What are the Goals of the Affordable Care Act and Redesign?

- Increased Coverage
- Better Population Health
- Higher Quality, More-Patient Centered Care
- Insurance Reform
- More Affordable Care
ACA Funding in New York

- Close to $369 Million in Marketplace Grants
  - Includes Navigator and In-Person Assistance Funding ($27 million annually)
- Health Center grantees in New York have received $216,260,090 under the Affordable Care Act
- Community Transformation Grants
  - $287,100 for Family-to-Family Health Information Centers
Improving Quality and Care Coordination

Why?
- 2,000 deaths/year from unnecessary surgery
- 7,000 deaths/year from medication errors in hospitals
  - Medication errors are among the most common, harming at least 1.5 million people, costing $3.5 billion
- 20,000 deaths/year from other errors in hospitals
- 80,000 deaths/year from infections in hospitals
- 13% of Hospital Readmissions are avoidable
  - Cost $45 Billion/year
Improving Quality and Care Coordination

How?
- Employ Electronic Health Records to
  - better coordinate care
  - reduce errors, i.e. medication
  - Reduce duplication, i.e. tests
- Pay for Care Coordination and Quality Performance
Improving Quality and Care Coordination

Who?

- Centers for Medicare and Medicaid Innovation
  - Initiatives to redesign how care is provided:
    - Accountable Care Organizations
    - Medical Homes
    - Partnership for Patients
  - Pay providers for care coordination and quality
Health Homes Program

- Section 2703 of the federal Patient Protection and Affordable Care Act (ACA) allowed states to develop and receive federal money for a set of health home services for their state's Medicaid populations with chronic illness.
Health Homes

- Designed to improve health outcomes
- Reduces preventable hospitalizations and emergency room visits
- Promotes use of health information technology (HIT)
- Avoid unnecessary care.
Medical Home vs Health Home

- **The Patient-Centered Medical Home (PCMH)** is a model for care, provided by physician-led practices, that seeks to strengthen the physician-patient relationship with coordinated care for all life stages, and a long-term therapeutic relationship. The physician-led care team is responsible for coordinating care needs, and arranges for other qualified physicians and support services. *Usually a clinic*

- The **health home** model of service delivery expands on the traditional medical home model to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic illnesses. *Usually a Health System/Network*
Health Homes

**Health Home services include:**
- Comprehensive care management,
- Health promotion; transitional care including appropriate follow-up from inpatient to other settings,
- Patient and family support,
- Referral to community and social support services,
- Use of health information technology to link services.
Health Homes

- Must have multiple chronic conditions, or have one and be at risk of acquiring another, or one serious persistent mental health condition.
- Chronic conditions include substance use disorders, HIV, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index over 25. **Viral Hepatitis is not on the list.**
- Program targets 975k high need, high cost Medicaid recipients.
Community Care Transitions Program

- Brooklyn Care Transition Coalition
- Mt. Sinai Hospital
- New York Methodist Hospital
- Queens Care Transition Collaborative
What IS AN ACCOUNTABLE CARE ORGANIZATION (ACO)

- “Shared Savings Program” rewarded for:
  - Lowering health care costs
  - Meeting high quality of care standards
  - Putting patients first
  - See any provider you like.

- Coordination and cooperation and the use of Health Information Technology
  - Necessary for this model’s success
FORMING AN ACCOUNTABLE CARE ORGANIZATION (ACO)

- Requires the following participants:
  - Eligible providers,
  - Hospitals, and
  - Suppliers

- Improve beneficiary health and reduce costs by:
  - Promoting accountability for the care of Medicare FFS beneficiaries
  - Requiring coordinated care for all services provided under Medicare FFS
  - Encouraging investment in infrastructure and redesigned care processes
Other Opportunities

- Hepatitis Wraparound Provision
- ACA reauthorizes demonstration programs to provide patient navigator services within communities to assist patients with overcoming barriers to health services by coordinating health services and provider referrals, assisting community organizations in helping individuals receive better access to care, providing information on clinical trials, and conducting outreach to health disparity populations.
Changing Landscape

- More Technology
- More Cost and Performance Focused
- Broader list of chronic conditions
  - Strategies must suit varied population
ACA Resources

- www.healthcare.gov
- www.medicaid.gov
- Marketplace.cms.gov
- innovations.cms.gov
- www.cms.gov
- www.kff.org
- cciio.cms.gov
- www.nycreach.org
Questions

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