Who will pay?

Numerous publications from various sources, including Harvard University and Rand, have explored both the cost of implementing connected Health Information Technology and the return on investment from such systems. Most of these studies conclude that the payers of health care – government and commercial health plans – will reap the major benefit with only a small portion of the return going to providers of health care – clinicians and facilities. With both the number of studies and the prestige of the institutions authoring them, most have axiomatically accepted the notion that it is the payer who primarily “wins” and that it is the payer who should assume the greatest proportion of cost. However, underlying this conclusion is an intrinsic assumption that the US health care system continues to operate in the same manner it has for decades, based on volume reimbursement rather than upon quality and outcomes performance. Yet, the current system is now almost universally acknowledged to be reckless, unsustainable and in desperate need of change. Furthermore, both through the HITECH Act and Health Care Reform, the federal government is seeking to drive change toward a system of “accountable care”, where providers of care assume responsibility for performance, not just volume. The question of who pays, therefore, is more related to who ultimately must bear and manage risk. Traditionally, payer organizations have borne that risk, for which they have already invested significant sums in sophisticated data mining and care management applications. These applications assist payers with their Case Management and Disease Management programs. Using these tools, they process large volumes of administrative data to identify and stratify at-risk patients and to recognize the gaps in care, which, when addressed, will bring targeted populations into compliance with Evidence Based Medicine.

These systems have been built upon the same (or similar) rules necessary for generating the Clinical Decision Support and the Clinical Quality Measurement reporting capabilities required for Electronic Health Record (EHR) Meaningful Use objectives and Certification criteria. Most legacy EHRs, on the other hand, lack these analytics tools. By merging clinical data with administrative information, many of these same tools are being adapted for integration with EHRs to provide patient management, population management and quality performance reporting to clinicians at the point of care.

Certainly, incentives under the HITECH Act will begin to change the value equation for providers. But, more importantly, as reform takes hold, risk will increasingly pass to provider organizations and change attitudes. In such an environment, having EHRs with tools to increase quality, improve population health, and enhance revenues will be appreciated as a valuable advantage and a necessary cost of doing business. Arguably, one could assert that payers have already made a significant down payment on developing many of the technologies to be adapted and used by providers. Will the newly evolving health care system materially change the currently accepted conventional wisdom and impact the cost/benefit distribution among stakeholders? This is an era of great transition, and only time will tell.