Policy Brief & Testimony of

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on
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Sustaining DOH-Health Homes Care Management:
A Medicaid ROI for NYS.

INTRODUCTION

iHealth is a not-for-profit, statewide collaborative of New York State Department of Health (DOH)–authorized community-based Care Management Agencies, including community-based organizations (CBOs) and long-standing local providers. Together with the NYS Health Home Coalition, iHealth represents a network of more than 4,500 community-based care managers who are the backbone of the DOH Health Home Care Management (HHCM) program, serving more than 185,000 vulnerable New Yorkers in every legislative district across the state.

Founded in 2013 in response to sweeping healthcare reforms, iHealth was created to support community-based providers transitioning from legacy case management programs to the Health Home model of care. Over time, iHealth's membership has expanded to include a diverse range of CBOs providing care management services, as well as organizations seeking to strengthen service delivery, integration, and connectivity with managed care plans, Performing Provider Systems under the Delivery System Reform Incentive Payment (DSRIP) program, and other healthcare payers.

Today, iHealth serves as a unified statewide voice for community-based care management providers—advocating for sustainable policy and funding, negotiating on behalf of its members, and ensuring that the needs of chronically ill and high-need New Yorkers are represented within the broader healthcare system.

We join with our Health Home Leads and partners throughout NYS in thanking the Chairs Senator Liz Kruger and Assemblymember J. Gary Pretlow, Senator Gustavo Rivera, Assemblymember Amy Paulin, and all the members of the Assembly and Senate Committees for holding this hearing on the health-related proposals in the Governor's Executive Budget for the State Fiscal Year 2026-27. We especially thank you for the opportunity to share the urgent needs of the Health Homes Care Management (HHCM) Program system.

URGENT: SUSTAIN THE HEALTH HOME CARE MANAGEMENT SYSTEM

On behalf of thousands of vulnerable New Yorkers served by the Health Home Care Management program, and the New York State Department of Health–supported community-based organizations that operate Health Homes across New York State, we urge the following actions to preserve continuity of care, strengthen the healthcare safety net, and ensure that New York's Medicaid system remains effective, equitable, and fiscally sustainable.

WE URGE YOU TO INCLUDE A RATE ADJUSTMENT OF +15% FOR THE NYDOH HHCM PROGRAM.

- Despite wage inflation, rising acuity, and increasing administrative workloads, the NYSDOH HHCM program has been among the few to receive no rate adjustment during this administration. This will stabilize the network by preventing additional Care Management Agency (CMA) & CBO closures by reinvesting in the workforce & infrastructure that serve as the backbone of New York's community-based safety net (*Sustaining Workforce & community presence/CBOs, a call from the Governor).*

WE URGE YOU TO RESTORE THE PRIOR DRACONIAN $130 MILLION CUTS! NO MORE CUTS!

- Fund the NYSDOH HHCM Program to operate as the DOH intended by providing revenue that supports basic operations. This means the 2023 level is $262 million in one-year appropriations, rather than the $196 million one-year appropriation noted in this year's budget.

WE URGE YOU TO ADDRESS THE TARGETED OMISSION OF TII/COLA FOR THE "DOH" HH WORKFORCE THIS PAST 7-8 YEARS.

- While TII/COLAS were afforded to ALL covered by the Mental Hygiene Bill (i.e., OMH, OASAS, *et. al.)* during this administration, our DOH-HHCMs were specifically overlooked (along with the HH High-Fidelity Wraparound program for children with SED). HHCMs are a workforce of over 4500, with 47% being BIPOC (Black, Indigenous & people of color), serving 77% of HH enrollees, also BIPOC.

Health Homes are a proven, cost-effective investment for the State, reducing unnecessary emergency department visits, hospital admissions, and institutional care while improving outcomes for high-need complex Medicaid populations. Despite these documented savings, the program continues to face financial pressure due to reimbursement rates that have remained essentially unchanged since 2018. Inflation has risen more than 25 percent over this same period. Furthermore, the DOH portion of the Health Home program—which represents the majority of the program—has received no cost-of-living or inflationary adjustment.

DATA & OUTCOMES SUPPORTED

Data from the DOH, MCOs, and large healthcare/hospital providers show clear and positive outcomes for members concurrently enrolled in the HH program (compared with Medicaid recipients not enrolled in the DOH HH CM Program). These outcomes are associated with long-term ROI in Medicaid utilization & savings, which are crucial at this time of pending federal cuts and eligibility barriers. The HHCM program is a counterbalance to the negative fiscal impacts expected from H.R. 1.

The HHCM program data show (Cf. References):

ADMISSIONS TYPE	HEALTH HOME %	STATEWIDE %	Difference
Inpatient Admissions	-32.5%	**-4.8%**	-27.7%
ER Visits	-18.5%	**-4.0%**	-14.5%

Costs

- **Plan-Level Evidence:** Northwell Health and Healthfirst's joint analysis found a $288 PMPM reduction, 33% fewer ED visits, and 56% fewer inpatient admissions within 12 months of HHCM engagement.

- **DOH Data:** Inpatient admit amount decreased by 33% for Health Home-enrolled adults, while the statewide change was +1.6%, and Emergency Department visit amount decreased by 18.2%, while the statewide change was 1.6%, for a remarkable difference of 16.6% for Health Home-enrolled adults.

- **LTC Impact**: A 25.7% reduction in Skilled Nursing Facilities costs (vs. 13% higher, not in the HH).

- **Equity Impact:** HHCM serves disproportionately high-need populations—members are twice as likely to be Black and 15% more likely to be Puerto Rican/Hispanic than the overall Medicaid population, with 40% reporting multiple social determinant needs.

PROGRAM OUTCOMES — DOCUMENTED PERFORMANCE AND COST SAVINGS

NYS Department of Health (DOH) data confirms that Health Home members achieve substantially better performance across behavioral health and health outcomes than the overall Medicaid population (cf. nys-doh-health-home-data-set_2024.pptx). Below are the highlights from the NYS DOH data demonstrating the outcomes.

- *Adult Health Home Members — Better Outcomes Across 19 of 22 Measures*
- *Children's Health Home Members-Better Outcomes Across 15 of 15 Measures*

Adult Measure Name	Medicaid	HH Enrollees	Difference
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (30 Days)	41.5%	63.4%	**21.9%**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (7 Days)	29.9%	45.8%	**15.9%**
Follow-Up After Hospitalization for Mental Illness (30 Days)	58.7%	81.1%	**22.4%**
Follow-Up After Hospitalization for Mental Illness (7 Days)	41.2%	61.8%	**20.6%**
Follow-Up After Emergency Department Visit for Mental Illness (30 Days)	54.5%	76.1%	**21.6%**

Note: Health Home members enrolled 9 months or more had a 54.3% increase in outpatient services (including Primary Care & preventative psychiatric visits) and a 32.2% increase in pharmacy services (including renewing psychiatric medications for the Seriously & Persistently Mentally ill), *both meeting the Governor's mandate to connect the disconnected from care to care and prevention.*

These findings show that Health Home members are more engaged in care, experience faster follow-up after critical behavioral health episodes, and have higher screening completion rates, all of which contribute to measurable Medicaid cost savings and improved population health outcomes.

SUSTAINING THE FUNCTIONING HHCM PROGRAM IS FISCALLY RESPONSIBLE & ADDRESSES MANY OF THE ACTIONS CALLED FOR BY THE GOVERNOR.

Despite its proven success in improving outcomes and reducing Medicaid costs (cf. References), the omission of rate and Workforce adjustments threatens the stability of the community-based infrastructure that supports New York's most vulnerable populations.

Health Home Care Management is uniquely positioned as an integrated, statewide model that connects healthcare, behavioral health, and social care systems to support Medicaid-enrolled adults and children with the most complex needs. Investment in HHCM is also essential to New York State's success in significant transformation efforts, including the 1115 Medicaid waiver and Rural Health Transformation Program, where coordinated care, navigation, and community-based supports are critical to improving outcomes and reducing avoidable utilization.

Restoration of the HHCM appropriation and rates, as noted above, would allow Health Homes to not only operate as designed but also address many of the high-ticket/cost items the Governor promised in the State of the State Budget announcement through an already operational NYS program.

Restoration of funding would allow us to:

- **Expand, not Curtail, Eligibility (*in light of the associated Medicaid ROI*)**: HHCMs target the most vulnerable in-the-community Medicaid utilizers. Restoration of appropriate funding would enable the already functioning HHCM program to expand to include individuals at elevated risk due to frequent acute-care utilization (including ER visits) and/or significant unmet health-related social needs, such as housing instability, food insecurity, transportation barriers, or disruptions in benefits. *This would capture a population (i.e., the severely disabled) whose complex clinical & social needs render them vulnerable to avoidable care utilization & poorer outcomes.*\

- **Streamline Re-Entry:** Restore the ability to re-enroll members within 180 days of closure for members *with "post-discharge" adverse events or benefit loss*. This DOH-imposed waiting period (because of prior budget cuts) is detrimental to those with persistent mental illness who decompensate. Those are the Governor's call for NYS to keep connected to care.

- **Make Health Home CMs an option for discharges from nursing homes, drug treatment facilities, hospitals/ERs, jails & criminal justice settings:** Health Homes must be included in discharge plans for patients & clients who would benefit from post-discharge care coordination and community engagement. *It comes down to an HH CM connection vs. the street, or lost to care. Those who do not renew their psychiatric meds after the initial Rx are those likely to be in the news.*

SUPPORT HEALTH HOMES NOW

As New York State navigates mounting federal Medicaid pressures and significant fiscal uncertainty, policymakers face a critical decision about how best to protect both vulnerable populations and the stability of the healthcare delivery system. Strategic investments in proven, community-based infrastructure—particularly the Health Home Care Management (HHCM) program—offer a cost-effective approach to mitigating downstream Medicaid expenditures while supporting hospitals, health centers, and Social Care Networks statewide.

- **Federal Medicaid Pressures**: **New York faces unprecedented fiscal headwinds due to federal Medicaid policy changes**, including redeterminations and potential work requirements. Analysts project up to $8 billion in lost hospital revenue and $300 million in reduced health center funding annually upon full implementation. The HHCM provides an immediate, evidence-based strategy to mitigate these losses by preventing avoidable institutional care and maintaining continuity for those most at risk of losing coverage. A common sentiment among Health Home Leads and MCOS is that it's a ***"Pay Now or Pay Later" situation.***

- **SCNs and Hospitals are increasingly relying on the HHCM Program, which already has the infrastructure, workforce, and expertise to support** the goals of the 1115 Waiver Amendments. The HH Leads (and member agencies) are embedded within the formal infrastructure of the SCNs and maintain more than 589 contractual relationships across the state, in every county and community. The hospitals (e.g., Northwell) are using them now more than ever to reduce Medicaid costs and preventable expenditures.

- **NYS would be leveraging a successful and tested existing infrastructure**: HH CMs have strong partnerships with the MCOs, as well as large hospital and health centers, to assist members who are often disengaged from care and difficult to locate, thereby minimizing fiscal impact & loses to Providers (Up to $8B in potential losses for NYS hospitals and ~$300M for health centers) (Cf. References 2-9).

  The Health Home program provides the Medicaid care management solution that curbs *preventable* Medicaid costs while supporting the stabilization of uninsured members who decompensate and become eligible for Medicaid.

SUMMARY OF OUTCOMES

- Health Homes CMs Help Manage those with *Serious and Persistent* Mental Illness in the community.
- Health Home (HH) members have higher behavioral health needs and greater medical complexity.
- HHCM program prevents Involuntary Hospitalization by keeping the participant/patient connected to care in the community (to their mental health prescriptions, HIV care & medication, provider visits, and much more). The HH CM does not provide crutches, but provides tools for *self-management & prevention*.
- The HHCM program is essential in meeting NYS & Governor Hochul's objectives/the Triple Aim (*Better care, lower cost of care & better health outcomes*), providing defined & intense care coordination to a chronically ill complex Medicaid cohort.
- CMs and CBOs are in crisis. 2023 data confirm that Health Home Care Management Agencies (CMAs) face significant challenges in recruiting and retaining Care Managers (CMs). *Governor Hochul pledged to support and sustain the Social Services, CBOs & on-the-ground resources and workers.*
- HHCMs are a workforce of over 4000 CMs with 47% being BIPOC (Black, Indigenous, and people of color) serving 77% of HH enrollees who are also BIPOC.
- *HHCMs Respond to the Governor's State of the State call to be in the community and connect vulnerable individuals to care. For those enrolled in the HH program, the percentage (%) rate of Resolved Needs:*

- ✓ **57% of members with housing issues- Resolved**
- ✓ **55% of members with insufficient food-Resolved**
- ✓ **72% of members with a transportation need-Resolved**
- ✓ **74% of members with threat of physical violence-Resolved**

CONCLUSION

As New York State confronts the risk of historic federal Medicaid cuts, the New York State Department of Health Health Home Care Management (DOH-HHCM) program remains a trusted, community-based partner—helping Medicaid members stay enrolled, access essential services, and avoid preventable hospitalizations and emergency department use. Strengthening this program is critical to protecting continuity of care, stabilizing the safety net, and ensuring that the State's broader healthcare reform initiatives achieve their intended impact.

Available outcomes and data demonstrate that failing to sustain the Health Home program and its workforce as designed is counter to the goals of the Governor's New York State Triple Aim, and directly undermines the State's commitment to keeping the most vulnerable New Yorkers connected to care. The Health Home model relies on community-based organizations and an on-the-ground workforce that meets people where they are—an approach that is essential to improving health outcomes for high-need populations. The mission and daily operations of the DOH Health Home Care Management program align squarely with the Triple Aim's core objectives: improving population health, enhancing quality of care, and reducing per-capita healthcare costs. This alignment is also consistent with the Centers for Medicare and Medicaid Services (CMS) Triple Aim framework, which emphasizes safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

Finally, the Governor's State of the State includes significant investments that further underscore the relevance of Health Home Care Management—such as the $722 million commitment to Medicaid Community Engagement initiatives, including member education related to work requirements, and a $454 million proposal through OASAS and SUD programs to expand medication treatment access and street-level outreach to individuals not currently connected to services. These are functions that DOH Health Home Care Managers already perform every day: keeping eligible individuals enrolled, engaging hard-to-reach populations, and maintaining continuous connections to care. Rather than duplicating infrastructure, New York State should direct these funds toward strengthening and stabilizing the existing Health Home Care Management program. This proven, operational model is already delivering results. This represents a respectful and fiscally responsible call not to reinvent the wheel, but to invest in what is already working.

OUTCOMES/DATA/SOURCE REFERENCES

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