HOUSING FOR HEALTH:

The Impact of Housing on Healthcare Costs and Utilization for Unhoused New Yorkers

Evidence from MetroPlusHealth
and NYC Health + Hospitals
Housing for Health Partnership



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Executive Summary

Recognizing the strong connection between housing, homelessness and patient health, there is a growing understanding among healthcare systems and managed care organizations that "housing is healthcare." The partnership between NYC Health + Hospitals, the nation's largest municipal healthcare system, and MetroPlusHealth, a high-quality affordable health plan, demonstrates the positive social and economic return on investment of connecting patients experiencing homelessness to permanent housing. Together, this partnership supports members in breaking the cycle of homelessness through linkage to permanent housing and intensive case management.

Wakely Consulting Group (Wakely) performed a comparative analysis of MetroPlusHealth-insured patients (or MetroPlusHealth members) experiencing homelessness who were housed through the NYC Health + Hospitals Housing for Health (HfH) housing navigation program. The analysis evaluated medical costs and utilization before and after housing placement and compared outcomes relative to two control groups. The comparison group used in this analysis was a high morbidity control group of MetroPlusHealth members experiencing homelessness with a similar cost profile.

This analysis showed that mutual NYC Health + Hospitals/MetroPlusHealth patients housed by HfH showed decreased acute care utilization, especially in the first year of being housed.

Key Findings

In the two years following housing placement, patients experienced significant reductions in acute care utilization, including a 40% reduction in emergency department (ED) visits and 36% reduction inpatient hospital admissions. Over the course of the 24 months following housing, the number of inpatient days per person per year decreased from an average of 10 days (pre-housing) to 5 days per year. Over the same time period, patients had 0.9 fewer emergency department visits per person per year (from an average of 2.3 emergency department visits per person per year before being housed to 1.4 visits per person per year after being housed).

Medical and pharmacy Medicaid managed care costs showed savings of $17,000 over the first two years after housing—equivalent to $3.2 million in aggregate—primarily driven by a 50% to 60% decrease in inpatient costs.

Engagement in primary and specialty care increased, likely due to patients' ability to manage their ongoing and preventive care once housed. In the second year following housing, the number of average preventive visits per person per year increased from an average of 1.7 (pre-housing) to 1.9 visits per year.

Findings from a matched control group analysis suggest that this pre/post-analysis was not driven solely by expected cost reversion among a high-cost population, but was instead consistent with meaningful change in utilization patterns following housing placement.

Recommendations

This unique partnership demonstrates a model for shared savings between a public safety net healthcare system and value-based payment health insurance provider. Health systems, payers, and policymakers can use this model as a framework for investment in housing navigation and placement for patients experiencing homelessness by demonstrating the financial return through shared savings and preferential changes in utilization patterns.

The findings suggest that housing can function as an effective health intervention for a high-needs population experiencing homelessness by reducing reliance on crisis-driven care and supporting more appropriate patterns of service use. For health systems, Medicaid managed care organizations, and policymakers, the results provide evidence that housing-related interventions may reduce avoidable utilization while improving access to care. These findings should be interpreted with appropriate caution given the limited study population and the constraints inherent in a nonrandomized observational study; however, they do support continued evaluation of HfH and the broader role of housing in population health and total cost of care strategies.



Why Housing Matters for Health

Patient health outcomes are demonstrably tied to housing status, as individuals experiencing homelessness have poorer health outcomes than the general population. Even when controlling for socioeconomic status, individuals experiencing homelessness have higher rates of premature mortality, chronic and infectious disease, mental health conditions, and substance use disorders.[1,2] Hospital systems in communities with a large, unhoused population, such as NYC Health + Hospitals, must grapple with unmet social needs to adequately treat their patients' medical and behavioral health conditions.

Homelessness rapidly ages people because of their substantial unmet health-related social needs. Patients experiencing homelessness present with the clinical profile of housed patients who are 20 years older.[3] The medical and social complexity of patients experiencing homelessness is therefore out of sync with the typical needs of a patient of the same biological age. Recent data show that the aged homeless population—individuals living in shelters who are ages 65 and older—has quadrupled.[4] A cohort study showed that among older homeless adults, the leading causes of premature mortality were heart disease and cancer.[5]

Under value-based payment arrangements like that between NYC Health + Hospitals and MetroPlusHealth, healthcare costs are reimbursed in a manner that reflects quality, safety, and efficiency—not volume of services rendered like in a typical fee-for-service model. It is therefore of concern that, in addition to poorer health outcomes caused by housing insecurity, patients experiencing homelessness account for a disproportionately higher percentage of healthcare spending[6] due to higher rates of ED utilization, more unmet medical needs, and longer inpatient stays.[7,8]

Although homelessness remains an acute public health challenge in New York and nationwide, research shows that placing formerly homeless patients into permanent housing positively affects both their physical and mental health.

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1 Garcia C, Doran K, Kushel M. Homelessness and Health: Factors, Evidence, Innovations That Work, and Policy Recommendations. Health Aff. February 5, 2024. doi:10.1377/hlthaff.2023.01049

2 Burgard SA, Seefeldt KS, Zelner S. Housing Instability and Health: Findings from the Michigan Recession and Recovery Study. Soc Sci Med. doi:10.1016/j.socscimed.2012.08.020

3 Brown RT, Hemati K. Riley ED, Lee CT, Ponath C, Tieu L, Guzman D, Kushel MB. Geriatric Conditions in a Population-Based Sample of Older Homeless Adults. Gerontologist. 2017. doi:10.1093/geront/gnw011

4 Culhane D, Treglia D, Byrne T, Metraux S, Kuhn R, Doran K, Johns E, Schretzman M. The Emerging Crisis of Aged Homelessness: Could Housing Solutions Be Funded by Avoidance of Excess Shelter, Hospital, and Nursing Home Costs? University of Pennsylvania. 2019. Available at: https://www.aisp.upenn.edu/wp-content/uploads/2019/01/Emerging-Crisis-of-Aged-Homelessness-1.pdf

5 Brown RT, Evans JL, Valle K, Guzman D, Chen YH, Kushel MB. Factors Associated with Mortality Among Homeless Older Adults in California: The HOPE HOME Study. JAMA Intern Med. doi: 10.1001/jamainternmed.2022.3697

6 Doran KM, Misa EJ, Shah NR. Housing as Health Care — New York's Boundary-Crossing Experiment. N Engl J Med. doi:10.1056/NEJMp1310121

7 Lebrun-Harris LA, Baggett TP, Jenkins DM, et al. Health Status and Health Care Experiences Among Homeless Patients in Federally Supported Health Centers: Findings from the 2009 Patient Survey. Health Serv Res. doi:10.1111/1475-6773.12009

8 Taylor SN, Munson D. Health Care of People Experiencing Homelessness: Part I. NEJM Evid. doi:10.1056/EVIDra2300123

In 2016, the Federal Department of Housing and Urban Development's Family Options study found that after receiving long-term housing subsidies through the Housing Choice Vouchers program (i.e., Section 8 vouchers), families demonstrated improved health and well-being, as well as housing stability, in years two and three following housing placement.[9] Likewise, research conducted by the Center for Outcomes Research and Education at Providence Health and Services found that formerly homeless patients placed in permanent supportive housing reported improved physical and mental health status and overall well-being, as well as an improved ability to get their healthcare needs met.[10]

Addressing unnecessary utilization of acute services and increasing access to preventive care are tenets of the value-based payment framework. Research shows that housing formerly homeless patients strongly affects their healthcare utilization as well, reducing acute hospital use, including ED visits and admission days, and decreasing Medicaid costs—especially when housing programs focus on frequent utilizers.[11,12,13,14]

For example, a 2017 evaluation of Los Angeles County's Housing for Health program found that placement into permanent supportive housing showed significant impacts on healthcare utilization. After just one year, the program saw a 68% reduction in ED visits, a 77% drop in inpatient hospitalizations, and a 60% decrease in mental health crisis stabilization services. Further, the program saved over $1.20 for every dollar spent, totaling more than $6.5 million in healthcare savings for Los Angeles County.[15]

Existing studies show that most individuals who move into permanent supportive housing remain stably housed, with a long-term retention rate of 98%.[16,17] Placement in secure housing provides the stability patients need to manage their health and promote improved long-term health outcomes. Utilization of outpatient care increased upon permanent housing placement, such as increased engagement with primary care, specialty care, and substance

9 Gubits D, Shinn M, Wood M, et al. Family Options Study: 3-Year Impacts of Housing and Services Interventions for Homeless Families. US Department of Housing and Urban Development, Office of Policy Development and Research. October 25, 2016. Available at: https://www.huduser.gov/portal/publications/Family-Options-Study.html.

10 Wright BJ, Vartanian KB, Li HF, Royal N, Matson JK. Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing. Health Aff. doi:10.1377/hlthaff.2015.0393

11 Doran KM, Misa EJ, Shah NR. Housing as Health Care — New York's Boundary-Crossing Experiment. N Engl J Med. doi:10.1056/NEJMp1310121

12 Wright BJ, Vartanian KB, Li HF, Royal N, Matson JK. Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing. Health Aff. doi:10.1377/hlthaff.2015.0393

13 Levanon Seligson A, Lim S, Singh T, et al. New York/New York III Supportive Housing Evaluation: Interim Utilization and Cost Analysis. A report from 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, 2013. Available at: https://shnny.org/images/uploads/NY-NY-III-Interim-Report.pdf.

14 Housing Alliance of Pennsylvania. Housing Is Health Care for Persons Experiencing Homelessness. Available at: https://housingalliancepa.org/wp-content/uploads/HAPA001_1911_HousingisHealthcare-Homelessness-C3.pdf.

15 Hunter SB, Harvey M, Briscombe B, Cefalu M. Evaluation of Housing for Health Permanent Supportive Housing Program. RAND Corporation. December 5, 2017. Available at: https://www.rand.org/pubs/research_reports/RR1694.html.

16 National Alliance to End Homelessness. What Is Housing First? March 20, 2022. Available at: https://endhomelessness.org/resources/toolkits-and-training-materials/housing-first/

17 Lim S, Singh TP, Hall G, Walters S, Gould LH. Impact of a New York City Supportive Housing Program on Housing Stability and Preventable Health Care among Homeless Families. Health Serv Res. doi:10.1111/1475-6773.12849

Housing for Health and MetroPlus Success Story

After years of chronic homelessness, Mr. R achieved what once felt out of reach: a full year of being stably housed in his own apartment. In February 2025, the MetroPlus Housing Task Force referred Mr. R to HfH for housing navigation and placement. The housing specialist soon met with Mr. R in the community at his shelter to assess his eligibility for housing opportunities and assemble the application materials needed for housing, including vital documents and proof of income.

HfH identified multiple housing opportunities, and he quickly began housing interviews. The HfH housing specialist coached him before the interviews and accompanied him to these interviews.

By May 2025, Mr. R had successfully moved into a supportive housing unit. The HfH team continued to work with him after he moved in, ensuring he had basic household items in his apartment as well as the community-based supports needed to thrive in his new neighborhood.

Once housed, Mr. R was able to actively engage in his own recovery journey. Through his HfH team and supportive housing case managers, he was able to connect with behavioral health providers, improve his mental health and develop vocational skills. He soon developed more confidence and built new meaningful social connections. Less than one year after move in, Mr. R successfully completed peer counselor training and began working as a peer counselor in the healthcare field.

Today, Mr. R remains stably housed, actively engaged in mental health treatment, and fully employed, helping others navigate their own journey—an inspiring example of resilience and recovery. This success story reflects both Mr. R's determination, as well as the strength of a comprehensive collaboration like HfH and the MetroPlus Housing Task Force. Hospital-based housing navigation programs like HfH are critical to breaking cycles of homelessness, by delivering coordinated, person-driven care that advances both individual recovery and broader system impact.

use treatment. [18,19] Although the findings in this report focus on healthcare savings, it is also relevant to note reduced societal costs due to decreased days in jails, emergency shelters, and state psychiatric institutions.[20]

18 Miller-Archie SA, Walters SC, Singh TP, Lim S. Impact of Supportive Housing on Substance Use-Related Health Care Utilization Among Homeless Persons Who Are Active Substance Users. Ann Epidemiol. doi:10.1016/j.annepidem

19 National Academies of Sciences, Engineering, and Medicine. Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness. doi:10.17226/25133

20 Levanon Seligson A, Lim S, Singh T, et al. New York/New York III Supportive Housing Evaluation: Interim Utilization and Cost Analysis. A report from 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, 2013. Available at: https://shnny.org/images/uploads/NY-NY-III-Interim-Report.pdf.

Recognizing the influence that housing and homelessness have on patients' health, more healthcare systems and managed care organizations are investing in housing for their members.[21] A 2020 study found that 52 hospitals and healthcare systems across the country had committed over $1.6 billion in housing-related projects.[22,23]

NYC Health + Hospitals and MetroPlusHealth's analysis of patient experience (page 7) reinforces that the population we serve is representative of the literature. On average, NYC Health + Hospitals patients experiencing homelessness visited NYC Health + Hospitals EDs three times more often than their housed peers. Further, patients experiencing homelessness were more likely to have an inpatient visit and stayed four times longer across their admissions. NYC Health + Hospitals and MetroPlusHealth have invested in the HfH initiative based on a shared understanding that the placement of this population into stable housing saves lives, improves health outcomes, and reduces avoidable ED and inpatient care.

The successful partnership between NYC Health + Hospitals and MetroPlusHealth adds to the existing literature, reinforcing the connection between health outcomes and a patient's housing status. By sharing the results from the first two years of this partnership, NYC Health + Hospitals and MetroPlusHealth seek to demonstrate how strategic investments in housing navigation and placement can be mutually beneficial for provider systems, payers, and, importantly, patients themselves. This partnership can serve as a replicable model for other health or payer systems seeking to address homelessness among the people they serve.

Housing for Health Program Overview

NYC Health + Hospitals is the nation's largest municipal safety net healthcare system, serving over 1 million patients annually across an integrated network of hospitals, neighborhood health centers, long-term care sites, and home health services in the five boroughs of New York City. NYC Health + Hospitals is the city's largest healthcare provider for Medicaid enrollees, behavioral health patients, and uninsured individuals.

MetroPlusHealth, a wholly owned subsidiary of NYC Health + Hospitals, contracts under a value-based payment arrangement and provides health insurance coverage to hundreds of thousands of New Yorkers through Medicaid, Medicare, Marketplace, and commercial plans. MetroPlusHealth's mission is to ensure every New Yorker has access to affordable, quality healthcare, with a firm belief that everyone deserves the peace of mind that comes with guaranteed healthcare at little to no cost. In 2025, more than 61,000 adult and 17,000 pediatric patients of NYC Health + Hospitals

21 Garcia C, Doran K, Kushel M. Homelessness and Health: Factors, Evidence, Innovations That Work, and Policy Recommendations. Health Aff. February 5, 2024. doi:10.1377/hlthaff.2023.01049

22 Ibid

23 Horwitz LI, Chang C, Arcilla HN, Knickman JR. Quantifying Health Systems' Investment In Social Determinants Of Health, By Sector, 2017–19. Health Aff (Millwood). doi:10.1377/hlthaff.2019.01246

experienced homelessness—more than any other healthcare system in New York City. Further, MetroPlusHealth serves a significant number of members experiencing homelessness, with over 19,000 MetroPlusHealth members known to the City's shelter system during the past year. Given the high proportion of MetroPlusHealth members who receive care at NYC Health + Hospitals, this presents clear opportunities for collaboration.

As New York City contends with high rates of homelessness—the average daily census of individuals in shelter exceeded 80,000 every month of fiscal year 2025—NYC Health + Hospitals and MetroPlusHealth have launched several initiatives to enhance healthcare access for people experiencing homelessness and create more pathways to temporary and permanent housing.[24] Launched in 2018, the MetroPlus Housing Task Force was developed to address the needs of their highest risk members experiencing homelessness. The MetroPlus Housing Task Force's primary goal is to help stabilize these members, assist in finding appropriate housing placements, and provide ongoing care management to improve their overall health and well-being.

Alongside MetroPlusHealth' efforts, in 2022, NYC Health + Hospitals launched Housing for Health, a comprehensive initiative to facilitate a universal point of access to housing for patients experiencing homelessness. HfH provides access to housing navigation services and housing opportunities through cross-sector collaborations with community-based organizations, city and state government agencies, funders, housing developers and owners. HfH receives referrals directly from the healthcare system's frontline providers and MetroPlus Housing Task Force, connecting patients to housing navigation supports, and collaborates with sister agencies and housing developers to facilitate access to housing opportunities.

New York City has a robust but complex public and private housing ecosystem. High-risk or medically vulnerable unhoused New Yorkers often need additional support to navigate into permanent, stable housing. HfH offers intensive housing navigation and housing retention support to ensure NYC Health + Hospitals patients can successfully navigate to and stay in permanent housing. Through contracted community-based providers, HfH meet patients within the healthcare system's facilities and in the community to conduct housing assessments, assemble housing packages, identify housing opportunities, and navigate their placement into permanent housing. HfH stays connected with the patient in the first year post-housing to ensure patients have what they need to successfully transition into permanent housing through flexible housing retention supports.

As part of the NYC Health + Hospitals and MetroPlusHealth partnership to better serve mutual patients experiencing homelessness, the MetroPlus Housing Task Force works with HfH to identify and refer MetroPlusHealth members to HfH for housing navigation and permanent housing opportunities. As of June 30, 2026, HfH and the MetroPlus Housing Task Force have jointly placed 918 households (1,357 individuals) in permanent housing.

24 NYC Department of Homeless Services. DHS Data Dashboard – Fiscal Year 2025 Q4. Available at: https://www.nyc.gov/assets/dhs/downloads/pdf/dashboard/FY25-Q4-DHS-Data-Dashboard-Charts.pdf.

Study Design and Methodology

This analysis was designed to estimate the impact of the HfH program on healthcare utilization and costs for MetroPlusHealth members experiencing homelessness who were subsequently housed through the program.

Longitudinal Pre- and Post-Housing Methodology

Wakely's analysis involved a longitudinal comparison of utilization and Medicaid costs for the cohort of members who were part of the HfH program pre- and post-housing. The HfH study group was composed of Medicaid MetroPlusHealth members that secured housing through HfH at any point during our study period. Wakely further limited the cohort to members with at least six months of living unhoused before the HfH housing move-in date. The analysis used medical and pharmacy claims data from January 2022 through October 2025 among MetroPlusHealth Medicaid members, with claim costs trended to October 2025 to bring these data to a consistent cost basis. Experience was evaluated for the following three enrollment segments relative to the housing move-in date:

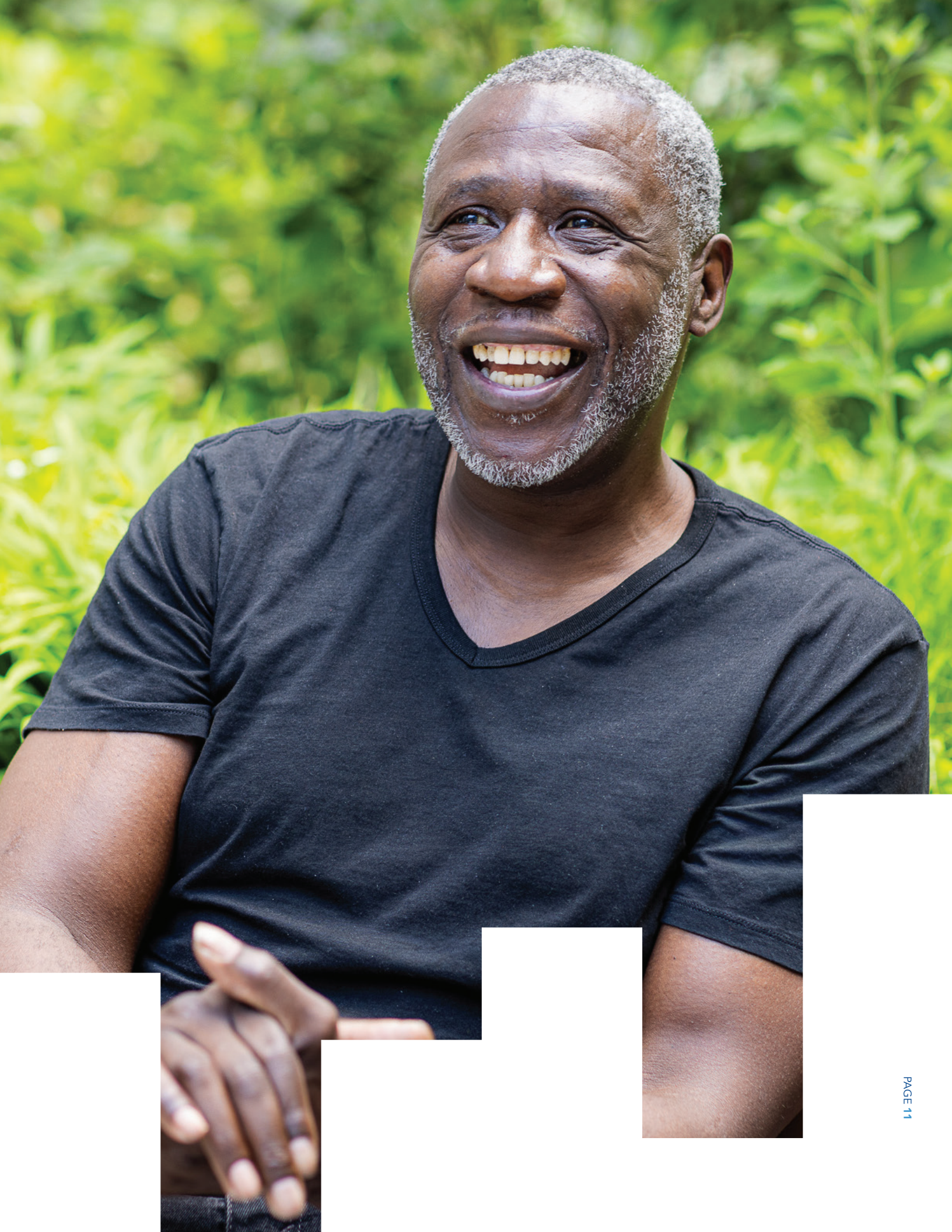
1. 12-month pre-housing period
2. 12-month post-housing period
3. 13- to 24-month post-housing period (where available)

For the HfH study group cohort, we were able to identify 259 distinct members, with 2,594, 2,760, and 1,572 member months in the three enrollment segments, respectively. The members had above average risk, with Clinical Risk Group (CRG) scores ranging from 1.42 to 1.61 by enrollment period segment (see Table 1).

Medicaid claims data were limited to the earliest of: the study end date (October 2025), loss of enrollment with MetroPlusHealth, or return to unhoused status. MetroPlusHealth monthly eligibility data combined with the shelter data provided by Maximus[25] showed that six members have returned to the unhoused status (shelter) during our study period after a period of securing housing through HfH.

The primary outcome measures included medical and pharmacy costs and key utilization indicators. Costs were evaluated on a per member per month (PMPM) basis and summarized across inpatient (IP), ED, outpatient (OP), professional (primary care, specialty, and other), ancillary, and pharmacy services. Utilization was measured per 1,000 members per year, with particular emphasis on ED visits and inpatient admissions. This structure allowed the analysis to assess both total savings and changes in service mix patterns following housing placement.

25 Maximus is a New York State Department of Health contractor that operates New York Medicaid Choice (NYMC), New York State's Medicaid enrollment broker. Maximus supports Medicaid enrollment activities and provides managed care organizations with member data, including reports to identify Medicaid members residing in homeless shelters.



Control Group Validation Methodology

To reduce the risk of overstating program impact as the result of regression to the mean over time, the pre-/post-analysis results were validated against control group experience to better isolate the effects associated with housing placement. Two control group populations were selected:

1. Control Group 1 consisted of members meeting the same homelessness criteria as the study group, including at least six consecutive months flagged as unhoused, but who were not housed through HfH. This broader control population had materially lower average morbidity than the HfH study group, so a second comparison population was also created.
2. Control Group 2 was defined as the highest-morbidity subset of Control Group 1, representing the top 20% of members ranked by CRG risk score and selected to more closely resemble the study group's pre-housing cost profile.

Control group experience included only months during which members met homelessness criteria, maintained MetroPlusHealth coverage, and had reached six months of observed homelessness. Table 1 summarizes the comparison of the analysis groups' characteristics.

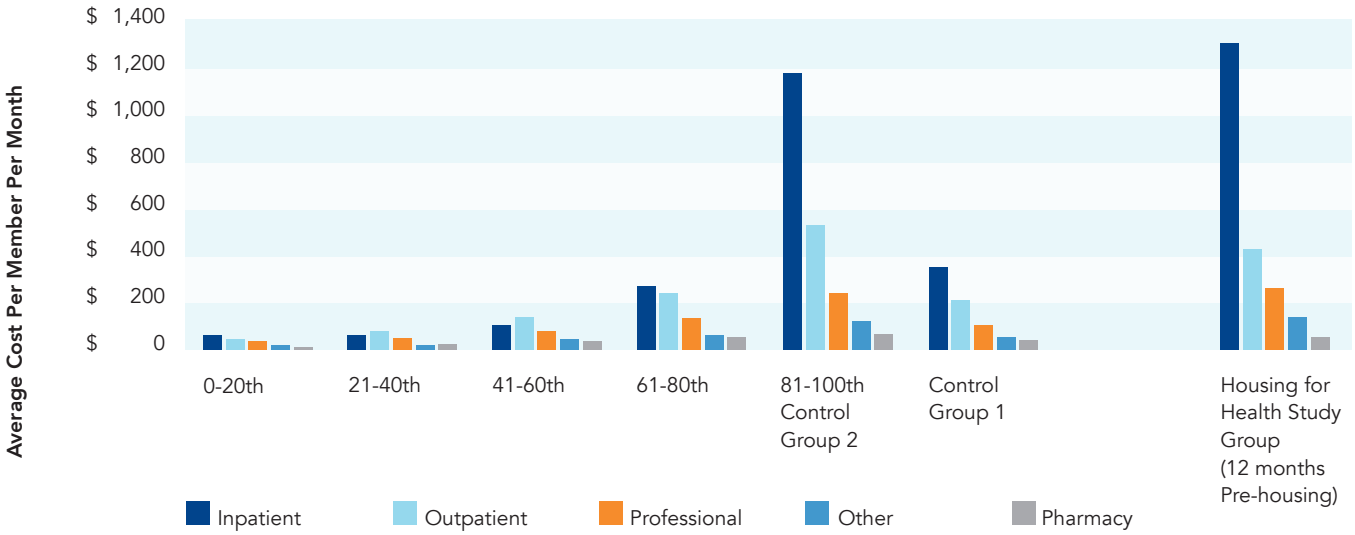
Table 1. Analysis Cohort Group's Characteristics

	Housing for Health Study Group (12 months Pre-housing)	Housing for Health Study Group (12 Months Housed)	Housing for Health Study Group (13-24 Months Housed)	Control Group 1	Control Group 2
Total Member Months [a]	2,594	2,760	1,572	253,385	54,699
Number of Members per Year[26] ([a]/ 12)	216	230	131	21,115	4,558
Avg CRG Risk Score	1.49	1.42	1.61	0.92	2.79

26 Because most members do not have 12 months of enrollment in any given year, this metric translates the total members months into full member years by dividing the total number of member months by 12.

Figure 1 presents the comparison of the Control Group 1 split into risk score quintiles, with the top quintile being selected as Control Group 2. The lowest three quintiles of Control Group 1 reflect low-utilizer members with lower than average costs in all service categories (inpatient, outpatient, professional, pharmacy and other services). The top quintile cost profile aligns closely with the cost profile of the study group's experience 12-months preceding the participation in the HfH housing program. In contrast, the Control Group 1 overall average cost profile is significantly below the study group's costs.

Figure 1. Analysis Groups Comparison



Risk adjustment was incorporated to improve comparability between the HfH study group and Control Group 1. CRG risk scores were used to normalize differences in morbidity, recognizing that the HfH study group entered the program with substantially higher average risk and costs than the broader unhoused control population. During data review, additional adjustments were made in cases where members had significant allowed costs but a CRG score of zero, with prior-year scores substituted when appropriate.

Even with this normalization, the CRG methodology was limited for fully matching the HfH study group. Hence, Control Group 2 was constructed as a higher-morbidity comparison group with a raw cost profile more closely aligned with the HfH study group, allowing for a more intuitive benchmark of post-housing performance. This approach reduced the bias inherent in a simple pre-/post-analysis and provided a more reliable basis for interpreting the estimated savings and utilization changes associated with HfH program.


Woodhull
Ambulatory Care
Safety Net

Key Findings

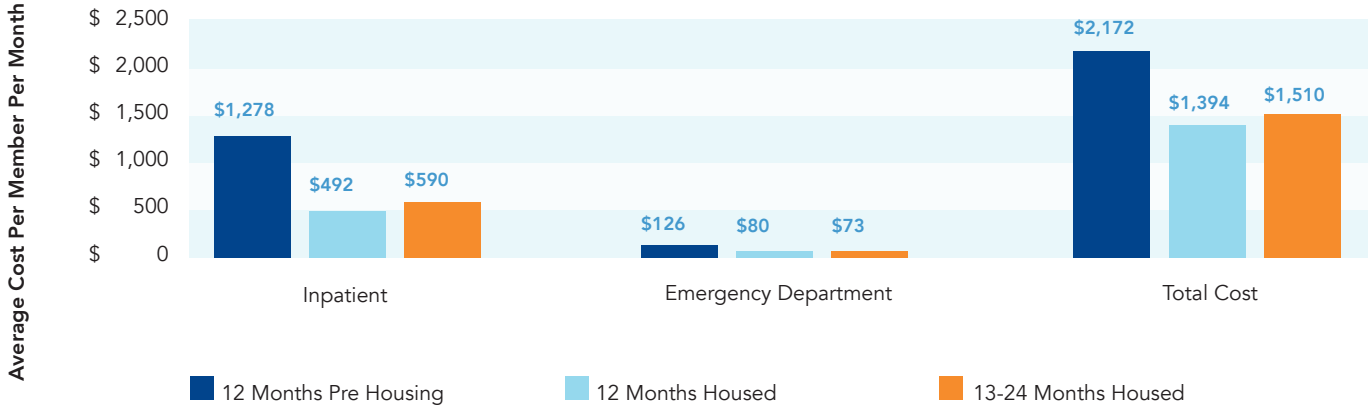
Longitudinal Pre- and Post-Housing Analysis Findings

The analysis found that housing placement through HfH was associated with meaningful reductions in total medical and pharmacy spending. Total allowed costs declined from $2,172 PMPM in the 12 months prior to housing to $1,394 PMPM in the first 12 months after housing placement, a reduction of $778 PMPM. In the 13–24-month post-housing period, total allowed costs remained below baseline at $1,510 PMPM, or $662 PMPM lower than pre-housing experience. On a per member per year basis, these changes corresponded to estimated savings of approximately $9,337 in the first post-housing year and $7,939 in the second year, with aggregate annual savings estimated at $2.15 million and $1.04 million, respectively.[27]

The largest source of savings was a substantial decrease in inpatient costs. Inpatient costs fell from $1,278 PMPM before housing to $492 PMPM in the first post-housing year and remained well below baseline at $590 PMPM in the second year. This reduction—representing a decrease of roughly 54% to 61%, depending on the comparison period—was the primary driver of the overall savings observed. These cost reductions were accompanied by corresponding decreases in utilization, as inpatient admissions per 1,000 fell from 800.3 pre-housing, 682.6 in the first year post-housing placement, and 511.5 in the second year.

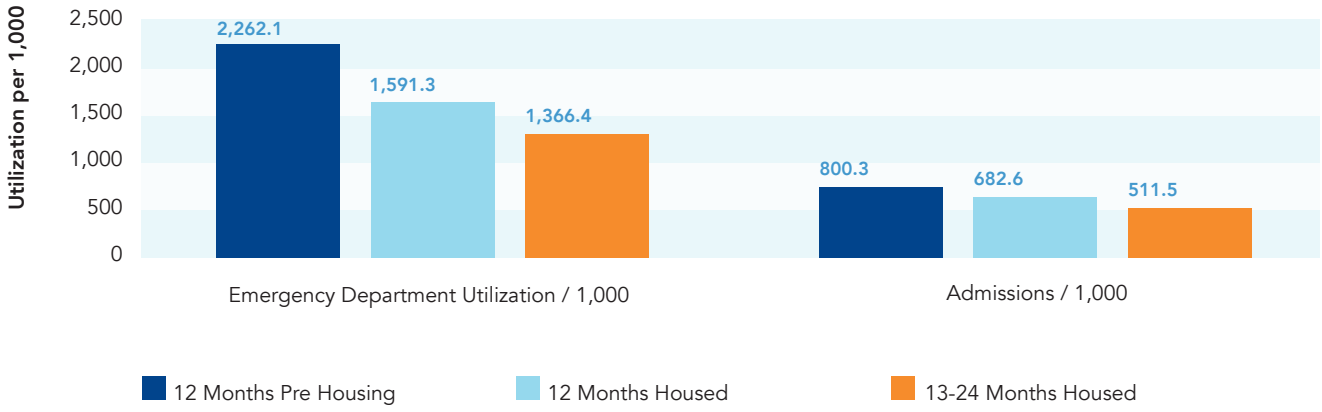
ED utilization also declined materially following housing placement. ED visits per 1,000 decreased from 2,262.1 in the pre-housing period to 1,591.3 in the first year post-housing placement and 1,366.4 in the second year. ED costs showed a parallel decline, falling from $126 PMPM before

Figure 2. Pre/Post-Housing Cost Reduction Comparison



27 Aggregate savings for the HfH study group are calculated as follows: 2,760 member months post HfH x ($1,394 - $2,172) PMPM savings = $2.15 million 12 months following housing placement, and 1,572 member months post HfH x ($1,510 - $2,172) PMPM savings = $1.04 million 13-24 months following housing placement. See Table 2 for details.

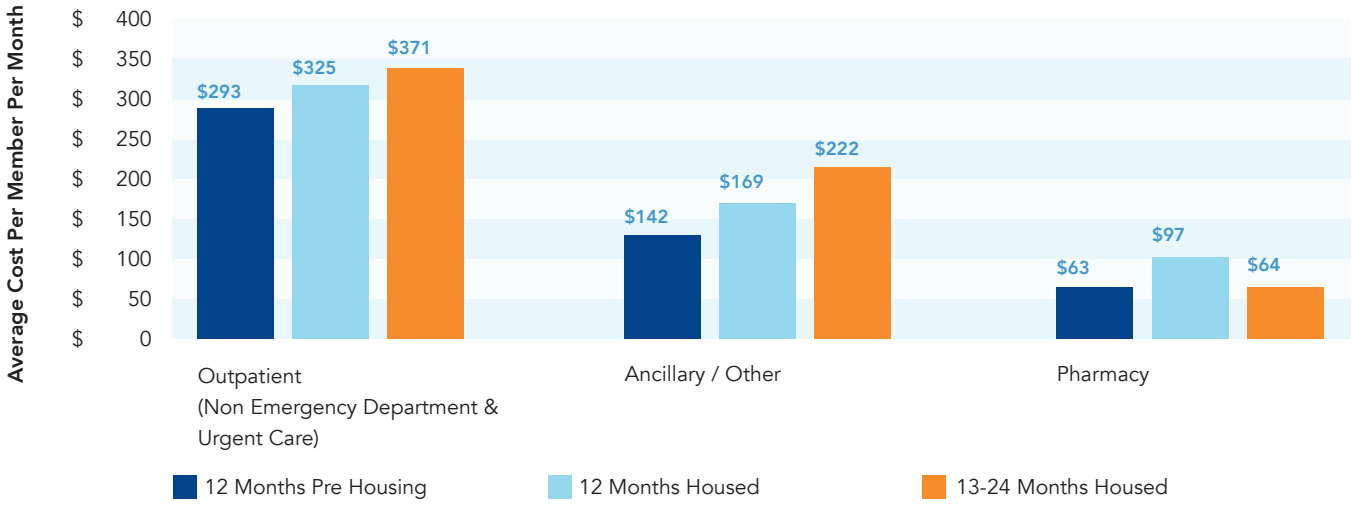
Figure 3. Pre/Post-Housing Utilization Comparison



housing to $80 PMPM in the first post-housing year and $73 PMPM in the second. When normalized for risk, ED utilization still showed notable improvement, reinforcing the conclusion that reductions in acute care use were not solely attributable to changes in measured morbidity.

Not all service categories declined after housing placement. Relative to the pre-housing period, modest increases were observed in several categories that may reflect greater engagement with routine healthcare services. Outpatient non-ED costs increased from $293 PMPM to $325 PMPM in the first year post-housing, then to $371 PMPM in the second year. Ancillary or other services increased from $142 PMPM pre-housing to $169 PMPM and then $222 PMPM across the two post-housing periods, while pharmacy spending rose from $63 PMPM to $97 PMPM in the first post-housing year before moderating to $64 PMPM in the second. These categories include services such as ambulance rides, dental services, durable medical equipment, prosthetics, hearing aids, vision hardware, and home health services. Increased use of these services may indicate improved access to ongoing care after members obtain stable housing.

Figure 4. Pre/Post-Housing Cost Increase Comparison



Control Group Validation Analysis Findings

The comparison with the higher-morbidity matched control group further supports the overall direction of the findings. Although the HfH study group remained more costly than the broader unhoused Control Group 1 after risk normalization (using CRG risk scores), its first year post-housing total cost of $1,394 PMPM was substantially below the $2,111 PMPM observed in Control Group 2, a difference of $717 PMPM. Similarly, inpatient costs, ED use, and admissions were all lower for the HfH study group than for the higher-morbidity Control Group 2. These results suggest that the savings observed in the pre-/post-analysis were driven by more than expected cost reversion among a high-cost members, consistent with a meaningful change in care patterns following housing placement.

What the Findings Mean

Taken together, the findings suggest that stable housing may improve patient health and enable a meaningful shift away from the reliance on high-cost acute care. The clearest signal is the sharp decline in inpatient spending and the corresponding reduction in hospital admissions after housing placement. ED utilization also fell materially in the two years after housing placement. These patterns are consistent with the view that housing functions as an important health intervention for individuals experiencing homelessness by reducing instability, lowering exposure to environmental stressors, improving continuity of care and management of disease, and lowering reliance on crisis-driven care.

At the same time, the analysis shows that lower acute care spending does not necessarily yield lower utilization across all services. Increases in outpatient, ancillary, and pharmacy costs may reflect improved engagement with care that had previously been deferred or disrupted. For a population with significant health and social needs, greater use of primary care, specialty care, medications, dental services, home health, and medical equipment does not represent an adverse financial outcome. Rather, increases in outpatient utilization may represent improved long-term disease management and continuity of care. These increases should therefore be interpreted alongside the larger decreases in inpatient and ED use rather than in isolation.

The control group comparisons support this interpretation. A simple pre-/post-comparison alone could raise concerns that the study group was identified at time of unusually high need and would have improved eventually regardless of intervention. Nonetheless, the comparison against both a broader unhoused population (Control Group 1) and a higher-morbidity matched group (Control Group 2) indicates that HfH participants continued to perform favorably on total cost, inpatient cost, and acute care utilization after housing placement. This finding supports the conclusion that the observed changes are directionally consistent with a program effect rather than solely with natural cost reversion.



From a broader strategic perspective, these findings are relevant to health systems, Medicaid managed care organizations, and other entities responsible for total cost of care. The results suggest that housing-related interventions may produce measurable financial and utilization benefits while also improving access to more appropriate services. For organizations pursuing value-based care and population health strategies, the HfH experience provides evidence that addressing the housing needs of patients experiencing homelessness may be a practical lever for reducing avoidable utilization and improving care delivery for a high-need population. Although continued evaluation is warranted, the current findings support the inclusion of housing interventions as part of a more comprehensive approach to managing medical risk and improving outcomes.

Policy and Operational Implications

The direct partnership between NYC Health + Hospitals and MetroPlusHealth demonstrates a replicable model by which provider and payer systems can address their patients' unmet social care needs. As a safety net healthcare system and health insurance provider, together, the organizations aligned on a mutually beneficial approach to address the public health crisis of homelessness in New York City.

Part of NYC Health and Hospitals' mission is "to promote and protect, as both innovator and advocate, the health, welfare, and safety of the people of the City of New York."[28] While housing may fall outside the traditional service model offered by a hospital system or health insurance payor, NYC Health + Hospitals' investment in the HfH program furthers the organization's mission of improving patient care. NYC Health + Hospitals and MetroPlusHealth share this mutual commitment to addressing the physical, mental, and social well-being of the people they serve through direct collaboration.[29]

Based on the key findings described above, the HfH program resulted in significant reductions in Medicaid managed care costs and acute care utilization for the study group, especially in the first year after being housed. Areas that indicate unmanaged medical needs fell, as evidenced by a significant decrease in the use of the emergency services and inpatient admissions. In contrast, modest increases were identified in use of outpatient services (e.g., primary care, specialty care, and durable medical equipment). This finding aligns with the existing literature, demonstrating that permanent housing placement provides the stability needed to engage in ongoing care.

NYC Health + Hospitals and MetroPlusHealth are not alone in their exploration of how public and private investments in stable housing can result in Medicaid and healthcare savings. Through Section 1115 of the Social Security Act, the US Secretary of Health and Human Services has the authority to consider waiving certain provisions of Medicaid law, providing states with flexibility to design

28 NYC Health + Hospitals. Mission & Values. Available at: https://www.nychealthandhospitals.org/mission-values/.

29 Ibid

and improve their Medicaid programs.[30] As of April 2026, at least 24 states had leveraged the 1115 framework to offer approved housing-related services.[31] The cost savings associated with this initiative's success in mitigating healthcare expenses for MetroPlusHealth Medicaid managed care members adds to the literature demonstrating the financial return on investment of housing interventions for Medicaid recipients.

During a period of reduced federal support for housing first programming, we trust this study adds to the literature, demonstrating the case for hospital systems and managed care providers' upfront investment in housing navigation programs for their patients. [32,33] The NYC Health + Hospitals and MetroPlusHealth direct partnership provides a potential framework for other healthcare systems nationally who seek alternative opportunities for housing placement-related investments. While the business case is clear here, investing in these programs have an undeniable positive impact on the health, well-being, and dignity of patients experiencing homelessness.

The NYC Health + Hospitals/MetroPlusHealth housing partnership should be viewed as an indispensable component of a shared commitment to providing housing to people experiencing homelessness. The cost savings and clear social benefits of securing permanent housing placement for formerly homeless New Yorkers reinforce a need to continue to center housing as healthcare in the larger vision of addressing social determinants to health among New Yorkers. This partnership has had a clear impact on the patients served and continued investment would allow NYC Health + Hospitals and MetroPlusHealth to serve more of the most vulnerable New Yorkers—those experiencing homelessness.

Limitations and Considerations

These findings should be interpreted in light of several important limitations. First, the HfH study population remains relatively small, with fewer than 3,000 member months (or 230 average members per year) of observed post-housing experience. As a result, the estimates are subject to limited statistical credibility, and individual high-cost events may meaningfully influence the results. Member disenrollment, program exits, and return to unhoused status also reduce the amount of follow-up experience available, particularly in the later post-housing period.

Second, although the analysis was designed to mitigate bias through the use of comparison groups and risk normalization, no nonrandomized observational study can fully eliminate the possibility of residual confounding. The HfH

30 Medicaid. Section 1115 Demonstrations. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations.

31 KFF. Table 3: Section 1115 SDOH & Other DSR Changes - Approved SDOH Provisions as of July 14, 2026. Available at: https://www.kff.org/medicaid/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table3.

32 Lanz PM, Hiltner S. Addressing Health-Related Social Needs Through Medicaid Section 1115 Waivers: Challenges and Opportunities. Health Aff. doi:10.1377/hpb20260108.28767

33 American Hospital Association. Making the Case for Hospitals to Invest in Housing. Available at: https://www.aha.org/system/files/media/file/2019/05/AIHC_issue_brief_final.pdf.

study group differed materially from the broader unhoused control population in both measured morbidity and cost profile. While Control Group 2 was developed to better approximate the study group's baseline acuity, the available risk measures capture most but not all dimensions of clinical and social complexity. In addition, changes in measured risk over time, including movement in CRG scores between the first and second post-housing years, may affect comparability across periods.

Third, the results depend on the completeness and accuracy of the source data provided for the analysis, including homelessness indicators, housing placement records, enrollment files, claims data, and CRG risk scores. Wakely reviewed the data for reasonableness but did not independently audit the underlying systems or source files. Any inaccuracies, delays, or inconsistencies in those data could affect the resulting estimates. The analysis also relies on assumptions regarding claim completion and trend normalization, which are reasonable for the purposes of this study but inherently uncertain.

Finally, caution should be exercised when generalizing these results beyond the specific HfH study population and operating environment studied here. The program serves a defined population of MetroPlusHealth members experiencing homelessness within the New York City healthcare and social service context. Outcomes may differ in other markets, populations, or housing intervention models. Continued evaluation will be important as more members are housed and additional experience emerges. A larger and more mature dataset would improve credibility, support more granular subgroup analysis, and allow for a more robust assessment of the persistence of savings over time.

Technical Appendix

The appendix includes supporting details for the findings summarized in this white paper. Table 2 presents the full cost results by cohort, service category, and study period, including pre-housing, post-housing, and control group comparisons. Table 3 provides the corresponding utilization results, including emergency room visits and inpatient admissions per 1,000 members, as well as normalized measures used to support the comparative analysis.

The analysis relied on data from MetroPlusHealth, including Maximus unhoused indicators, enrollment files, medical and pharmacy claims, HfH housing records, and CRG risk files. Wakely reviewed these materials for reasonableness but did not independently audit the underlying source data.

The analysis relied on the following data sources provided by MetroPlusHealth:

+ Historical unhoused status indicators from Maximus (January 2022–October 2025)
+ Monthly eligibility and enrollment files (January 2022–October 2025)
+ Medical and pharmacy claims experience data (January 2022–October 2025)
+ HfH program housing files, including move-in and exit dates (January 2022–October 2025)
+ CRG risk adjustment files (January 2022–October 2025)

Allowed claim completion factors were applied at the claim level, and utilization measures were aggregated monthly at the member level. Wakely reviewed all data for reasonableness but did not independently audit the underlying source files.



Table 2. Summary of Analysis Results: Costs and Savings

Summary of Allowed Claim Costs Per Member Per Month by Cohort	Housing for Health Study Group (12 Months Pre-Housing), [1]	Housing for Health Study Group (12 Months Housed), [2]	Housing for Health Study Group (13–24 Months Housed), [3]	Control Group 1, [4]	Control Group 2, [5]	Difference Pre/12-mo Housed ([2] – [1])	Difference Pre/24-mo Housed ([3] – [1])	Difference Control Group 1 vs. Housing for Health Study Group ([2] – [4])	Difference Control Group 2 vs. Housing for Health Study Group ([2] – [5])
Total Member Months [a]	2,594	2,760	1,572	253,385	54,699				
Average Lives ([a]/ 12)	216	230	131	21,115	4,558				
Average CRG Risk Score [b]	1.49	1.42	1.61	0.92	2.79				
Inpatient	$1,278	$492	$590	$350	$1,153	($786)	($688)	$142	($661)
Outpatient (Non-Emergency Department and Non-Urgent Care)	$293	$325	$371	$132	$317	$32	$78	$193	$8
Emergency Department	$126	$80	$73	$72	$194	($46)	($53)	$7	($115)
Urgent Care	$5	$6	$9	$7	$8	$0	$4	($1)	($2)
Professional (Non-Primary, Non-Specialty Care)	$37	$22	$34	$20	$56	($15)	($4)	$3	($33)
Primary Care	$122	$109	$93	$51	$98	($13)	($28)	$58	$11
Specialist	$107	$93	$55	$42	$85	($13)	($52)	$51	$9
Ancillary / Other	$142	$169	$222	$59	$126	$27	$80	$111	$43
Total Medical [c]	**$2,109**	**$1,297**	**$1,447**	**$733**	**$2,036**	**($813)**	**($663)**	**$564**	**($740)**
Pharmacy [d]	$63	$97	$64	$43	$74	$34	$1	$54	$23
Total [c]+[d]	**$2,172**	**$1,394**	**$1,510**	**$776**	**$2,111**	**($778)**	**($662)**	**$618**	**($717)**
Normalized Total ([c]+[d])/[b]	**$1,455**	**$984**	**$939**	**$843**	**$757**	**($471)**	**($516)**	**$141**	**$227**
Total Change in Cost (Savings) / Loss (Millions)						**($2.15)**	**($1.04)**	**$1.71**	**($1.98)**
Average Change in Cost (Savings) / Loss (PMPY*)						**($9,337)**	**($7,939)**	**$7,417**	**($8,602)**

Table 3. Summary of Analysis Results: Utilization

Summary of Utilization per 1,000 per Year by Cohort	Housing for Health Study Group (12 Months Pre-Housing), [1]	Housing for Health Study Group (12 Months Housed), [2]	Housing for Health Study Group (13–24 Months Housed), [3]	Control Group 1, [4]	Control Group 2, [5]	Difference Pre/12-mo Housed (2 - 1)	Difference Pre/24-mo Housed (3 - 1)	Difference Control Group 1 vs. Housing for Health Study Group (2 - 4)	Difference Control Group 2 vs. Housing for Health Study Group (2 - 5)
Total Member Months [a]	2,594	2,760	1,572	253,385	54,699				
Average Lives ([a]/ 12)	216	230	131	21,115	4,558				
Average CRG Risk Score [b]	1.49	1.42	1.61	0.92	2.79				
Emergency Department / 1,000	2,262.1	1,591.3	1,366.4	1,566.5	3,884.8	(670.8)	(895.7)	24.8	(2,293.5)
Admissions / 1,000	800.3	682.6	511.5	542.3	1,524.0	(117.7)	(288.9)	140.3	(841.4)
Normalized ED / 1,000	1,515.2	1,123.4	849.3	1,702.1	1,394.0	(391.7)	(665.9)	(578.7)	(270.5)
Normalized Admits / 1,000	536.0	481.9	317.9	589.3	546.9	(54.1)	(218.1)	(107.4)	(64.9)

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