NY Health Home Coalition

NYS Health Home Funding Analysis

Problem Statement: There is a gap between State-share funding of the New York State (NYS) Medicaid Program that is projected to expand from $3.1 billion in FY 2021 to $3.9 billion in 2023. This funding gap is due to an increase in projected spending above the approximately 2.2% rate that the program has grown between FY 2013 and FY 2018 under strategies introduced by the Medicaid Redesign Team (MRT) I and implemented since 2014 with the help of DSRIP funding that is now expiring. Governor Cuomo has created MRT II charged with making recommendations for reducing the projected Medicaid cost trend and closing the gap it creates between anticipated funding.

MRT II has examined underlying causes of the spending growth and identified long term services and support, the recently implemented $15 per hour minimum wage, increased support of financially distressed hospitals, the state assumption of responsibility for growth in the state's portion of Medicaid cost growth form local taxing bodies and growth in health care coverage for NYS residents as main causes of the rising cost of state share of Medicaid spending. This has been partially offset by reduction in preventable hospitalizations (21%) and readmissions (17%) achieved under MRT I strategies supported by the DSRIP program including expansion of patient-centered medical homes, care management, addressing social drivers of health, development and use of the state's health information exchange and the push toward advanced alternative payment methodologies.

One of the strategies was the significant expansion of Health Homes in NYS. High-risk complex individuals enrolled in Health Homes have reached targeted outcomes for 20 of 24 quality and process metrics in relation to comparable Medicaid beneficiaries who are eligible but unenrolled in that program. Chronic condition hospitalization, all-cause readmission, potentially preventable emergency room visit rates are not included in that list of metrics in the MRT II summary report of February 2020 but in Citizen Budget Commission Special Event presentation of May 1, 2018, they were all improving. Total cost of care trends were not reported in the February 2020 report but the May 1, 2018 showed it increases slightly as the significant saving in inpatient costs and unchanged cost in emergency room costs were more than offset by increases in pharmacy and other ambulatory services. The cost of the health home program was not included in total cost of care calculations in that report.

Care management costs including Health Homes is one of six areas identified by MRT II where a course correction may be needed. It appears to be targeted as an opportunity by MRT II as NYS Medicaid care management expenditure has increased significantly since the start of the NYS Health Home Program in 2012, reaching $380 million for the CCO Health Home program (primarily related to rate increases) and $528 million for non-CCO Health Homes (primarily related to enrollment growth).

What is conspicuously missing in the MRT II overview report of February 2020 is an update on the return on investment (ROI) calculation for the NYS Health Home Program. A negative ROI in terms of medical

and program costs doesn't justify elimination or significant downsizing of the program but rather a more detailed analysis that can inform some redesign, given the current NYS budget situation. We are recommending that the following questions be explored as part of the work of MRT II:

1. Within the group of individuals currently eligible for Health Homes in NYS, are there subsets who are benefiting more than others? For example, within the current eligibility criteria, are there subsets with certain demographics, chronic conditions, social drivers of health or health care utilization patterns that are disproportionately accounting for more or less of the benefit in terms of the 24 metrics and the ROI? Should eligibility be expanded to any groups of complex, high risk individuals who are currently ineligible for the program who would significantly benefit from a cost as well as health outcomes perspective? Are there some enrollees who meet eligibility criteria but whose self-management has improved to where they no longer require Health Home services? If so, MRT II can explore Health Home program eligibility based on those findings.
2. Would ROI be improved by better enrollment of a subset of the currently eligible who are highest risk and highest cost but unenrolled population and if so, what new approaches beyond those already tried should be implemented? For example, can we improve communication and workflows between hospitals and Health Homes that would facilitate enrollment from eligible beneficiaries who present to the emergency room or are hospitalized?
3. Do we have the right list of Health Homes service and administrative requirements for each of the three tiers of eligibility? For example, once a face-to-face relationship is established between the enrollee and his/her care manager, is it beneficial that all subsequent contacts be in-person or does that add unnecessary travel cost and create a barrier for the enrollee to stay in the program? Would fewer monthly contacts allow care managers to carry a larger case load without compromising outcomes?
4. Are staff credential requirements for the Health Home Plus tier appropriate or should such individuals be served by a licensed and non-licensed care team member, each assigned tasks that are appropriate for their training?
5. Which of the 24 quality and performance metrics are most predictive of a positive ROI? Are there ROI-sensitive metrics that should be added, and should the list be prioritized in terms of importance as informed by ROI implications?
6. Are health homes properly integrated with IDS and MCOs in terms of timely information sharing, common workflows and aligned financial incentives? For example, can we improve transitions of care handoffs with hospitals and can health plans share timely information that an enrollee is late filling a critical medication? Are care plans being shared and optimally used by these three groups?
7. Have financial payments and incentive structures for Health Homes, health care provider groups and health plans been optimally aligned to facilitate collaboration and elimination of duplication of services?
8. Is there unwarranted and undesirable variation in performance among Health Home Lead Agencies and among Health Homes that can be addressed through better standardization of approaches, training and reporting to identify opportunities for improvement?

9. To what extent is funding of key social services such as supportive housing limiting the effectiveness of Health Homes and what are the opportunities to either enhance those services with a ROI perspective or improve the ability to prioritize those individuals who might benefit the most from those limited resources?
10. Can we expand evaluating Health Home Program ROI beyond just Medicaid costs to include savings in other societal costs such as the justice system and other safety net programs?

The New York State Coalition of Health Homes appreciates the budgetary challenges the State Medicaid Agency faces and the need to enhance the cost effectiveness of the Health Homes Program. We are prepared to work with MRT II to share our experience working with these complex populations since 2012 but urge not to recommend cuts that are uninformed by answers to the questions we have posed above.