Health Information Technology: Who Pays and Who Benefits? It Depends

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Conventional Wisdom

“Although the savings would accrue to different stakeholders, in the long run they should accrue to payers. If we allocate the savings using the current level of spending from the National Health Accounts (kept by the Centers for Medicare and Medicaid Services), Medicare would receive about $23 billion of the potential savings per year, and private payers would receive $31 billion per year. Thus, both have a strong incentive to encourage the adoption of EMR systems. Providers face limited incentives to purchase EMRs because their investment typically translates into revenue losses for them and health care spending savings for payers.”

Richard Hillestad, James Bigelow, Anthony Bower, Federico Girosi, Robin Meili, Richard Scoville, and Roger Taylor Health Affairs
~ Volume 24, Number 5
Conventional Wisdom with a Caveat

“If, indeed, one of the benefits of EHRs is to reduce overall healthcare costs, those benefits largely accrue to the buyers of healthcare and not the providers, yet the providers currently pay for the systems. Therefore, in today’s environment, there is a financial disincentive for physicians to adopt EHRs for the purpose of healthcare cost reduction.”*

What Are Payers Doing in “Today’s Environment”?

- **Pay for Use Programs**
  - E-Prescribing
  - EHR adoption

- **Direct Subsidies and Grants**
  - BCBSMA - $50 M for state project
  - Highmark - $7 K per adopting physician

- **Provision of Hardware, Software and Services**
  - BCBST – Shared Health
  - Aetna – Active Health
  - Payer sponsored E-Rx programs

- **Challenge for self insured employers**
What Are Payers Doing in “Today’s Environment”? Cont.

- Massive Investments in Systems **to Manage Risk**
  - People
    - Case Management
    - Disease Management
  - Analytics and Tools
    - Data mining and rules engines
    - Risk assessment and stratification
    - Artificial Intelligence
    - Care gap identification
    - Clinical data acquisition (to augment administrative data)
Solutions for a Broken Health Care System Portend a New Environment: Risk Shifting to Providers

- Transparency Initiatives to Continue – CMS and Commercial
- Affordable Care Act 2010 – Accountable Care Organizations (ACO)
- HITECH Act Initiatives and Incentives - ONC
  - Emphasis on Clinical Quality Measures (CQM) for performance
  - Meaningful Use transitions from process to outcomes measures
  - Beacon Grants
- All Payers Beginning to Transition to Value Based/Risk Contracting
  - P4P from process toward outcomes
  - Case rate contracting
  - The return of a new capitation model via the ACO
What Happens When Accountable Care Drives Reimbursement?

Based on retrospective analysis of Community Tracking Study (CTS) Physician Survey from Round Three (2000–2001)

“Differences in the type and source of physician revenues were associated with differences in the use of IT in patient care in 2000–2001.”*

*Furukawa et al • Medical Care • Volume 45, Number 2, February 2007
Risk Changes the HIT Value Equation for Providers

- **Legacy EHRs Focused on Old Volume Paradigm Must Change**
  - “EHRs have had to promote other features to provider organizations to convince them to purchase their products.
    - Improved revenue from higher Evaluation and Management (E&M) codes
    - Time saving devices for physician documentation.”*

- **Accountable Providers Need New Tools to Manage Risk**
  - Longitudinal view of care, not a paper metaphor with sequential templates
  - Advanced systems that leverage payer developed analytics, adapted for clinical care
    - *Physician driven* Disease and Case Management
    - Clinical Decision Support (CDS)
    - Patient risk identification and stratification
    - Performance measurement, tracking and reporting

The Wild Card

The Seatbelt Factor