Testimony to Senate Finance Committee and the Assembly Ways & Means Committee

2018-2019 Executive Budget Proposals on Health Care

February 19, 2018

iHealth, Inc. is a coalition of pioneering community-based organizations that advocates for our members and the chronically ill Medicaid recipients they serve. iHealth providers reach New York's most marginalized residents who are faced with chronic illness such as HIV/AIDS, substance use, mental illness and other behavioral health challenges.

Founded in 2013 in response to significant healthcare reforms impacting low-income communities across New York State, iHealth has emerged as an expert in the provision of care coordination services through the establishment of the Medicaid Health Homes program. The Health Homes program remains a top priority for iHealth members across New York State, and we are united in the belief that care coordination is the most effective model to reach Medicaid's highest need individuals.

Many of Medicaid's chronically ill patients face numerous barriers to consistently accessing medical care, making it hard for them to get well and stay healthy. The Health Homes program was designed to address the social determinants of health, such as food insecurity, housing instability, addiction, mental illness, trauma, violence, illiteracy. New York State's Medicaid Health Home program has consistently and successfully helped vulnerable and marginalized New Yorkers to obtain high-quality outpatient medical care, concurrently reducing expensive emergency room visits and avoidable hospital stays through engagement, service coordination, housing placement assistance, and linkage to community-based social support services.

The Medicaid Health Home program is vital to helping chronically ill New Yorkers to navigate complex health systems, and to receive high quality outpatient care that both improves their health and reduces expensive medical costs associated with avoidable readmissions and preventable emergency department visits. It is New York State's Health Home program that is successfully reaching and connecting Medicaid recipients with multiple chronic conditions to the care and treatment they need and deserve. It is the Medicaid Managed Care companies in New York that must be compelled to devote a portion of their significant resources to improving and sustaining the life-saving Medicaid Health Home program in New York State.

The Health Home Program has made tremendous strides over the past year and iHealth has the data to prove it:

- In a preliminary study done at **Flushing Hospital, inpatient admissions decreased by 44% among patients enrolled in the Health Home program**.

- In a similar study done at **Wyckoff Hospital, inpatient admissions decreased 24% among enrolled Health Home program participants**.

- Strikingly, the study found that for patients who were Health Home eligible (due to multiple chronic conditions) but **declined to participate in the Health Home program, hospital admissions for those patients increased by 37%**.

- Across NYS, the Health Home Program has led to significant reductions in inpatient hospitalization stays (-8%) and emergency room use (-6%).

- **One federal study of the program completed by Maimonides Medical Center in Brooklyn, found $48 million-dollar savings in just three years among 7,500 individuals with severe mental illness.**

- *Also see Client Stories attached.*

Care coordination for individuals with severe mental illness, HIV and multiple chronic health conditions is critical to controlling our ever-soaring healthcare costs. Having initiated in 2012, the Medicaid Health Home Program's positive impact on improved health outcomes for participants will continue to achieve cost savings and improved health for New York State's vulnerable populations now and into the future.

It is imperative that we continue to improve the quality of life and health for New Yorkers facing multiple chronic conditions by investing in and building upon the long-term savings generated by the Health Homes program to-date.

Last year, Health Homes was cut by $20 million. iHealth is requesting a restoration of these cuts and preventing additional cuts, which will allow for enhanced enrollment rates that support more reasonable caseloads, better outcomes for Health Home members and clients and sustained savings for Medicaid. iHealth is requesting the $20 million go towards increasing community based (*bottom-up*) outreach and improving caseload ratios.

Managed care companies in New York must not be allowed to step back from the progress we have made. Instead, Managed care companies must be compelled to devote a portion of their significant resources to improving and sustaining the Medicaid Health Home program.

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Understanding the Impact of the Health Homes Program
Client Stories

The following NADAP client stories reflect the success of the Health Homes program and the coordinated care model of service.

Mr. Martinez

Mr. Martinez is an 87-year-old Hispanic queens senior who is diagnosed with hypertension, hyperlipidemia, coronary heart disease, chronic ischemic heart disease and depression. Mr. Martinez lives in a NYCHA apartment with his daughter and grandchildren and attends the Ridgewood Adult Day Center several times a week. Mr. Martinez was enrolled in February 2017. At enrollment, Mr. Martinez only requested assistance with being linked to a mental health provider, ophthalmologist, and transportation services. However, when coordinated care (cc) provider Estevez accompanied Mr. Martinez to a PCP appointment in June, his primary care physician informed CC Estevez of concerns about Mr. Martinez's health and possible diagnosis of prostate cancer. **Mr. Martinez's PCP had tried numerous times to engage Mr. Martinez in treatment, but he declined and chose not to attend appointments scheduled on his behalf.** Mr. Martinez reported having no interest in seeking treatment or seeing any providers except his PCP. While trying to consider what motivates Mr. Martinez, CC Estevez recognized how much he loves going to the Adult Day Center. **CC Estevez reached out to the center and was able to collaborate with his trusted providers at the program to finally engage him in treatment!** Recently, Mr. Martinez attended appointments with a new urologist and GI specialist and is preparing to have a biopsy completed to determine the appropriate course of treatment. **Thanks to CC Estevez's creative thinking and client-centered approach, Mr. Martinez is finally getting the treatment he needs to maintain his quality of life and be able to continue spending time doing what he loves at the Adult Day Center**.

Tonya

Tonya is a 22-year-old African-American single female diagnosed with bipolar disorder and due to meningitis at the age of 12, has had the toes on her right foot amputated. Tonya was enrolled in October 2015. **When Tonya entered the HHCC program, she had a lot of goals but felt stagnated due to limitations imposed by her amputation.** Throughout 2015 and 2016, CC Wheat assisted Tonya with obtaining food stamps and getting connected to medical and mental health providers. Tonya began GED classes in the beginning of this year and completed an orientation with ACCESS-VESID to further her education and career. Tonya recently had surgery on her foot and obtained specialized shoes to allow her more mobility. **With her new found freedom and confidence, Tonya was able to obtain employment and continue consistent engagement in MH**

treatment. CC Wheat also assisted Tonya with identifying and applying for housing opportunities to build on her independence.

John

John is 58-year-old veteran who is diagnosed with diabetes, high blood pressure and heart disease. John also faced complications from unmanaged diabetes, **struggled with regularly attending appointments and actively engaging in his providers' plans for treatment** and as a result lost his right eye. John was finally enrolled in the program in April 2014. His coordinated care specialist, SCC Okobi worked on establishing a strong working relationship with his caseworker at the V.A. Center where John resided. Together they made a plan to address barriers to treatment. Okobi linked John with transportation services and attended appointments with him to provide support. SCC Okobi also linked John with a home health aide, Meals on Wheels an endocrinologist, a new PCP, ophthalmologist, dentist and cardiologist. John is now regularly seeing his providers and following his treatment plan.

Jose

Jose is a 38-year-old Latino American male who was diagnosed with schizophrenia at age 36. Jose currently resides in the McGuiness Men's Shelter in Greenpoint, Brooklyn, and was enrolled in December 2016. **When enrolled, Jose was not taking any psychiatric medication and did not have a psychiatrist in place.** He was experiencing severe auditory hallucinations, sometimes violent and commanding in nature, and was experiencing significant distress and paranoia as a result. He was on the brink of eviction from his home and he did not know where he would go upon leaving this living arrangement. Sarah assisted Jose in voluntarily entering a psychiatric hospital unit, so that he could receive a psychiatric evaluation and safely return to a medication regimen as treatment for schizophrenia. While he was in the hospital, Sarah applied for supportive housing on Jose's behalf and he was approved! He has since been discharged from the hospital and has been **seeing a psychiatrist weekly without missing any appointments and has been taking his medication daily, which has greatly improved his distress.** Jose has shown great strengths and resiliency in managing his diagnosis of schizophrenia.

Kayla

Kayla is 23-year-old single mother, who is diagnosed with asthma, diabetes, obesity, sickle cell anemia, vitamin D deficiency, and depression. Kayla was enrolled in November 2016. At enrollment, Kayla was living in an unhealthy environment with her son and her mother. Kayla identified that a lot of her feelings of depression stemmed from her living situation. Ultimately, in January 2017, Kayla and her son were evicted. Kayla's son was able to stay with his father, while Kayla started couch surfing. **At this time, Kayla was also disconnected from providers and frequently utilized the ER for treatment of her sickle cell diagnosis**. CC Okobi was able to assist Kayla with being linked to permanent providers at Brooklyn Plaza Medical Center, where she also receives behavioral health services. **Kayla, a recent graduate of the Franklin Career Institute, has also landed a full-time job at TJ Maxx and a part-time position at Starbucks**. SCC Okobi assisted Kayla with obtaining SNAP benefits to supplement her income as well. Kayla has been stably housed for the last four months, has consistent income and is actively engaged with her medical and mental health providers.