Center for Health Care Strategies

Partnering to Improve Care Coordination and Engagement for People Facing Housing Insecurity: Staten Island Performing Provider System, Healthfirst, Ready Computing, and Samaritan

People experiencing housing insecurity are a priority population for many state Medicaid programs, including in New York State. Housing insecurity negatively impacts physical and mental health and is a barrier to health care access.[1] Within the health care sector, it can be difficult to engage people experiencing housing insecurity for various reasons, including due to a lack of reliable communication channels or individuals who routinely relocate, making it difficult to manage this population's care and improve their health.

New York State Medicaid addresses health-related social needs (HRSN) through a range of initiatives,[2] including a 2024-approved 1115 waiver that established Social Care Networks (SCNs).[3] SCNs are centralized entities that coordinate networks of community-based organizations (CBOs) that provide social needs assessments, care navigation, and services such as nutrition, housing, and transportation to Medicaid enrollees.[4]

AT-A-GLANCE

Goal: Help connect Medicaid enrollees with housing insecurity to social and medical services by integrating information technology systems and implementing member incentives.

Partners: Staten Island Performing Provider System, Healthfirst, Ready Computing, Samaritan

Location: Staten Island, New York

Target Population: Medicaid enrollees facing housing insecurity and with insulin dependence and type 1 diabetes; pilot later expanded to all Medicaid enrollees facing housing insecurity

Key Outcomes: Participating members had high engagement in completing action steps related to addressing their health and social needs. The completion of these action steps helped members earn incentive payments that could be used to help pay for essential needs and led to increased visits to primary care.

In alignment with New York State's HRSN priorities and in support of individuals facing housing insecurity, the Staten Island Performing Provider System (SIPPS) — one of nine SCNs in New York State — partnered with Healthfirst (a Medicaid health plan), Ready Computing (a tech company focused on care coordination and HRSN), and Samaritan (a company offering a tech-enabled member engagement and support model).

Together, they launched a pilot program to better connect people facing housing insecurity to medical and social services. Between May 2024 and February 2025, the pilot sought to: (1) enhance care coordination to address HRSN; and (2) test how financial incentives could motivate members to engage with care managers and achieve personal health goals. The pilot was supported through the *Medicaid Innovation Collaborative* (MIC).

Implementation Approach

For the pilot, SIPPS acted as the convener for all partners — including Healthfirst, Ready Computing, and Samaritan — and served as the main contracting entity. The partners organized their implementation efforts around three tightly linked workstreams. Following is a brief overview of each activity:

- **Connecting IT systems.** Prior to the launch of the pilot, from February through April 2024, the project partners integrated their systems to support seamless data sharing. Ready Computing, which had an existing relationship with Healthfirst and SIPPS, provided the Channels 360 platform used by SIPPS case managers to conduct health risk assessments and make referrals if a need was identified. For the pilot, Ready Computing connected its system to Samaritan's platform. Samaritan was a new partner offering one of the member services during the pilot.

- **Participant identification and enrollment**. Pilot participation initially included Healthfirst enrollees who were: (1) living in Staten Island with a homeless designation; and (2) insulin dependent and diagnosed with type 1 diabetes, as identified by ICD-10 and prescription data. Healthfirst provided a list of 597 eligible members to Ready Computing, with a goal of including 100 participants in the pilot. The criteria were later expanded to include all enrollees facing housing insecurity because there were not enough individuals who had type 1 diabetes and were housing insecure to form a sufficient sample size. Using Ready Computing's platform, SIPPS care managers conducted outreach to eligible members and completed health risk assessments. If the assessment identified an unmet need, SIPPS care managers made referrals to appropriate HRSN services, including Samaritan's incentives program (described below).

- **Member-level support and incentives**. A total of 81 individuals consented to join the pilot and signed up for a Samaritan membership. Samaritan provides members with financial bonuses for completing steps outlined in their care plan, and connects them to a social safety net to encourage successful, long-term engagement with health and social care. Members then flexibly use the funds they receive to overcome financial barriers to improved health and housing access.

  Care managers — either employed by SIPPS or Project Hospitality Health Homes, a SIPPS partner — used the Samaritan platform to create personalized monthly

health and health-related action steps for members to complete through text message or a web portal. Action steps included activities that were important to members' care plan (e.g., visiting a primary care physician) and related to well-being needs (e.g., visiting a local food bank). Completion of action steps triggered financial incentives: members earned $10 per action completed, up to $40 per month, distributed through Samaritan-issued debit cards. The cards functioned as traditional debit cards, but included restrictions on businesses that primarily sell substances, like smoke shops or liquor stores, and on cash withdrawals or money transfers. The incentives were funded by SIPPS through MIC, with additional support through local community donations. Throughout the pilot, participants received encouragement by text messaging and through direct contact from their SIPPS care managers to keep them motivated.

Implementation Lessons

- **Integrating systems to enhance care coordination.** An important component of this pilot was making sure the partners were able to easily share data across platforms to support continuity of services, identify gaps in services, and better evaluate services. Ready Computing's support in integrating systems and developing a mobile app for care managers enabled partners to refine their workflows, better connect people to services, and coordinate work across organizations, ultimately making care coordination more effective.

- **Commitment to program evaluation.** Gathering robust data to support a strong pilot evaluation was a shared priority among all partners. In addition to supporting care coordination, integrating IT systems was critical to collecting data for program evaluation. The pilot participants successfully collaborated to implement the necessary data reporting to inform the evaluation. For future work, participants also learned that data collection could be improved by proactively identifying key data elements and developing a plan to capture them consistently across IT systems.

- **Building on existing partnerships and organizational strengths.** Existing relationships provided a solid foundation for the pilot, with SIPPS, Healthfirst, and Ready Computing having relationships and systems that were already integrated with each other. SIPPS' role as the main contracting organization in the pilot was also helpful, given its prior experience as a convener on an array of Medicaid initiatives. Ready Computing and Samaritan also appreciated the open line of communication and relationship with Healthfirst, which made it easier to identify the target population and quickly launch the pilot. These relationships made it easier to link platforms, share data, and refer enrollees to the services needed.

Impact

The targeted outcome goals for the pilot, outlined in **Exhibit 1**, included the number of enrolled members, completion of action steps, dollars earned through incentives, and primary care utilization. The pilot partners selected these measures to assess the ability to reach and engage the target population, identify and meet enrollees' HRSN, and engage individuals in primary care. As summarized in Exhibit 1, the initial outcomes for the pilot were promising, exceeding most of the targets. Financial incentives were associated with a high percentage of action steps completed.

Exhibit 1. Initial Outcomes from Pilot (as of February 2025)

Measure	Target Goal	Outcome
Member engagement	>=100 members	81 members (received SIPPS HRSN assessment and Samaritan membership)
Percentage of action steps completed	>=60% action steps completed	90.5% action steps completed
Dollars earned through Samaritan	Not set during the pilot	Average $434.25 per enrollee; $37,345.50 for all enrollees
Primary care utilization post engagement	>=75% with at least one primary care claim in the post-engagement period*	94% had at least one primary care claim in the post-engagement period*

The post-engagement period is the timeframe after a member receives a Samaritan membership, which could have been anywhere between May 2004 and February 2025.

In addition to these quantitative measures, the pilot evaluation also captured member experiences. For example, one member completed 20 health care appointments and worked with her case manager to achieve HRSN goals, like engaging in meal planning and job searching. She used financial incentives earned from completing action steps to cover transportation costs. With Samaritan's support, she was able to better manage her health, improve her well-being, and overcome health barriers. Another member used incentive earnings to pay for a late cell phone bill, a GED study guide, and a calculator.

Healthfirst intends to conduct a final, in-depth analysis in September 2025 to assess return on investment of the pilot. The upcoming analysis will look at claims data to evaluate primary care and emergency department use in the 12 months post-engagement period, A1C levels, and total cost of care.

Looking Ahead

Based on the initial results, the pilot partners have expressed interest in further collaboration and are exploring opportunities to continue partnerships in the future. Sustainability is a key challenge to address: while the Samaritan platform and intervention are aligned with New York State's 1115 waiver priorities of increasing HRSN screenings and navigation, the model does not currently qualify for Medicaid payment. SIPPS and Samaritan are exploring adapting the pilot's approach to more closely align with the state's current policy framework for supporting the development of HRSN infrastructure to support providers in engaging and retaining unstably-housed Medicaid members.

Going forward, renewed federal policy interest in individual-level incentives, as signaled by the Centers for Medicare & Medicaid Services' Innovation Center strategy to "Make America Healthy Again," may open new avenues for Medicaid stakeholders to test and sustain innovative approaches to care.[5]

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ENDNOTES

1 U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Housing Instability*. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability

2 New York State Department of Health. (2024). *Social Care Initiatives*. https://www.health.ny.gov/health_care/medicaid/redesign/sdh/#:~:text=Promoting%20Health%20Equity%20Through%20Integrated,@health.ny.gov.

3 NYC Health. (n.d.). *New York Medicaid 1115 Waiver*. https://www.nyc.gov/site/doh/providers/resources/medicaid-1115-waiver.page

4 New York State Department of Health. (2025). *Social Care Networks (SCN).* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/

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