NY Health Home Coalition

Health Homes Improving Outcomes

The New York Health Home Coalition 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, behavioral health and social service needs and medical fragility. 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 respectfully submit the following points for your consideration during the MRT process. We are happy to provide additional detail on any of the below positions.

1. Health Homes are **saving money in the right places**, shifting utilization and costs from inpatient and emergency departments to outpatient, medications, transportation and specialty care.

    - 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.[1]
    - 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.[2]
    - 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[3]

2. Pharmacy. Rather than evaluate cutting valuable services and supports, we strongly recommend evaluating 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. These costs are skewing total cost of care calculations for the individuals who take them, but they can have a profound impact on outcomes.

3. **Population health management.** Health Homes play a critical role in improving population health management across the State. Some are also already involved in VBP arrangements and others are moving in that direction. This includes Health Homes as critical partners with ACOs, IPAs and other accountable networks. It would be wasteful and inefficient to discard these and the infrastructure we've spent the last 8 years building rather than to continue to improve and enhance them. 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 including revenue cycle management support, quality oversight, training and technical assistance, care management and data analytic support and much more.

4. **Social determinants.** Health homes are a critical tool for ending the epidemic, reducing homelessness and incarceration and many other key social determinants of health. Some are also playing roles as organizing hubs for community-based organizations as they seek to connect with the healthcare system.

    - Based on a representative sample, there was a 29% reduction in homelessness and a 37.5% reduction in incarceration[4]

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

    - There was an 8.4% improvement in adherence to antipsychotics for individuals with schizophrenia (State established measure) enrolled in health homes from 2013 to 2017[5]
    - 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[6]
    - There was an 11.4% improvement in follow-up after hospitalization for mental illness within 30 days statewide for health home enrollees.[7]
    - 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).[8]

    We acknowledge the limitations of our data and that of the State continue to work closely with the NYS Department of Health, our IT vendors, the Office of Quality and Patient Safety (OQPS) as well as with other offices to leverage PSYCKES and other data sources to continuously improve the program and effectively evaluate performance and impact.

6. **Continuing improvements:** The Coalition is working with diverse stakeholders to reduce administrative burden, support Health Homes in entering into VBP arrangements, engage with the health plans to address gaps in care, evaluate streamlining rates, implement standardized best practices, and improve the overall efficacy of care management statewide. These efforts should continue in the correct venues with changes being made in the nuanced and sophisticated way this complex service requires. We are happy to be partners in continued conversations about rightsizing the program,

tightening eligibility so the program is reaching the right people at the right time, etc. and do so on an ongoing basis with many other stakeholders.

7. **Naturally occurring consolidation.** Health Homes acknowledge the need for consolidation and are undertaking voluntary and organic efforts to do so. This will result in limited efficiencies and improvements across the state.

8. **Expanding the role of Health Homes.** We believe the answer is to expand Health Homes to provide a platform to aggregate a full continuum of care management beyond the narrow definition of Health Home eligibility and reimbursement. Many Health Homes are already doing so. They are knit into the fabric of health systems, PPSs, ACOs, IPAs, and other effective strategies. Health homes have been at the core of many successful DSRIP projects including the Millennium Hearts Initiative, the New York Presbyterian HIV efforts. featured in the UHF best practices report and are critical to the sustainability of the gains of these projects. To cut or dismantle this program would have a domino effect that we do not believe is well understood. Children's Health Homes have been critical to the Children's Transformation.

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.[9]

Collaboration with the Health Plans

- We've been working closely with plans across the state to improve workflows and collaboration, integrate and better use data, target priority populations including those with high utilization, gaps in care and with complex needs.
- We acknowledge that some plans are suffering from imperfect premium calculations and that there is a need to rebase the rates as they have not changed since 7/1/18 even though enrollment and composition of enrollment have. We have advocated on behalf to the plans to this end with the State and been told "they'll get back to us."

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.

Health home care managers are located in communities where individuals live and provide both in-person and telephone support to their members. 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.

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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 cannot be underestimated. Health Homes have experience in organizing the networks of care management agencies necessary to provide care management services. As networks of 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.

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

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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

[1] Citizen Budget Commission Special Event. New York State Health Home Program. PPT delivered by Greg Allen, May 1, 2018. Slide 19.
[2] Health Home Update. 2018-2019 Legislative Briefing. October 17, 2018. PPT delivered by Greg Allen. Slide 18.
[3] Citizen Budget Commission Special Event. New York State Health Home Program. PPT delivered by Greg Allen, May 1, 2018. Slide 18-19.
[4] Coalition of NYS Health Home analysis of 14 Health Homes across the State totaling over half of all health home enrollment. Of those enrolled on 1/1/18 who were still enrolled on 1/1/19, significant reductions were seen in homelessness and incarceration rates according to the NYS Department of Health's HML system. All data are available for review.
[5] Health Home Update. 2018-2019 Legislative Briefing. October 17, 2018. PPT delivered by Greg Allen. Slide 17.
[6] Health Home Update. 2018-2019 Legislative Briefing. October 17, 2018. PPT delivered by Greg Allen. Slides 17 and 22.
[7] Ibid.
[8] NYS Department of Health 2018 Health Home Performance Report.
[9] Health Home Update. 2018-2019 Legislative Briefing. October 17, 2018. PPT delivered by Greg Allen. Slide 6.