NY Health Home Coalition

Testimony to Senate Finance Committee and the Assembly Ways & Means Committee 2020-2021 Executive Budget Proposals on Health Care February 5, 2020

The Coalition of NYS Health Homes is pleased to submit this testimony regarding Governor Cuomo's 2020-2021 Executive Budget Proposal. The Coalition of New York State Health Homes represents 34 Health Homes across every region of New York State, and covers 97% of all Health Home membership totaling over 175,000 Medicaid enrollees including both adults and children with the highest medical and behavioral health needs. The 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 recommend that you:

- Evaluate savings from better managing and reducing pharmacy costs including and especially those for specialty drugs such as long acting injectables, antipsychotics, opioid replacement therapies, hepatitis C and other medications critical to the recovery of these individuals
- Exclude health home care management services from the 1% cut including and especially children's health home services
- That funding be increased to Health Homes including incentives for serving the highest need highest risk individuals (i.e. individuals enrolled in HARPs or those living with HIV/AIDS)
- 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 over 200,000 individuals per year providing a wide range of face-to-face care management services 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.

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 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 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.

In 2018-2019, this program achieved over $70M of savings through the restructuring of the outreach component of the program, placing additional burden on the remaining rates to support all outreach, engagement, enrollment and ongoing care management.

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

- There was a 27% decrease in PMPM inpatient costs from 2016 to 2017 (most recent period for which the State has issued this data) which translates to approximately $309M in estimated savings from inpatient utilization.
- There was an 11.1% reduction in all-cause readmissions – the number of acute inpatient stays followed by a readmission from 2014 to 2017 for Health Home enrollees.
- Based on a representative sample, there was a 29% reduction in homelessness and a 37.5% reduction in incarceration
- There was an 8.4% improvement in adherence to antipsychotics for individuals with schizophrenia enrolled in health homes from 2013 to 2017
- 86% of Health Homes improved comprehensive diabetes care rates between 2013 and 2017 with a corresponding statewide 4.5% improvement rate during that time period
- There was an 11.4% improvement in follow-up after hospitalization for mental illness within 30 days statewide for health home enrollees.
- Individuals enrolled in Health Homes also saw improvements in rates of chlamydia screenings, colorectal cancer screenings, follow-up after emergency department visits, engagement in comprehensive HIV/AIDS care including viral load monitoring, medication management for people with asthma and overall prevention quality of care (HEDIS measure).
- 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.

Care Management is Foundational to any Value-Based Arrangement: As NY seeks to build on DSRIP, care management is not just an important component of achieving the goals of the value-based payment roadmap but is a necessary element of achieving any value-based outcomes. The criticality of effective care management for high-cost, high-need populations when it comes to achieving a substantive return on investment in any value-based arrangement cannot be underestimated. Health Homes have experience in organizing the networks of care management agencies necessary to provide care management services. As community-based providers they have demonstrated expertise in reaching high-need, high-risk individuals and successfully engaging them in care, and linking them to other social services. No accountable entity (ACO, IPA, or VMO) should build their care management capacity from scratch when they can build on the already-existing capacity that Health Homes have developed and can provide. Nationally, States have concurred that effective care management for high need high risk individuals can and should be provided most effectively by community-based providers. Additionally, Health Homes organize and aggregate networks of social service providers into meaningful interfaces with the healthcare system.

Expanding the Role of Health Homes: Health Homes can and do provide population health management. They are an already-existing infrastructure with necessary expertise. New York claims to be committed to VBP so why dismantle something that already exists rather than continue to enhance and improve it. Health homes have been at the core of many many successful DSRIP projects including the Millennium Hearts Initiative, the New York Presbyterian HIV efforts. featured in the UHF best practices report. Health homes are a critical tool for ending the epidemic, reducing homelessness and incarceration and many other key social determinants of health.

Health Homes continue to work with the State Department of Health to improve our ability to collect data, better manage the program and demonstrate impact.

Coalition Health Home Membership

Bassett Healthcare Networks
Best Self Behavioral Health (Formerly Lake Shore)
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
Cityblock
Collaborative for Children and Families, Inc. (CCF)
Community Care Management Partners Health Home (CCMP)
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
Hudson River HealthCare Community Health Community Health Care Collaborative (CCC)
Huther Doyle Memorial Institute - Finger Lakes
HHUNY (Health Homes of Upstate New York)
Hudson Valley Care Coalition
Independence Care System
Institute for Family Health (IFH)
Kaleida Health
Maimonides Brooklyn Health Home
Montefiore Bronx Accountable Health Network Health Home
Mount Sinai St. Luke
New York Presbyterian Hospital
Niagara Falls Memorial Medical
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 Hospital, Syracuse
St. Mary's Healthcare