Achieving New York's Medicaid Redesign Goals through Supportive Housing

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CSH
The Source for Housing Solutions

About CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

Introduction

As New York State (NYS) continues to restructure how health care services are delivered under its Medicaid program, there is increasing opportunity to better position the supportive housing industry to help the state meet its desired goals of achieving the Triple Aim: improved health outcomes, quality and reduced health care costs for some of its most vulnerable members. This paper summarizes the state's efforts under the Medicaid Redesign Team (MRT) to reduce avoidable health care expenditures and increase quality of services using supportive housing as an intervention to stabilize its neediest, high-cost utilizers of health care. It also examines the opportunities and challenges in leveraging Medicaid as a potential funding source for supportive housing services.

The Costly {And Deadly} Intersection of Homelessness & Poor Health

Despite having the most expensive health care system, the United States ranks last among most industrialized nations on measures of health system quality, efficiency, access to care, equity, and healthy lives.[1] And NYS, like the rest of the country, faces daunting health care challenges and is developing strategies to comprehensively address them. These challenges are compounded by the State's growing homelessness problem.

According to the 2014 Annual Homeless Assessment Report to Congress (AHAR), between 2013 and 2014, New York had the distinction of having the largest increase in its homelessness numbers (3,160 more people experiencing homelessness than the previous year) for a total of 77,430 individuals experiencing homelessness in the State. While New York makes up less than 7% of the nation's total population (19,746,227 of 318,857,056 in 2014) the State accounts for 13% of the nation's homeless (77,430 people)[2]. Many people who experience long-term or multiple episodes of homelessness have high health care needs at an exorbitant cost. Adults who become homeless – particularly those who experience chronic or long-term homelessness, are far more likely to suffer from chronic medical conditions, such as serious mental illness, HIV/AIDS, hypertension, and diabetes, and to suffer complications from their illnesses due to lack of housing stability and regular, uninterrupted treatment[3]. A New York study aimed at establishing a methodology to identify persons at the highest risk for frequent hospital admissions found that homeless or precariously housed patients were more than six times more likely to name the emergency department as their usual source of care or to say they had no usual source of care than patients who had stable housing[4].

[1] Mirror, mirror on the wall, 2014 update: How the performance of the U.S. health care system compares internationally. New York: Commonwealth Fund, June 16, 2014 Available: here: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

[2] Annual Homeless Assessment Report to Congress, 2014 https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf

[3] Sadowski LS1, Kee RA, VanderWeele TJ, Buchanan D. "Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial" JAMA. 2009 May 6;301(17):1771-8. doi: 10.1001/jama.2009.561.

[4] Raven, Billings, Goldfrank, Manheimer, & Gourevitch, Medicaid patients at high risk for frequent hospital admission: real-time identification and remediable risks. J Urban Health. 2009 Mar;86(2):230-41. doi: 10.1007/s11524-008-9336-1. Epub 2008 Dec 12.

This lack of investment in the social determinants of health, like housing, contributes to disproportionate spending in medical care – costs that can be largely offset by strategic investments in evidence-based health interventions, like supportive housing[5].

Homelessness and poor health have been intertwined in a cyclical battle of cause and effect, spiraling constantly downward[6]. Homelessness creates new health problems and exacerbates existing ones, and poor health puts individuals and families at risk for homelessness. Housing – one of the most basic, and powerful social determinants of health, can entirely dictate an individual's health and their health trajectory.

What is Supportive Housing?

Supportive housing combines affordable housing with supportive services that help people who face the most complex challenges to live with stability, autonomy, and dignity. Supportive housing is a specific intervention designed for individuals and/or families who are homeless, at risk of being homeless or institutionalized, and experience multiple barriers to independent housing. These vulnerable individuals would not succeed in housing without access to critical support services, and would not partake in services without a stable living environment. The housing in supportive housing is affordable, permanent, and independent. The services are comprehensive, flexible, tenant-driven, voluntary, and housing-based.

Supportive Housing: A Proven Evidence-based Intervention

There is a growing body of evidence that shows that permanent supportive housing can decrease the use of crisis Medicaid-funded care as people stabilize in their housing. Many people who experience chronic homelessness make frequent and avoidable use of emergency rooms and inpatient hospital treatment. This use of expensive crisis public services has been a major motivator for developing supportive housing, which has been shown to help tenants reduce inappropriate use of services and improved outcomes for the tenants.

Housing as a Social Determinant of Health

Social determinants of health are the economic and social conditions that affect health outcomes and are the underlying, contributing factors of health inequities. Examples include housing, educational attainment, employment and the environment. Access to safe, quality, affordable housing - and the supports necessary to maintain that housing - constitute one of the most basic and powerful social determinants of health.

In 2014, CSH released, "Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health" a paper examining the connection between supportive housing and health and the strategies needed to bring housing solutions to scale to improve the overall health of the most vulnerable while building strong, healthy communities.

[5] Shah, Nirav R., Kelly M. Doran, and Elizabeth J. Misa. "Housing as Health Care: New York's Boundary-Crossing Experiment." New England Journal of Medicine (2013): 2374-77. Print

[6] National Health Care for the Homeless Council. Health Care and Homelessness , July 2009 Available here: http://www.nationalhomeless.org/factsheets/Health.pdf

New York/New York III Supportive Housing Evaluation Interim Utilization and Cost Analysis

The New York City Department of Health and Mental Hygiene, in collaboration with the New York City Human Resources Administration and the New York State Office of Mental Health, released a preliminary cost evaluation of the NY/NY III Agreement in December 2013[7]. The NY/NY III Supportive Housing Agreement created 9,000 units of supportive housing for nine different populations. New units created under this agreement were both scatter-site and congregate housing. The evaluation utilized an intervention group of individuals who were placed in NY/ NY III housing for at least one year, and a comparison group of those who were eligible but not housed. Propensity score matching was used to improve the comparability of the two groups. The evaluation reported outcomes for days in institutions, shelter costs, jail costs, cash assistance receipt, and health care utilization and costs. While there was variability for each population, overall the evaluation showed that after one year in supportive housing, there was net savings of $10,100 including service and operating costs. Outcomes included:

- Net savings of $77, 425 for placing single adults from state operated psychiatric facilities into supportive housing.
- Decreased shelter use for almost all populations targeted by the program that resulted in population level savings that ranged from $626 for youth aging out of foster care to $18,280 for heads of family who were diagnosed with a serious mental illness or were dually diagnosed with both mental illness and substance abuse disorder.
- Decreased time spent in jail for specific populations which resulted in net savings in the cost of jail for $1,298.

Getting Home, Outcomes from Housing High-Cost Homeless Hospital Patients

The Economic Roundtable released an evaluation of the Frequent Users Systems Engagement (FUSE) 10th Decile Project in Los Angeles in September 2013. The FUSE 10th Decile Project helps hospitals identify the highest-cost, highest need homeless individuals and then partners them with community providers to house those individuals. The highest cost individuals are identified by administering a triage tool that uses accurate, statistical models to identify the 1/10 of homeless individuals with the highest public costs. This study evaluates outcomes from April 2011 to May 2013 for 163 hospital patients. The evaluators collected patient demographics, engagement and housing retention information, and costs both incurred and avoided. To collect cost information, the evaluators formed a comparison group with non-housed homeless individuals in the community with similar characteristics to the FUSE participants and collected pre and post billing information for FUSE participants. The evaluation found that:

- For the 10th Decile patients studied in this evaluation who obtained housing, total annual average public and hospital costs per person are estimated to have decreased from $63,808 when homeless to $16,913 when housed – excluding housing subsidy costs.
- Total health care costs, including jail, medical and mental health care, are estimated to have declined an average of 72 percent, from $58,962 to $16,474 per person. Initial cost savings and hospital utilization reductions were seen prior to housing placement but after enrollment into the program and case management began.
- Every $1 dollar in local funds spent to house and support 10th Decile patients is estimated to reduce public and hospital costs for the housed evaluation population by $2 in the first year and $6 in subsequent years[8].

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[7] New York/New York III, Supportive Housing Evaluation: Interim Utilization and Cost Analysis Available here: http://www.nyc.gov/html/doh/downloads/pdf/mental/housing-interim-report.pdf

[8] Flaming, D., Burns, P. (2013). Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients. Economic Roundtable. Available here: http://www.csh.org/wp-content/uploads/2013/09/Getting_Home_2013.pdf

An Imperative for Change: Bending NY's Medicaid Cost Curve

When Governor Andrew Cuomo first took office in 2011, New York State had the largest Medicaid program in the nation, spending nearly $53 billion in 2011 for 5 million people – twice the national average when compared on a per recipient basis.[9] In addition to the State's cost problem, it had a quality problem: the State ranked 22nd out of all states for overall health system quality and 50th among states for avoidable hospital use and costs.[10]

Recognizing the urgency for change, the Governor issued Executive Order #5 establishing the Medicaid Redesign Team (MRT) designed to comprehensively address escalating costs and quality issues in the state's Medicaid program through the development of a comprehensive, multi-year action plan. The MRT focused much of its attention on the 20% of high-need Medicaid recipients who use up to 80% of all NYS's Medicaid spending – with a majority of those dollars spent on treating patients with multiple chronic conditions, most often complicated with mental health and substance abuse. Some of the immediate measures taken by the Governor included:

- *Global spending cap* on the State's share of Medicaid expenditures. If spending is projected to exceed the global cap, DOH is authorized to take unilateral action to reduce spending to remain within the cap.
- A *2% across-the-board* Medicaid rate cut to all service sectors
- Phased-in *implementation of Health Homes*

Core Components of New York's Medicaid Redesign

- Transition to Care Management for All: gradually eliminating Medicaid fee-for-service whereby providers are paid per service rendered – and not outcomes – which rewards volume over value, and replacing it with a values-based managed care model whereby managed care plans will be held accountable for meeting the needs of its Medicaid members.
- Implementation of Affordable Care Act of 2010 (ACA) Medicaid Health Homes – an optional Medicaid benefit authorized under the ACA that allows communities to create care management and care coordination networks whereby people are enrolled in the network and all of an individual's caregivers communicate with one another so the patient's needs are addressed in a comprehensive manner.
- Addressing Social Determinants of Health – addresses housing as a social determinant and expands access to supportive housing in New York as a platform to improve patient outcomes and lower program costs.

[9] A Plan to Transform the Empire State's Medicaid Program Better Care, Better Health, Lower Costs MULTI-YEAR ACTION PLAN
[10] The Commonwealth Fund Commission on a High Performance Health System, State Scorecard (2009), available at http://www.longtermscorecard.org/databystate/state?state=NY#.VRtFTst0zZ4

Care Coordination among Housing Providers and Health Home Care Coordinators

Health Homes in NY are required to include supportive housing providers as part of their network; however, this integration has not been seamless or well understood. In order to bridge this critical gap, CSH received support from the van Ameringen Foundation and the New York State Health Foundation, to advance systems-level changes to help ensure successful implementation of Health Homes on the ground in New York State, through its "*Housing and Health Homes Integration*" initiative, whereby CSH helped to build the capacity of over 600 Health Home care coordinators and their network of providers to effectively serve their homeless and unstably housed clients who are high utilizers of crisis care. The regional trainings equipped Health Home care managers with the knowledge, tools, and partnerships to identify appropriate clients for supportive housing, successfully navigate the application process, and leverage case management support offered in supportive housing.

A Focus on Frequent Users & Persons Inappropriately Institutionalized

The small, yet significant group of Medicaid beneficiaries who are responsible for a majority of the systems costs are habitually caught in the tragic cycle of homelessness, hospitalizations, detox, and other institutionalization. These frequent utilizers fall in between the cracks, due to fragmented coordination among the health, behavioral health, and homeless systems resulting in higher rates of emergency department utilization, and hospital admissions/readmissions – at an enormous cost to the public. Taking advantage of reforms under the Affordable Care Act while simultaneously implementing MRT initiatives, the State implemented a series of reforms designed to improve care coordination and management for this critically vulnerable and expensive group.

Medicaid Health Homes

In NYS's attempt to address the care management and coordination needs of its high-need, high cost Medicaid members, in 2011 it took advantage of the Affordable Care Act's (ACA) Medicaid Health Homes (HHs). Health Homes are an optional State Plan benefit designed to manage the care of Medicaid members with the most complex medical, behavioral, social and long-term care needs in a comprehensive and coordinated manner. The ACA allowed for a temporary 90% federal match rate authorized for Health Home services for the first 8 quarters (2 years) of implementation. Eligibility for NY Health Homes requires an individual to have either 2 chronic conditions or a single qualifying condition (HIVS/AIDS or serious mental illness). Early into HH implementation, lack of stable affordable housing presented as a major challenge to coordinating care for its vulnerable members.

With the expansion of Medicaid, hundreds of thousands of New Yorkers now have insurance coverage, including those who are chronically homeless. New York is capitalizing on these service options, as a way to provide these new beneficiaries with care management services linked to supportive housing.

MRT Supportive Housing Initiative

The State's Medicaid Redesign Team (MRT) energized a focus on this high-cost population and the benefits of connecting them to supportive housing in order to reduce costs and improve health outcomes. The MRT developed a series of work groups designed to address specific aspects of Medicaid reform, including the MRT Supportive Housing Work Group which was charged with making recommendations to the Governor for allocating Medicaid savings into supportive housing. Through this work group, the State demonstrated its commitment to supportive housing as a way to both address chronic homelessness as well as lower Medicaid costs. Based on this "housing as healthcare" premise, NY recently became a pioneer in using its State share of Medicaid dollars to fund housing. Since 2011, the State has spent nearly $400 million of its state Medicaid savings on capital investments (construction) 40%, operating (rent) subsidies and

services for individuals in supportive housing, 60%. One of the most pressing issues facing the Initiative is bringing supportive housing to scale for this high cost/need population. The need for housing units, particularly in New York City, far exceeds the supply and even with crucial investments in capital by the State, there still remains a critical gap.

The 2013-14 MRT Supportive Housing Initiative also created seven pilot projects to test models of care:

1. Health Homes Pilot Project (DOH): supports 500 rent and service subsidies for supportive housing providers to house and serve unstably housed high cost Medicaid recipients in scattered-site market rate rental apartments. Funding serves persons referred from Health Homes.
2. Step Down/Crisis Resident Pilot (OMH): supports capital and operating funding to convert some beds in existing community residential service providers into crisis or step-down service units. The goals are to transition individuals from psychiatric hospitals into community settings and divert individuals in crisis,
3. Nursing Home to Independent Living (DOH): supports rent and service subsidies to individuals with mobility impairments or other severe physical disabilities an alternative pathway to community living.
4. OMH Supported Housing Supplement (OMH): supports rent and service subsidies to supplement supportive housing providers to offer limited service enhancement to high-cost Medicaid recipients with serious mental illness enrolled in Health Homes and living in scattered-site apartments. It allows for necessary day-to-day continuity of place-based, wraparound support services through a flexible critical time intervention approach.
5. Homeless Senior Placement (Office for Temporary Disability Assistance - OTDA): Provides rent supplement to older individuals residing in homeless shelters for long periods of time who receive SSI/SSD but are not eligible for existing supportive housing programs. It intends to reduce Medicaid spending that is predictive and targets a group of individuals who are likely to become high Medicaid users.
6. Health Home HIV Rental Assistance Pilot (DOH): supports rental assistance for homeless and unstably housed Health Home participates diagnosed with HIV infection but medically ineligible for the existing HIV specific enhanced rental assistance program for New Yorkers with AIDS or advanced HIV-illness.
7. Senior Supportive Housing Pilot: supports capital and supportive services to enable low-income seniors to remain in the community, including seniors aging in place in supportive housing.[11]

Delivery System Reform Incentive Payments (DSRIP)

In August, 2012, New York submitted an 1115 waiver request to the federal Center for Medicaid Services (CMS) to reinvest $10 billion of the expected $17.3 billion in MRT-generated federal savings back into New York's health care delivery system over the next 5 years (such waivers are authorized under Section 1115 Social Security Act). This request served as a means to test approaches to financing and delivering health care for low-income people – many experiencing homelessness. The waiver request included a "Medicaid Supportive Housing Expansion Program" to dedicate $150 million annually ($750 million over 5 years) to expand access to supportive housing by creating a supportive housing capital expansion program and service program. Waiver requests must be cost neutral, therefore, the New York waiver requested permission from CMS to reinvest savings generated from its other MRT reform efforts into supportive housing.

In April 2014, New York received approval for its 1115 waiver request; however CMS rejected the State's $750 million proposal to reinvest the federal portion of projected cost savings into supportive housing operating and capital costs. As a rule, CMS typically does not allow Medicaid dollars for capital expenses and rental subsidies. Another possible reason for the denial was that the State was not compelling in its case targeting the highest utilizers for the housing intervention as an individual could be a high utilizer one year and not the following year.

[11] More information on the Supportive Housing MRT pilots can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/affordable_housing_workgroup.htm

Finally, CMS is also concerned with how long a beneficiary may need rental assistance and how states can transition people to longer term traditional housing rental assistance knowing that waiting lists are long and resources are limited. While CMS denied the request to use federal Medicaid dollars for housing, CMS did approve using a portion of the federal savings for services. New York State remains committed to finding ways to increase supportive housing capacity using Medicaid financing. New York is allowed to invest state-only Medicaid dollars into housing. New York became the first state to commit state Medicaid dollars for housing--$500 million over 5 years (2011-2016).

A majority ($6.42 billion) of the approved $8 billion dollar waiver is being reinvested in the Delivery System Reform Incentive Payments (DSRIP) program. Several states, including Texas and California, are using a DSRIP program to alter traditional payment and delivery systems. The main objective of New York's DSRIP program is to reduce avoidable hospital use by 25% over the next 5 years. Twenty-five distinct projects have been approved by NYS; these are led by eligible safety net providers (major public general hospitals, FQHCs, nursing homes) – referred to as Performing Provider Systems (PPS) - who oversee collaborations of engaged community stakeholders. The PPSs receive incentive payments based on their performance and outcome milestones as delineated in their approved project plan.

Of interest to housing and homeless providers is one specific initiative that directs PPSs to partner with housing providers to develop transitional housing for high risk patients who are unable to safely transition from a hospital when the acute medical needs are fully met. This transitional housing would provide short-term care management to allow transition to longer-term care management and would allow additional time to support rehabilitation, stabilization, and patient confidence in self-management before returning to permanent housing. Unfortunately, only 1 PPS of the approved 25 decided to undertake this initiative. However many PPSs have included supportive housing providers as key stakeholders in the development of their community needs assessments (CNA) and have included supportive housing providers as part of their networks to help mitigate some of the housing challenges they anticipate.

Behavioral Health Transition to Managed Care

In order to fully integrate behavioral health and physical health services and offer them in a comprehensive, accessible and recovery-oriented manner, the State is transitioning its behavioral health services from a Fee-for-service to a managed care structure. These services will be provided through two behavioral health managed care models:

1. Qualified Mainstream Managed Care Organizations (MCO): This model will integrate all Medicaid State Plan covered services for mental illness, substance use disorders and physical health conditions.
2. Health and Recovery Plans (HARPSs): This model will manage care for adults with significant behavioral health needs. In addition to State Plan Medicaid services, HARPs will offer an enhanced benefit package comprised of Home and Community Based Services (HCBS) to eligible beneficiaries to receive person-centered recovery services in their own community.

Home and Community Based Services (HCBS) allow Medicaid beneficiaries with disabilities to receive services in their own home or community as an alternative to costly institutional settings (e.g. nursing homes, hospitals). In early 2014, CMS released its final rule for HCBS and the qualifications that all HCBS settings must meet. Essentially, CMS wants to ensure that Medicaid only supports services that are community-based and delivered at the choice of the patient – which aligns. Through the implementation of HCBS, some services provided in supportive housing in NY will now be reimbursable through Medicaid – these services include non- medical transportation, family support and training and habilitation services.

Opportunities and Challenges: Leveraging Medicaid as a Potential Funding Source for Supportive Housing Services

The ever-shifting landscape of health reform in NYS comes with several opportunities to leverage Medicaid financing in ways that supportive housing providers in NY have never done before. For example, with the imminent transition of behavioral health services into Medicaid Managed Care, therein lies opportunities for supportive housing providers to now bill for Medicaid services; however, many – if not most supportive housing providers in NY do not currently have the capacity to do so. Providers in NY have historically relied on state grants distributed without the complex requirements of Medicaid. However, state resources can only be stretched so far and fail to bring supportive housing to scale to meet the huge demand. Medicaid reimbursement for some services in supportive housing could allow state resources to only pay for the services Medicaid will not reimburse –including rent - allowing for substantial supportive housing growth.

Becoming a Medicaid biller is not a simple task. In order for the supportive housing industry to take advantage of financing opportunities through Medicaid, there needs to be some education and potential technical assistance to strategically navigate Medicaid's requirements to pay for supportive housing services.

- **Medicaid Learning Curve for Providers**
  Some supportive housing providers, similar to the substance use treatment industry, have little Medicaid experience and would need assistance translating the services they deliver into Medicaid recognizable services – both in language and sometimes altering the service delivery model. Technical assistance on understanding the implications of becoming a Medicaid biller is essential as well as identifying new organizational configurations that will be necessary to help bridge the gap between current supportive housing capacity and Medicaid requirements. Providers must meet requirements established by the state's Medicaid program for documenting the delivery of covered services to recipients who are eligible to receive those services.
- **Need for Efficient Targeting Through Coordinated Assessment and Placement System (CAPS)**
  In order to realize the cost-effectiveness of a supportive housing intervention under Medicaid, it is critical that high-need, high cost Medicaid members are efficiently targeted and placed into the most appropriate settings. Making the business case for supportive housing is especially effective when it's targeted to individuals who frequently and inappropriately utilize acute and emergency settings. The hallmark of CAPS is the use of standardized intake and assessment criteria among all supportive housing providers, and to match clients to the most appropriate housing option based on need, rather than on a first-come, first-served basis.
- **Safeguarding Quality in Supportive Housing against Untenable Medicaid Reimbursement Models**
  There needs to be a safe space where supportive housing providers can share their needs, concerns and opportunities with transitioning to a Medicaid managed care payment structure for some of the existing services they provide. Early concerns expressed include under a managed care model, reimbursement for services may not be sufficient to cover the actual cost of services for high-need, high-cost individuals. There is a need to identify a payment structure model that promotes the goals of costs containment for high-need individuals while ensuring quality of care in supportive housing.
- **Exploring What Other Supportive Housing Services Can Potentially Be Reimbursed through Medicaid**
  A crosswalk of services provided in supportive housing and what Medicaid traditionally covers will need to be examined to identify which services Medicaid can reimburse and where non-Medicaid state resources are needed to fill gaps and grow capacity.

- **Opportunities to bill Medicaid as a result of ACA**

  With implementation of the ACA, New York and 24 other states and DC have chosen to expand Medicaid eligibility to adults aged 18-64 if their household income is at or below 133 percent of the federal poverty level – thus allowing nearly all chronically homeless people who lacked health insurance to become eligible for Medicaid. Many more supportive housing tenants as well as people still experiencing chronic homelessness are now eligible for Medicaid. This means that understanding Medicaid's potential as a funding source for the services in supportive housing is even more important now than ever. Medicaid can serve as a critical funding source for some services in supportive housing.

- **Making the Business Case for Supportive Housing**

  While Medicaid does not traditionally fund housing and CMS has been reluctant to allow states to use Medicaid dollars for housing, CMS already does pay for housing in the form of costly nursing homes. As NY expands access to Medicaid, increasingly homeless individuals with high levels of need are being covered. Without stable housing, some of these individuals will continue to make inefficient use of hospitals and other crisis health care and Medicaid ends up paying a disproportionate amount for those high utilizers. Supportive housing – a proven cost-effective intervention can, for example, help health plans achieve performance goals related to improved health outcomes and reductions in avoidable hospital readmissions. These supportive housing -attributable savings can then be reinvested to right-size this targeted intervention for other high-need, high-cost beneficiaries. States could achieve cost savings and restore dignity for many individuals with disabilities and housing instability.

- **Opportunities to improve care coordination practices**

  The implementation of Medicaid Health Homes and DSRIP provide fertile ground for improved care coordination practices and meaningful integration among hospitals and community-based service providers – like housing. But as we learned from the Health Home experiment, achieving this type of integrated and coordinated care requires work on the part of all stakeholders involved. Effective and meaningful partnerships between housing and stakeholders from the health care sector to coordinate care for people living with complex health and social conditions has the opportunity to achieve cost-savings on all sides and improve quality and experience in the health care system.