NY Health Home Coalition

Submitted electronically by email to VBP@health.ny.gov

April 30, 2026

Department of Health
Office of Health Insurance Programs
99 Washington Avenue
Albany, NY 12210

Re: Public Comment – NYS Medicaid Value-Based Payment (VBP) Roadmap

We appreciate the opportunity to submit public comments on the New York State Department of Health, Office of Health Insurance Programs' Medicaid Value-Based Payment (VBP) Roadmap.

The Coalition of New York State Health Homes represents 19 Health Homes serving every region of the state. Collectively, Coalition members support more than 183,000 adults, children, youth, and families, including those with the most complex medical, behavioral health, and social care needs. CNYSHH is committed to improving outcomes for these populations by supporting Health Homes and their associated Care Management Agencies in delivering high-quality, cost-effective complex care management.

Health Homes have over a decade of success improving health outcomes, reducing avoidable utilization, generating cost savings across the Medicaid system, and addressing health-related social needs for New York's most complex populations. Through a community embedment model, Health Home Care Management (HHCM) plays a critical role in targeting the underlying drivers of poor health in underserved communities by delivering culturally competent, person-centered care tailored to the unique needs of the populations most impacted by health disparities.

As New York advances its VBP strategy, it is critical to fully leverage Health Homes as the central care management entity for complex Medicaid populations. Earlier misalignment between care management and attribution has led to fragmentation and duplicative costs, but it is not too late to correct this. By realigning attribution and integrating Health Homes into VBP design, especially as the State approaches significant Medicaid changes, New York can strengthen care coordination, improve outcomes, and drive meaningful cost savings.

NY Health Home Coalition

Health Home Program Outcomes — Documented Performance and Cost Savings

State Department of Health (DOH) data confirms that Health Home members achieve substantially better performance across behavioral health and health outcome measures than the overall Medicaid population.[1]

Adult Health Home Members-Better Outcomes Across 19 of 22 Measures

Children Health Home Members-Better Outcomes Across 15 of 15 Measures

Adult Measure Name	Medicaid Performance	Health Home Performance	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%**
Follow-Up After Emergency Department Visit for Mental Illness (7 Days)	38.7%	57.1%	**18.4%**

Individuals enrolled in Health Homes experienced significantly lower rates of inpatient admissions (**27.7 % reduction** versus the statewide average) and emergency department visits (**14.5% reduction** versus the statewide average) than those not enrolled in Health Homes.

[1] NYS-DOH-Health-Home-Data-Set_2024.pptx

NY Health Home Coalition

Costs

- **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 difference of 16.6% for Health Home enrolled adults.
- **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**.[2]

We respectfully submit the following recommendations:

1. **Formal Inclusion of Health Homes in VBP Contracting Language**

   The Coalition strongly supports the Roadmap's emphasis on, whole-person care, health equity, and integrated care across health, behavioral health, and social care. Health Homes are already operationalizing these goals by serving as the **central hub coordinating care across fragmented systems**, ensuring continuity and person-centered care planning.

   Health Homes serve as the primary coordinators of care across medical, behavioral health, and social systems, making them uniquely positioned to drive performance across quality and cost metrics.

   Recommendation:
   The VBP Roadmap explicitly identifies Health Homes as eligible and **expected providers** within VBP arrangements, **including shared savings and downside risk models.**

   Without explicit inclusion:
   - VBP arrangements risk excluding the entity most responsible for managing high-need Medicaid populations.

[2] NYS-DOH-Health-Home-Data-Set_2024.pptx

- Opportunities for cost savings and quality improvement will be diminished.
- Existing Health Home-MCO contract negotiations will continue to face barriers.
- Fragmentation of care and duplication of costs will persist, as multiple entities continue to manage the same population without alignment.

Currently, MCOs may either invest resources to manage these populations directly or assign members to VBP arrangements with provider systems, effectively delegating risk and care management. In both scenarios, however, multiple entities remain responsible, and are being reimbursed, for managing the same members, leading to inefficiencies and misaligned incentives. For Health Home enrolled individuals, the Health Home should serve as the centralized care coordination entity.

The Coalition has consistently recommended updating VBP language and contracting structures to ensure Health Homes can participate directly, including in **downside risk arrangements.**

2. Expand Health Home Member Attribution Beyond HARP Enrolled

We appreciate that the NYS VBP Roadmap specifically lists that member attribution can be assigned to the Health Home based on HARP enrollment "MCO-assigned Health Home could drive the attribution for the Health and Recovery Plan (HARP) population."[3] However, language does not reflect the full breadth of complex need Medicaid members that Health Homes serve and for whom they drive quality outcomes with enrollment and care management interventions.

Recommendation:

Attribution language should be expanded so that MCO-assigned Health Homes drive attribution for all Health Home enrolled members.

Health Homes serve the most complex Medicaid members while successfully addressing quality measures, inappropriate utilization, and system cost savings.

These Medicaid members include:

- HARP enrolled adults
- High utilizers of emergency room and in-patient stays
- Recent involvement in criminal justice system
- Disconnected from medical and/or behavioral health care.

[3] NYS Medicaid Value-Based Payment (VBP) Roadmap

- Significant unaddressed social care needs
- Health Home Plus eligible (SMI and HIV)
- Children with a K Code and enrolled in HCBS
- Children involved with the child welfare system, including children placed in 29-I Voluntary Foster Care Agencies
- Children enrolled in BHCC or CFTSS
- Medically complex/ medically fragile children
- Children with Serious Emotional Disturbance (SED)

We support the roadmap's recognition of integrated pediatric primary care models such as Healthy Steps as a basis for team-based attribution. For children with complex medical, behavioral health, or child welfare–involved needs, however, attribution should sit with the Health Home Serving Children and its CMA network, which delivers longitudinal, cross-system coordination that pediatric primary care alone is not resourced to provide. Healthy Steps and Health Homes Serving Children should be treated as complementary, with attribution flowing to the Health Home for higher-acuity pediatric populations.

3. **VBP Contracting Requirements and Provider Participation**

The current roadmap outlines expectations for expanded VBP adoption but does not clearly define the role of care management providers. Health Homes are not consistently identified as eligible or required participants in VBP arrangements, despite being the entity most responsible for managing high-cost, high-need populations.

Recommendations:

- Explicitly include Health Homes as **required** or **priority partners** in VBP Level 2 and Level 3 arrangements.
- Allow Health Homes to participate directly in **shared savings** and **downside risk** models.
- Update model contract language to support Health Home inclusion.

4. **Advance Data Sharing and Performance Measurement**

Successful VBP implementation requires access to **timely, member-level data** across systems.

Recommendations:

- Expanding data sharing between MCOs, Health Homes, and SCNs
- Providing actionable, **near real-time data** to support care management interventions
- Ensure access to **member-level cost and utilization data.**
- Aligning performance metrics across programs to reduce administrative burden

5. **Aligning Quality Metrics with Care Management Impact**

Health Homes directly impact a wide range of quality measures, including:

- Behavioral health follow-up and medication adherence
- Chronic disease management (e.g., diabetes, hypertension)
- Preventive care and utilization metrics

As shown in the Coalition's quality metric analysis (Appendix A), Health Homes contribute to performance across, and have reporting performance requirements, across multiple VBP-relevant domains, including care coordination, behavioral health, and utilization.

Recommendation:
The VBP Roadmap should:

- Attribute appropriate credit to care management interventions.
- Include care coordination and social care metrics.

6. **Pediatric Populations Require Tailored VBP Design**

Children's VBP arrangements have historically lagged adult arrangements, and the 2026 Roadmap risks perpetuating this gap by addressing pediatrics primarily through maternity care and pediatric primary care models. Children, particularly those served by Health Homes Serving Children require a purpose-built VBP design.

Recommendations:

- **Quality measures:** VBP arrangements covering Health Home–enrolled children should incorporate the pediatric measures Health Homes already collect, including Well-Child Visits (First 15 Months; 3rd–6th Year), Childhood Immunization Status, Immunizations for Adolescents, Lead Screening in Children, Adolescent Well-Care Visits, Follow-Up Care for Children Prescribed ADHD Medication, and

Child/Adolescent Major Depressive Disorder Suicide Risk Assessment. (See Appendix A.)

- **Risk adjustment and stop-loss:** Pediatric populations per Health Home are smaller than adult populations, with higher per-member variability driven by medically fragile and complex behavioral health subgroups. Downside risk arrangements involving children must include adequate risk adjustment and stop-loss provisions to enable Health Home participation without destabilizing small denominators.
- **Performance measurement timeframe:** Pediatric outcomes, developmental, educational, behavioral health mature over multi-year timeframes. VBP arrangements should not penalize Health Homes based on annual outcome targets that misalign with the developmental trajectory of pediatric quality measures.
- **Social drivers of health:** Children's outcomes are influenced by family-level social determinants. Health Homes Serving Children should be explicitly recognized as the entity coordinating SCN-delivered Enhanced Services for Health Home–enrolled children, with attribution and shared savings flowing accordingly.

General Comments:

- The current care management landscape remains fragmented, with multiple overlapping programs creating inefficiencies and confusion for members.

  The VBP Roadmap should support a **streamlined continuum of care management** by:
  - Recognizing Health Homes as the central coordinating entity for complex need Medicaid enrolled adults and children
  - Reducing duplication and creating efficiencies across care management programs
  - Aligning fiscal investments and incentives across Health Homes, MCOs, SCNs, and other partners to drive outcomes in a coordinated and cost-effective manner.

Conclusion

The Coalition appreciates the State's continued commitment to advancing Value-Based Payment as a strategy to improve outcomes and drive accountability across the Medicaid program. Health Homes are a proven, statewide infrastructure that improve outcomes for the

most complex Medicaid members, reduce unnecessary utilization and costs, address health-related social needs, and serve as the central hub within an otherwise fragmented system.

As New York advances its VBP strategy, it is essential to fully integrate Health Homes into VBP design, contracting, and implementation. Failure to do so risks undermining the State's goals for value-based care, health equity, and broader system transformation at a time when the State cannot afford any additional costs to the Medicaid system.

To fully realize the State's vision, the VBP Roadmap should explicitly include Health Homes in VBP contracting, leverage them as the central care management infrastructure, and align VBP, Social Care Networks (SCNs), and the 1115 waiver through more integrated models. Additionally, Health Homes must be supported with the data, funding, and operational flexibility necessary to succeed in these arrangements.

Health Homes are a proven model already delivering on the core goals of VBP. Fully integrating them into the Roadmap is essential to achieving improved outcomes, reduced costs, and greater health equity for New York's Medicaid population.

The Coalition appreciates the opportunity to provide input and welcomes continued partnership with the Office of Health Insurance Programs to ensure the VBP Roadmap aligns with the State's vision for integrated whole-person care.

Respectfully submitted,

Laurie Lanphear
Executive Director
Coalition of NYS Health Homes
www.hhcoalition.org
llanphear@hhcoalition.org

NY Health Home Coalition

Appendix A- Program Quality Metric Collection

Children Only | CCO

Quality Metric Category	Measure Name	Health Home	PCMH	SCN	MCO	CCBHC
Behavioral Health	Adherence to Antipsychotic Medications for People with Schizophrenia	X			X	
	Adult Major Depressive Disorder: Suicide Risk Assessment		X			X
	Anti-depressant Medication Management	X	X		X	
	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment		X			X
	Depression Remission		X			X
	Follow-up after hospitalization for Mental Illness – within 7 days and 30 days	X			X	
	Follow-Up Care for Children Prescribed ADHD Medication	X	X		X	
	Screening for Depression and Follow-Up Plan		X			X
	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	X			X	
Care Coordination	Closed loop referral rate	X	X	X		
	Employment	X			X	
	Screening for Social Drivers of Health	X		X	X	X
Care for Chronic Conditions	Appropriate Treatment for Children with Upper Respiratory Infection	X	X		X	
	Comprehensive Diabetes Care: Hemoglobin A1c test	X			X	
	Controlling High Blood Pressure	X	X		X	X
	HIV/AIDS Comprehensive Care	X			X	
	Medication Management for People with Asthma	X			X	
	Persistence of Beta- Blocker Treatment after a Heart Attack	X			X	
	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		X		X	
Experience of Care	Member satisfaction			X	X	
Preventive Care	Adolescent Well-Care Visits	X			X	
	Annual Dental Visit	X			X	
	Appropriate Testing for Children with Pharyngitis	X	X		X	
	BMI Assessment	X	X		X	
	Breast Cancer Screening		X		X	
	Cervical Cancer Screening		X		X	
	Childhood Immunization Status	X	X		X	
	Chlamydia Screening	X	X		X	
	Colorectal Cancer Screening	X	X		X	
	Fall: Screening for Future Fall Risk	X	X			
	Immunizations for Adolescents	X			X	
	Lead Screening in Children	X			X	
	Tobacco Use: Screening and Cessation Intervention		X			X
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	X	X		X	X
	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	X			X	
	Well-Child Visits in the First 15 Months of Life	X			X	
Utilization	Inpatient Utilization	X			X	
	Mental Health Utilization	X			X	
	Plan All-Cause Readmission	X			X	