

Using Medicaid Resources to Pay for Health-Related Supportive Services: Early Lessons

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IN BRIEF

Although 95 percent of health care spending is devoted to direct medical services, roughly 50 percent of preventable deaths are attributable to non-medical indicators, such as social circumstances, environmental factors, and individual behaviors.^{1,2} Health-related supportive services and other non-medical interventions that address these social determinants of health can both improve outcomes among Medicaid beneficiaries and reduce health care spending. Accordingly, a number of states are testing models that incorporate supportive services into their Medicaid state plans as part of broader delivery system reform efforts.

This brief, made possible by The Commonwealth Fund, explores state strategies for using Medicaid funds to pay for health-related supportive services. Case studies from four states -- **Oregon, Vermont, New York** and **Massachusetts** – plus a snapshot of **Utah's** model, examine options for providing supportive services within accountable care organizations (ACOs), health homes, community care teams, accountable communities for health, and other value-based delivery system reforms, as well as implementation challenges. The brief draws from conversations with Medicaid officials, program directors, community providers and other national experts across the country.

Federal and state policymakers increasingly recognize the role of social determinants of health on overall health and well-being. Research has shown that health outcomes are not primarily determined by the health services a population receives, but rather by a host of non-medical factors.³ Despite the fact that the United States spends up to 95 percent of health care dollars on direct medical services, roughly 50 percent of preventable deaths are attributable to non-medical indicators, including social circumstances, environmental factors, and individual behaviors.^{4,5}

The social determinants of health particularly influence the health of low-income patients enrolled in Medicaid. Supportive services and other non-clinical interventions that address these determinants can both improve low-income patients' health and curb health care spending. For example, supportive housing programs for chronically homeless individuals have been shown to reduce hospital and emergency department visits and result in significant per-person savings.⁶ Typically, Medicaid reimburses only for direct medical care or "enabling services" that facilitate a connection to social supports, such as care coordination, interpretation, and transportation. A handful of states, however, are implementing innovative models that go beyond reimbursing solely for direct medical care to pay for a broader range of "non-traditional" supportive services.

Recognizing the value of such services, the Center for Medicare & Medicaid Services (CMS) released an informational bulletin in June 2015 outlining Medicaid reimbursement options for housing-related activities and services.⁷ Several states are piloting programs, such as Washington State’s Accountable Communities of Health,⁸ that seek to coordinate the full range of enrollees’ medical and non-health care needs. In addition, a number of managed care organizations and state-based accountable care organizations (ACOs) are incorporating non-medical services into care plans with the aim of addressing the social determinants of health.

Massachusetts, New York, Oregon, Utah, and Vermont have all developed reimbursement strategies to pay for certain supportive services within their Medicaid programs. Building off previous work by the Center for Health Care Strategies (CHCS), this brief examines how these states are using Medicaid funding for supportive services as part of broader delivery system and payment reform efforts.⁹ CHCS conducted interviews with state officials, community providers, and national experts to identify how these Medicaid programs are determining the appropriate scope of services and incorporating them into their state plans. Drawing from these interviews, this brief provides practical state case studies to help inform supportive service payment strategies within ACOs, health homes, community health teams, accountable communities for health, and other value-based delivery system reforms.

Defining Health-Related Supportive Services

Health-related supportive services—housing, employment support, education and training, and environmental modifications, to name a few—can improve health and well-being, meet care plan goals, enhance the patient experience, and control costs. The focus on health-related supportive services aligns with the goals of the Triple Aim, which aims to improve the patient experience of care; improve the health of populations; and reduce per capita spending on health care. For this brief, the term “supportive services” refers to the actual services themselves, as opposed to the coordination of and connection to such services, which is often covered under care management or care coordination payments.

In June 2015, CMS provided guidance to help states design benefit programs that include a range of flexible services to expand home- and community-based living opportunities and achieve community integration, such as support to individuals experiencing chronic homelessness, assistance with utilities/critical repairs, and tenancy sustaining services.¹⁰ In interviews, CMS officials noted that the new guidance focused on housing and long-term supports and services to create an opportunity for providers to develop relationships with specialized housing-related organizations rather than general care coordination entities. CMS is encouraging state Medicaid programs to “optimize their Medicaid authority” to provide housing-related services, which could potentially free up other state funds for capital housing development.

Most states interviewed for this brief are refining their approaches to providing health-related supportive services with the recognition that these services are essential to improving the health of a patient population; improving quality of care delivery and health outcomes; and reducing disparities for vulnerable populations. Exhibit 1 provides examples of the types of services states are funding as well as payment vehicles used.

Exhibit 1: State Supportive Service Payment Strategies

Program	Payment Model	Examples of Services Offered
Oregon <i>Coordinated Care Organizations</i>	<ul style="list-style-type: none"> Global budget 	<ul style="list-style-type: none"> Education/training Self-help/support group Home remediation
Utah <i>Accountable Care Organizations</i>	<ul style="list-style-type: none"> Risk-adjusted, capitated model with annual increase of no more than two percent 	<ul style="list-style-type: none"> Home remediation Housing assistance
Vermont <i>Blueprint for Health</i>	<ul style="list-style-type: none"> Pooled PMPM for Blueprint providers Capacity payment for CHTs Braided funding for SASH Shared savings for ACOs 	<ul style="list-style-type: none"> Nutritional education Self-help/support group
New York <i>Supportive Housing Services</i>	<ul style="list-style-type: none"> State-only Medicaid funds 	<ul style="list-style-type: none"> Rental subsidy assistance Job training Tenancy support/mediation
Boston, Massachusetts <i>Children’s High-Risk Asthma Bundled Payment</i>	<ul style="list-style-type: none"> Bundled payment 	<ul style="list-style-type: none"> Home visits from CHWs Environmental mitigation supplies

State Case Studies

Oregon Coordinated Care Organizations

Under 1115 Medicaid waiver authority, Oregon uses Medicaid dollars for a broadly defined set of health-related supportive services designed to improve the quality of care while controlling health care expenditures. Oregon’s Coordinated Care Organizations (CCOs), created under the §1115 waiver, are regionally based partnerships of payers, providers, and community organizations that provide coordinated health care for all Medicaid enrollees in the given community. Oregon’s CCOs are paid a global budget with a fixed trend rate and receive incentive payments for meeting performance goals. Per the 2012 waiver terms, this financing strategy requires CCOs to create alternative payment methodologies for providers and implement innovative strategies to support transformation based on community needs.¹¹

To that end, the Oregon Health Authority (OHA) included flexible spending as an element of the CCO program. CCO contract language defines flexible services, in lieu of traditional benefits, as health-related, non-State Plan services intended to improve care delivery, enrollee health, and lower costs. OHA used the following parameters to define the scope of flexible services:

- Health related;
- Not covered benefits under Oregon’s State Plan;
- Lacking billing or encounter codes;
- Consistent with a member’s treatment plan as developed by the member’s primary care team and documented in the member’s medical record;
- Likely to be cost-effective alternatives to covered benefits and likely to generate savings; and
- Likely to improve health outcomes and prevent or delay health deterioration.

Using these parameters as a starting point, OHA engaged a broad set of stakeholders to develop the range of flexible services, conferring with clinical and non-clinical providers as well as non-traditional health workers, such as community health workers, peer wellness specialists, and health navigators.¹² The breadth of categories, including the catchall “other,” was intended to encourage CCOs to be forward-thinking partners; and give care teams authority to provide tailored services for patients on an as-needed basis (see Exhibit 2).

Exhibit 2: Oregon’s CCO Categories of Flexible Services

Category	Examples of Services Offered
1. Training/education for health improvement or management	Class on healthy meal preparation or diabetes self-management curriculum
2. Self-help or support group activities	Postpartum depression programs, Weight Watchers groups
3. Care coordination, navigation, or case management activities not covered under State Plan benefits	High-utilizer intervention program
4. Home/living environment items or improvements, including non-DME items to improve mobility, access, hygiene, or other improvements to address a particular health condition	Air conditioner, athletic shoes, or other special clothing
5. Transportation not covered under State Plan benefits	Transportation to a gym, cooking classes
6. Programs to improve the general community health	Farmers’ market in the “food desert”
7. Housing supports related to social determinants of health	Shelter, utilities, critical repairs
8. Assistance with food or social resources	Supplemental food, referral to job training, or social services
9. Other	At the discretion of the care coordinator

While OHA initially required each CCO to develop a policy broadly defining the scope and implementation plan for flexible services, ultimately OHA elected to use individual patient care plans to identify necessary health-related supportive services. The care manager, with input from the patient, can identify a service need. Then, the Patient Centered Primary Care Home (PCPCH) or another primary care provider from the network collaborates with the CCO to furnish the particular service. While interviewees noted that this process is becoming more familiar to providers, it has taken a while for providers to incorporate flexible services into patients’ care plans and establish procurement procedures.

Oregon’s implementation experiences to date suggest that despite a nearly unanimous agreement that flexible services is an essential component to high-quality care, challenges remain to achieving the broad program aims. CCOs have each had to develop their own policy around the range of supportive services and the delivery strategy. This shift in thinking required by providers to address the full range of patients’ needs and move away from billable codes has taken some time to realize. Achieving consensus between OHA, the CCOs, and community stakeholders regarding the categories of flexible services, implementation policies, and reporting mechanisms required considerable effort and was “not a process that [could] be rushed,” according to one interviewee.

Another challenge to implementing flexible services may have resulted from the broad definitions created by OHA as well as the wide latitude CCOs were given to implement supportive services. While providers were generally on board with this delivery system transformation, the

absence of a defined list of services created considerable ambiguity for the CCOs and the PCPCHs. One interviewee noted that CCOs were more likely to provide flexible services if members of their governing boards were involved in the provision of supportive services in their communities within their communities. Conversely, some interviewees felt that if OHA had defined an explicit list of flexible services, patients and advocates might consider them benefits to which they were legally entitled, which would undermine the objective of the model.

Initial involvement of a broad group of stakeholders, including leadership across CCOs, provider organizations, and members was key to ensuring that all stakeholders understood OHA's goals for the program. Ongoing engagement and technical assistance to the CCOs on implementation have been essential in achieving those goals and working through challenges that have arisen. To assist with the implementation and monitoring of supportive services, OHA provided CCOs with a tracking document to report the services provided, largely at the aggregate cost level. Informants felt that more granular-level reporting (including service and associated cost) might provide more useful information on the types of services provided and may help ensure consistency across the CCOs.

UTAH: ACCOUNTABLE CARE ORGANIZATIONS

Similar to Oregon, Utah also uses §1115 Medicaid waiver authority to finance health-related supportive services to improve health care quality and reduce costs. The state's Medicaid program has enlisted four managed care organizations to serve as ACOs, giving them fairly broad latitude to reward their providers and engage their Medicaid clients. The ACOs, which are full-risk, capitated models, are eligible to use savings to cover health-related supportive services. In 2013, the Utah state legislature passed legislation instructing the Department of Health to pay Medicaid health care providers "for delivering the most appropriate services at the lowest cost" while maintaining or improving quality.¹³ Utah ACO contracts do not specify the range or scope of health-related supportive services, though ACOs have the flexibility to use funds to pay for home/living improvements, self-help support activities, and housing supports.

Vermont Blueprint for Health

Vermont's Blueprint for Health Initiative (the Blueprint is described in statute as "a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care cost by promoting health maintenance, prevention, and care coordination and management."¹⁴ It includes a multi-payer patient centered medical home (PCMH) program, community health teams, a learning system to support continuous improvement, and other programs. Interviewees characterized the delivery of health-related supportive services within Vermont's model as a flexible and cooperative system.

As part of the Blueprint, Vermont has implemented targeted programs such as the Support and Services at Home (SASH) initiative, which connects older Vermonters and persons with disabilities with community-based support services and affordable housing communities. Through SASH, regional affordable housing organizations partner with local service provider organizations, such as home health, mental health agencies, and councils on aging, to create a community-based SASH Team. This team provides comprehensive health and wellness assessments; individualized care plans; on-site one-on-one nurse coaching; care coordination;

and wellness programs. While many of these services are not deemed medically necessary, the Blueprint Initiative funds SASH for these health-related supportive services. Originally solely funded through state and philanthropic support, SASH now also receives funding through Medicare's Multi-Payer Advanced Primary Care Practice Demonstration program (MAPCP). The MAPCP Demonstration provides \$70,000 in funding annually for each panel (roughly 100 patients), which covers the cost of the SASH coordinator and the wellness nurse.¹⁵ Medicaid is the second largest contributor, sourcing funds at both the federal and state level. The Department of Aging and Independent Living, the Department of Vermont Health Access, the Department of Health, and various foundations and grants also provide support. These sources fund the SASH program and not the actual health or long-term care services arranged for through the SASH program. About 4,300 Vermonters are enrolled in SASH at 118 affordable housing sites in all 14 Vermont counties.¹⁶

The primary care providers that are part of the Blueprint use Community Health Teams (CHTs)—multi-disciplinary teams of clinical and non-clinical providers—to connect high-need, high-cost beneficiaries to medical and supportive services in the community. Members of the CHT include nurse care coordinators; case managers; community health workers; and mental and behavioral health workers. CHTs may also include dietitians, asthma educators, and nutritional specialists. The array of health-related supportive services provided by a CHT is at the discretion of CHT leadership, which allows each team to tailor services based on the needs of the community. Accordingly, the range of services provided by CHTs varies widely. Some CHTs have more prescribed processes for managing patients' care, graduating them from intense case management after a defined period, while other CHTs have a more flexible process focused on sustaining partnerships with service providers and community resources to respond to beneficiary needs on a case-by-case basis.

The Blueprint for Health is a multi-payer effort and includes Medicaid, Medicare, and private insurers within the state. Blueprint PCMH providers receive a per-member, per-month (PMPM) payment related to their National Committee for Quality Assurance rating for each patient served. Insurers participating in the Blueprint share the cost for CHTs (called a capacity payment), which amounts to about \$1.50 PMPM.¹⁷ The Medicaid portion of the capacity payment is made monthly and is based on a quarterly count of attributed patients.

CHTs and Blueprint providers track the provision of supportive services on an individual basis—largely through care plans—but do not report utilization to the state. Interviewees identified the use of various data systems in the state as a challenge and Vermont is currently developing plans to improve the integration of health information technology across the state and with providers.

A common theme that all interviewees noted was the importance of stakeholder engagement to ensure comprehensive understanding of the health care delivery model and Vermont's health care reform goals. One administrator credited the success of CHTs to the fact that "everybody has a voice" in the process. Most interviewees felt that the Blueprint model has allowed CHTs to be creative and innovative at delivering cost-effective care with sufficient flexibility to tailor services. Early evaluation results suggest that the Blueprint program is yielding reductions in costs and increased use of preventive services.¹⁸

New York Supportive Housing Services

Supportive housing has been proven to reduce the emergency and inpatient Medicaid costs of homeless individuals and families with behavioral health issues, chronic illnesses, and other barriers to independence.¹⁹ In New York, supportive housing is part of a larger Medicaid Redesign Team (MRT) effort, initiated in 2011.²⁰ The MRT, commissioned by Governor Cuomo to redesign New York's Medicaid program, is a multi-pronged reform effort that includes integrating care for dually eligible beneficiaries, establishing Medicaid health homes, rebalancing services for long-term services and supports, and implementing care management for high-risk populations.

As part of the state's MRT effort, an Affordable Housing Work Group was formed to identify barriers to providing supportive housing and propose solutions. The group of more than 40 stakeholders included: advocates; agencies that operate housing programs; developers; and providers. It recommended allocating funds for capital projects, operating expenses, rent subsidies, and a range of case management services in supportive housing units targeting high-need, high-cost Medicaid recipients. In October 2015, the state launched a two-year, \$10 million project, the *MRT Supportive Housing Olmstead Housing Subsidy Program*, to provide housing services for Medicaid beneficiaries who require nursing home level of care but are not currently residing in a community-based setting.²¹ The program, which will contract with one provider to deliver the services statewide, is designed to satisfy the state's requirements under the U.S. Supreme Court's *Olmstead* decision requiring appropriate home- and community-based services for long-term care recipients. It will use non-Medicaid state funds to provide rental subsidies to participants as well as coordinate those payments with other community services.

This new MRT Housing Subsidy Program connects eligible beneficiaries to housing and related supportive services through a number of different mechanisms and partners. For example, individuals who are eligible for Medicaid health home services also have access to care coordinators who can evaluate patients' supportive housing needs and connect them to available resources. Medicaid health homes, which provide care coordination and referral services to high-risk patients, are required to coordinate with non-health service providers, including supportive housing, and have explicit relationships with community partners that coordinate these services. The supportive housing program also dovetails with the New York's Delivery System Reform Incentive Payment (DSRIP) program. DSRIP has allocated \$9 million dollars over two years for a rental subsidy program to facilitate supportive housing programs in DSRIP provider networks.²²

While Medicaid pays for housing in the form of nursing homes, current federal Medicaid rules do not allow reimbursement for capital funding or rental subsidies for supportive housing.²³ New York is investing state-share Medicaid dollars to expand access to supportive housing for beneficiaries. This includes capital funding for services such as expanding housing units for high-cost Medicaid populations and home modifications to enable individuals to transition or remain in their homes. It also includes rental subsidies, tenancy advocacy, and, for beneficiaries at-risk for becoming homeless, it supports counselling, case management, job development, and clinical supervision. In fiscal year 2015-2016, New York allocated \$47 million in state-share Medicaid funding to expand supportive housing units for high-cost Medicaid populations, \$38 million in rental subsidies and related supportive services, and \$24 million for new supportive housing pilot programs as well as \$2.5 million for tracking and evaluation.²⁴

The Department of Health partners with several state and local organizations (selected through a competitive bidding process) to provide the range of supportive housing services. Sister agencies, such as the Office for Persons with Developmental Disabilities and the Office of Mental Health, are reimbursed through a monthly voucher process with funding decisions determined by the MRT Affordable Housing Workgroup. This workgroup meets regularly to: (1) identify barriers to moving high-needs individuals into supportive housing; (2) evaluate new supportive housing models; and (3) ensure that participating programs are successful. The MRT Supportive Housing program has a robust evaluation component, and the Department of Health is examining enrollee Medicaid spending and utilization to see if housing is having an impact on emergency department and primary care utilization.

Massachusetts' Children's High-Risk Asthma Bundled Payment

Massachusetts chose a targeted approach to paying for the delivery of asthma-related care for high-risk pediatric Medicaid patients. The services that can help ameliorate asthma—such as air filters, pillow covers, and pest control—have documented evidence in the medical literature.²⁵ However, traditionally, Medicaid fee-for-service payments do not cover these services. This set of services, as well as education around disease management, fits well into a bundled payment approach, which provides a single payment for the cost of services delivered by providers over a defined period for an episode of care.²⁶

In 2010, the Massachusetts legislature authorized bundled payments to providers for high-risk pediatric asthma patients enrolled in MassHealth, Massachusetts' Medicaid program. The state worked with the University of Massachusetts Medical Center (UMass) to develop the Children's High-Risk Asthma Bundled Payment (CHABP) program. In 2011, CMS approved an extension to Massachusetts Medicaid's §1115 waiver allowing MassHealth to launch a pediatric asthma pilot program that “may include non-traditional services, supplies, and community supports for environmental home mitigation associated with pediatric asthma.” Finally, in 2014, CMS approved the non-traditional payment protocol, granting authority for the state to implement the program.

CHABP was designed to use an alternative payment methodology to align incentives for appropriate care, including the provision of supportive services. Phase I of CHABP included a \$50 PMPM payment to providers for their high-risk asthmatic patients age two through 18.²⁷ The payments covered an array of well-defined services, including community health workers (CHWs) and supplies to alleviate environmental asthma triggers. Under the proposed program, participating practices were required to use CHWs as part of the care team, monitor the enrollee's need for asthma services monthly, contact the enrollee's family at least every six months, administer an asthma control test at every office visit (at least every six months), and offer self-management education to patients and their families. Participating providers could use a portion of their bundled payments for home environmental assessments, care coordination, and additional contacts with patients and their families for the purposes of disease management. These practices could provide enrollees with environmental supplies to mitigate asthma, such as mattress and pillow covers, HEPA filters, and pest management supplies. Practices could also authorize the CHWs to support families' advocacy with landlords and property managers to ameliorate environmental causes.

In a planned Phase II, the commonwealth intended to evaluate Phase I specifications and develop a new bundle of ambulatory services that would go beyond the supportive services offered in Phase I. Additionally, in Phase II, Massachusetts planned to develop new payment methodologies, including risk adjustment and shared savings.

Unfortunately, CHABP never left the planning stages. By the time MassHealth and UMass were authorized to implement the program, the health care landscape had changed dramatically, including the award of the State Innovation Model Test grant and the development of a Medicaid payment reform program. In addition to a lengthy negotiation period with federal officials to obtain approval for the payment model, challenges to implementing CHABP included: (1) obtaining stakeholder consensus for program features and reimbursement rates; (2) calculating the return on investment; (3) creating an agreed-upon strategy for identifying eligible patients; and (4) ensuring the delivery of appropriate services.

Key Considerations

While there is a strong rationale to pay for supportive services using Medicaid funding, this broadened definition of what is important to maintain the health of populations represents a clear shift from the traditional medical care delivery model. Health care providers, whose clinical training is typically almost exclusively centered on clinical care, have to expand their focus to include both medical and nonmedical supports. As states make this shift, they will need to bring a level of “change management” to their design and implementation approaches. On a practical level, this means that states will want to carefully plan: (1) upfront and ongoing stakeholder engagement; (2) the scope of services initially provided; and (3) tracking and reporting mechanisms.

Engage key stakeholders: Early involvement of stakeholders is a key element in identifying the needs of a patient population along with the array of supportive services available in a community. Oregon and New York involved a broad range of stakeholders from the start, including providers, plans, patients, and advocates to develop the approach for the delivery of supportive services. This kind of engagement can help facilitate relationships with community providers and resources to ensure the non-medical needs of patients are adequately met. Strategic stakeholder engagement also builds a common understanding and commitment to the value of supportive services for the overall health and well-being of a population. This common vision is critical to overcoming initial “start-up” challenges.

Define scope and roll-out of support services: Implementation of supportive services benefits from a flexible approach that balances the need for accountability with program goals. For example, Oregon’s development of flexible services began with broad guidance from OHA, allowing CCOs and providers to determine exactly what services enrollees needed and could be provided. An alternative approach could be for a state to phase-in supportive services, starting with a narrow set of categories and moving toward more broad categories over time, as Massachusetts planned to do with the CHABP. In this case, the first set of flexible services put into place could be relatively narrow (e.g., durable goods, such as athletic shoes, health-related education, or training) with an option to expand later based on feedback from patients and

providers. This would allow a gradual shift in thinking related to these types of services, making it easier for providers to conceptualize, manage, and track.

Establish tracking mechanisms: Tracking and reporting supportive services can be done iteratively during the implementation phase, with the goal of working toward more detailed data reporting in subsequent periods. This ensures consistency across providers, though the challenge with reporting rests in the need to maintain the flexible nature of health-related supportive services and avoid the services becoming viewed as entitled benefits.

These are key factors states need to consider related to the implementation of nonclinical and flexible services for Medicaid beneficiaries. The states profiled in this brief are pioneering new payment approaches to support non-medical services for Medicaid enrollees. While the design and evidence for these programs are still emerging, the experiences of these states provide early lessons to help inform other states in designing programs to better address the social determinants of health for their Medicaid populations.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

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