NY Health Home Coalition

NEW YORK STATE CARE MANAGEMENT COALITION
The Key to Integrated Care

Executive Summary based on NYS DOH 2024 Health Home Data for Adults

Health Homes Serve a Diverse, High Needs, and Medically Complex Population

Health Homes are networks of community-based care management agencies that work to engage individuals with serious and complex physical health, mental health and substance use disorders in their local communities to achieve better health outcomes, member satisfaction and overall reduction in the cost of care. Health Homes provides comprehensive care management to the highest need, highest risk Medicaid members in NYS.

Health Home members have **higher behavioral health needs and are more medically complex** than most Medicaid members, which means the Health Home outcomes indicated below are even more significant.

Behavioral Health Diagnoses
The prevalence of all of the top 10 diagnoses were many times higher in the Health Home population than in the general Medicaid population

- **Chronic stress and anxiety diagnoses:** more than **4x higher** in the Health Home population
- **Chronic mental health diagnoses (moderate):** almost **9x higher** in the Health Home population
- **Major depression and depression:** more than **6x higher** and more than **5x higher**, respectively

Medical Diagnoses
The prevalence of many medical conditions is significantly higher in the Health Home population than the general Medicaid population

- **Asthma:** approximately **5x higher** in the Health Home population
- **Diabetes:** more than **3x higher** in the Health Home population
- **Obesity/BMI 30-39.9:** almost **3x higher** in the Health Home population
- **Hypertension:** more than **3.5x higher** in the Health Home population
- **Hyperlipidemia:** almost **2x higher** in the Health Home population

**data was only available for either dual or non-dual population rather than both*

Health Homes Save Money and Improve Quality of Care

A recent fiscal analysis of health home enrollment data from 2024 for members enrolled for 9+ months reveals ***significant savings*** as outlined below.

Health homes saw a significant reduction in Inpatient and ER visits as compared to those not enrolled in health homes:

Individuals enrolled in Health Homes experienced significantly lower rates of inpatient admissions and emergency department visits than those not enrolled in Health Homes.

				AMOUNT	
ADMISSIONS TYPE	HEALTH HOME %	STATEWIDE %	REDUCTION	% CHANGE	STATEWIDE % CHANGE
Inpatient Admissions	-32.5%	-4.8%	-27.7%	-33.0%	1.6%
ER Visits	-18.5%	-4.0%	-14.5%	-18.2%	-1.6%

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 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**.

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.

Health homes understand the importance of the ongoing connection to outpatient care as a means of stabilizing a condition and preventing crises that result in readmissions. Using National Quality measures, health homes have demonstrated outstanding outcomes in connecting health home members to care upon discharge from an emergency room visit or inpatient stay for a MH/SUD condition:

Measure Name	Medicaid	HH	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%**

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.

Please click here for the full DOH 2024 report containing this data. All excerpts and conclusions in this Executive Summary were verified with DOH.

For more information:
Laurie Lanphear, Coalition of NYS Health Homes . llanphear@hhcoalition.org
Jackie Negri, NYS Care Management Coalition . nyscaremanagement@gmail.com
Evan Sullivan, Ostroff Associates . esullivan@ostroffassociates.com