



Schwartz Communications

Federal Telemedicine News

July 21, 2010

Updates on Key Issues

<http://telemedicineneeds.blogspot.com/search?updated-max=2010-07-25T08:41:00-04:00&max-results=7>

By Carolyn Bloch

Updates on the just released regulation defining meaningful use was one of the key topics introduced by Neal Neuberger, Executive Director for the Institute for e-Health Policy at the July 14th Capitol Hill Congressional Seminar. First on the agenda, experts discussed the Medicare and Medicaid Incentive Programs final rule and how both physicians and hospitals can become eligible for both Medicare and Medicaid incentive payments.

Specifically, the incentive payments can range from \$44,000 to \$64,000 per physician over the next five years. Hospitals are eligible for both Medicare and Medicaid incentive payments and could receive more than \$5 million per program.

Joel C. White, Executive Director of the HIT Now Coalition reported that there are a total of 25 objectives that must be met by eligible professionals and 23 objectives for hospitals in their use of EHRs. The final rule divides the requirements into a core group of requirements that must be met, plus an additional menu of procedures from which providers may choose

Meredith Taylor, HIMSS Director Congressional Affairs, discussed another final rule just issued by the Office of the National Coordinator for HIT. This rule identifies the standards and certification criteria needed for the certification of EHR technology so that the systems adopted are capable of performing the required functions.

As for the EHR adoption issue, Taylor reports that the quarterly health IT implementation census data just released by HIMSS Analytics shows that the use of health IT among providers has steadily increased over the past four years. The EMR Adoption Model tracks the adoption of EMR applications for all U.S. civilian hospitals and health systems. As of June 2010, 16.3 percent of U.S. hospitals have achieved “stage 4” or higher of the adoption model and another 50.2 percent of hospitals have achieved “Stage 3”.

Prominent speakers from TriZotto, Wellpoint, and Premier Health Alliance presented their ideas on how value-based insurance design and purchasing can effectively reduce healthcare dollars

and be utilized in the healthcare field.

Jeff Rideout, M.D, Senior VP, and CMO at TriZetto, said, “The healthcare share of GDP made its biggest one year jump ever in 2009 and went from 16.2 to 17.3 percent but even with the higher costs, there is still substantial underutilization of high value healthcare services.”

He reports that up to 60 percent of chronically ill patients have a history of poor adherence to evidence-based treatments resulting in up to one quarter of all hospital and nursing home admissions. The cost from poor medication adherence is estimated to exceed \$100 billion annually with several factors contributing to the costs such as increased ambulatory care copayments and high co pays.

Gail Knopf, Vice President for Enterprise Strategy at TriZetto described how Value-Based Insurance Design (VBID) can actually work to help people to get preventive and effective patient care. This is accomplished by providing incentives and rewards to the consumer for making the right choices and discouraging procedures proven to be ineffective or dangerous.

For example, QuadMed LLC found that the overall average healthcare cost per employee from 2000-2007 increased by 4.9 percent. To address the problem, QuadMed established a program where there are no co-pays for chronic care treatment for diabetes, asthma, and hypertension. The goal is to stress and incorporate fitness and better health management among employees.

Both TriZetto speakers discussed how Congress should address VBID. The Health Care Reform Law does include section 2713(c) on VBID. According to the law, the Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs. Both Rideout and Knopf want Congress to continue to promote legislation that supports VBID in both the public and private sectors.

Also Senators Kay Bailey Hutchison and Debbie Stabenow introduced the “Seniors’ Medication Copayment Reduction Act of 2009” (S1040) to direct the Secretary of HHS to establish a demonstration program to test VBID methodologies for Medicare beneficiaries with chronic conditions. In 2009, the bill was referred to the Senate Committee on Finance

Lisa M. Guertin, Senior Vice President for Marketing and Products at Wellpoint agrees that 33 percent to 69 percent of all medication related hospital admissions are due to poor medication adherence and costs the health system approximately \$100 billion a year.

Wellpoint is using VBID to drive behaviors and eliminate cost barriers by integrating medical, pharmacy and disease management programs to target chronic conditions such as diabetes, asthma, coronary artery disease, COPD, and heart failure.

Wellpoint manages the program by engaging high and moderate risk members in the program. Health Outreach specialists proactively reach out to these members via telephonic education and support. The members then agree to engage in a disease management program. At that point, the member and any covered dependents begin to receive value tier benefits. Members must remain

engaged in the program to continue to receive reduced cost shares.

Blair Childs, Senior Vice President Public Affairs for Premier Healthcare Alliance, Inc. emphasized that value not volume is the answer and can be achieved with value-based purchasing and the use of HIT.

Premier's demonstration project with CMS, the "Hospital Quality Incentive Demonstration" proved that payment and transparency drives better results. This was demonstrated in five clinical areas, such as with patients that had heart attacks, heart bypass surgeries, heart failure, hip and knee surgeries, or were sick with pneumonia. The average improvement across all 5 clinical areas was 18.5 percent.

Childs mentioned the provision in the health reform provision that will establish Accountable Care Organizations (ACO) to begin no later than 2010 to help hospitals and physicians work together to manage total patient cost of care and outcomes, and at the same time, meet quality requirements. ACOs stand to save \$4.9 billion over 10 years.

According to Childs, an ACO environment needs to use HIT to provide for a population-wide data warehouse, to provide population health analytic capabilities, provide medical cost analysis systems, provide for case management systems, do physician profiling, predictive modeling, develop an clinical intelligence system and decision support, enable patient portal and personal health records, and use technology to connect with health information exchanges.