The patient protection and affordable care act (ppaca) of 2010 essays example

Economics, Money

Discuss the origin, structure, and purpose of the new organizations formed under PPACA. and evaluate the challenges and opportunities facing payers and providers as ACOs and PCMHs are implemented:

Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs) are part of the reforms brought about by the Patient Protection and Affordable Care Act (PPACA). These organizations representing the models of delivery of patient care seek to improve patient care, control patient health care costs and improve the care experience for Medicare and Medicaid beneficiaries. Some experts have voiced their concerns about the ACO's potential to create market concentration among providers shifting costs to private insurers.

Accountable Care Organizations

ACO is an institution of professionals rendering service that undertakes to be accountable to the Medicare beneficiaries enrolled in the fee-for-service program in respect of the standard of care provided and expenses. The ACOs are federally recognized and are sought to be used to cater to the requirements of Medicare beneficiaries as envisioned in sections 3022 and 2703 of the PPACA. However, private payers outside Medicare have started using the ACO model. It is expected that the ACOs will make the providers accountable for the quality of their care besides the volume and intensity of their services. ACOs that satisfy the quality performance standards for shared savings will be able to provide financial incentives to the medical professions and institutions for keeping costs to a minimum without diluting the quality of care they provide. The ACOs that would hold providers accountable for per-capita costs do not have to require lock-in of the

patients. Hence, policy analysts prefer this model to other payment reforms such as PCMCHs, bundled payments, etc. The ACO model come in variety of forms in terms of care delivery mechanisms as allowed by the PPACA for integrated delivery systems, multispecialty group practices, physician hospital organizations, independent practice associations, physicians group practices, physician practice networks and others. ACO market is envisioned to emerge stronger than any other single model. Different ACO models aforesaid such as physician practice-based ACO will be predominant according to local conditions. The Medicare ACO model will provide a profit-sharing bonus incentive and Fee-For-Service (FFS) payments to providers that meet the clinical performance and per capita FFS Cost estimates. The ACOs will also use the metrics to show the quality and cost of care provided by making physicians and hospitals to meet the pre-determined benchmarks such as low mortality rates or reduced hospitalizations to be eligible for shared savings. Unlike the patient-centered medical home that seeks to enhance of coordination of care among physicians, ACOs aim at coordinated care among not only physicians but also other segments of healthcare such as physicians, hospitals and clinicians. The concept was developed in 2006 by Dr Elliott S. Fisher of the Dartmouth Institute for Health Policy and Clinical Practice in order to reduce fragmented care for ultimate cost savings and improved outcomes.

Structure of an ACO

Minimum stipulated number of Medicare beneficiaries is 5, 000 patients except in shortage areas or areas with critical care hospitals. ACOs can be

established by primary care physicians, primary care independent practice associations or employee groups. Hospitals, specialists and other providers can participate in the ACO, which should be a legal entity with a separate tax identification number and its own governance and management structure.

Challenges and opportunities facing payers and providers as ACOs and PCMHs are implemented:

Although it is true that he existing system of healthcare has failed in several respects, the ACO regulations are too much rule oriented proving to be burdensome on the providers who lack administrative infrastructure The savings in costs sought to be achieved are not significant. It has been found in an analysis by the University Health System Consortium that a significant number of ACOs with 5, 000 or more attributed lives would incur unwarranted penalties due to random fluctuation of expenditures in the population. The scheme entails a large investment in view of the need to hire chronic-disease managers and the newer concept of continued care. Retrospective assignment of a beneficiary is not welcome in several quarters. The tendency among the groups to be aware sufficiently earlier about the beneficiaries to whom they are financially committed is not welcome and a rule proposed for prospective assignment has since been rejected. The rule requiring to be responsible for a patient for the entire year even with a single visit of the patient is considered highly risky especially when the patient is free to choose his care anywhere with the expense burden remaining with the ACO of the first visit. There are as many as 65 quality metrics which are considered too high to be measured and reported by the organizations involved. The advertising materials on the ACO

intended for the patients must get the approval of Medicare, which involves unnecessary delay and burden. Absence of specialists proves to be less cost effective for patients of terminal illnesses such as HIV, end-stage renal disease, malignancies, and chronic congestive heart failure. It is considered as problematic for small practices to be responsible for patients of the physicians leaving the plan although substitution of the provider is not allowed for three years.

Patient Centered Medical Homes (PCMH).

Characteristics of the PCMH are: Every patient is assigned a personal physician who will give the patient continuous and comprehensive care on an ongoing basis. The assigned physician who is backed by a professional team with a collective responsibility for the continuous care of the patients. The personal physician is made responsible ensure provisioning of all the health care requirements of patients including care from other professionals. The PCMH model is claimed to be a solution to several chronic challenges faced by the health care system. However, it is argued that PCMH is not a comprehensive remedy for many reasons. In the first place, implementation of the PCMH model entails heavy investment as significant financial implications are involved in the acquisition and maintenance of HIT, setting up of processes to ensure team-based care, population management and continuous quality improvement. Further, the PCMH model requires considerable work-flow design and changes in organizational culture. Thirdly, the various practices must achieve a high level of co-operation among them so as to achieve the aims of the PCMH. This model is meant to give better

primary care and chronic care. Many PCMH programs have proved themselves with improved quality, cost savings and positive care coordination efforts. This is true of the ACOs also.

Ten potential mistakes

Singer and Shortel (2011) argue that in implementing the Accountable Care Organizations, ten mistakes are likely to be encountered. The three aims of the ACO are high-quality patient centered care, improvement of the health of the population and minimizing per capita costs. The authors caution that there will be a tendency on the part of organizations to be overconfident of managing risk. Overestimation of the use of electronic records. Overconfidence about reporting performance measures. Overconfidence in the implementation of standardized care management protocols. There can be a failure in balancing the interests of various stakeholders. The professionals may not succeed in engaging the patients in their self-care management and self –determination. It may not be easy to establish contracts with the specialists who are cost effective. It is not easy to go through the complicated rules and procedures. There can be a failure to integrate heath care professionals beyond the formal levels. Importance of interdependencies cannot be easily recognized.

Conclusion

The two models of ACO and PCMH are promising enough and have evolved over time. They are not the schemes announced in a hurry or rushed through. Many mistakes and shortcomings of the past have been sought to be remedies through integrated care and cost savings. Commentators have

been voicing their concerns over the successful implementation of the new models and not to replace them for their obvious potential benefits to the patients.

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