COALITION OF NYS HEALTH HOMES

Testimony to Senate Finance Committee and the Assembly Ways & Means Committee 2018-2019 Executive Budget Proposals on Health Care February 19, 2018

The New York Health Home Coalition is pleased to submit this testimony regarding Governor Cuomo's 2018-29 Executive Budget Proposal. The NYHH Coalition represents 31 Health Homes across every region of New York State, and covers 97% of all total Health Home membership totaling over 160,000 Medicaid enrollees with the highest medical and behavioral health needs. The NY Health Home Coalition seeks to improve the health and lives of all individuals served in health homes by enabling providers to deliver the highest quality, most cost-effective care management to all.

We are writing to seek:

- Restore last year's $40M cuts to reinvest in effective outreach strategies - targeting high volume/high need settings i.e. emergency rooms and homeless shelters.
- Protect current funding to health homes for care management at current funding levels through the current structure with no further cuts, savings targets or erosion of the program's funding. The program currently serves up to 200,000 individuals per year at approximately $500M or a modest $2,500/participant for a wide range of face-to-face care management services provided in individuals homes and communities and connecting them to more stable housing, employment and education resources, access to benefits, coordination of primary care, behavioral health and specialty care settings and many other supports that work to improve their overall health, wellbeing and quality of life.
- That any savings generated from assessed penalties be reinvested back in the program to support a better rate structure, effective outreach activities and incentives for quality outcomes and enrollment targets.

New York's health home program is designed to identify Medicaid beneficiaries with complex physical health, behavioral health and substance use disorders, who are high utilizers of health care services, and correspondingly high cost to the Medicaid program, and provide them with care management services. When an individual is enrolled in a Health Home, a care manager develops a comprehensive plan of care with the member and helps the member navigate the health care delivery system, schedule appointments, arrange transportation and communicate between health care providers. Additionally, care managers educate members about chronic conditions, medication

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adherence, understanding and complying with complex discharge plans, and care transitions after a hospitalization.

Health homes provide an effective strategy for managing the care of New York's most vulnerable Medicaid beneficiaries. Health home care managers are located in communities where individuals live, and provide both in-person and telephone support to their members. An average of 15% of our members have been homeless at some point during 2017, 73% of members have some type of behavioral health diagnosis, and at least 10% are diagnosed with HIV/AIDS. Of those members with a behavioral health diagnosis, at least 8% of these members had some type of hospitalization related to mental health or substance abuse in 2017.

Health Homes have demonstrated a significant impact on the lives of their members to date:

- Inpatient costs per member per month are down 8 percent, according to the state Department of Health, and utilization is down 6 percent.
- There was a 17 percent drop in preventable hospital readmissions between 2014 and 2015, according to the Department of Health, and a 17 percent increase in colorectal cancer screening.
- Primary care costs are up 23 percent, and pharmacy costs are up 12 percent, according to the Department of Health – both of which indicate that individuals are going to their PCP and taking their medications – major goals of the program

The core of case management is to advocate for, link to, monitor and support clients in their acquisition of all necessary services that will support their integration into community living, with services that include mental health, health and other human services. Health homes improve outcomes for their members by coordinating those services, leading to greater linkages with primary and preventive care, better management of chronic health conditions, and a reduction in avoidable hospital use, both inpatient stays and emergency department visits. These outcomes also reduce cost for the Medicaid program.

New York has demonstrated its commitment to the health home model by proposing a systematic effort to increase enrollment. Medicaid managed care plans have not been effective in identifying their most vulnerable, highest cost patients, and developing successful interventions for them. When dealing with a high-risk population, telephonic intervention is an important but not sufficient or adequate level of care to improve outcomes, and a community presence is needed to effectively engage consumers.

Coalition Health Home Membership

Adirondack Health Institute (AHI)
Best Self Behavioral Health (Formerly Lake Shore)
Bronx Accountable Healthcare Network Health Home (BAHN) Montefiore
Bronx-Lebanon Hospital Center
Brooklyn Health Home (Maimonides_
Care Central - VNS Home Care of Schenectady
Central New York Health Home Network, Inc.
Chautauqua County Department of Mental Hygiene
CHHUNY (Children's Health Home of Upstate New York)
Circare
Collaborative for Children and Families, Inc. (CCF)
Community Care Management Partners Health Home (CCMP)
Community Health Care Collaborative (CCC)/Hudson River HealthCare Community Health
Community Healthcare Network (CHN)
Coordinated Behavioral Care, Inc. (CBC)
Encompass Health Home and Catholic Charities of Broome County
Greater Buffalo United Accountable Healthcare Network (GBUAHN)
Health Home Partners of WNY, LLC
Huther Doyle Memorial Institute - Finger Lakes
HHUNY (Health Homes of Upstate New York)
Hudson Valley Care Coalition
Institute for Family Health (IFH)
Kaleida Health
Mount Sinai St. Luke
New York Presbyterian Hospital
Northwell
NYC Health + Hospitals
Queens CC Partners
Rochester Integrated Health Network, Inc. Greater Rochester Health Home Network, LLC.
Samaritan Hospital/Capital Region Health Connections
St. Joseph's
St. Mary's Healthcare