HIT Perspectives

Perspectives and Updates on Health Information Technology

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Accountable Care Organizations

Government Issues New ACO Regulation and More

By Tony Schueth, Editor-in-Chief

October 20th was a big day for accountable care organization (ACO) junkies. The Centers for Medicare and Medicaid Services (CMS) published its "dramatically revised" final rule spelling out requirements for getting Medicare ACOs up and running. Numerous other agencies weighed in with supporting guidance, including the Department of Health and Human Services' Office of the Inspector General (OIG), Internal Revenue Service (IRS), Federal Trade Commission (FTC) and the Center for Medicare & Medicaid Innovation.

For most *HIT Perspectives* readers, the ACO regulation is most important—although knowing how to stay afoul of Stark, FTC and IRS requirements is not to be sneezed at. New funding from the Innovations Center is also a good thing, especially for smaller or disadvantaged entities, such as those in rural areas.

The new ACO regulation was extensively retooled in response to objections by major stakeholders to the proposed rule published this past spring…

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Electronic Health Records

In Search of the EMR of Tomorrow

By Kurt Andrews, PhD

It seems as though just about everyone is deeply focused on ensuring that electronic medical record (EMR) functionalities are in lock step with requirements for meaningful use (MU) stage 1. While Point-of-Care Partners analyzes how MU affects our clients, we also look to see what the future will hold for EMRs and where opportunities will lie.

We believe EMR adoption will continue to increase but opportunities will change as we progress from the basics called for under stage 1. This paradigm shift will be driven by the functionalities and analytics needed for accountable care organizations (ACOs) and patient-centered medical homes. It is an evolutionary process that can be viewed in three phases...

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Telemedicine

Telemedicine: Another Tool in the HIT Arsenal

By Mihir Patel, PharmD, RPh

Telemedicine was conceived early in the space program to help monitor astronauts' vital signs. Like many National Aeronautics and Space Administration innovations, it has spun off and taken on a life of its own, spurred in large part by the growth in technological innovation in health and communications.

Advances like Skype, mobile health (m-health) apps, video conferencing and encrypted digital software through Web portals, coupled with wider availability of broadband, have expanded access to care through telemedicine. Now, telemedicine is seemingly everywhere. Consultations, treatments and education are available for a wide array of conditions and other uses, such as psychiatry, home health care, remote patient monitoring, emergency care, and case management.

Telemedicine services now go to a wider array of patients than ever before — and they're not just out in the boondocks...

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Key provisions of the final rule include:

- Providers will not be required to share downside risk in order to participate in an ACO and will be able to more quickly earn revenue sharing based on ACO savings.
- Elimination of the previous requirement that half of physicians participating in ACOs must meet meaningful use measures.
- Simpler and more streamlined quality and reporting measures. ACOs now will only have to meet 33 quality measures to qualify for performance bonuses, as opposed to the original 65. In addition, participants can use survey, claims and administrative information to report quality measures instead of electronic health records. There is also a newly introduced Web-based group practice reporting option.
- Community health centers and rural health clinics are now in the game. They were originally not allowed to form ACOs, but now can lead ACOs.
- ACOs will know sooner rather than later which Medicare beneficiaries are likely to be put into their system, which has major implications for risk and risk mitigation.
- Adjustments have been made to the financial model for increasing incentives to participate.
- Greater flexibility was created in ACO governance, legal structure and timing for repayment of losses.

The question now is: So what? Will these massive — and watered down — changes be enough to lure providers and others into forming Medicare ACOs or will everyone continue to migrate toward private ACOs, which could promise the same cost savings and financial benefits as the Medicare ACO model without the intrusiveness and hassle of federal regulation? Time will tell. In the meantime, Point-of-Care Partners is tracking how things will sort out and helping clients adapt to the new world of ACOs. Write or give us a call so we can let you know how ACO formation is shaping up in your market.

By the way, if you have the time, the inclination and an adult beverage in hand, you can read:

- The 696-page ACO final rule on the *Federal Register* Web site.
- An interim final rule, with comment period from the CMS and OIG, establishing waivers of the Physician Self-Referral Law (“Stark Law ”), the Anti-Kickback Statute, and certain civil monetary penalty law provisions to specified arrangements involving ACOs.
- Statements regarding ACOs from the FTC and Antitrust Division of the Department of Justice (“Statement of Antitrust Enforcement Policy”) and the IRS (Notice Concerning Tax- Exempt Organizations).
- Guidance from the Center for Medicare & Medicaid Innovation concerning its ACO advanced payment model. This model is intended for organizations, including rural and physician-led ACOs, in need of capital to make necessary investments to coordinate care. Additional information is available here.

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- Phase 1: Basic EMR functionalities. This is essentially automating fundamental functions through basic EMRs. These are closely in sync with stage 1 requirements and include patient history and demographics, patient problem lists, physician clinical notes, computerized provider order entry (CPOE), and the ability to view lab and imaging results.
- Phase 2: Advanced EMR Functionalities. This evolutionary phase begins with such MU functionalities as those found with ePrescribing. It then transitions to computerized orders for lab tests and radiology and to the electronic return of those results, with out-of-range values that are highlighted.
- Phase 3: EMR functionalities for patient-centered accountable care. This phase moves beyond the traditional route of automating the paper-based clinical workflow with health information technology as an enabler. It will require a major leap forward – one that is more transformational than evolutionary. It transcends stage 3 functionalities into uncharted territory where an EMR is not sufficient for the requirements of tomorrow's care models and thus cannot be just a jerry-rigged version of today's advanced EMRs. The new standard will be an electronic health record (EHR) in the true sense — one that is interoperable with health information exchanges. As a result, innovations emphasizing analytics will be needed, such as electronic reporting from the EHR to registries for patients, public health and specific diseases; clinical guidelines at the point of care; post-visit care management, which identifies gaps in care and patient non-adherence; and tools for patient self-support management, including a personal continuity of care record. New technologies will also be needed to help shift the paradigm from today's incredibly complex and inadequate referral management systems, in which a patient's continuity of care record and gaps in care follow him or her throughout the referral process.

So, where do the opportunities lie? The initial opportunities for vendors will be in closing the functionality gap between basic and advanced EMRs. This window will be open for the next 2 to 4 years, resulting in a convergence somewhere between 2016 and 2020. At the same time, another set of opportunities will arise in creating EHRs that will be the heart and soul of patient-centered medical homes and ACOs as they get off the ground.

These opportunities will not be limited to vendors. New kinds of workers — beyond those traditionally found in the path of care — will be needed to access this wide array of information and handle the advanced analytical functionalities that will help tomorrow's care organizations meet their quality and cost targets. This is a significant paradigm shift that POCP will be monitoring closely. Read all about it in *HIT Perspectives* or let us know if we can do a custom analysis for you.

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Telemedicine

Telemedicine: Another Tool in the HIT Arsenal

By Mihir Patel, PharmD, RPh

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Telemedicine today is being used for patients in various inpatient settings, including intensive care units (ICUs), prisons, nursing homes, in-hospital dialysis facilities and veterans' facilities. On the outpatient side, telemedicine is found in community mental health clinics and many other settings, such as connecting chronic care patients in private residences with case managers.

Telemedicine has become increasingly popular because patients may find it difficult and/or expensive to visit a physician or hospital — especially if they have debilitating, chronic conditions or live in areas lacking the specialists they need. Others like the flexibility of scheduling the "visit" around their treatment schedules. And, needless to say, the attractiveness of telemedicine is just as great to caregivers as it is to patients.

At the policy level, the allure of telemedicine goes beyond convenience. It is seen as an answer to the shortage of primary care physicians, nurses and specialists such as those in critical care. Naturally, it is all about cost savings. According to an estimate by the Center for Information Technology Leadership, widespread implementation of telemedicine could save the health care system some $4.28 billion by reducing transfers for medical exams from one location, such as a nursing home, to a hospital or doctor's office and eliminating unnecessary tests. Individual examples are just as compelling:

- Texas prisons report the combined use of telemedicine with EMRs has saved the state nearly $1 billion over 10 years. On an individual basis, the cost per day, per inmate, to provide medical care has been slashed from about $19 to less than $10.
- Researchers have found that effective "telestroke" care could be provided to rural stroke victims at a cost of around $2,500, compared with the usual $50,000 price tag.
- A program that integrates telehealth technology with case management tools could reduce Medicare spending for chronic care between $32 and $542 per beneficiary per quarter.
- A Center for Connected Health Policy report finds that a new law aiming to expand telehealth in California could result in annual Medi-Cal savings of more than $1 billion. Much of the savings would come from using telehealth for chronic disease management.
- According to research published in the *Journal of the American Medical Association*, patients in a Massachusetts hospital operating an eICU system suffer significantly fewer infections and fatalities. Almost 2 million Americans become infected in hospitals annually, resulting in nearly 100,000 deaths.

Although telemedicine is promising, barriers must still be overcome. Experts point to opposition from the medical community, resistance to change, and laws having to do with restrictive in-state licensing requirements, which limit how telemedicine can be implemented across state lines.

Then, there is the reimbursement issue. Medicare is still the gold standard and is proceeding cautiously about expanding reimbursement to emerging telemedicine services. State Medicaid programs and private payers have differing payment policies for telemedicine, which often are governed by a patchwork quilt of state laws and regulations. Together, these variable and overlapping payment policies create a major implementation barrier.

Despite implementation issues, vendors and others see major opportunities. The market for remote patient monitoring — a new kid on the telemedicine scene — is expected to reach $22.2 billion by 2015. That is more than triple the 2010 market valuation for this one segment. Other telemedicine areas are expected to significantly expand as well. Point-of-Care Partners will continue to monitor

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the growth of and opportunities in telemedicine as part of our overall focus on various HIT components and market segments. Stay tuned.