HEALTH REFORM IMPACT

What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

ACOs Part V: "Unplugged" Versions Unwelcome

May 13, 2011

This issue of *Health Reform IMPACT*, the fifth in our series on Accountable Care Organizations ("ACOs"),[1] focuses on the critical role of health information technology ("health IT"), particularly electronic health records ("EHRs"), in the development of ACOs. Because the success of an ACO is dependent on providers' ability to exchange data and to demonstrate quality and savings measures through electronic reporting methodologies, health IT forms the necessary backbone for ACO development. As a result, ACOs should further drive the development of a nationwide health IT framework, which is already underway.

The Role of Health IT in Building an ACO

The health IT landscape has been developing rapidly in recent years. The Health Information Technology for Economic and Clinical Health Act, or "HITECH," implemented as part of the American Recovery and Reinvestment Act of 2009, established the Medicare and Medicaid EHR incentive program, which provides incentive payments for the "meaningful use" of certified EHR technology. On April 18, 2011, the Centers for Medicare & Medicaid Services ("CMS") opened the process by which eligible hospitals and eligible professionals can attest to and demonstrate meaningful use and thereby qualify for EHR incentive payments.

Alignment Between Proposed ACO Rule and EHR Incentive Program

The proposed rule on ACOs published last month by CMS (the "Proposed Rule")[2] aligns the goals and processes of the Medicare Shared Savings Program with the EHR incentive payment program in several ways. For example, CMS proposes to require that at least 50 percent of the primary care providers in an ACO qualify as meaningful users of certified EHR technology by the start of the second Medicare Shared Savings Program performance year in order for the ACO to continue participating. Further, CMS indicates that this requirement is only the first step towards its longer-term goal that *all* ACO providers be participants in the EHR incentive payment program. Therefore, providers can expect the required percentage of physicians meeting the meaningful use requirements to increase in the future. CMS also has requested public comment on a proposal to require that 50 percent of eligible *hospitals* participating

[1] For the previous installments of our *Health Reform IMPACT* series on ACOs, please **click here**.

[2] On April 7, 2011, the Centers for Medicare & Medicaid Services ("CMS") published in the Federal Register the much-anticipated proposed rule implementing provisions of the Patient Protection and Affordable Care Act relating to the Medicare Shared Savings Program and defining the elements of an ACO (the "Proposed Rule"). *See* 76 Fed. Reg. 19528 et seq. (April 7, 2011).

in ACOs also be meaningful users of certified EHR technology by the start of the second Medicare Shared Savings Program performance year.

Further strengthening the alignment between these two incentive programs, CMS has proposed to require that ACOs coordinate patient care through the use of telehealth, remote patient monitoring and other health IT tools. In addition, ACOs are required to submit data measures in order to be evaluated on their quality of care, and CMS has indicated that some of these measures will rely on and overlap with e-prescribing and EHR incentive program data.

Interoperability

In order to become meaningful users of health IT, providers in an ACO must not only have in place the required technology, but their systems must also be *interoperable*. In other words, the systems must have the ability to meaningfully exchange clinical data. Similarly, interoperability plays a central role in the shift towards coordinated care by enabling providers to facilitate their patients' transitions between different care settings and providers. Accordingly, the Proposed Rule would require that the ACO have a process in place to electronically exchange summary of care information when patients make such transitions both within and outside the ACO, in a way that is consistent with the meaningful use requirements under the EHR incentive payment program.

Privacy and Security Concerns

Providers should be aware of the issues related to privacy and security standards of the Health Information Portability and Accountability Act of 1996 ("HIPAA") that arise in the development and implementation of an ACO, particularly in light of the proposed modifications to HIPAA mandated by HITECH.[3] In the Proposed Rule, CMS highlights these privacy and security issues as a point of intersection between the Medicare Shared Savings Program and the EHR incentive payment program, since both programs depend on the sharing of individually identifiable health information among providers. Recognizing the sensitivity of sharing such information, CMS proposes to allow beneficiaries to opt out of the data sharing portion of the Medicare Shared Savings Program. However, CMS makes clear that a beneficiary's decision to opt out does not affect his or her assignment to the ACO; in other words, the ACO is still accountable for the quality of care furnished to that patient. Thus, providers should consider that if a significant number of patients from their assigned population choose to opt out, this fact could limit their ability to collect and maintain data measures on those patients (and potentially to demonstrate the savings necessary to qualify for payments under the Medicare Shared Savings Program).

Practical Considerations for Participating and Nonparticipating Providers

Many in the health IT industry, including providers, vendors and consumers, are wary of the ability of participating providers to implement and coordinate the necessary health IT infrastructure for building an ACO. Indeed, the widespread adoption of EHRs has been building more slowly than anticipated, largely due to cost concerns and practical barriers to getting physicians and hospitals "on board" with meaningful use. The estimated costs of purchasing an EHR system are significant, and the costs of ongoing maintenance of a system are potentially even greater. Providers may also experience lost profits due to the disruption of workflow associated with implementing an EHR system. Further, the successful implementation of an EHR system involves much more than the purchase of IT software. It may be difficult for providers to find, and pay the costs associated with, qualified experts to install systems and adequately train physicians in the use of the systems. Parties to an ACO should consider the long-term

[3] On July 14, 2010, the Department of Health and Human Services ("HHS") published a Notice of Proposed Rulemaking to implement HITECH-mandated modifications to the HIPAA Privacy, Security and Enforcement Rules. *See* 75 Fed. Reg. 40868 (July 14, 2010). Such proposed modifications include more stringent privacy and security requirements for both Covered Entities and Business Associates, as well as enhanced penalties for HIPAA violations. To date, HHS has not issued a Final Rule to implement these modifications, but HHS representatives have indicated that the Final Rule will be released by the end of 2011.

planning and implementation process involved in becoming a meaningful user of certified EHR technology.

But even providers that decide against forming or participating in an ACO should keep in mind that they will need to become meaningful users of certified EHR technology to avoid incurring penalties under Medicare. As required by HITECH, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare beginning in fiscal year 2015 for eligible hospitals and calendar year 2015 for eligible professionals. Providers are advised to begin implementing certified EHR technology effectively in order to avoid such penalties.

If you have questions, please contact any of the attorneys in our Healthcare Practice Group listed below.

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