month as described in a Memorandum of Understanding to be executed between the LE and MDH. The ACIS rate may vary by LE and will be developed based on a target cost per ACIS service, along with variables such as geographic location, salary costs, ACIS related travel costs, intensity of services, and duration of services or contracted provider per unit costs."[23]

By developing rates based on real-life agency costs estimates, Maryland is ensuring that providers have the funding needed to sustain the program at a quality level over the long term. By working through a county system, the state is easing the systems integration process by leveraging the network and expertise at the county level as the county acts as a network convener across multiple providers.

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[20] https://www.chcf.org/resource-center/medi-cal-academy/
[21] https://www.chcf.org/resource-center/medi-cal-academy/
[22] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/md-healthchoice-ca-020722.pdf
[23] IBID., p98

Where do I start?

A few potential activities or projects can jumpstart this process and build on any health sector analysis of their housing system partners including,

- Develop funding (either state or philanthropy) to support Community Based Organizations who are housing and homeless focused in your state and wish to bill Medicaid via the state's new or developing **Housing Related Services** program for supportive housing services.
- Develop opportunities for specialized housing and homelessness sector technical assistance to help these agencies learn what they need to know to transition to Medicaid billing. State supported tools and templates are valuable as many agencies are starting at a similar level of operations, knowledge and understanding.
- Study the rates needed for local agencies to deliver fiscally sustainable, evidenced-based services models. Develop budgets based upon using those rates to reimburse **Housing Related Services** providers.
- Review your state's rate setting process for these services. How can cost-based billing be integrated into that process?
- Consider having your county or other entity develop a business line as an Administrative Services Organization or ASO that assists agencies not wishing to develop the infrastructure to bill Medicaid directly. If your community has an Administration for Community Living (ACL) Community Care Hub, consider a partnership using their capacity.[24] Cities or counties could also seed an existing or current agency to fulfill that ASO role.

[24] https://www.ta-community.com/media/download/18jk6z/NLC_Participants_October_2022_508.pdf

6. Align Quality Metrics across Medicaid and Housing

States with Medicaid financed **Housing Related Services** programs have made a commitment to CMS to track certain quality metrics. Homeless and housing sectors have their own required quality processes and metrics from HUD and other traditional housing funders. Providers who are braiding funding will need to collect the metrics required by both funding sources. To ease this burden, CMS and state Medicaid offices should work with HUD and state and local systems to create joint quality metrics. In lieu of federal guidance, state Medicaid offices can work with housing sector partners to create statewide quality supportive housing standards. Those standards ought to integrate what is needed for quality services (led by the Medicaid office and their quality commitments to CMS) and quality housing (led by housing sector partners and their HUD Housing Quality Standards requirements[25]). An integrated housing and services quality process can ease the burden on providers and allow them to pay more attention to delivering direct services.

Where do I start?

With projects that blend or braid funding, each funding stream requires its own reporting and quality standards. At the system level, integrate standards into one seamless process, which reduces burden for providers. What are the most common funding streams to create supportive housing in your state or community? If your state has a **Housing Related Services** Medicaid program, what quality standards has your state committed to providing the federal government as part of their metrics reporting?

Compile a joint list of required reporting and quality metrics that each system uses and work with a cross sector planning team to create statewide supportive housing standards.

[25] https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/hqs

States' awareness and commitment to supportive housing is growing as an evidence-based approach to addressing a variety of needs in our communities including access to healthcare, aging in place, homelessness and to realize the vision of the Olmsted decision. Over 30 states' Medicaid programs now include **Housing Related Services** (HRS) with one goal being creating high quality supportive housing. As CSH reviews these programs, we offer these six strategies for reflection on state choices and activities that are integral to ensuring that new Medicaid services can create new supportive housing. By working together, health and housing leaders can promote quality supportive housing in our communities.

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