Week 2 Project

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The United states of America faced a short period where the cost curves of health care were almost flat. This was majorly because of settled and well-established care system for well-managed practices (Baird, 2011). However, the health care system of US with time required enhancements to cater a large population. The Patient Protection and Affordable Care Act (PPACA) is an act passed on 23rd of March, 2010, with new regulations and strategies about healthcare facilities available to US citizens. The two parts of legislation that constitutes the reform law of US Healthcare include Health Care and Education Reconciliation Act (HCERA) and Patient Protection and Affordable Care Act (PPACA). Previous President, Mr. Barack Obama gave a complete overview and evaluation of this PPACA. According to it, after Medicare PPACA is the complete and inclusive health care plan. PPACA was passed with only 60 votes in the Senate and 219-212 votes in the House. However, Medicare was approved in 1965, in the Senate with total of 68-21 votes and 313-115 in the House. As reported by Barack Obama, not only PPACA passed with a smaller number of votes, it also had to face several encounters by Supreme Court and Congressional. He claims it a political wonder which is obvious from facts stated above. The main purpose of the PPACA is to facilitate maximum people with health insurance, provide health care at lesser cost and advance the care system management. This law was modified and later termed as “Obamacare” and “Affordable Care Act”. PPACA provides comprehensive set of regulation for provider, employers, health insurance companies, and individuals related to health care field. On 30th of March 2010, this reform was modified by Health Care and Education Reconciliation Act (HCERA). Different law section of this act was called effective on different dates. The Individual Mandate, for example, section of PPACA, according to which a person can obtain specified aid for healthcare facilities which is also called minimum essential coverage or has to pay tax as consequence, was effective from 2014. On the other hand, the Employer Mandate, according to which employers are obliged to pay specified amount of coverage to stated employees was made effective next year, that is in 2015. As PPACA is detailed and vast, it covers various health care areas and constitutes of multiple discrete provisions. To combat healthcare issues like poor management, uneven distribution, and costly expenditures, new reforms were introduced which included patient-centered medical homes (PCMH) and accountable care organizations (ACOs). (Longworth, 2011). They are described as follows:

# Accountable care organization (ACO)

Accountable care organization (ACO) is one of the significant features of PPACA. The goal of ACO is to minimize disintegration and inadequacy of present health care system. This goal is to be realized by reassuring an advanced and restructured system of healthcare and analysis of health benefits which will be based on treatment methodology and physician guided proficient system.

**Origin**

The idea of establishing ACOs was first presented by Elliott S. Fisher, MD, MPH, of the Dartmouth Institute for Health Policy and Clinical Practice in 2006. The main concept behind ACO is that minimizing disintegration in system, decreasing care cost, and enhancing coordination among ACO, the output can increase. ACO are described by State of Massachusetts’ Special Commission on the Health Care Payment System as it is part of reform for health care.it is described as delivery system of health care constituting hospitals, physicians, as well as clinical and non-clinical providers who are responsible for management. For an ACO, it can be either a physically located organization or virtually networked organization. A huge physician association would develop an agreement with other hospitals and supplement providers can be an example. According to a report to Congress, the Medicare Payment Advisory Committee (MedPac) defined the ACO is almost same fashion. However, in MedPac, the financial risk was also included. It said that an ACO will divide the profit in case of enhanced care integration but it will also be held liable for financial punishment if the condition of an ACO is not maintained or is not up to the mark according to structure of the ACO. But more importantly the ACOs are motivated by the new health reform presented. The Centers for Medicare and Medicaid Services put forward regulations to execute ACOs for patients of Medicare on March 31, 2011. It has three fundamental aims. Firstly, as mentioned by the 6 aspects of these quality in Institute of Medicine report: safety, patient focused, time accuracy, equity, efficiency and effectiveness, better care must be taken for every patient based on these. Secondly Better health of population should be focused, I regard with creating awareness about annual medical checkup, influenza vaccination and basic reasons of illness that include physical inactiveness, poverty, malnutrition, and substance abuse. Thirdly, decreasing cost by reducing waste and inadequacies and also not suppressing the beneficiaries to get any help they need (Longworth, 2011).

**Structure**

According to proposed statement, the least number of people befitting from Medicare are 5000, including some exemptions from rural and underdeveloped areas. Thee founder of an ACO can be mainly a physician, an independent practice care or group of employees. Participants of ACO can be providers, specialist, hospitals or emergency hospitals. The condition for becoming ACO is that it must be a lawfully a discrete unit, having personal tax identification number, personal administration and management hierarchy. Keeping this in view, concern have risen that some of the association or entities with more than half population, may join hands and become market dominant. To tackle this concern, it is stated that any ACO that has less than 30% of market share will be excluded from this concern, but any ACO with more than half of market share will face a comprehensive review (Longworth, 2011).

**Purpose**

Many of the ACOs are considered effective as they have brought improvements in quick access to physicians, patient gratification and health system parameters. With any other challenges faced by ACOs, one of them is that few organizations are unaware of its cost structure, they have limited authority over physicians who are loosely associated and cannot execute sharing of patient cost in case of unjustified medical treatment. But the continuous development of ACO contracts, also commercially proposes positivity by professionals and originations affiliated to health care as well as health insurance companies involved (Skinner, 2016).

**Origin**

Originally, The American Academy of Pediatrics introduced the idea of a medical home in 1967 to take care of children suffering from chronic diseases. They improved this idea in 2002 and provided key rules which now are referred as structural features of PMCH. These include integrated and in time care, support of electronic medical information available at places at all time, ethnically driven and quality ensured and associated to community services. It was later observed that much more efforts are required to help people with chronic diseases and to cater that need, this concept was further expanded for adults also. Given that, the adult population tends to have more advantage from PCMH because of its affordable, integrated, and comprehensive structure. After the enhancement, many related organizations evaluated what term “medical home” suggested. And now an association of expert physician organizations recommends the coordinated key features of PCMH. The Joint Principles were ratified by American Medical Association in 2008 (Bolin, 2011).

**Structure**:

There exist in total six concepts of predominate idea of PCMH. To achieve status of PMCH, an entity has to be sufficing according to criteria in all concepts. The concept areas are similar to the standard according to the NCQA PCMH Recognition. These criteria are established by proof-based regulations and finest practices. Each practice to get recognized must comply with all forty core criteria and at minimum, 25 of elective criteria of the concept.

**Purpose**:

The key role of PMCH is based on practice features and defining PCMH as a place for care incorporation, active engagement of patient and family, implementation of fundamental care principles, extensive and joint care. However, the highlighted aim of this structure is varied in different states in the country (Kieber-Emmons & Miller, 2017)

In present, PCMH is encouraged by many skilled professionals and humanitarian special interest groups, public and private funders. It is because of the aptitude of the combined and unified system.

**Conclusion**

There is no doubt that PPACA has benefited a lot of people and is truly a significant achievement. PPACA is required and it is difficult to replace with any other reform as it is more affordable. However, till date it is not able to fulfill its purpose like it was proposed (Skinner, 2016). Another key purpose of ACA was to make the health care system convenient and affordable for everyone. During the first 5 years ACA was implemented, according to President’s Special Communication reports, a significantly slower increment in expenditure of health care is observed. But it is not determined if the slow increment was because ACA was implemented or due to other aspects like recession’s long-term effects or increment in copayments and deductibles. It is observed that there are various improvements and changes required in PPACA and it suggest that more key improvements are required for proficient use of this reform. In conclusion, this model can be basis to improve and provide a better one in future at lower cost and more facilities.

References

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