# Planning for Success as a PSH Provider

## A Guide for Community-Based Organizations Evaluating Participation in Medicaid

ATRÓMITOS
CONSULTING DONE FEARLESSLY

## Who Is This Toolkit For

Welcome to this comprehensive toolkit to support small, nonprofit community-based organizations in evaluating the decision to create or expand a permanent supportive housing (PSH) program and whether to become a Foundational Community Supports (FCS) provider within Washington State's Medicaid program.

This toolkit provides valuable resources and guidance for organizations to understand and effectively implement PSH programs. Through an exploration of the fundamental principles and objectives of permanent supportive housing (PSH) and a strong emphasis on addressing the complex needs of individuals facing homelessness or housing instability, this comprehensive toolkit provides an extensive array of information, resources, and strategies. Its purpose is to enrich understanding, facilitate effective implementation, and ultimately promote overall success within PSH initiatives.

### ACKNOWLEDGMENT OF THE STAFF

The dedicated staff at Atrómitos, a team of experienced professionals committed to supporting PSH, meticulously developed this toolkit to provide comprehensive resources for individuals and organizations involved in PSH initiatives. This was made possible by an Apple Health and Homes Capacity Building grant from the Washington Department of Commerce. Atrómitos is deeply committed to promoting social equity and improving outcomes for individuals experiencing homelessness or housing instability, aiming to provide tangible support to those working towards the common goal of providing stable housing and comprehensive support services to vulnerable populations.

### HOW TO USE THIS TOOLKIT

This extensive downloadable document has the elements needed to create and expand supportive permanent housing programs successfully.

Many elements within this toolkit are interactive, enabling users to use the tools digitally through a PDF provider such as Adobe Acrobat or Apple Preview, and are printable for manual use. References and source links are available throughout the toolkits and the endnotes.

Utilize our complementary video for a step-by-step introduction to each tool by clicking the image below.


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## Introduction



## Toolkits

## Overview of Permanent Supportive Housing (PSH)

Lack of adequate, affordable housing and the stress associated with the risk of homelessness profoundly impacts an individual's access to employment opportunities, health services, and other basic needs such as healthy food, transportation, and education. Permanent Supportive Housing (PSH) refers to interventions that combine (1) affordable housing assistance and (2) support services to address the needs of individuals experiencing or at risk of homelessness.[1] More than half a million people in the United States are estimated to have experienced homelessness in 2022.[2]

Today, many PSH programs (including Washington's AHAH Initiative and the Foundational Community Supports Program) are modeled around the evidence-based practices of the Substance Abuse Mental Health Services Administration's (SAMHSA) "Housing First" approach.

## Understanding the Housing First Approach

The nonprofit Pathways to Housing developed the "Housing First" approach to meet the housing and treatment needs of those experiencing chronic homelessness. In the 1980s and 1990s, the typical approach to housing support and interventions made housing support dependent upon accepting and maintaining sobriety and mental health treatment.

The Housing First approach flipped the model, prioritizing stable housing, with the consumer driving decisions about housing options and support services.[3] The model is predicated on the principle that adequate housing is a human right and individual consumer choice must direct all support and interventions. Since its inception in the 1990s, numerous studies and evaluations have demonstrated the effectiveness of Housing First's pragmatic and principled approach to improved health outcomes and maintaining health and sobriety goals. In 2014, SAMHSA published an evidenced-based toolkit for implementing the Housing First approach based on seven core principles.

1. **Choice of Housing:** Individuals have the right to direct their housing selection.
2. **Separation of Housing and Services:** Access to housing is wholly independent of accepting other supportive services, including (but not limited to) health interventions.
3. **Decent, Safe, and Affordable:** This means that allAll units meet US Department of Housing and Urban Development (HUD) quality standards, and tenants do not pay more than 30% of their income on rent and essential utilities.
4. **Integration in the Community:** Available housing options should be integrated into residential areas.
5. **Full Rights of Tenancy**: Individuals receiving housing support shall have a lease that complies with local landlord/tenant laws and regulations.
6. **Access to Housing:** Housing is never denied based on evaluating whether an individual is "ready" for housing. Housing and is never dependent upon other treatment or health goals but is a priority of its own.
7. **Flexible, Voluntary Services:** PSH services are tailored to the client's individual needs; this includes identifying client preferences and priorities at entry and throughout the program.

The bottom line of the Housing First approach is that establishing and maintaining adequate, affordable housing is an end goal in and of itself. A Housing First approach which prioritizes individual choice in housing, the services offered, and personal social and health goals, translates to improved housing retention *and* health outcomes, including adherence to health goals set by the individual.

> **FOR EXAMPLE**
>
> in 2020, the Seattle City Council estimated that approximately 90-95% of individuals placed in PSH remained housed a year later.

## Housing *Plus* Services

In addition to the Housing First principles that prioritize individual choice, autonomy, and empowerment, PSH programs recognize that establishing and maintaining adequate housing often requires more support and services than referral to an affordable housing unit. As provided through Apple Health's Foundational Community Support (FCS) program, PSH services include housing case management and tenancy support services,[4] which incorporates:

- Conducting housing assessments (including client preferences and priorities)
- Identifying housing resources, including conducting outreach to landlords to identify available housing
- Assistance with housing applications and support in obtaining a lease
- Provide support to individuals obtaining a lease
- Referral to and assisting in the application of housing subsidies and community supports
- Support and advocacy in landlord/ tenant disputes
- Education, training, and coaching

In addition to individual case management and tenancy support services through the FCS, Washington has adopted a three-pronged model (or three-legged stool) to PSH services through Apple Health. This recognizes that addressing the housing needs of individuals and the community requires:

- **Individualized Support Services** (as delivered through FCS Services),
- **Direct Assistance in Housing Costs** through Rental Assistance and other subsidies (as delivered through Apple Health and Homes Rental Assistance), and
- **Infrastructure Development** through incentives to landlords and partnerships with housing units and community-based organizations to expand the availability of affordable housing, as delivered through the Apple Health and Homes Initiative.[5]

## ENDNOTES

[1] National Alliance to End Homelessness, "Permanent Supportive Housing," April 26, 2023. Available at https://endhomelessness.org/ending-homelessness/solutions/permanent-supportive-housing/#:~:text=Permanent%20supportive%20housing%20is%20an,needs%20of%20chronically%20homeless%20people.

[2] U.S. Department of Housing and Urban Development, The 2022 Annual Homelessness Assessment Report (AHAR) to Congress, December 2022. Available at https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf.

[3] Sam Tsemberis, Leyla Gulcur, Maria Nakae, "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis." American Journal of Public Health, 94, no. 4 (April 1, 2004): 651-56. Available at https://doi.org/10.2105/ajph.94.4.651.

[4] Amerigroup, Foundational Community Supports, Orientation Presentation, 2022. Available at https://provider.amerigroup.com/docs/gpp/WAWA_CAID_ProvOrienPres.pdf?v=202205261318.

[5] Washington State Health Care Authority, "Introducing the Apple Health and Homes (AHAH) Program." February 8, 2023. Available at https://www.youtube.com/watch?v=6LcF7OqoR1U.

## Apple Health and Homes Overview

In 2022, the Washington General Assembly passed Engrossed Substitute House Bill 1866[1] to create Apple Health and Homes (AHAH). The AHAH initiative was designed to align housing resources (rental assistance and capital financing) with supportive services (Foundational Community Supports) for some of Washington's most vulnerable residents. AHAH requires close collaboration between multiple state agencies, given the integration of service delivery and the braiding of funding sources.

Washington recognizes the importance of addressing the social determinants of health (SDOH)[2] by providing integrated services and supports that take a holistic perspective of an individual's needs. Social determinants of health significantly impact people's health, well-being, and quality of life. AHAH is predicated on the fact that housing is an SDOH, and a lack of safe housing can contribute to health inequities and impede improving an individual's medical, behavioral health, or physical impairments.

### Understanding the Housing First Approach

The AHAH legislation included funding for multiple components that aim to:

- wrap services and supports around individuals with complex needs,
- increase the inventory of housing available for individuals receiving permanent supportive housing (PSH) services, and
- build the capacity of Washington's provider community to provide PSH.

#### FOUNDATIONAL COMMUNITY SUPPORTS

Foundational Community Supports (FCS) is a Medicaid-funded service that provides supportive housing and supported employment to high-risk/high-cost Medicaid recipients. These services are targeted toward individuals experiencing significant barriers to finding stable housing and employment. FCS is designed to promote self-sufficiency and recovery by helping participants find and maintain stable housing and employment. While FCS was not funded under the AHAH legislation, as the state's supportive housing service, FCS is the foundational component of the AHAH program.

#### RENTAL ASSISTANCE

The Department of Commerce (Commerce) in 2023 SFY received $6M to provide rental subsidies to landlords on behalf of AHAH-eligible individuals. This funding will be used to offer tenant-based rental assistance (TBRA) or project-based rental assistance (PBRA) vouchers. Commerce has contracted with a third-party vendor (H2 Consulting) to facilitate rental assistance payments to landlords on behalf of AHAH participants.

### CAPITAL FUNDING

In SFY 2023 Commerce was allocated $60 million in capital funding to increase housing availability for AHAH-eligible participants. These funds will be used for the construction of PSH units or to acquire property that can be converted into PSH units. Units built or acquired with these funds must be restricted to AHAH referrals. Nonprofit housing providers and community organizations can leverage funding to expand their capacity for PSH.

### CAPACITY BUILDING GRANTS

In addition to capital funding, Commerce will issue capacity grants to support organizations interested in providing PSH. The goal is to create a strong network of providers to support the AHAH program. These grants are designed to enhance the ability of community support services providers and housing providers to deliver FCS and PSH services through the provision of technical assistance and other training activities.

## AHAH Eligibility

AHAH benefits are provided to individuals with the greatest need in WA state, as determined by their eligibility for FCS supportive housing services. AHAH participants must meet specific medical risk factors and have a disability or long-term care need. The AHAH eligibility criteria are as follows:

1. be enrolled in Apple Health (Medicaid),
2. be at least 18 years old,
3. Meets the requirements for a complex need:
    a. Mental health need
    b. Substance Use Disorder
    c. Needs assistance with activities of daily living
    d. Be a person experiencing homelessness with chronic health conditions
4. Have one of the following risk factors:
    a. Be homeless or chronically homeless
    b. History of lengthy institutional contacts
    c. History of stays at adult residential care facilities or residential treatment facilities

AHAH units and rental assistance are only available to individuals authorized to receive FCS supportive housing services. Individuals who only receive FCS supported employment services are not eligible for AHAH rental assistance.

## AHAH Eligibility Process

The first step in the process for accessing AHAH rental assistance services is for an individual to receive a comprehensive assessment from an FCS provider. During the assessment, the provider determines whether the individual is eligible for the program and identifies what type of housing they need (i.e., housing preferences, environmental conditions, and support needs).

The FCS provider shares the results of the housing assessment with the AHAH coordinating entity, Amerigroup. As the FCS third-party administrator of the FCS program, Amerigroup utilizes the housing platform to find a unit within the available AHAH inventory that best meets the individual's assessed needs and preferences.

## AHAH Program Authorities and Administrators

Commerce is responsible for creating the Office of Apple Health and Homes/ Permanent Supportive Housing (The Office of AHAH/PSH). The Office coordinates with the Health Care Authority (HCA), other state agencies, and housing and service providers. The Office of AHAH/PSH is responsible for implementing the following components of the program:

- Rental assistance vouchers
- Capital financing to build and acquire housing
- Capacity building and technical assistance for PSH providers

HCA is the agency responsible for Apple Health's administration, including the FCS Program. HCA holds the contract with the FCS coordinating entity.

Amerigroup, the FCS coordinating entity, is a managed care organization. Amerigroup manages the FCS provider network, determines participant eligibility, authorizes services, and provides administrative oversight for the program.

## ENDNOTES

[1] Engrossed Substitute House Bill 1866. “Apple Health and Homes: Supportive Housing and Community Support Services,” June 9, 2022. Available at https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session Laws/House/1866-S.SL.pdf?q=20230228162351

[2] “Social Determinants of Health - Healthy People 2030,” Office of Disease Prevention and Health Promotion, accessed April 27, 2023. Available at https://health.gov/healthypeople/priority-areas/social-determinants-health.

# Board Engagement Strategy: Permanent Supportive Housing

Most nonprofit organizations looking to develop Permanent Supportive Housing (PSH) services will need the approval of the Board. This is because implementing PSH likely represents a significant alteration in operations and, as a result, will require allocating additional resources (staffing, training, processes, and technology) to comply with contract requirements and meet performance expectations. Furthermore, alterations to governance policies, especially when a high-value contract is on the table, often require approval from the Board. If the bylaws require that the Board approve the contract, then steps must be taken to educate members regarding the opportunity. PSH positively impacts the community but is a massive evolution for some organizations, given that leaders may choose to include their Board in the process even if the bylaws do not require their approval.

A Board has a fiduciary obligation to minimize risk to the organization. This guide is intended to facilitate the organization's ability to present PSH to the Board so that a proper evaluation of the opportunity, its risks, and obligations can occur, thus enabling the Board to allocate the resources necessary to implement the required changes. Conversely, the absence of essential background details increases the likelihood that Board members (mindful of their fiduciary duty) may default to a more conservative perspective regarding risk.

This guide identifies the information organizations should provide to the Board as they evaluate the business case for the institution of a PSH program. The information is presented as a step-by-step guide that can be tweaked per the organization's needs. Also included is a proposed agenda, sample prompts to enable leadership to facilitate Board discussions, and a Board Score Card the Board members can use to evaluate PSH.

## Step One: Presenting Information to the Board or Basic Training

During Step One, leaders will assemble the basic information the Board will need to evaluate the case for PSH and whether to move forward with further planning and development into implementing the model. This "Basic Training" period should include, based on the bylaws and the vision of the organization's executive leadership, what the role of the Board is to be. While some Boards are very involved, engaged from soup to nuts in the operations of the organization they serve, others have a more limited capacity or are strictly responsible for fiduciary oversight. Therefore, before beginning to unpack for the Board the "what" of PSH, it is important to define the role of the Board in this evaluation and the oversight of the is to be and confirm that it is fully understood. That role is to make high-level strategic planning decisions, ensure that an organization's operations align with the organization's mission, vision, and values, and that resources are allocated effectively based on those strategic priorities.

Once the Board understands its role, explain PSH and the reasons behind the organization's interest. Provide simplified information that boils PSH down as much as possible while providing the most germane details. Basic Training should remain basic. The details will be broken down more fully in later stages. Be careful not to overshare and overwhelm Board members who may be naturally cautious when confronted with such a significant systemic change.

Carefully outline changes the organization must undergo, providing sufficient detail and offering solutions to the most evident hurdles where possible. For example, if staffing is challenging, ensure this issue is acknowledged when staffing changes are discussed. The Board will want to know that organizational leaders have carefully analyzed the pluses and the deltas and are considering remedies for all possible roadblocks. Don't minimize the issues but make sure possible solutions are presented to the Board.

Speak to staffing and the need for renovation, acquisition, and partnerships. Basic Training should include the possible models of PSH under consideration if, for example, the organization wishes to explore a scattered site model, be sure to explain to the Board why this option is the more appealing one; show that leaders considered each allowable element before choosing and presenting that choice to the Board.

**STEP ONE RECAP:**

I. Define the Board's role, authority, and responsibilities. Present a positive statement of the Board's role and how that role relates to organizational leadership.

II. Define the opportunity for the Board.

III. Articulate why the organization is considering this opportunity and how it fits within its strategic plan, mission, vision, and business plan.

IV. Identify the operational impact of the proposed change (What does this change for the organization? What is the cost of implementation?)

V. Be mindful of the need for investments or changes to staffing, building renovation/ acquisition, and referral workflows.

## Step Two: Determining the cost/benefit of the PSH opportunity.

With the Board's approval, the organization is moving forward with an in-depth analysis of how PSH will impact the business. In this step, organizational leaders will put in place a process for making recommendations so that the Board can make an informed decision regarding whether it is in the organization's best interest to move forward with PSH. This will require due diligence investigatory work with oversight. Appoint an Advisory Committee that plans how PSH will be incorporated or developed. The Advisory Committee should include Board members, an executive leader whose participation lends credence to the work, managerial or line-level staff with relevant expertise, persons with lived experience (sometimes called peers, these are individuals who have used these services or have family/friends who needed them), and community leaders with the knowledge or who will need to approve of the project for one reason or another.

Once the Advisory Committee is in place, the first task should be the develop a work plan that outlines how the group will achieve the activities. The group may wish to create a Gannt chart that illustrates the workflow while showing the timeline or schedule the work is on. They may also want to use a RAID document to identify when a task is complete or at risk quickly. RAID stands for Risks, Assumptions, Issues, and Dependencies and allows work groups to analyze the progress of their project in an organized way.

The tool shows who is responsible for a task, how long it may take, and if the work is at risk, and it logs the various elements or occurrences for each item so that readers can identify steps taken by reading the notes left. Keep the document in a central location but maintain tight version control to ensure the document's integrity. The process outlined in Contract Evaluation Process can be adapted to this stage. Alternatively, consider using the evaluation worksheet at the end of the Business Considerations portion of the toolkit.

The work plan, no matter the format the group decides on, should define objectives and activities and provide a clear reporting structure. Whether there is one group or multiple work groups, each assigned a different portion of the work, make sure that the deliverables and the dates by which they are due are clear.

Assign an administrative role to one person and allow that person to assist the team in keeping track of the work due and providing generalized assistance. Define the deliverables ahead of time and ensure the group understands their task and the required format so that it is understandable and expected when it's reported back to the group.

Define compliance requirements, performance standards, and other reporting requirements or metrics. Perform a simple gap analysis that allows for a side-by-side comparison of the organization's current state versus the state under PSH, what is currently evaluated and monitored, and what must change. Break the team into subgroups as needed: compliance, contracting, finance, human capital, environmental services & facilities, and cultural competence.

If work groups exist, for instance, a Contract Review Work Group or Compliance Work Group, as suggested in other tools in this kit, leverage the existing resource. As subgroups form, consider the need for additional expertise; legal professionals, current PSH owners, or regulatory experts may be desirable additions to subgroups, or subgroups may wish to conduct key informant interviews with individuals who can best inform the project without inviting more in-depth participation.

As the groups work through each piece of the analysis, ensure regular progress reports are made to the Board. Reports do not need to be in-depth but should be comprehensive and illustrate the group's awareness of progress and roadblocks.

Consolidate the work into the simplest terms, pulling out the key points that must be analyzed and discussed. A SWOT (strengths, weaknesses, opportunities, threats) analysis needs to be conducted now that the information-gathering period is over.

**STEP TWO RECAP:**

I. Develop an Advisory Committee
II. Develop a work plan; guide the work with a RAID document or workflow chart.
III. Break the work down into subgroups by subject matter
IV. Prepare reports for the Board to keep them abreast of the work
V. Consolidate the information into a simple SWOT breakdown.

### *Pro Tip #1*

**Operational Evaluation**

1. Conduct an Operational Cross Walk based on current policies and procedures. This work will help inform who needs to be involved in the evaluation. As the crosswalk is assembled, it will become clear what departments or individuals need to provide information.
2. Make sure leaders have a firm handle on the current state to perform a gap analysis. Knowing what will need to change and what remains the same is important, given the financial implications. Make sure the organization has in place what's needed, knows where a quick pivot will be required, and has clarity around the missing pieces.
3. Pay special attention to staffing capacity and needs. Does the organization have the right staff? Is there staffing available, or has it been challenging to hire? Does HR or an external staffing agency need to be involved at this evaluation stage?

### *Pro Tip #2*

**Financial Evaluation**

1. Immediately pull in the organization's financial guru and contact a professional if the organization lacks an expert. If the organization is at sea with this, consider contacting the regional U.S. Small Business Administration's offices for advice. Alternately. The Washington Small Business Development Center offers a Directory of Business Resources, which may be helpful.
2. Be transparent about financial barriers, risks, and assumptions. The Board is aware of where the organization stands fiscally, ensuring that transparency continues through the discovery process.
3. Have a section of the financial work group outlining a mitigation plan that addresses the steps to be taken in the unlikely event that PSH does not work out for the business.

*Pro Tip #3*

**Hang onto the Advisory Committee**

1. The people who led the charge in analyzing the opportunity will be some of the most committed to the project's success. Their excitement will allow the necessary momentum to build behind the PSH project and help maintain it in the future.
2. Those who participated in this work know best what the pitfalls will be and can help alleviate the pain or assist the organization in avoiding it through their connections in the community and using that same energy that got the organization through the assessment process.
3. Those who weren't Board members as the analysis rolled out may want a deeper connection with the origination now that they've been through some of the fire and helped the organization grow to its full potential, these kinds of allies are difficult to come by, and their connection to the organization deserves nurturing.

## Step Three: Evaluation by the Board

The time has come for leadership to tee up the presentation of information. In this step, the Board will consider the proposition of PSH more in-depth, carefully assessing each aspect examined by the Advisory Committee. Perhaps some Board members participated in the analysis, but not all, maybe all of them participated, but no one yet has the whole picture; possibly every Board member was a part of the work, but now everyone needs a recap and a formal process is necessary to get the work on track fully.

As the Board has read the reports from the group, the information formally reported should come as no surprise. Make sure that any in-depth information that cannot be broken down is provided ahead of the scheduled presentation as a pre-read so that Board members can take the time to familiarize themselves with the information in advance and are poised to ask clarifying questions.

As the information is presented, part of the work will include information to the Board on cultural competence related to PSH and the population served. While some industries and workplaces are doing what is needed to assist their staff and the surrounding communities in learning cultural competence, it should not be assumed that any Board member fully knows. It is the organization's responsibility to provide detailed information and instruction to the Board so that they can develop the necessary skills and obtain the required information related to diversity, equity, and inclusion and how it relates to the PSH model.

As the initial presentation to the Board ends, set up subsequent meetings to perform the formal analysis of the prospect. Now that the Board is fully informed, it is time for them to sit with the information and absorb it. Do not rush the process; allow for information to settle in so that logical follow-up questions can be asked and rational decisions can be made. When the Board meets next, through a special meeting or retreat or during the next scheduled Board meeting, bring the process to a close.

Request that an initial set of Board Score Cards be filled out ***in advance*** based on reports given to the Board throughout the discovery process and pre-reads offered. This will allow executive leaders to note and address issues that have arisen for Board members, adding these items to the agenda to be discussed. The purpose of this meeting will be to determine if PSH is a good fit. As a result, everyone involved in the process must be transparent, allowing for informed analysis and response. Leaders should have internally analyzed the materials in the same manner as the Board.

A second set of Board Score Cards should be issued at the beginning of the meeting, allowing members to reevaluate their thoughts as they learn more or point out additional barriers. A responsible party should collect, organize, and report the contents of the scorecards allowing leaders to assess the contents.

If conclusions differ, leadership should be prepared to explain why the organization will be overriding the Board's thoughts if allowable or determine if it's possible to reconsider if further work is done to evaluate the opportunity.

### STEP THREE RECAP:

I. Develop a presentation for the Board informed by the Advisory Committee's work.
II. Develop pre-reads for information that cannot be broken simply so the Board is very prepared.
III. Provide information specific to Cultural Competence as it may fall outside the general business knowledge of members.
IV. Allow for pre and post-assessment using the Board Score Card.
V. Dependent on the outcome, determine if further investigation is needed. If so, develop a plan to address outstanding questions and concerns.

**Toolkit Resource Note:** For the RAID document is presented in a spreadsheet, which is available here through this file download. For instructions on how to use the RAID document, please watch the video tutorial that can be found here.

## ENDNOTES

[1] A contract evaluation *Work Plan Template* is available in the Contract Evaluation tool

[2] A *Compliance Requirements Template* is located in the Contract Compliance tool

[3] U.S. Small Business Administration. "SBA District Offices," Accessed May 25, 2023. Available At: https://www.sba.gov/about-sba/sba-locations/sba-district-offices.

[4] Business WA. "Business Resources," Accessed May 25, 2023. Available At: https://www.business.wa.gov/site/alias__business/972/business-resources.aspx.

[5] Mental Health First Aid. "Mental Health First Aid USA - Mental Health First Aid," Accessed May 25, 2023. Available At: https://www.mentalhealthfirstaid.org/.

# SWOT ANALYSIS
## INTERNAL FACTORS

| Strengths | Importance | Weakness | Importance |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

# SWOT ANALYSIS
## EXTERNAL FACTORS

| Opportunities | Importance | Threats | Importance |
|---|---|---|---|
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# BOARD SCORE CARD

Including Foundational Community Supports – Permanent Supportive Housing (PSH) in our services reflects a change in operations. To nimbly comply with alterations to contractual requirements and performance expectations, the organization must evaluate operational readiness and the ability to pivot to align adjustments with current policies and procedures. Additionally, an assessment of the opportunity is needed to determine the financial and social impact on the organization and the community it serves.

As a board member, you are asked to evaluate this opportunity's "fit" or alignment with the organization's mission, strategic direction, and current operations. To assist in this evaluation, the following scorecard was created.

## HOW TO USE THIS SCORE CARD

While this is a "scorecard," no minimum "score" needs to be reached for an organization to pursue contracting as an FCS provider. Instead, the purpose of this scorecard is to help Board members to organize their evaluation and to facilitate discussion. This means it helps identify gaps, including where additional information or research is needed.

The questions on this scorecard cover three areas relevant to this evaluation: organizational fit, organizational capacity, and the cost of providing FCS services as a Medicaid provider.

A component of each category includes whether the scorer feels that they have sufficient information to provide an informed assessment. This is also an opportunity for the scorer to identify what additional information (if any) is needed.

The scorecard presents a series of 13 statements across these three categories. Users should select a response, 1 – 5 to reflect the degree to which the respondent agrees with the statement, with:

- "1" reflecting "strongly agree,"
- "2" for "agree,"
- "3" for "neither agree nor disagree,"
- "4" for "disagree," and
- "5" for "strongly disagree."

For any scoring of an element above "3," the respondent should identify the factors behind this conclusion in the Notes section of the Chart. A higher score reflects a higher risk of contracting as an FCS provider.

| | Element | 1 | 2 | 3 | 4 | 5 | NOTES |
|---|---|---|---|---|---|---|---|
| | Evaluating Organizational "Fit" and Alignment | | | | | | |
| 1 | I have sufficient information to evaluate whether contracting as an FCS provider aligns with the organization, mission, strategic direction, and business model. | | | | | | |
| 2 | FCS aligns with the organization's mission | | | | | | |
| 3 | FCS aligns with the organization's current growth strategy | | | | | | |
| 4 | FCS aligns with the organization's business model | | | | | | |
| | Evaluating Organizational Capacity | | | | | | |
| 5 | I have sufficient information to evaluate whether the organization has the capacity to adapt to the delivery of FCS services to fulfill its contractual obligations | | | | | | |
| 6 | The organization currently has the capacity to encompass FCS into the business model | | | | | | |
| 7 | The organization is well-positioned to recruit staffing to support the FCS model | | | | | | |
| 8 | The organization has or can acquire the necessary financial resources to support the FCS model | | | | | | |
| 9 | The FCS model will help the organization meet long-term capacity goals | | | | | | |
| | Evaluating Contract Costs and Resources Needed | | | | | | |
| 10 | The organization has collected sufficient information to estimate the likely costs of implementing FCS services and contracting as an FCS provider. | | | | | | |
| 11 | The pro forma budget presented to the Board accurately projected the cost of the addition of FCS services. | | | | | | |
| 12 | The organization's assessment of the pro forma includes an estimate of foreseeable administrative costs associated with becoming an FCS provider. | | | | | | |

# BOARD SCORE CARD

## FREE RESPONSE AND NOTES

**USE THE FOLLOWING SPACE TO IDENTIFY ANY OTHER QUESTIONS OR CONCERNS NOT OTHERWISE ADDRESSED.** *Examples may include questions about the process the organization is using to evaluate the opportunities; identifying additional sources of information to address questions; or concerns, questions, or recommendations about the Board's continuing involvement in and oversight of the evaluation.*

# SITUATION, BACKGROUND, ASSESSMENT & RECOMMENDATION (SBAR)

| **GENERAL PROJECT INFORMATION** | |
|---|---|
| Project Name: | |
| Project Lead: | |
| Advisory Council Members: | |
| Executive Sponsor: | |
| Date Prepared: | |

***Purpose of this document:*** *Use this document to identify the goal of the proposed project, identify barriers and propose solutions. Explain the benefits and costs of the project. Update the document periodically through the discovery process, archiving older versions. The primary purpose of this document is to build a case for change while identifying the resources necessary to execute the change and the process that will need to be in place for implementation.*

| **SITUATION / EXECUTIVE SUMMARY:** *Describe what is the issue/need that will be addressed in this document? (1 or 2 sentences)* |
|---|
| |

| **BACKGROUND PROBLEM / NEED / OPPORTUNITY STATEMENT:** *Describe the current state of the organization as it relates to the issue at hand. Break the problem into bullet points, separating them into action and impact. Include any current state data both qualitative and quantitative.* |
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| |

| **PROPOSED GOAL:** *Describe the goal and include information regarding the financial impact, the tenant experience, staff experience and needs, regulatory and contractual requirements, and other areas impacted.* |
|---|
| |

| **POTENTIAL OBSTACLES:** *What are the most likely barriers we will encounter in addressing this problem / need / opportunity? Examples would be Financial, Competing Priorities, and Resources.* |
|---|
| |

# SITUATION, BACKGROUND, ASSESSMENT & RECOMMENDATION (SBAR)

**ASSESSMENT:** *Identify the proposed goals and include the benefits and risks for each option. Use information that can be measured in actual dollar return, tenant value, colleague value, or business growth.*

| **OPTION 1** (PREFERRED)**:** | |
|---|---|
| PRO: | CON: |
| **OPTION 2:** | |
| PRO: | CON: |
| **OPTION 3:** | |
| PRO: | CON: |

| **RECOMMENDATION:** *After careful assessment the following is the best path forward.* |
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| |

# PSH ADVISORY COUNCIL

| SUBGROUP NAME<br>To be presented at Advisory Council meetings to inform each subgroup in a succinct manner | |
|---|---|
| **[A] Accomplishments:**<br>*Since the assessments* | **[D] To Dos:**<br>*Major activities/milestones planned* |
| **[B] Barriers/Risks:**<br>*Actual/potential barriers for awareness/action* | **[C] Countermeasures:**<br>*Actions for removing or preventing barriers* |

# Evaluating the Business Case for Permanent Supportive Housing Program

Before signing on the dotted line to become an FCS Provider, organizational leadership must evaluate critical business considerations to determine the organizational "fit" of Permanent Supportive Housing (PSH), both as it relates to current capacity and future growth and development. Contracting with Medicaid as an FCS provider requires a significant investment of resources, including time, capital, and adaptation of operational processes.

This transformation is most successful and sustainable where there are:

1. Alignment with an organization's core mission and advances the organization's vision for its continuing growth and impact;
2. Clarity as to program requirements and how those requirements impact current operations;
3. A feasible, actionable plan to identify and address operational gaps in the short term to meet program requirements, and
4. Alignment with the organization's strategic and business plans for sustained financial growth and operational development.

## Consideration #1:

### *Do PSH services align with your Organization's Mission and Vision?*

First, some definitions:

- An organization's mission is its purpose and is articulated through its mission statement, which succinctly describes the organization's goals (its "why") and how the organization will meet those goals (e.g., what it is the organization does and how it does it).
- An organization's vision refers to the desired future impact that the organization will have on society. It is aspirational and transformative.
- In brief, an organization's mission reflects its current operations and impact, and the vision is what it is working towards – including its broader impact across society.

When evaluating a new contracting opportunity, jumping directly to the financial and operational impact side of the equation can be tempting. But before moving into the nuts and bolts, it is essential to pause and confirm "organizational fit" and alignment with broader organizational purpose, values, and strategy. Change takes time and resources and is easiest (and most likely to "stick") when the change reinforces the organization's "why." An organization and its team members are more likely to have the motivation and self-efficacy to initiate and sustain change if it is a necessary or natural component of its shared mission and vision.

**Questions to Ask:**

- *The organization's mission is to serve vulnerable populations, including individuals and families experiencing homelessness, inadequate housing, or barriers to housing stability.*
- *The target populations either experience, are at significant risk of or are directly impacted by homelessness or housing instability, such that the vision (the desired future impact on the community) cannot be realized without addressing this common need.*

## Consideration #2:

### *Do PSH Program Requirements align with the organization's operations, expertise, and capacity?*

Briefly, does the organization have the knowledge, infrastructure, and staff to:

1. **Evaluate** the cost and operational requirements of new or expanded services
2. **Reliably assess** the impact that new or adapted services will have on existing operations and workflows;
3. **Implement** a plan to mitigate operational disruption associated with implementation; and
4. **Effectively deliver** (and bill for) new or expanded services.

This is important for two reasons. First, an organization's prior experience (including staff experience in Medicaid contracting and healthcare billing) means that an organization is better able to anticipate the operational requirements *and impacts* associated with Medicaid contracting. Secondly, the most straightforward implementations build upon an existing infrastructure in the immediate term. The proposed changes are "edits" or "adaptions" to existing operations, as opposed to those that require reversals or complete pivots.

This is *not* to say that an organization shouldn't pursue PSH contracting if there isn't a close match between current capacity and program requirements ***or*** that they must already be providing PSH services. There will *always* be gaps in operations and the need for further capacity development. The organization must have a realistic perception of program requirements, how it will impact existing processes and resources, and an actionable plan to address deficits and grow over time. If this is a new area for the organization, it will take then more time to evaluate and learn "what they don't know." Seek direct input from other organizations contracted as FCS providers, and lean on team members with experience in Medicaid contracting and managed care.

**Be aware of all the implementation costs.**

If an organization already provides similar services, be aware of "hidden" operational costs implicit with contracting with the state and other healthcare payers. Generally, there is no such thing as "free money" to "do what you are already doing." Being a Medicaid provider carries additional operational and administrative costs that must be accounted for. Even when there is a (near) perfect overlay regarding the scope and delivery of services, there is always an implementation cost. Billing and the Accounts Receivable process are frequent points of friction for organizations. Still, an organization's compliance operations are likely to require greater focus and investment. An organization may need to plan for (and finance) more regular audits and implement greater policies and controls to ensure adherence to program integrity, privacy and security (i.e., HIPAA), and other contractual requirements.

### Questions to Ask:

- *Do PSH services require the addition of new service lines by the organization? If so, which ones and how will they be delivered?*
- *Do PSH services require the modification of existing service lines? If so, how so?*
- *How do PSH contract requirements impact current workflows? (e.g., How do program requirements impact received referrals? Document referrals? Deliver Services?)*
- *How do PSH contract requirements impact the workforce? Do PSH program requirements (e.g., professional qualifications) alter which staff members can deliver services? Do team members need additional IT, documentation, or administrative skills?*
- *Will a PSH contract significantly alter the volume of referrals received? If so, how will the organization adapt to that change in volume?*
- *How will the expansion or modification of PSH services impact other services delivered by the organization? How will the organization anticipate and mitigate the impact?*

## Consideration #3:

### *Do the Numbers Work? Does Contracting as an FCS Provider offer greater Financial Stability or opportunities for Financial Growth?*

While evaluating the opportunity for organizational "fit" and impact on operations, organizations can't neglect the numbers. As introduced in Consideration #2, an organization must have a realistic perception of the costs associated with contracting as a Medicaid provider. They need to immediately confirm an adequate "rate of return" and that the investment in delivering services furthers its strategic plan and business objectives.

This means that the compensation for delivering services (considering the rate of reimbursement **and** projected volume of referrals) provides an adequate rate of return to ensure sustainable growth and reinvestment for the organization over time. Finally, the investment required to deliver new services and adapt to Medicaid requirements is offset by the opportunities presented for additional revenue sources (additional grants, other contract opportunities), operational efficiencies, or where the investment aligns with the organization's strategic plan for sustainable growth.

### Questions to Ask:

- *What is the total cost of delivering and billing for PSH services as a Medicaid Provider in the next year?*
- *Can the organization deliver services within the existing budget and resources? If so, double-check by identifying all reasonably foreseeable contingencies and interdependencies.*
  - *e.g., What assumptions are part of this calculus (i.e., minimum referral volume or cadence, staff time to deliver services, the number of cases that 1 FTE can handle)?*
  - *What are the potentially "hidden" costs associated with providing and billing for FCS services (e.g., compliance updates or expansions, IT needs, auditing expenses, additional administrative costs related to billing and invoicing?).*
- *Becoming an FCS provider or entering the healthcare ecosystem creates new contracting opportunities or makes the organization a more competitive candidate for existing opportunities.*
  - *e.g., Are there opportunities to contract with other health providers or payers to provide services to non-Medicaid populations? Does the investment associated with FCS contracting make the organization more competitive for additional grants in your industry?*
- *Can the organization develop partnerships or vendor relationships to deliver services more efficiently or effectively?*
- *What additional financial investments (i.e., people, platforms, partnerships, and processes) will be needed to ensure that FCS services are delivered efficiently and effectively?*

## Consideration #4:

### *Is there a commitment across the organization to Continue to evolve and develop the capacity to deliver and Improve PSH Services?*

It is about more than what the organization can do today; they must also plan for the future. Medicaid contracting and contracting compliance is not a "one and done" thing, and FCS service contracting, specifically through Medicaid, is an innovative and evolving program. These programs will continue to change, and providers will need to be able to keep up. This will require continued investment and capacity development over time.

Therefore, PSH contracting and compliance requirements must align with the organization's long-term plans for organizational investment and capacity development. The organization must have the motivation and the resources to *continue* to grow with and around the program and contract requirements.

**Questions to Ask:**

- *What are the skills, training, and qualifications will the workforce need in the future to continue to evaluate and improve the efficiency and effectiveness of services?*
- *What technologies and resources will the organization need to invest in over time?*
- *How will the organization engage with and educate the governing board to identify and plan for future growth and investment?*

## Recommendations

Having identified the key considerations, the next question is how to get answers.

This sort of undertaking must start with leadership. Still, an organization must obtain input from stakeholders to have a comprehensive (and accurate) evaluation of current capacity, operational impact, gaps, and the feasibility of long-term integration and sustainability. That includes the front-line internal operations "subject matter experts" who will be responsible for the implementation of the new requirements **and** the organization's board members or governance committee, who are responsible for ensuring alignment with the organizational mission, strategy, and adequacy of funding to support (short and long term) capacity development.

This means that there are two competing interests: (1) the efficiency and nimbleness of the evaluation and (2) its accuracy and inclusivity. Both are important. Leadership should consider approaching evaluation in a staged process to accommodate both objectives. Once leadership has conducted its own initial evaluation, convening a team of staff members tasked with formally evaluating the opportunity, identifying where investment and adaptations will be needed, and the desirability and feasibility of those adaptions. While the core team responsible for the evaluation should be "tight," – those team members should engage with other staff members to collect information to inform that evaluation.

For this evaluation, the team should use a structured evaluation process to provide organization and ensure completeness. As a first step, the team should brainstorm and refine the operational, strategic, and cultural questions most pertinent to the implementation. A shortened sample worksheet is provided based on the first three (operationally oriented) considerations discussed in this section to illustrate how this can be formatted. The worksheet should be expanded to address other critical considerations identified in the evaluation process.

Upon the completion of this evaluation (resulting in a "go-no-go" recommendation, leadership and the evaluation team can then turn to (1) investigating more granular operational changes and investments, (2) clarifying assumptions, and (3) preparing to integrate the governing board in their own evaluation. Table 1 provides a walk through snapshot of how one organization might present and answer these questions.

## TABLE 1

| Consideration 1 | Response | Identified Gaps | Sources[1] | Notes |
|---|---|---|---|---|
| **Do PSH services align with mission and vision?** | | | | |
| Our target population is at high risk for or experiences homelessness, inadequate housing, or barriers to housing stability. | Yes. Strongly Agree. | n/a | Mission statement | Consider impact/ intersection with Goal 5 in our 2023 Strategic Plan. |
| **Consideration 2** | **Response** | **Identified Gaps** | **Sources** | **Notes** |
| **Do PSH services align with existing operations, expertise, and capacity?** | | | | |
| Will PSH services require the addition of new service lines by your organization? If so, which? | No. Nonprofit X already provides placement and case management support to individuals at the shelter. | While no new service lines are required, significant adaptations to current processes will be needed including greater documentation and adapting to referrals from outside the shelter. | Shelter Case Workers, Service Line Descriptions, Organization's Operational Manual | Will require investment in more CM staff, training, and process development. Input from board needed to allocate budget / plan for capacity development. |
| **Consideration 3** | **Response** | **Identified Gaps** | **Sources** | **Notes** |
| **Does contracting provide greater financial stability and opportunities for growth?** | | | | |
| Can we deliver services within the existing budget and resources? | Maybe. We can profitably deliver services at reimbursed rate to existing clients. More information/ eval needed to determine referral volumes and timeline for additional staff | Additional staff will be needed to develop and manage billing operations. This is a new area for organization. Likely need for expanded clinical CM staff based on additional time required for documentation... | KIIs with Finance Manager, Social Services Director, FCS Reimbursement Rates | Need more information on referrals outside of the shelter. Question for HCA/Amerigroup. |
| **Consideration 4** | **Response** | **Identified Gaps** | **Sources** | **Notes** |
| **Is there a commitment across the organization to continue to evolve and develop the capacity to deliver and Improve PSH Services?** | | | | |
| What skills, training, and qualifications will the workforce need in the future to enhance service evaluation and improve efficiency? | Ensure team is enabled by enhancing data analysis, technological capabilities, continuous learning... | Limited time frame, lack of specificity, absence of metrics or evaluation criteria... | n/a | Need to consider availability and... |

[1] Sources is a way of "showing your work" to demonstrate the process the team used

| Consideration 1 | Response | Identified Gaps | Sources | Notes |
|---|---|---|---|---|
| **Do PSH services align with mission and vision?** | | | | |
| Our target population is at high risk for or experiences homelessness, inadequate housing, or barriers to housing stability. | | | | |
| Our target populations either experience, are at significant risk of or are directly impacted by homelessness or housing instability, such that the vision (the desired future impact on the community) cannot be realized without addressing this common need. | | | | |
| **Consideration 2** | **Response** | **Identified Gaps** | **Sources** | **Notes** |
| **Do PSH services align with existing operations, expertise, and capacity?** | | | | |
| Do PSH services require the addition of new service lines by the organization? If so, which ones and how will they be delivered? | | | | |
| Do PSH services require the modification of existing service lines? If so, how so? | | | | |
| How do PSH contract requirements impact current workflows? | | | | |
| How do PSH contract requirements impact the workforce? Do PSH program requirements alter which staff members can deliver services? Do team members need additional IT, documentation, or administrative skills? | | | | |

| Consideration 2 | Response | Identified Gaps | Sources | Notes |
|---|---|---|---|---|
| **Do PSH services align with existing operations, expertise, and capacity?** | | | | |
| Will a PSH contract significantly alter the volume of referrals received? If so, how will the organization adapt to that change in volume? | | | | |
| How will the expansion or modification of PSH services impact other services delivered by the organization? How will the organization anticipate and mitigate the impact? | | | | |

| Consideration 3 | Response | Identified Gaps | Sources | Notes |
|---|---|---|---|---|
| **Does contracting provide greater financial stability and opportunities for growth?** | | | | |
| What is the total cost of delivering and billing for PSH services as a Medicaid Provider in the next year? | | | | |
| Can the organization deliver services within the existing budget and resources? If so, double-check by identifying all reasonably foreseeable contingencies and interdependencies. | | | | |
| Becoming an FCS provider or entering the healthcare ecosystem creates new contracting opportunities or makes the organization a more competitive candidate for existing opportunities. | | | | |
| Can the organization develop partnerships or vendor relationships to deliver services more efficiently or effectively? | | | | |

| Consideration 3 | Response | Identified Gaps | Sources | Notes |
|---|---|---|---|---|
| **Does contracting provide greater financial stability and opportunities for growth?** | | | | |
| What additional financial investments (i.e., people, platforms, partnerships, and processes) will be needed to ensure that FCS services are delivered efficiently and effectively? | | | | |

| Consideration 4 | Response | Identified Gaps | Sources | Notes |
|---|---|---|---|---|
| **Is there a commitment across the organization to continue to evolve and develop the capacity to deliver and Improve PSH Services?** | | | | |
| What are the skills, training, and qualifications will the workforce need in the future to continue to evaluate and improve the efficiency and effectiveness of services? | | | | |
| What technologies and resources will the organization need to invest in over time? | | | | |
| How will the organization engage with and educate the governing board to identify and plan for future growth and investment? | | | | |

## Capital Financing Options and Considerations

Nonprofit housing providers and community organizations seeking capital dollars to expand permanent supportive housing (PSH) may apply for funding through the Housing Trust Fund. In fiscal year 2022, the Washington State legislature appropriated $60 million to cover the construction and acquisition costs of housing to support Apple Health and Homes (AHAH) initiatives that will shelter some of the state's most vulnerable residents.

Capital projects are being processed by the WA Department of Commerce's Multifamily Housing Unit (MHU) in tandem with the AHAH-PSH Office. Applications are, in general, processed once per year and are dependent on annual appropriations by the Legislature; on page 11, an example of the appropriations and solicitations timelines[1], gives an idea of the cadence of funding availability, the source of the funding, funding limits, and estimated release dates for Requests for Proposals (RFP).

In addition to capital financing available through AHAH, supplementary, diversified capital funding may be needed to support capital costs associated with developing PSH. Multiple funding sources are available through government entities, private financial institutions, and philanthropic avenues.

It is a common practice in large-scale social service projects to braid or blend multiple sources of funding to ensure that the various costs of the start-up for the project are covered, the services offered can be perpetuated, and, in the case of a housing project, the quality of the housing stock can be maintained.

Additionally, funder priorities may shift during the course of a project, which may lessen the pool of funds available to support a PSH project. Ensuring multiple streams of funding to support the project provides some safeguards.

## Sources of Capital Financing & Searching for Funding Opportunities

### *Federal Funding*

The Grants.gov data bank is a primary source to identify federal funding that may be appropriate for a PSH program. Grants.gov is also a valuable source of information on acquiring and managing federal funding. For instance, the Grants 101 portion of the site offers training on The Grant Lifecycle,[2] Grant Eligibility[3], and finding Grant Programs.[4] An essential reference to review is the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards[5] – or Uniform Guidance – issued by the Office of Management and Budget (OMB), which oversees federal agency oversight budgets, among other things.

The Uniform Guidance outlines cost reporting guidelines for federal awardees and outlines requirements around cost principles and audit requirements. As budgets are built for a federal grant application, applicants must reference both the Notice of Funding Opportunity (NOFO) for restrictions or requirements specific to the opportunity response and the Uniform Guidance for general allowability of costs as prescribed by the federal government.

New users should use the navigation bar to the *Learn Grants*[6] page and peruse the Grants.gov Community Blog[7] to familiarize themselves with the terms the government uses to discuss grants (FOA, Subaward, Subrecipient, Unique Entity Identifier (UEI), Block Grant, Federal Award).

Those with more experience may proceed directly to the *Search Grants*[8] function. Using this point, begin searching grants using either a keyword, opportunity number (issued by the granting agency), or CFDA (catalog of federal and domestic assistance) number. Agencies of the federal government (e.g., the U.S. Department of Housing and Urban Development (HUD)) list their forecasted, posted (open), closed, and archived grant opportunities on Grants.gov. From the search page, narrow the search using the following criteria:

- Opportunity Status (forecasted, posted, etc.),
- Funding Instrument Type (Grant, Procurement Contract, etc.),
- Eligibility (city or township governments, nonprofits having a 501(c)3 status with the IRS, small businesses, etc.),
- Category (health, housing, etc.),
- Agency (All Agencies, All Department of Housing and Urban Development, etc.).

To do business with the federal government, applicants must register with the System for Award Management (SAM)[9] and acquire a Unique Entity ID. During registration with SAM and creating accounts in other agency sites, the question of creating a Login.gov account may arise. Login.gov is a “secure sign-in service used by the public to sign in to participating government agencies.” Applicants can access information about creating an account by visiting the “create an account” page.[10] While applying for a grant or loan, post-award government staff will be assigned to support and assist in ensuring applicants keep funding on track.

Table 1 provides a small snapshot of some funding that could support the capital needs related to PSH. Capital funding acquired through federal grants for social service projects is rare. However, some funding methods backed by the federal government through the Department of Treasury provide loan products at competitive rates, which may require less cash upfront. In most cases, the most direct path to determining eligibility is to contact the local or regional office responsible in the immediate geographic area. Each opportunity has its own set of requirements.

Applicants may consider joining listservs to receive updates from agencies/entities who have traditionally funded similar projects to remain abreast of application openings, deadlines, and any changes to the program parameters. Oftentimes, agencies have archived accessible webinars to learn about their programs.

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## TABLE 1: PSH FUNDING SUPPORT

| Funding | Description | Resources | What Now? |
|---|---|---|---|
| **HUD Community Development Block Grant (CDBG)** | CDBG allocates funding based on a formula to help build stronger communities by addressing needs identified by the community itself. Where the funding is allocated – for instance, to the state or local government – depends on the type of CDBG funding. Applications are then solicited through that entity, and funding is passed through to entities, such as a PSH, to support activities that address identified needs in the community.<br><br>States and Entitlement Cities[11] have contacts that can help determine eligibility, how to get onto listservs that will provide information when funding becomes available, and how to apply. | Hud Awards & Allocations[12]<br><br>WA Commerce: Community Development Block Grants[13] | Utilize How to Use CDBG for Housing Activities[14], which takes a deeper dive into how CDBG funding might be right for a project.<br><br>For more questions, applicants should contact their state CDBG office[11] to discuss details or receive copies of past projects that may better help applicants understand how this funding stream could work for them. |
| **HUD Continuum of Care (CoC) Program** | The purpose of the CoC is to support the community's commitment to ending homelessness by funding efforts to rehouse unhoused individuals and families while minimizing the risks to those experiencing homelessness and assisting them to achieve self-sufficiency and access needed health services.<br><br>Searching through the CoC Eligible Activities[15], among the activities are acquisition, rehabilitation, new construction, etc. | Continuum of Care (CoC) Program[16] | To better understand how HUD funding and other resources the department provides may be of assistance, visit the regional HUD office's website.[17]<br><br>Opportunities for funding through the CoC program will be listed on the Grants.gov website, but perusing through the CoC virtual binder[18] to check on eligibility and requirements will help determine if this funding stream can help support a project's needs. |
| **HUD Section 811** | Section 811 is funding that supports the development of rental housing that includes access to supportive services for very low- and extremely low-income adults with disabilities. | Section 811[19] | Additional information on Washington's program can be found on the section of the Department of Commerce's website[20] devoted to the program. |

## TABLE 1: PSH FUNDING SUPPORT (CONTINUED)

| Funding | Description | Resources | What Now? |
|---|---|---|---|
| **USDA Farm Labor Housing Direct Loans and Grants** | This program provides competitive financing for affordable multifamily rental housing for low-income, elderly, or disabled individuals and families in eligible rural areas. Utilize the USDA rural eligibility map.[21] | Multifamily Housing Direct Loans [22] | Applicants should check the eligibility map to see if their property qualifies. If so, check "To Apply"[23] to determine if the application process is open. The Western Region office can be contacted with any questions about eligibility or the application process at: MFHFODWest@usda.gov |
| **Community Development Financial Institutions (CDFI)** | CDFI are "mission-driven financial institutions certified by the U.S. Department of Treasury's CDFI Fund. CDFIs include credit unions, loan funds, and venture capital funds that operate primarily to serve low-income communities."<br>A list of certified CDFI,[24] along with the awards database, shows where CDFI funds have been allocated in the State of Washington and elsewhere in the country. | CDFI Fund Home[25]<br>OR<br>CDFI Fund New Markets Tax Credit Program[26] | Pertinent to the development of PSH is the Capital Magnet Fund[27] which issues applications for competitive grants to nonprofit affordable housing organizations to address the community's housing needs.[28]<br>CDFI financial institutions receive the funding and turn it into opportunities for local housing providers to access loans to finance projects, or it's distributed directly to qualified nonprofit organizations. |

### *Foundation Funding*

Foundation funds are grants made to organizations or individuals by private foundations for giving. The grantor sets restrictions on foundation funding, and so the requirements vary from funder to funder. Some foundations require, for example, a great degree of reporting on metrics throughout the life of the project, while others may be more focused on final outcomes. Some foundations may allow capital and indirect expenses, while others target only projects. There are multiple ways to find foundation funding opportunities.

The Foundation Center, now Candid's Foundation Directory, is an extensive repository of foundation grant opportunities. It is a paid service, but some libraries have accounts that the public may access. For instance, NCW Library (Chelan, Douglas, Ferry, Grant, and Okanogan) can access Foundation Directory Online and assist with funding searches (info@ncrl.org).

Other popular services include GrantWatch[29] and the Grantsmanship Center.[30] Additionally, applicants may wish to use the Community Foundation Locator[31] to explore options through their local foundation. Compared to government grant applications, the application process set forth by most foundations is less taxing and post-award monitoring requirements are less comprehensive in nature. Foundations are also often geographically driven as well as driven by subject matter.

For instance, foundations in the State of Washington may restrict applicants to those physically located in the state. They may further restrict applicants to those serving a specific demographic needing a specific service. For example, a foundation may only grant funds to nonprofit organizations in Okanogan County serving at-risk youth in need of new lunchboxes; if the applicant's entity is not doing this exact thing, applying to the foundation for funding is fruitless.

Along these same lines, it is often in the applicant's best interest to contact foundation staff before applying to get to know them and what they're about and give them a chance to get to learn about the applicant's organizational needs and purposes. During this conversation, both parties can determine if the fit is good.

## Social Impact Bonds (SIB)/Pay for Success (PFS) Models

In recent years social impact investing has become more prominent. The mechanics of the funding are essentially the same in that an organization presents a project to a funder or group of funders who weigh the merits of the proposal, the possible positive and negative outcomes of the project, and their return on investment. However, the model is designed to be performance-based on a community impact viewpoint rather than strictly a financial viewpoint. Innovative interventions that propose cost-savings and address a pressing social issue (homelessness, for example) are suggested to an impact investor. Rigorous performance targets are developed to measure success, and the project commences over, usually, an extended period.

This model transfers the onus of the risk from the public to the private sector. Cost savings may be used to return the funds to the investor. Additionally, these efforts may include a fixed maximum payout for the investor allowing any additional cost savings to perpetuate the project and impact additional communities. Philanthropy Northwest[32] provides support concerning impact investing.

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## Managing Braided or Blended Funding Streams

Combining diverse funding streams is called braiding (many sources) or blending (many funding options from a single source) funding. As a provider of PSH, there are multiple funding streams to organize, including rent from tenants, rental assistance, which covers the remainder not paid by the tenant, grants, loans, and other funding supports.

Each funding stream may present a unique set of requirements regarding expenditure and tracking; some funds may be collected monthly, some may be collected post-expenditure from an external source, and some may be front-loaded and drawn down internally. Keeping track of the requirements for each funding stream is imperative.

**Understand proper use and institute internal controls.**

- As applicants seek funding, ensure there is clarity about the proper uses of each fund and ensure there are internal controls in place that allow the differentiation of streams.
- Ensure senior leadership and finance teams know the desired funding and the unique requirements specific to each option.
- Analyze the flexibility and longevity of each type of funding and whether it aligns with the organization's mission and goals. Look at each funding stream's restrictions and assess if requirements can be met.
- Remember that most federal dollars cannot supplant funding but can supplement it.

**Engage the financial team and systems.**

- Ensure an accounting system is in place to track individual funding sources and consider if internal staffing and infrastructure are in place to manage funding successfully.
- Make adjustments before applying for funding to increase readiness to manage and revise policies or procedures to properly manage diverse funding options.
- Work with leadership and finance teams to budget for project needs, identify the various sources, and develop a mechanism to track the budget versus actuals.

**Create organizational accountability.**

- Before acquiring funding, ensure teams know their responsibilities for monitoring and what activities fall to them that impact budget and finance.
- Train staff and provide opportunities for continuous review to ensure new developments are communicated effectively and to avoid adverse impacts on project(s).

### *Funding Checklist*

- ☐ Search for grants applicable to the project
  - ○ Federal funding
  - ○ State funding
  - ○ Foundation funding
  - ○ Loan funding
  - ○ Pay for Success of Social Impact Bond Funding
- ☐ Review the grant requirements and determine if institutional needs can be met
  - ○ The goals of the funder align with the organization's goals
  - ○ The organization suits the funder's requirements
- ☐ Determine if sufficient time remains to develop an application
  - ○ Develop a stash of generic narrative and budget templates to be nimble in developing responses
- ☐ Assemble a work group to perform an in-depth dive into the funding opportunity
  - ○ Include project managers and finance staff
  - ○ Review grant objectives, budget parameters, and project evaluation requirements
- ☐ Create a loose framework for the project proposal
  - ○ What is being achieved (the goals)?
  - ○ How is it going to happen (the objectives)?
  - ○ What does the timeline look like?
  - ○ Is staffing required?
  - ○ How much will it cost?
  - ○ Is there a cost-matching requirement?
  - ○ What is the final result expected?
- ☐ Present project proposal to senior leaders, including finance and board of directors
- ☐ Approve or reject proposal submission

*If approved, applicants may begin to design their application using the materials issued by the funder.*

- [ ] Assign a project lead
- [ ] Note dates for submission of questions to the funder
- [ ] For online grant submissions, applicants should determine if a web login sign up is required to submit a proposal
- [ ] Develop a timeline for when each piece of the grant is due
- [ ] Note any external needs (letters of support, certifications, documentation) and assemble them immediately
- [ ] Engage staff more globally to ensure project buy-in post-award
- [ ] Outline the pieces of the grant narrative and assign them to a work group to begin narrative assembly
- [ ] Work with finance and budget teams to ensure internal controls and external requirements are met
- [ ] Select a date to review the entire proposal as a team before finalizing
- [ ] Develop a post-award marketing plan to thank the funder

# 2021-23 Biennial Appropriations - Housing Finance Unit

| Amount | Name | Source Section | Use Section | Estimated Release Date | Funds Expiration Deadline |
|---|---|---|---|---|---|
| **$23,000,000 Total:**<br>• $18M for competitive noncongregate shelters<br>• $5M | **HOME-ARP (American Rescue Plan)** | WA Operating Budget - State appropriation of federal funds (ARP) (ESSB 5092, Section 129 §90) | Assuming HOME requirements | **Spring 2023** | December 2024 (Obligated by HUD) |
| **$6,322,281 (2021)**<br>**$7,076,367 (2022)** | **HOME** | HUD Allocation | HOME Investment Partnerships | **Winter 2021**<br>**Summer 2022** | Subject to HOME requirements |
| **$29,097,000 Total:**<br>• $22,532,000 Competitive<br>• $6,565,000 Direct Appropriations | **Rapid Capital Housing – FEDERAL** | WA Capital Budget - State appropriation of federal funds (SSB 5651, Sect. 1021) - Corona Virus Capital Projects Account | Rapid Capital Housing Acquisition - direct appropriations, competitive | **Fall 2021** | December 2024 |
| **$90,138,000 Total:**<br>• $71,300,000 Competitive<br>• $18,838,000 Direct Appropriations | **Rapid Capital Housing – STATE** | WA Capital Budget (SSB 5651, Sect. 1021) - State Building Construction Account (Grants) | Rapid Capital Housing Acquisition - direct appropriations, competitive | **Summer 2021** | June 30, 2023; Re-appropriable |
| **$300,000,000**<br>• $207,628,000 Competitive<br>• $2,172,000 Direct Appropriations<br>• $20,000,000 Rural Set Aside<br>• $10,000,000 Funding Gaps<br>• $60,000,000 Rapid PSH (Apple Health & Homes)<br>• $200,000 Real Estate Broker | **Rapid Capital Housing – STATE** | WA Capital Budget (SSB 5651, Sect. 1024) – Capital Community Assistance Account<br>Apple Health & Homes Account | Rapid Capital Housing Acquisition - direct appropriations, competitive, rural set aside, funding gaps<br><br>Rapid Capital Permanent Supportive Housing - direct appropriations, competitive<br><br>Real estate broker to identify opportunities for rapid acquisition or conversion | **Fall 2022** | June 30, 2023; Re-appropriable |
| **$10,000,000** | **Washington Housing Trust Account - Intellectual & Developmental Disabilities** | WA Operating Budget (ESSB 5092, Sec. 129 §128) | Housing for people with intellectual & developmental disabilities | **Summer 2021**<br>**Summer 2022** | June 30, 2023; NOT Re-appropriable |
| **$5,000,000** | **Developmental Disabilities Set Aside in WA Capital Budget** | WA Capital Budget (SSB 5651, Section 1020) | Housing for people with developmental disabilities | **Summer 2021**<br>**Summer 2022** | June 30, 2023; Re-Appropriable |
| **$20,000,000** | **Housing Trust Fund Portfolio Preservation** | WA Capital Budget (SSB 5651, Section 1020) | Rehabilitation of HTF portfolio properties | **Fall 2021** | June 30, 2023; Re-Appropriable |
| **$10,000,000 Total:**<br>• $8,775,000 Competitive<br>• $1,225,000 Direct Appropriation | **Community Housing & Cottage Communities** | WA Capital Budget (SSB 5651, Section 1020) | Construction of minimum of 4 separate housing units for people who are homeless at entry | **Summer 2021**<br>**Summer 2022** | June 30, 2023; Re-Appropriable |
| **$243,000,000 Total:**<br>• $191,478,000 Competitive<br>• $26,422,000 Direct Appropriations<br>• $100,000 DSHS I/DD Housing Study<br>• $25,000,000 Homeownership Set Aside | **Traditional Housing Trust Fund** | WA Capital Budget (SSB 5651, Section 1020) | Traditional Housing Trust Fund program – direct appropriations, competitive<br><br>Housing study of people with intellectual & developmental disabilities | **Summer 2021**<br>**Summer 2022** | June 30, 2023; Re-Appropriable |
| **$10,000,000** | **Continuing Affordability** | WA Capital Budget (SHB 1080, Sec. 1072) | Preservation of non-HTF portfolio multifamily housing at risk of losing affordability due to expiring use restrictions | **Summer 2021**<br>**Summer 2022** | June 30, 2023; Re-Appropriable |
| **$15,685,029 (2021)**<br>**$16,889,505 (2022)** | **National Housing Trust Fund (NHTF)** | HUD Allocation | National Housing Trust Fund | **Winter 2021**<br>**Summer 2022** | Subject to Federal HTF Requirements |

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# Beyond Capital Financing: Permanent Supportive Housing Funds Fact Sheet

Permanent Supportive Housing is a feature of Washington State's Medicaid Transformation Project, which provides those in need of housing support and services with avenues to independence and, in some cases, a return to a life in the community that may have heretofore seemed impossible to them. Consumers who use these services come from varied backgrounds and live with various health issues that impede their ability to access or maintain more traditional living or working arrangements. Those accessing PSH are persons enrolled in Apple Health who are a minimum of 18 years old and live with mental health, substance use disorder (SUD), restrictions on activities of daily living (ADL), complex physical needs which restrict successful independent living, or a combination of these factors.

PSH providers are needed in a multitude of locales—urban, rural, and elsewhere—and often require financial support to provide shelter and services. Financial tools are available through several avenues and support capital needs, operating costs, and the provision of services depending on the funder and funding opportunity.

This fact sheet differentiates between operating costs and service costs, breaks down possible avenues of funding to support operating costs for PSH, reviews key aspects of managing braided and blended funding sources, and discusses the important impact that diversity, equity, and inclusion have on funding PSH.

## Understanding PSH Operating Costs

Some providers of PSH, whether individuals, agencies, or other entities, may rely mainly on the collection of rent to cover the cost of operating their housing model. Rent for PSH tenants may be subsidized by the government, requiring eligible tenants to pay, usually, about thirty percent of the rental costs from their income. Payments may be handled by the tenant, by a community support program through a Community-Based Organization (CBO), or by a tenant's behavioral health provider rather than directly by the tenant. Some PSH is subsidized by unit rather than by tenant.

Forecasting operating costs ahead of developing a PSH project is vital. Operating costs for PSH include such things as: (1) **Utilities** including needs like water, electricity, sewer; (2) **Maintenance** which might include things like painting, repairing flooring, walls or ceilings, janitorial services, window and door repair, stairs and sidewalks, or other outdoor spaces; (3) **Property management** help with setting the rental prices and then collecting the rent, filling vacant units, screening maintenance requests, building annual budgets for the property that adequately cover costs, and intersecting with the community to maintain positive relationships and stay on top of legislative and regulatory changes that impact the site; (4) **Staffing** depends on the model of PSH offered and includes the property manager but may also include administrative staff, social service staff, a program manager, and facilities maintenance staff depending on the size of the site; (5) **Insurance** and **legal services** may also be included in operating costs as would **taxes** that may be due on the property dependent on municipal or other requirements and whether the provider of PSH holds not-for-profit status which may or may not be extended to the property as prescribed by pertinent governing code.

In many ways, the operating costs for PSH are not so different from those landlords outside the PSH model deal with or even private homeowners may face. However, be mindful that regulatory requirements[1] may impact how the property must be maintained.

Service costs related to PSH fall into the case management bucket and include life skills training, budgeting, treatment assistance, and assistance accessing and maintaining benefits such as food stamps, health care, or other needed entitlements. Additionally, case management services might include crisis management, assistance with vocational or educational services, eviction prevention services, and learning how to work with property managers and the PSH to plan how best to meet treatment and service needs.

Services in tandem with housing are meant to support consumers to live as independently as they can and will vary from tenant to tenant. Medicaid covers PSH service costs for individuals eligible for Apple Health. The following section provides information about potential funding sources owners may access to offset PSH operating costs not covered under Medicaid.

## Potential Funding Sources to Subsidize PSH Operating Costs

### STATE OF WASHINGTON FUNDS

Apple Health and Homes (AHAH) is a multi-agency initiative that pairs healthcare services with housing resources. Washington AHAH's PSH Office focuses specifically on PSH programs. It offers two programs which provide assistance with operations and maintenance costs[2] these are the Permanent Supportive Housing Operating, Maintenance, and Services Program (PSH-OMS) and the Operations & Maintenance Program (OM).

PSH-OMS, administered by the Department of Commerce, currently supports roughly 160 distinct PSH sites throughout Washington. The purpose of the PSH-OMS is to support multifamily housing projects, which include units specifically reserved for PSH. Appropriated for the first time in 2018, this funding is meant to provide "gap" operating and maintenance funding to address gaps in operating revenue in housing operations providing PSH[3] units. The Washington State Department of Commerce currently appropriates roughly $47 million annually to support this program to reimburse PSH project owners for operating and maintenance costs as well as an array of supportive services required by unit residents.

Since 2002 OM has assisted projects that house consumers unable to generate sufficient income to pay rent. Funds are meant to cover the costs of such things as maintenance and utilities. Eligible organizations are local governments, local housing authorities, nonprofit organizations, federally recognized tribes, and regional support networks[4]. An example of an eligible reimbursement expense would be the repair of a leaky roof; replacement of that same roof would represent a capital expense, and would, therefore, not be eligible, however, making repairs on the roof would be considered maintenance. The parameters around each Notice of Funding Availability (NOFA) may differ, though, and it is best to carefully read the announcement and pose questions during the cited *Question & Answer* timeframe. Funding for this program is generated through the *Affordable Housing for All Surcharge*, which is charged at the county level when legal documents are recorded. The way funds are acquired results in variability of availability, and interested parties should check with OM staff ahead of making any application; this is a best practice, in any case, when making an application for funding through the Housing Trust Fund (HTF) as most funding streams are subject to change and connecting with staff ahead of assembling an application makes good sense.

The Washington State Housing Trust Fund Handbook[5] can help PSH providers understand the criteria for funding. Funding for these programs is offered competitively through the *Housing Trust Fund Multifamily/Rental* funding schedule.

Washington Commerce offers resources and training[6] as well as annual workshop trainings that help new and current PSH project holders to understand PSH and acquire information on funding coming down the pipeline[7] to support projects. Commerce also provides Property Management Resources[8] that may give prospective PSH projects an idea of the types of things that landlords consider as they develop and manage PSH projects.

## CAPITALIZED OPERATING RESERVE

PSH projects may choose, as allowable, to use funds set aside during the capital development phase of the project to later support the costs of operating the housing. This funding allows the PSH owner to fund utilities, management, staff salaries, and maintenance while the project is budding and rent is not fully covering operating costs. PSH owners may choose to manage such funds as a revolving fund that creates a margin that is used and replenished to ensure during tenant-light periods, the continuity of operations is maintained.

## HOUSING CHOICE VOUCHER

The Housing Choice Voucher (HCV) – sometimes still referred to as Section 8—can be project-based as well as tenant-based. Tenant-based vouchers follow the individual voucher holder from unit to unit. In contrast, project-based vouchers (PBV) subsidize the unit itself and are generally acquired through the local Public Housing Authority (PHA) through a competitive process that results in a contract with the PHA to provide the units. These funds intend to help pay for rent and may be used to support operating costs. Owners agree to maintain a specific, agreed-upon number of units for eligible persons. This program is separate from but a subset of the HCV program; as a result, all HCV regulatory requirements[9] also apply to PBV holders.

## CROSS SUBSIDIZATION

Cross Subsidization is when properties offer both extremely low-income units alongside market-rate units which persons with higher incomes can afford. In this model, the higher rents from some units help cover the costs of renting other units at a lower cost. This model supports equity in a way that is positive for the community and is most feasible in areas that already have a strong market for rentals and homes.

## PROJECT GRANTS

Projects grants are offered through government granting agencies as well as private foundations. An example of a project grant through the federal government would be the Cooperative Agreements to Benefit Homeless Individuals (CABHI)[10] grant through the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant allows nonprofit organizations to apply to provide services in tandem with permanent supportive housing to address the needs of persons living with serious emotional disturbance, serious and persistent mental illness, substance use disorder, or both. While funding must address accessibility to services and treatment for these health conditions, the grant includes outreach and engagement, as well as assistance with identifying sustainable permanent housing. This allowance leaves space for partnerships with PSH projects to support operations, for instance, a portion of the PSH provider's marketing budget or tenant referral costs.

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## Managing Braided or Blended Funding

Most providers of PSH will not fund their projects through a single funding stream. Combining diverse funding streams is called braiding (many sources) or blending (many funding options from a single source) funding. As a provider of PSH, there are multiple funding streams to organize, including rent from tenants, rental assistance, which covers the remainder not paid by the tenant, grants, loans, and other funding supports. Each funding stream may present a unique set of requirements regarding expenditure and tracking; some funds may be collected monthly, some may be collected post-expenditure from an external source, and some may be front-loaded and drawn down internally.

**Keeping track of the requirements for each funding stream is imperative. The following steps may help ensure the maintenance of compliance with multiple funding streams:**

**Understand proper use and institute internal controls.**

- As applicants seek funding, ensure there is clarity about the proper uses of each fund and ensure there are internal controls in place that allow the differentiation of streams.
- Ensure senior leadership and finance teams know the desired funding and the unique requirements specific to each option.
- Analyze the flexibility and longevity of each type of funding and whether it aligns with the organization's mission and goals. Look at each funding stream's restrictions and assess if requirements can be met.
- Remember that most federal dollars cannot supplant funding but can supplement it.

**Understand proper use and institute internal controls.**

- Ensure an accounting system is in place to track individual funding sources and consider if internal staffing and infrastructure are in place to manage funding successfully.
- Make adjustments before applying for funding to increase readiness to manage and revise policies or procedures to properly manage diverse funding options.
- Work with leadership and finance teams to budget for project needs, identify the various sources, and develop a mechanism to track the budget versus actuals.

**Create organizational accountability.**

- Before acquiring funding, ensure teams know their responsibilities for monitoring and what activities fall to them that impact budget and finance.
- Train staff and provide opportunities for continuous review to ensure new developments are communicated effectively and to avoid adverse impacts on project(s).

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## Health Insurance Portability and Accountability Act (HIPAA) and PSH

The Health Information Portability and Accountability Act (HIPAA) is a federal law that (among other things) establishes national standards to protect sensitive patient information from being disclosed without the patient's knowledge or consent. As a Medicaid provider and a business associate of Amerigroup, the third-party administrator of the Foundational Community Supports program, Permanent Supportive Housing (PSH) providers are subject to HIPAA privacy and security standards and regulations.

HIPAA can be complicated, and its enforcement is rigorous and closely scrutinized. This is because personally identifiable health information is private, valuable, and sensitive. While many PSH providers have experience managing sensitive, confidential information, becoming a Business Associate to a Covered Entity means complying with expansive and evolving standards regarding how protected health information is generated, stored, and exchanged. This can represent a sharp learning curve.

### HIPAA 101

HIPAA regulates how Protected Health Information (PHI) can be **used** and **disclosed** by **Covered Entities** and their **Business Associates**. It creates (and enforces) a national baseline privacy right and right of access for patients. Under HIPAA, Covered Entities and Business Associates have a duty of stewardship for PHI under their control. This means that in addition to restricting what can be done with PHI, **there is a positive duty to secure and protect PHI**.

Let's break that down with some definitions.

**HIPAA is composed of four (4) primary components:**

1. The Privacy Rule;
2. The Security Rule;
3. The Breach Notification Rule;
4. The Enforcement Rule.

The Department of Health and Human Services Office for Civil Rights (OCR) enforces HIPAA.

#### *Who Does HIPAA Apply To?*

HIPAA applies to Covered Entities (health insurers, health providers, and healthcare clearinghouses) and their Business Associates. Business Associates are persons or entities that contract with a covered entity to perform activities that involve the use or disclosure of PHI.

For a Covered Entity to properly share PHI with a Business Associate, there must be a Business Associate Agreement (BAA). This written agreement ensures that the Business Associate is held to the same standards of data stewardship as the covered entity, including the duty to notify the Covered Entity of any violations and data breaches.

### What This Means For PSH Providers:

When contracting to become a PSH Provider, organizations will attest that they either are a Covered Entity (and are those qualified to receive PHI under the Treatment, Payment, and Operations HIPAA exception) or that the organization will enter into a valid BAA before the exchange of any PHI. Therefore, PSH providers that are not healthcare providers will need to review and execute a BAA as part of the contracting process. These BAAs mean that, by contract, PSH Providers will be held to the same standards as the Covered Entity (Amerigroup) regarding the protection, use, and disclosure of PHI.

PSH Providers must review the BAA closely to ensure they can implement and comply with all terms. This includes implementing processes to monitor, detect, and respond to potential violations and data security breaches.

***What is "Protected Health Information"?***

**Protected Health Information (PHI)** is any information about health status, healthcare delivery, or payment that is (1) created or collected by a Covered Entity or Business Associate that (2) can be linked back to a specific individual. This includes any part of a patient's medical record and payment history.

Put Simply: **PHI = (medical or health information) + (a personal identifier)**

OCR has published guidance identifying 18 types of personal data or identifiers[1] constituting PHI. Many of these are intuitive (e.g., names, identification numbers, biometric data), but it also includes IP address numbers and geographical identifiers smaller than the state level (some exceptions).

PHI applies any personally identifiable protected health information – regardless of the format of that data. This means that PHI can be written, recorded, or electronic. Electronic PHI is known as ePHI.

### What This Means For PSH Providers:

PSH Providers need to be aware that just because THEY are not providing direct health services doesn't mean that the data they receive and generate isn't PHI. To be eligible for PSH services under Apple Health (Medicaid), an individual must have at least (1) one qualified health need; and (2) one defined risk factor.

The qualification for referral to PSH services is based on an individual's health and health needs assessment and constitutes PHI. This applies not only to information that PSH Providers receive from Covered Entities but to the information that PSH Providers generate themselves.

## THE PRIVACY RULE (45 CFR § 160 and §164 Subparts A and E)

The Privacy Rule represents the core of HIPAA, and all other rules relate to the Privacy Rule in some way. The rule:

1. Requires appropriate controls or safeguards to protect the privacy of PHI. This includes limits on the conditions under which PHI may be used or disclosed.
2. Gives individuals rights over their PHI. This includes the right to examine and collect a timely copy of their health records, to direct the sharing ("transmittal") of their PHI to others, and to request corrections to the record.

In general, a Covered Entity or Business Associate can only **use** or **disclose**[2] PHI if either: (1) the Privacy Rule specifically permits or requires it; or (2) the individual who is the subject of the information gives authorization for its use or disclosure in writing.

### *The Minimum Necessary Requirement*

The Privacy Rule permits the use and disclosure of PHI where necessary for treatment, payment, and healthcare operations. This is commonly known as the "TPO Exception." These are broadly construed and are considered routine disclosures. However, even when a Covered Entity or Business Associate is operating in the TPO exception, it is still responsible for making reasonable efforts only to access and use the minimum amount of PHI necessary to meet its goal (i.e., appropriate use).

This is known as the Minimum Necessary Requirement or "Minimum Use." It means that Covered Entities and Business Associates must make reasonable efforts to ensure that access to PHI is restricted to a particular purpose, use, disclosure, or request.

This Minimum Necessary Requirement plays out at both a practice or systemic level and on an individual level. This means that the Covered Entity or Business Associate is responsible for setting up default settings that restrict access to PHI to appropriate (minimum) use.

**Examples of what this looks like in practice:**

- A healthcare provider restricts which staff members have access to Electronic Health Records so that only those individuals who need to access PHI to perform their jobs have routine or direct access to records.
- A nurse providing care management services only has access to the medical records of those patients assigned to them.
- When sending a referral or sharing information with another provider on a patient, a healthcare provider only includes the personal identifiers and health information relevant to the interaction or purpose, redacting or not including multiple identifiers or extraneous health information.

**Examples of what this looks for a PSH provider:**

- Access to electronic documents and folders (including referral intake, case records and documentation, and billing) is segregated so that only staff with a legitimate and routine need based on job responsibilities can access individual folders containing this information.
- When sending information to other agencies and organizations related to a PSH client, a case worker limits the information provided to only include what is necessary and relevant to the communication. For example, in a communication with a landlord, the caseworker does not attach the entire case file or include multiple identifiers.

## THE SECURITY RULE (45 CFR § 160 and §164 Subparts A and C)

Under the Privacy Rule, Covered Entities and Business Associates must safeguard and protect the confidentiality of all PHI. PHI applies any personally identifiable protected health information – regardless of the format of that data. This means that PHI can be written, recorded, or electronic. The Security Rule establishes *additional* standards and protections for **electronic PHI** (ePHI).

This includes the requirement to "implement policies and procedures to prevent, detect, contain, and correct security violations."[3] This is based on the recognition that the nature (and ubiquity) of electronic records present unique risks to the confidentiality, integrity, and security of those records.[4] The Security Rule creates a positive and iterative duty to identify, evaluate, and protect against the actions of third parties that present a cybersecurity risk to the confidentiality, integrity, and availability of patient information.

**Covered Entities and their Business Associates, therefore, must use appropriate administrative, physical, and technical safeguards to:**

1. Protect the confidentiality, accessibility, and integrity of all ePHI they create, maintain, receive, or transmit records;
2. Identify and protect against reasonably foreseeable threats to the security or integrality of ePHI in their stewardship;
3. Identify and protect against reasonably foreseeable uses or disclosures of ePHI, and
4. Institute controls to ensure compliance across their workforce.

**These duties apply to ePHI "at rest" (or stored by the organization) and all data exchanges.**

### What Are Administrative Safeguards?

Administrative Safeguards are the policies and procedures an organization uses to select, develop, implement, and maintain the security measures deemed necessary to protect ePHI and manage the conduct of the organization's workforce as it relates to ePHI.

*All Covered Entities and Business Associates must perform a **periodic risk analysis** to:*

1. Identify potential risks to ePHI, including network vulnerabilities and threats,
2. Evaluate the likelihood and impact of those risks;
3. Identify and implement security controls to address the risks identified; and
4. Institute a process to continue to measure the adequacy and effectiveness of those security protections.

*Other administrative safeguards or controls include:*

- Policies and processes outlining the security management process and assigning accountability and responsibility for security controls;
- Workforce training on cybersecurity threats and data management;
- Business Continuity and contingency plans;
- Sanction or Disciplinary policies.

### What are Physical Safeguards?

Physical safeguards refer to the steps taken to protect the physical security of the locations where ePHI may be stored, maintained, or accessed by a covered entity or business associate. Covered Entities and Business Associates must secure and control access to the facilities, workstations, and devices used to store, exchange, or access ePHI. Some examples of physical safeguards include:

- Alarm systems;
- Locking areas where ePHI is stored (server rooms, workstation areas);
- Maintaining a visitor log and identification and escort policy; and
- Placement of workstations to avoid accidental disclosures;

### What are Technical Safeguards?

Technical safeguards include all the technical measures used to secure ePHI. Technical safeguards must consist of the following:

1. ***Access Controls:*** These are the technical policies and procedures to ensure that only authorized persons have access to ePHI. Examples include passwords, firewalls, encryption, penetration testing, etc.
2. ***Audit Controls:*** The mechanisms by which an organization can record and evaluate access to information systems containing ePHI.
3. ***Integrity Controls:*** The mechanisms by which an organization can monitor, detect, and prevent the unauthorized alteration or destruction of ePHI.
4. ***Transmission Controls:*** The measures by which an organization protects again unauthorized access (i.e., interception, misdirection, or malfeasance) of ePHI that is transferred electronically.

## THE BREACH NOTIFICATION RULE (45 CFR §§ 164.400-414)

The Privacy Rule and the Security Rule outline the responsibilities Covered Entities, and their Business Associates have as it relates to protecting against impermissible use or disclosure of PHI. The Breach Notification Rule governs what happens when there is an impermissible use or disclosure of PHI that compromises the security or privacy of the information. Under this rule, Covered Entities and Business Associates have a duty to (1) promptly notify individuals affected by the Breach ("individual notice") and (2) notify the Secretary of HHS of all Breaches. In certain instances (when a breach impacts 500 or more individuals), prompt notice must be made to the Secretary of HHS **and** the media.

But let's start by defining what constitutes a Breach.

> A breach occurs when there is unauthorized use or disclosure of PHI, and that unauthorized use results in an actual impact on the privacy or security of that information.
>
> **BREACH = (impermissible use or disclosure of PHI) + (actual impact on privacy or security)**

It can be tough to assess impact immediately, so any unauthorized use or disclosure of unsecured PHI is presumed to be a breach unless the Covered Entity or Business Associate can demonstrate a low probability that the PHI's security or confidentiality has been compromised. To do this, the Covered Entity or Business Associate must complete a risk assessment that evaluates:

1. The nature and extent of the PHI involved (i.e., what types of identifiers are involved, the likelihood of re-identification, and the sensitivity of the information involved);
2. The identity of the unauthorized user or the individual to whom the PHI was disclosures, including the likelihood or risk of redisclosure;
3. Whether the PHI was actually received or viewed; and
4. The extent to which the risk has or can be mitigated.

## THE ENFORCEMENT RULE (45 CFR §§ 160, Subparts C, D, and E)

The Enforcement Rule details the authority of OCR in investigating HIPAA violations and the availability of Civil Monetary Penalties and criminal penalties for intentional non-compliance with HIPAA.

Civil Monetary Penalties are intended to act as a deterrent, so the fines levied can be very significant, particularly as they are assessed individually (i.e., each PHI impacted constitutes an individual basis).

Penalties are assessed based on a four-tiered system based on the degree of perceived culpability (as determined by OCR), which ranges from where a violation occurred despite reasonable efforts to instances of neglect that go uncorrected for over 30 days. There is an annual limit (approximately $1.9 million) for any violation (but note that there are frequently multiple types of violations in any investigation).

Covered entities and individuals may be subject to criminal penalties, including imprisonment for intentional non-compliance with HIPAA protections.

## ENDNOTES

[1] "Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule," U.S. Department of Health and Human Services. October 25, 2022. Available at https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html

[2] "Use" refers to the access, exchange, or utilization of PHI within an organization. "Disclosure" is the release, transfer or sharing access to PHI to anyone outside that organization.

[3] 45 C.F.R. § 164.308(a)(1).

[4] The Security Rule is built around protecting the confidentiality, integrity, and availability of ePHI. Confidentiality here means that ePHI is restricted to appropriate uses and disclosures, consistent with the Privacy Rule. Integrity means that the ePHI is not altered or destroyed in an unauthorized manner. Finally, "availability" means that the ePHI is accessible and usable "on demand" by an authorized person for an appropriate purpose..

# Conducting a Compliance Readiness Assessment

Contracting as a Medicaid provider brings with it a significant increase in regulatory contract compliance requirements and scrutiny. This requires that a contracting organization have a coherent and robust compliance program able to:

1. **Identify** areas of risk;
2. **Prevent** non-compliance through the use of internal controls including the education and training of workforce members;
3. **Detect and Investigate** non-compliance;
4. **Report** (as indicated) **and Correct** non-compliance; and
5. **Monitor and improve** performance over time.

Many community-based organizations and nonprofits providing Permanent Supportive Housing (PSH) and other services operate with limited resources and low overhead. Smaller organizations often have not had to invest in or stand up the kind of formalized compliance operations that are required for Medicaid contracting.

### *How to Use this Toolkit*

The purpose of this toolkit is to provide practical guidance for how an organization can evaluate the effectiveness and adequacy of its compliance operations as it adapts to becoming a Medicaid provider.

**This process involves four steps:**

1. Identify the objectives and requirements of operations (what are the programmatic and regulatory requirements of operations? What are the areas of risk for the organization?)
2. Ensure that there are written policies and procedures touching on each area of compliance. These policies and procedures describe how the organization implements these programmatic and regulatory requirements in practice, so they must be "comprehensive" and inclusive of the full scope of risk of the organization.
3. Evaluate the *effectiveness* of written policies and procedures **and** of the mechanisms to monitor and evaluate the performance of the compliance program.
4. Once gaps in the content of the organization's policies and procedure or the application of the compliance program are identified, identify the steps to close those gaps.

The first section of this toolkit (Step One) provides a simplified framework which organizations can use to identify and organize the various categories of contractual and regulatory compliance which must be met. It walks through common Medicaid provider requirements and provides a template which organizations can use to identify their own areas of risk to be managed.

Once an organization understands the scope of compliance requirements (and risk exposure), the next step is to validate that the organization has a formal system for ensuring that the operational compliance with those contractual, professional, and regulatory requirements. This is first demonstrated by written policies and procedures. This includes not only the policies and procedures governing specific programmatic requirements ( i.e., an organizational policy directing how Protected Health Information is used within an organization) but *also* the policies and procedures governing compliance operations themselves.

In other words, the mechanisms by which the organization ensures that substantive policies and procedures are adhered to and that violations are detected and responded to effectively. That includes things like (1) identification of a compliance officer; (2) description of ways that team members can report incidents; (3) how incidents are investigated, responded to, and corrected; and (4) how team members are trained on policies and procedures, on areas of risk and expectations of performance.

Finally, in any readiness evaluation there are two key questions. The first is general how effectively an organization can identify risk, prevent or deter violations, detect and address incidents, and continuously improve. The "Seven Essential Elements of an Effective Compliance Program" discussed in the second section of this tool kit (Step Two) outline how to evaluate compliance operations *as a whole* and the adequacy of the organizational infrastructure. The second question is if an organization's policies and procedures sufficient to cover the scope of all operations *specific to* individual regulatory and contract requirements and areas of risk. This means that, for example, a healthcare provider (or FCS provider who has executed a Business Associate Agreement with a covered entity) has a written policy and procedure for every element of HIPAA requirements as it foreseeably intersects with that organization's operations.

This analysis is specific to the content of an organizations policies and procedures based on its regulatory risk exposure and contract requirements. The devil is always in the details. For this reason, the Toolkit concludes with a high-level walk through of the regulatory requirements in one area regulatory compliance (HIPAA) as an example of how an organization can break down compliance requirements to ensure that policies and procedures are sufficient both "on paper" and in practice.

## Step One: Identifying (and Understanding) Standard Compliance Requirements

The first step in evaluating the adequacy of an organization's compliance operations is to define the objectives of the compliance program. Broadly speaking compliance operations exist in order to ensure that an organization adheres to all regulatory and contract requirements, professional standards and ethical obligations and to identify and manage organizational risk. One of the biggest challenges when evaluating an organization's "readiness" to contract as a Medicaid provider is identifying and understanding the "universe" of contract and regulatory requirements and industry standards that apply.

**The breadth of regulatory and contract compliance requirements in healthcare contracting (generally) and Medicaid contracting (specifically) can feel overwhelming, however, these requirements can *generally* be thought of as falling into the six broad categories:**

1. Record Keeping and Documentation,
2. Fraud, Waste, and Abuse Prevention, Detection, and Reporting,
3. Privacy and Security,
4. Quality Assurance and Reporting,
5. Professional and Ethical Standards, and
6. Federal and State Regulatory Compliance.

Table 1 below describes each of these categories and provides an example of where such a requirement can be found in the FCS Participating Provider Agreement (2023). Please note that Table 1 is intended only to illustrate how compliance requirements are knitted throughout the Agreement. As such, it provides only one or two examples in each category **and is not a complete or comprehensive catalog of contract or regulatory compliance requirements.**

**TABLE 1.** ILLUSTRATIVE EXAMPLES OF CATEGORIES OF COMPLIANCE REQUIREMENTS

| Category | Description | Example(s) |
| --- | --- | --- |
| **Record Keeping and Documentation** | Providers are required to maintain accurate and updated documentation to support the delivery of and billing for their services. Statutory regulations and contract terms require a minimum period of document retention. Records are subject to audit by the Third-Party Administrator, the State, and CMS representatives. | Section 6.18 (Right to Review Records/Availability of Records); Section 7.1 (Records) |
| **Fraud and Abuse Prevention, Detection, and Reporting (i.e., Program Integrity)** | Providers are directly subject to state and federal regulations including the False Claims Act and CMS's compliance program. Providers also have a positive duty to implement controls to prevent, detect, report and correct instances of suspected fraud, waste and abuse of program resources. Finally, by contract Provider agrees to be subject to an cooperate with Amerigroup's anti-fraud compliance program and related policies and procedures. | Section 3.12 (Reporting Fraud and Abuse), Section 3.13 (Conformance with Law) |
| **Privacy and Security (including HIPAA)** | As a contracted Medicaid Provider an FCS provider is subject to HIPAA as a business associate of Amerigroup. This includes a duty to protect the confidentiality, integrity, and accessibility of protected health information (PHI). This requires the development of written policies, procedures and other controls to ensure adherence to HIPAA, including (but not limited to) appropriate use, required accounting and documentation of HIPAA operations and PHI disposition. | Section 5.1 (Business Associate Agreement); Section 3.10(b) (Proprietary Information, Confidentiality); Section 7.1 (Records). |
| **Quality Assurance and Reporting** | Providers are responsible for exchanging data in order to coordinate and manage care; to adhere to regulatory, professional and programmatic quality standards in the delivery and reporting of care (this includes timeliness and appropriateness of services). Provider must have an internal quality assurance mechanism to monitor and report on the quality of services delivered. Provider shall be subject to and cooperate with Amerigroup's Quality Assurance program and its policies and procedures. Material violation of Amerigroup's quality assurance standard is a basis for immediate termination of the agreement by Amerigroup. Provider will submit a monthly report on all covered members and quarterly progress reports to demonstrate performance outcomes and quality improvement activities. | Section 3.7 (Compliance with Credentialing, Utilization Management, Quality Assurance, Grievance, Coordination of Benefits); Section 6.19 (Provider to Monitor Quality); Appendix A (Provider Qualifications, 2a Adherence to Quality Standards Supportive Housing); Appendix A (Provider Qualifications, 3 (Administration); Appendix A (Reports Monitory, Quality Standards and Deliverables. |
| **Professional Standards** | Providers are responsible for adhering to all professional standards including licensures, scope of work, and relevant standards of practice. | Section 3.2 (Licensure and Accreditation); Section 3.7 (Compliance with Credentialing, Utilization Management, Quality Assurance, Grievance, Coordination of Benefits) |
| **Compliance with State and Federal Laws** | This is always the biggest, broadest and generally most vaguely defined category in a Provider Agreement. Important areas of federal and state laws and regulations include (but are not limited to):<br>• Non-Discrimination, anti-Harassment requirements<br>• Compliance with the Americans with Disabilities Act<br>• Annual Financial Auditing and Reporting requirements (which may vary dependent upon revenue volume and source of funds)<br>• Prohibition against anti-competitive practices<br>• Prohibition against retaliation of whistleblowers<br>• Performance of services within the United States<br>• Availability of interpreter services for Medicaid members | Article VI (Compliance with Regulatory Requirements); Section 6.1 (Compliance with Regulatory Requirements); Section 6.4 (Non-Discrimination); Section 6.11 (Compliance with Federal Regulations) |

## APPLICATION

The first step, therefore, in evaluating an organization's compliance "readiness" is to identify what that organization has to comply with. The following template can be used by an organization's compliance officer to "brainstorm" the scope of compliance requirements and risk exposure by each of these categories. The Template (Table 2) is divided into two domains, the first (Existing Requirements) references those requirements that an organization had to comply with prior to becoming a Medicaid Provider.

The second domain (FCS Contract Requirements) is for the identification of those new requirements imposed by the new FCS contract. Begin by filling out those requirements that the organization must meet today (Existing Requirements). Then review the FCS Contract and add new or expanded requirements in the right-hand column. Creating this side-by-side will enable the organization to clearly see the extent of the changes required to become an FCS-compliant provider.

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**TABLE 2.** COMPLIANCE REQUIREMENTS TEMPLATE

| Category | Existing Requirements | FCS Contract Requirements |
|---|---|---|
| **Record Keeping and Documentation** | | |
| **Program Integrity** | | |
| **Privacy and Security (including HIPAA)** | | |
| **Quality Assurance and Reporting** | | |
| **Professional Standards** | | |
| **State and Federal Laws** | | |

## Step Two: The Seven Essential Elements of a Compliance Program

Once an organization has determined the scope of regulatory (and contract) risk exposure, the next step is to evaluate the adequacy of the organization's mechanisms to promote compliance and risk management.

There is no "one size fits all" when it comes to what constitutes a robust or adequate compliance program across the healthcare industry. Recognizing this, the Office of the Inspector General for the Department of Health and Human Services has identified what it describes as the "Seven Essential Elements of a Compliance Program." While the compliance controls and the systems to monitor, detect, and correct compliance violations vary based on operations, size, and risk profiles, every compliance program must have each of these components, which are illustrated in Table 3, below.

**Table 3.** Description of the Seven Essential Elements of a Compliance Program

| Element | Description |
|---|---|
| **Written Policies and Procedures** | Written policies and procedures exist that comprehensively outline the compliance program, workforce responsibilities, and the organization's commitment to compliance with relevant regulations and requirements. These policies clearly outline standard expectations, are regularly reviewed, updated and communicated to employees and reflect the full scope of operations. |
| **Designation of a Compliance Officer and Compliance Committee** | There is a designated officer within the organization with the authority and responsibility for the development and administration of the compliance program. Reporting pathways exist to enable adequate oversite by the governing board. |
| **Effective Training and Education** | Training education programs are implemented to educate workforce members of the compliance program, policies and procedures, and compliance responsibilities. |
| **Reporting** | There must be multiple effective lines of communication across the organization to enable reporting of compliance incidence to the compliance officer and compliance committee, including the ability to submit anonymous reports and a guarantee and protection against the threat of retaliation. |
| **Auditing and Monitoring** | An organization has and deploys systems and mechanisms to (1) assess the effectiveness of the compliance program and identify areas for improvement and (2) identify, deter and correct violations. This includes regular and periodic audits; risk assessments, and use of data analytics and surveillance or monitoring systems. |
| **Corrective Action** | There is a formal process governing the timely investigation and response to compliance issues, including corrective actions to address violation or areas of identified risk. |
| **Enforcement and Disciplinary Standards** | An organization enforces compliance with its policies and procedures through disciplinary standards or sanctions in the event of non-compliance. |

## APPLICATION

With that background in the "essential elements" of a compliance program, the next step is to apply them to the organization. This can be divided into (1) the "content" and contextual adequacy of the organization's policies and procedures as it relates to each of the six domains identified in Step One and (2) the effectiveness of the infrastructure and mechanisms in place to ensure that those policies and procedures are adhered to across the organization ( i.e., element 2-7 of the "Seven Essential Elements). For the purposes of this Toolkit, this will focus on how to determine the content adequacy of policies and procedures.

1. For each of the six domains, consider the following questions:
2. Does the organization have a policy or procedure addressing each required element of that domain?
3. Is there are formal process for the development, modification and update of policies and procedures to ensure that they are reflective of all areas of risk and changing requirements?
4. Do policies provide adequate detail on the procedures necessary to follow in order to comply? ( i.e., Policies are not just broad statements of 'commitment to compliance' but include clear and complete procedures as to the application of that policy in usual operations).
5. Do written policies and procedures identify who is accountable for
    a. Performing specific compliance functions? (eg: conducting OIG required exclusion searches of staff and vendors? Maintaining HIPAA disclosure accounting logs?)
    b. Monitoring and evaluating adherence to procedures?
    c. Receiving and responding to compliance issues?
6. Do written policies and procedures adequately address all (relevant) operations?

Once the organization can evaluate the content adequacy of each area of risk ( i.e., the six compliance domains), it can evaluate how well the organization's compliance infrastructure and compliance program *operates as a whole*.

## Step Three: Zooming in on Specific Compliance Requirements—Sample HIPAA Compliance Assessment Template

Recognizing that one of the hardest parts in a compliance readiness evaluation is understanding the scope of the requirements that need to be implemented and monitored, the final section of this toolkit provides a high-level walkthrough of the components that must be addressed by an organization's Privacy and Security Policies in order to comply with Health Insurance Portability and Accountability Act (HIPAA). HIPAA was selected as an example because it is an area of regulatory compliance which many PSH providers have likely not had to deal with in previous operations.

It is, therefore, likely that many organizations will not have existing HIPAA policies and procedures. This template, Table 4, therefore, provides a detailed description of the components that need to be addressed in those policies. In addition to being a tool to evaluate compliance with HIPAA requirements, this table can also be used as a simplified "Table of Contents" to guide both the development of new policies as well as to guide the detailed evaluation of existing ones.

It should be noted that the proposed template provides a *simplified* snapshot, identifying at a high level the minimum standards associated with HIPAA Privacy and Security Regulations that need to be reflected in an organization's Policies and Procedures. The table identifies the general requirements in the first column, then details component elements of each category in the following column.

Users should use the third column (titled "Policy") to cite the organization's Policy that addresses each of the component parts of a general requirement. Multiple policies may cover each requirement, each should be referenced. The final column (Action Needed) is where the user identifies the gaps that exist ( i.e., where there isn't a policy or procedure addressing a component of a requirement) and details the steps needed to address the gap.

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**TABLE 4.** SAMPLE HIPAA COMPLIANCE ASSESSMENT TEMPLATE

| General Requirement | Component Parts | Policy | Action Needed |
|---|---|---|---|
| **Defines HIPAA Privacy, Security and Breach Notification requirements.** | • HIPAA regulatory requirements and responsibilities and defined and program for (and organizational commitment to) compliance is outlined.<br>• Process by which policies reviewed on an annual and periodic basis | | |
| **Appoint of Privacy and Security Officers and description of mechanisms to administer Privacy and Security program and conduct oversight** | • Privacy Officer identified and responsibilities outlined.<br>• Security Officer identified and responsibilities outlined.<br>• There is a meaningful process and reporting pathway by which the board can exercise oversight.<br>• Process by which policies reviewed on an annual and periodic basis | | |
| **Appropriate access to, use and disclosure of PHI** | • Defines permitted and non-permitted use of PHI and outlines the procedures and controls related to approved use.<br>• Defines permitted and non-permitted disclosure of PHI and outlines the procedures and controls for each.<br>• Defines required disclosures of PHI and the procedures associated therewith.<br>• Provides examples of permitted and non-permitted use and disclosure of PHI specific to the organization's routine operations. | | |
| **Minimum Necessary Use and Disclosure of PHI** | • Defines the standard of "Minimum Necessary Use or Disclosure."<br>• Access to PHI is stratified based on job functions.<br>• Provides criteria and examples to guide application of "Minimum Necessary" standard that are relevant to organization's operations. | | |
| **Patient Right of Access and other Rights** | • Includes the policies and procedures to ensure compliance with Patient's right to access, copy and request corrections to PHI and the associated notice and timeliness standards.<br>• Organization publishes Notice of Privacy Practices for reference by patients. | | |
| **Accounting and Record Retention** | • Disclosure of PHI that is not subject to (1) a written authorization or (2) an exemption ( i.e., Treatment, Payment, Operations), must be documented.<br>• Accounting of Disclosures and documentation related to the administration of the HIPAA compliance program must be retained for a minimum of 6 years. | | |

| General Requirement | Component Parts | Policy | Action Needed |
|---|---|---|---|
| **PHI Disposition and Destruction** | • Details the administrative, technological, and physical controls to ensure the confidentiality, integrity, and accessibility of PHI, including controls specific to the security of electronic PHI. Controls exist for PHI that is retained/stored, exchanged, and associated with its destruction. | | |
| **Minimum Security Standards** | • The program details the administrative, technological and physical controls required of individual users to protect PHI AND across the organization and system. Examples include: password protection standards, use of firewalls, encryption, locked doors and storage.<br>• Specific protections are applied to ePHI.<br>• Organization conducts annual and periodic risk assessments to confirm or correct the adequacy of security controls. | | |
| **Monitoring and Auditing** | • There exist mechanisms to evaluation effectiveness of the HIPAA privacy and Security program and detect noncompliance including pathways to report issues.<br>• These mechanisms and systems are tailored to the operations and risks of the organization. | | |
| **Training** | • There is a program to train workforce members on HIPAA policies and procedures, enforcement, and reporting pathways. Training includes awareness of risks to electronic data and systems. | | |
| **Investigations and Incident Responses** | • There are formalized procedures and resources allocated to investigated incidents of potential noncompliance.<br>• Where there is a breach of PHI, this includes completion and documentation of a breach risk assessment to determine responsibilities to report to business associate and up to DHHS. Policies and procedures include evaluation and implementation of corrective action or to otherwise mitigate impact. | | |
| **Sanctions** | • There are formal disciplinary sanctions associated with violation of HIPAA controls and policies and procedures. Sanctions are tailored to the factors associated with a violation and are sufficient to serve as a deterrent. | | |

## ENDNOTES

[1] DHHS, Office of the Inspector General, "The Seven Fundamental Elements of an Effective Compliance Program," Available at: https://oig.hhs.gov/documents/provider-compliance-training/945/Compliance101tips508.pdf.

# Foundational Community Supports (FCS) Contract Evaluation

Contract evaluation is a critical step in determining whether to participate in a new program or engage in a contractual relationship with another organization. The process must be thoughtful and thorough and include the perspectives and expertise of team members across the organization.

This toolkit provides organizations with a **process** that can be used to organize their Foundational Community Supports (FCS) provider contract evaluation as well as detail the necessary content of that evaluation. In addition to walking through a recommended process, this toolkit includes a sample work plan outlining how one hypothetical PSH organization organized its contract review project.

## Step One: Convene a Contract Review Work Group

When thinking of contract evaluation, one usually thinks of a legal review done by an attorney. In this scenario, a document goes "in" to the legal office for review and comes back out with redlines and cross-outs. But this is only ***one*** part of the contract review process (and sometimes, it isn't even the most important part). While a legal review is important, an attorney's review (or negotiation) of contract terms is only as strong as the input he or she receives regarding the operational and strategic objectives of any contract.

A "good" (and sustainable) Contract is one that aligns with an organization's operational and strategic priorities and that avoids the operational "pain points. Effective contract evaluation, therefore, requires input from across an organization. That means collecting feedback from not only the usual suspects (legal, compliance, and finance) but also the team members responsible for implementing a new program and the Contract's terms.

When an organization reviews the FCS standard contract to determine whether to proceed with contracting as a Medicaid provider (and to determine the operational changes needed to comply with the Contract and programmatic requirements), the first step is to convene a Contract Review Work Group, charged with overseeing the contract evaluation and providing leadership (or the governing board) with an analysis of the contract terms and recommendation on whether to proceed, and if so, the operational changes or investments that are needed.

### *Composition and Mandate of the Work Group*

The Work Group should be composed of no more than three to four (3-4) team members, one of which is identified as the project lead or program manager and who is individually responsible for keeping the review process on track and on time. Potential team members may include:

- Permanent Supportive Housing (PSH) Service Line Director or team representative
- Director of Operations
- Director of Finance or the Director of Strategy
- Compliance Officer

Collectively the Work Group is responsible for developing and implementing the review **process** (who reviews the Contract, how is the review conducted and over what time period, and how is feedback collected and integrated) as well as the criteria or **content** of the evaluation. The Work Group must include team members who are able to define, evaluate and integrate the strategic objectives and priorities of the arrangement as well as the operational priorities. This means:

1. articulating what are the strategic objectives of contracting as a Medicaid provider
2. how contracting as a Medicaid provider fits within the organization's strategic plan or mission and vision; and
3. identifying the operational "pain points," or those terms that the organization "must have" or cannot have in the Agreement.

Collectively, this can be understood as answering the "WHY" an organization ***should*** contract or "WHY" it should ***not*** (even in the event that there is alignment with strategic and business plans). While the terms of the FCS standard contract are generally not "subject to negotiation" by the Third-Party Administrator – it is essential that an organization be able to identify the operational "must haves" or "cannot tolerates" so that these are recognized during the contract evaluation.

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## Step Two: Develop a Work Plan

Once the Work Group is in place and has identified the high-level strategic priorities, objectives, and pain points relevant to the contract evaluation, the next step is to establish a work plan to track progress and organize the review. A work plan defines:

**WHAT** are the questions that need to be answered through the review?

Broadly the review **must** address the following 4 Domains (referred hereafter as the 4 Domains) in order to determine adaptation to contract requirements:

1. Programmatic Requirements and Service Delivery;
2. Operational Impact of the Contract on current and future operations and Procedures;
3. Billing and Reimbursement;
4. Compliance Requirements and Administrative Costs

**WHO** needs to review the Contract:

While the contract review Work Group is small (< 4), someone will likely need to collect feedback from staff who are "subject matter experts" on how to contract and programmatic terms impact current and future operations.

This includes those responsible for the implementation of PSH services as well as the additional administrative and operational components (e.g., billing, compliance operations).

Think about the 4 domains (What are the questions that need to be answered) and identify who are the parties able to evaluate each component.

**WHEN** that review will be completed?

What is the timeline both for the review by individual reviewers, but also for integrating responses and creating a final evaluation and recommendation?

In the absence of realistic deadlines that are communicated and enforced, there is a very high probability that, within a busy organization, the review will get sidelined and delayed.

**HOW** will the review be conducted and feedback from reviewers collected?

Will edits be collected as redlines on the Contract? Is a crosswalk document table or other document needed (highly recommended)?

Will the review be conducted consequentially (one person after another in a pre-determined order) or simultaneously?

Must all reviewers review the Agreement as a whole, or can (some) reviewers only review specific sections?

**HOW** will the Work Group complete the evaluation and present Recommendations?

Once feedback is collected from reviewers, how will the Work Group integrate and prioritize feedback?

How will Recommendations be presented to leadership?

**WHAT** are the questions that need to be answered through the review?

Broadly the review must address the following areas in order to determine if an organization can adapt to contract requirements: (1) Programmatic Requirements and Service Delivery; (2) Operational Impact; (3) Billing and Reimbursement; and (4) Compliance Requirements and Administrative Costs.

**WHAT** other documents or materials need to be included in the contract review (and WHO is responsible for reviewing them, and HOW will their findings be collected)?

Frequently the most important terms and requirements operationally are not actually contained in an Agreement itself but are instead outlined in Policies and Procedures (including but not limited to the Provider Manual), which are integrated by reference into the Contract.

**WHAT** resources are needed to effectively and efficiently complete the review?

Are there specific questions or prompts that reviewers individually or collectively need to answer during the course of their review?

Is any background or additional training needed to facilitate review?

### *Narrowing in on the Key Questions in the 4 Domains*

It is helpful to think about the Contract in each of the 4 Domains as it applies to the People, Processes, and Systems of the organization. Tying it back to these categories helps to keep the review concrete and practical as "People, Processes, and Systems (or Technology)" largely describe the resources available to an organization.

For example, when considering the Programmatic Requirements (service delivery) associated with a contract, this can break down as follows:

#### People:

- *What are the staffing requirements associated with providing these services (Are there specific qualifications or supervision requirements for team members in order to bill for specific services)?*
- *Can services be delivered with existing staff, or are additional hires needed?*
- *Are there specific skills needed by staff to be successful in these roles or delivering these services? (e.g., cultural competency training and resources? Are additional languages needed for the client base? Will team members need training in documentation, reporting, or IT platforms or on how to determine Medicaid eligibility?)*

#### Processes

- *How will the organization's existing service processes have to change to comply with program requirements?*
- *How will referrals to the organization be received, made, and closed?*
- *How will data reports be exchanged across the network?*
- *How will the organization's compliance and billing processes have to change to comply with program requirements?*

#### Systems

- *Are additional platforms or technology systems required in order to effectively deliver services under this Contract? If so, what are they? If not, how will current platforms or technology solutions be adapted for this program.*
- *Are additional platforms or technology systems needed to effectively manage contract compliance* ***within*** *the organization? If so, what are they? If not, how will current platforms or technology solutions be adapted for this program.*

## Step Three: Engage, Educate, and Execute (the Work Plan)

An ounce of prevention and planning is worth a pound of cure. The time invested in thinking through the process for the contract evaluation and the kind of feedback that is needed from reviewers is worth a pound of cure (and hours trying to pull feedback individually on the back end).

For example, reviewing a contract can be a daunting and *dense* practice for many people. The extent to which the Work Group can (1) identify the specific questions that need to be answered by reviewers (individually and as a group) and (2) help reviewers to understand the document as a whole, the easier the process and the work product.

### SAMPLE WORK PLAN

The following work plan is an example of a work plan for a contract evaluation occurring over seven weeks. In this scenario, the CEO of an Emergency Shelter and Housing Support Center (Rashid), assigned contract review and evaluation to a three-member team (Work Group), led by the Director of PSH Services (Susan) and including the organization's compliance officer (Lee), and the Grant Development Manager (Peter). The directive to the Work Group was to evaluate the contract terms and their projected application and impact on the organization's operations so that the CEO and leadership team could evaluate the opportunity in advance of the next quarterly Board meeting.

In this scenario, Susan developed the following work plan, breaking out the steps of the contract review process into three different phases. The first phase focuses on convening the Work Group and defining the objectives and parameters of the project. The second phase develops and finalizes the work plan and includes the actual contract review, including collecting feedback from operational subject matter experts across the organization. The Contract Work Group identified the need to have input from four additional team members in the organization.

This included the Director of Finance, the Director of Strategy, a member of the PSH team directly responsible for delivering services, and the Chief Operating Officer. The Work Group projects the creation of a shared document to identify contract concerns or questions shared across the organization's google drive platform. The final phase includes collecting and analyzing feedback from across reviewers to produce a final evaluation and Recommendations for the leadership team.

The work plan provided below outlines not only the assignment of responsibilities and timelines for each step of the project, but is also intended as an ongoing project management tool, which Susan and the Work Group will reference as the "point of truth" governing the status and management of the project. This is evidenced by the last two columns: Status and Notes. Status indicates the progress of each given step, whether it is (1) not started; (2) in progress, (3) at risk (i.e., at risk of not meeting the deadline) or (4) completed. The "Notes" section provides a means of identifying barriers and projected steps to resolution.

| ACTIVITY | PARTY | START DATE | DUE DATE | STATUS | NOTES |
|---|---|---|---|---|---|
| **PHASE ONE** | | | | | |
| Convene Work Group<br>• Recruit Work Group members | *Rashid* | May 1st | May 3rd | | |
| Circulate Contract for Initial Review | *Rashid* | May 3rd | May 3rd | | |
| Create and Circulate Agenda for Kick-Off Meeting<br>• Articulate Contract Objectives and Limitations (What are the "must have's")<br>• Define Domains for review<br>• Identify SMEs according to domains<br>• Determine how feedback will be collected from reviewers and if documentation tool is needed<br>• Confirm timeline and assign responsibilities | *Susan* | May 3rd | May 8th | | |
| Kick-Off Meeting | *Susan* | May 9th | May 9th | | |
| **PHASE TWO** | | | | | |
| Create and disseminate work plan to team based on Kickoff Meeting decisions | *Susan* | May 9th | May 12th | | |
| Recruit and communicate work plan to SMEs and team | *Susan* | May 9th | May 18th | | |
| Identify other documents that are incorporated by reference and are relevant to review (e.g., Provider Manual) and assign review | *Peter* | May 10th | May 10th | | |
| Create and disseminate tool for documenting feedback (if applicable)<br>• Include direction to reviewers on process of review (how to provide the feedback) and the content of the review needed. | *Peter* | May 10th | May 23rd | | |

| ACTIVITY | PARTY | START DATE | DUE DATE | STATUS | NOTES |
|---|---|---|---|---|---|
| Conduct "kick-off" meeting with SME reviewers not on Work Group | *Peter* | May 24th | May 25th | | |
| Review of Contract(s) by SMEs and Work Group | *All* | May 25th | June 2nd | | |
| **PHASE THREE** | | | | | |
| Consolidate and present feedback for analysis by work group | *Peter* | June 2nd | June 6th | | |
| Conduct work sessions to analysis collected feedback and complete evaluation | *Susan* | June 6th | June 9th | | |
| Draft Final Recommendations and Analysis for review | *Susan* | June 12th | June 16th | | |
| Present Final Recommendations and Analysis to Leadership | *Susan* | June 19th | June 21st | | |

## Contract Compliance Crosswalk

When it comes to contract evaluation, compliance, and anything touching on risk management and operations, it is important to start with the relevant disclaimers. First, the purpose of this tool is to identify *some* of the contract terms which PSH organizations should be aware of when preparing to implement PSH and FCS programs through Medicaid. This tool is not comprehensive, does not provide legal advice, and cannot replace individual evaluation and consultation with legal and compliance professionals. In creating this limited (illustrative) walkthrough or example, Atrómitos referenced the standard Amerigroup Participating Provider Agreement for the Foundational Community Supports (FCS) Program provided in March 2023 and last updated in May 2020.

What this tool *does* is provide a process and template that an organization can use to ensure that it has (1) identified relevant contract terms that impact operations and (2) a plan for how to address gaps in capacity and operations.

### A Closer Operational Review

**Toolkit #8 (Foundational Community Supports (FCS) Contract Evaluation)** outlined how to evaluate the FCS Contract to determine whether it aligns with an organization's strategic plan, current capacity, and operations in order to make a "go-no-go" recommendation to leadership. Once an organization determines to pursue FCS contracts or has contracted to be an FCS provider, the next level of review needed is more granular.

The purpose of this review is not just to determine if this is a good or feasible opportunity; instead, the focus is on implementation. This means that the focus turns from "can we do this" or "should we do this" to "how will we do this" and "what other resources (people, processes, systems, and time) do we need in order to meet this requirement."

#### THE PROCESS

For this reason, an individual or a Compliance Work Group (including and ideally led by either the Compliance Officer or the team member responsible for the implementation of FCS services) must go through the contract line by line to ensure that all contract requirements (regulatory, programmatic, and those directly related to services delivery) are fully identified and understood.

This can be done by a single individual, such as the team member responsible for PSH services, with the support of team members from across the organization tasked with reviewing and providing feedback within their specific domains.

Alternatively, this work can be completed through a Work Group, where the individuals whose feedback is needed are integrated upfront into the contract review planning and evaluation process.

**As described in Toolkit 8, a project plan should be developed defining:**

1. The parameters of the review (what are the questions that need to be resolved);
2. The timeline, associated tasks, and assigned responsibilities;
3. The process by which gaps in current capacity will be identified and prioritized;
4. The resources available to address gaps in compliance or capacity (in both the immediate and longer terms)
5. The process by which feedback will be collected and how it will be presented to decision-makers for action.

An operational review of a contract is intensive, comprehensive, and iterative. What is important is that the terms of the contract are **thoroughly** understood by the organization. This means identifying those areas where additional resources and capacity development are needed. There will likely be areas of operations where an organization does not have existing procedures and resources allocated. For example, suppose an organization has never contracted as a healthcare provider or business associate.

In that case, it may not have HIPAA Privacy and Security Policies and Procedures, or, if the organization has not previously contracted with the State, its document retention policy may not align with those standards. This is to be expected. What is important is that the full scope of contract requirements are identified and understood and that there is a plan and pathway to meet those terms, to evaluate and monitor performance on contract terms within the organization (including compliance requirements), and to continuously improve over time.

This means, first of all, that **there are no shortcuts when it comes to contract review and evaluation.** The contract has to be gone through line by line—and then also cross-referenced and evaluated against those documents that are incorporated into the agreement (such as the Provider Manual and the Business Associate Agreement).

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**The following are some practical recommendations when conducting this contract review:**

- Print out the Contract in order and mark it up with notes, highlighting areas, and raising questions.
- Familiarizing with the structure and "flow" of the contract. Think about how it is organized. How are sections categorized to recognize the 'logic' of its structure. Being comfortable with the document's structure is also important, as terms in the contract cross-reference with other sections.
- After completing a "first" review and mark-up, return to the contract and paraphrase each section in layman's terms. This exercise, explaining the content of each section in simpler terms, helps to ensure that the reviewer actually understands a section – and to identify where there are potential ambiguities or unanswered questions.
- Paraphrasing each section can also help the review of other team members ("subject matter experts" working in specific areas of operations) in their review, as well as helping to think through WHO in the organization is needed to provide feedback (i.e., who will have an answer to the question raised?).
- Use a contract crosswalk to organize and document the operational evaluation. A proposed contract compliance crosswalk template is provided in this Toolkit.

## ANATOMY OF THE FCS CONTRACT

Before turning to the proposed crosswalk template, it is helpful to "get comfortable" with the Contract as a ***document***, that means thinking of it in the context of its structure and objectives. This is one of those times in life when an English major comes in handy.

There are ten (10) sections or Articles to the Contract, as well as one (1) Appendix and one (1) Attachment. In addition to the 41-page document, other documents that are incorporated by reference and impact the application of the agreement include:

1. The HIPAA Business Associate Agreement with Amerigroup;
2. Amerigroup's Provider Manual; and
3. Amerigroup's Policies and Providers govern providers and the FCS Program's administration.

### Article I: Definitions

This includes a list of the defined terms that are used throughout the contract. Definitions tend to be statutorily or regulatorily directed.

### Article II: Amerigroup Obligations

This section outlines Amerigroup's obligations to the participating provider. Generally speaking, this includes the responsibility to (1) publish and make available a Provider Manual detailing the policies and procedures governing provider operations; (2) to provide Reports to Provider as required by regulatory Requirements (i.e., as required by the Medicaid agency); (3) conduct credentialing for the program; (4) furnish Provider with schedules of Covered Services and provide timely notice of any modifications.

While short, this can still be an impactful section to review, not least as there can include terms limiting the scope or extent of an obligation or imposing a responsibility on a provider. As one example, this section details that Amerigroup must make the Provider Manual available to Provider and reference "material policies and procedures" in the Provider Manual (Section 2.2: Policies and Procedures) and to give notice of material modification to policies and procedures to Provider. However, this section *also* requires Providers to comply with all policies and procedures communicated to providers (including policies and procedures not included in the Provider Manual).

### Article III: Provider Obligations

This is a denser section and is one of the areas requiring the closest review operationally. This includes a general statement of provider services (Section 3.1) and the responsibility to operate within all licensure and accreditation requirements, minimum standards of insurance (Section 3.8), and the identification of proprietary information between the parties and duty to maintain confidentiality (Section 3.10).

The Provider Manual and Policies and Procedures are ***most*** important to the evaluation in this section. Consider Section 3.7 (Compliance with Credentialing, Utilization Management, Quality Assurance, Grievance, Coordination of Benefits, Third Party Liability and other Rules, Regulations, Policies and Procedures). By contract, a provider is subject to these programs and requirements. Review of the Provider Contract, which summarizes the relevant programs and primary responsibilities, is critical to understanding how this will actually operate in practice.

### Article IV (Reimbursement)

This is a shorter section governing the terms by which providers must document and bill for services and by which Amerigroup will process those claims. This section does not provide the rate of reimbursement (which is detailed in Attachment A). Be mindful of the policies and procedures governing claims processing in the Provider Manual in order to better understand how claim submissions, reviews, appeals, and recoupments operate in practice.

### Article V (HIPAA)

This section references regulatory compliance with HIPAA. Be mindful that there is a positive duty for a provider to execute a Business Associate Agreement with the Administrator (Amerigroup) where the provider is not a "covered entity" under HIPAA (i.e,: a healthcare provider).

### Article VI (Compliance with Regulatory Requirements)

This section details the FCS program's regulatory requirements and under which the Administrator and all contractors must operate. Section 6.1 (Compliance with Regulatory Requirements) functions as a "catch-all" by which a provider agrees to comply with all regulatory requirements, regardless of whether they are expressly referenced in this section. This section then proceeds to give a detailed run through of the relevant operational requirements and prohibited practices. This section is integral to identifying, developing, refining, and 'testing' the scope and substance of an organization's compliance program.

### Article VII (Records)

Providers have a duty to create and retain adequate records related to the delivery of services. Those records must be maintained in a secure and confidential manner. Records are subject to audit by Amerigroup following reasonable notice. Providers have the duty to cooperate in the timely transfer of records to other Providers, as required.

### Article VIII (Complaint/Dispute Resolution)

This outlines the procedures associated with resolving disputes between Amerigroup and a provider.

### Article IX (Term; Termination)

This section outlines the term of the agreement (2 years), its default renewal, and the process for termination by either party.

### Article X (Miscellaneous)

While "miscellaneous" suggests a section that is a catchall of those terms that don't fit elsewhere in the agreement's structure, it still contains important terms that merit attention. This includes the terms which Amerigroup may amend the agreement, by which parties must provide notice, and indemnification.

The above is a brief snapshot of the "architecture" of the Agreement itself, but some of the most important terms are actually contained in the attachments.

### Appendix A (Foundational Community Supports Program)

This is the most important section as it relates specifically to the FCS program requirements and service delivery. This defines the FCS program, criteria, provider qualifications, and the specific capacity requirements relevant to the program.

Close attention to Sections 2a (Adherence to Quality Standards Supportive Housing), 3 (Administrative Requirements), and 4 (Reports, Monitoring, Quality Standards and Deliverables) are critical to understanding operational requirements and impact.

### Attachment A (Medicaid Reimbursement)

This details the Reimbursement rates and includes specific directions on the process of submitting claims ( i.e., use of CMS 1500 form and Availity).

## Putting Pen to Paper: The Proposed Contract Crosswalk

With that background in contract structure, and once each reviewer completes a hard copy (and marked up) review, the Project Lead should collect feedback in an operational contract crosswalk. This means that reviewers identify each section that has a significant operational impact, providing a citation (Section Column); a paraphrased description of the application (Description Column); an explanation for why it raises a concern or why there is a gap in current operations (Point(s) of Concern column); assign a level of priority (Priority Level); and detail how that gap can be addressed (Recommendations column).

For example, one entry under Article III (Provider Obligations) might reference Section 3.8 (Insurance Coverage), which stipulates that all (non-acute hospital) providers must maintain professional liability coverage with a minimum coverage of $1 million dollars per occurrence with coverage for $3 million in the aggregate.

A reviewer for an organization that didn't meet this minimum coverage level would identify this gap—give it a high priority level (signaling immediate action because the organization is out of compliance with the term) and describe the steps being taken (or that need to be taken to address this), such as "Alerted CEO and Legal of need to raise insurance coverage immediately. Legal has contacted Insurance company. Resolution expected within 3 days").

A snapshot of the beginning of such a Contract Crosswalk is provided in the table below. This table is provided for illustrative purposes to demonstrate how team members may develop the crosswalk.

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**TABLE 1.** FCS CONTRACT CROSSWALK – A SNAPSHOT

| Section | Description | Point(s) of Concern | Priority Level | Recommendations |
|---|---|---|---|---|
| **Article I (Definitions)** | This includes a list of the defined terms that are used throughout the contract. | | | |
| ***1.3 Clean Claim*** | Defined as claim that can be processed without additional documentation | No concern on definition. Flagging for reference to Billing team. | Low | Include in training for Billing team. Likely will be useful to reference for denied claims in reconsideration/reprocessing. |
| **Article II (Amerigroup Obligations)** | Summarizes Amerigroup's duties to providers. Includes duty to publish provider manual and share quality reports as directed by HCA. | | | |
| ***2.1 Provider Manual*** | Duty to publish manual and make available to providers. Provider is subject to terms of Provider manual. Amerigroup must provide 60 days notice of any material changes to provider manual. | Need to confirm how notice will be made ( i.e., formal notice through procedures in contract or through mass notification through provider newsletter). Need to review Provider Manual to determine acceptability of P&P imposed. | Medium | Provider Manual being review by PSH service director. Assign member of billing team to monitor monthly newsletters to identify notice of any changes. Develop procedure for evaluating modifications to manual to determine if additional review by management is needed. |