

Connected Care Is Key to Accountable Care: The Case for Supporting Telehealth in ACOs



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The vision of accountable care organizations (ACOs) is forcing new ways of thinking about care coordination, continuous population management, and maximization of appropriate treatment options outside high-cost settings. At the same time, patient engagement and empowerment are pushing the boundaries on how the medical community thinks about the patient and caregiver experience. Connected Care is an essential tool for achieving the goals of accountable care while improving patient and caregiver satisfaction. However, despite the rapidly developing technology and increasing interest among patients and providers in using Connected Care, statutory and regulatory barriers continue to limit its use in Medicare. These limitations can be lifted for ACOs without an act of Congress.

What Is Connected Care?

Connected Care is the real-time, electronic communication between a patient and a provider, including telehealth, remote patient monitoring, and secure e-mail communication between clinicians and their patients. Through Connected Care, healthcare providers can remotely communicate with their patients and other healthcare providers across care settings through iPads, laptops, and smartphones; patients and their caregivers can be more engaged in the delivery of their own care; and patients with limited access to healthcare providers can be treated in less costly and more accessible care settings, such as in their homes or at local retail clinics.

Evidence Around The Use Of Connected Care

A growing body of evidence is demonstrating how the benefits of Connected Care are improving healthcare access and quality and reducing costs for payers. A literature review that will be published in *Telemedicine and eHealth*, principally authored by Rashid Bashshur, PhD, of the University of Michigan, looked at the evidence related to 3 chronic diseases prominent in the Medicare population—con-

gestive heart failure (CHF), stroke, and chronic obstructive pulmonary disease (COPD). Among CHF patients, telemonitoring was significantly associated with reductions in mortality, ranging from 15% to 56% compared with traditional care. Meanwhile, telestroke provided an advantage for stroke patients without readily available access to stroke specialists. The various modalities of telestroke have demonstrated the ability to reduce mortality in the range of 25% during the first year after the event. Ultimately, the evidence supports the economic benefit of telemonitoring compared with traditional care among CHF, stroke, and COPD patients.

St Vincent Health in Indiana—a member of Ascension Health, the country's largest not-for-profit healthcare system—enrolled patients with CHF and COPD in a remote care management program following discharge from a group of its hospitals. The intervention consisted of daily monitoring of patients' biometrics, including blood pressure, body weight, and oxygen saturation. There were also regular videoconferencing visits with the patients as well as educational videos to help patients with their needs. Initial results showed that the care management program reduced hospital readmissions to 5% compared with 20% in the control group—a 75% reduction. Given that Medicare spends an estimated \$26 billion each year on readmissions, of which over \$17 billion is preventable, it is clear that the Medicare program has the potential to generate significant savings through similar remote care management solutions.¹

As for primary care, there is evidence that Connected Care is effective for managing care outside of provider settings. A recent RAND study published in *Health Affairs* found that patients who participate in primary care telemedicine “visits,” which consisted of remote physician consultations by phone or videoconference, were less likely to require follow-up visits for a similar condition in any setting.² Only 6% of patients sought follow-up care compared with 13% in the control group, whose participants instead visited a physician office or emergency department (ED). While cost savings were

not the focus of the study, the authors noted that the \$38 telemedicine visit as a replacement for physician office and ED visits could generate savings for payers.

Connected Care is also improving patient satisfaction in various ways. A recent Massachusetts General Hospital study examined the impact of online follow-up care for patients with the 10 most common chronic diseases: hypertension, arthritis, diabetes, anxiety, depression, GERD, headaches, asthma, back pain, and weight control issues.³ Patients completed online questionnaires regarding their condition in lieu of in-person follow-up visits and participated in telehealth consults with their physicians as necessary. Patients found the online consults to be quick and convenient, and reported high satisfaction with the clinical efficacy of the consults. Physicians found that remote care sessions, which included the online questionnaires, saved time, allowed for more regular follow-up, and provided a more complete picture of their patient's well-being. This study is another example of how Connected Care is finding alternative ways to improve care delivery for both patients and their providers.

Barriers to Use Of Connected Care in ACOs

While a handful of ACOs have invested in Connected Care and are using it with great success, the majority are reluctant to adopt such technology because of Medicare program coverage and reimbursement limitations. Specifically, section 1834(m) of the Social Security Act (the Act) only enables the Medicare program to cover and reimburse for a limited number of Part B services furnished to beneficiaries located at certain originating sites in rural areas.⁴ This serves as a disincentive for the vast majority of ACO providers, many of whom practice in urban areas, to use this type of technology.

Implementing a telemedicine or remote patient monitoring program requires up-front investment, mostly in the area of process design and training. Making the case to the chief financial officer of an ACO in a time when hospital budgets are being reduced and the future is uncertain is difficult. For many physician-led and smaller ACOs without access to a lot of capital, it is not even an option.

The Solution

Allowing ACOs to be reimbursed for Connected Care technologies will further the goals of the ACO program by providing additional tools to improve quality and reduce costs. Furthermore, it is consistent with the language of the Affordable Care Act (ACA), which directed ACOs participating in the Medicare Shared Savings Program to “define processes . . . to coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.”⁵ To that end, in the final regulations for the program, CMS indicated that it wanted to give ACO providers the flexibility to choose those tools that best facilitate care coordination for their practitioners and patients.⁶ However, this is not the case under the current statutory and regulatory framework.

Fortunately, the Secretary has the tools in place to address these barriers. Section 1899(f) of the Act gives the HHS Secretary the authority to “waive such requirements of sections 1128A and 1128B and title XVIII of [the] Act as may be necessary to carry out the

[program].”⁷ Separate from the waiver authority for the Center for Medicare and Medicaid Innovation demonstration projects, this authority applies only to ACOs. To date, this authority has been used to grant 5 waivers to the fraud and abuse laws and to the timing of ACO repayment for shared losses.⁸ The waiver of the 1834(m) restrictions is equally critical to achieving the success of ACOs and can be done without waiting for Congress to act.

Conclusion

Connected Care technologies can help achieve the core goals of ACOs and should be widely deployed. Although there is already evidence of its success in improving care and reducing costs, the current operational structure of the healthcare system makes investment in Connected Care technologies without reimbursement difficult, even for ACOs. The authority exists within HHS to waive the restricting language that limits reimbursement of telehealth to rural areas for ACOs. HHS should use its authority to lift those restrictions so more ACOs can serve patients with technology that will improve care and patient satisfaction, while lowering costs.

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REFERENCES

1. The Revolving Door: A Report on US Hospital Readmissions. Robert Wood Johnson Foundation website. <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404178>. Published February 2013.
2. Usher-Pines L, Mehrotra A. Analysis of Teladoc use seems to indicate expanded access to care for patients without prior connection to a provider. *Health Aff (Millwood)*. 2014;33(2):258-264.
3. Dixon RF, Rao L. Asynchronous virtual visits for the follow-up of chronic conditions [published online May 2, 2014]. *Telemed J E Health*.
4. Section 1834(m) of the Social Security Act, 42 USC §1395m(m).
5. Section 1899 of the Social Security Act, 42 USC §1395jij.
6. 76 Fed. Reg. 67802 (Nov. 2, 2011).
7. Section 1899(f) of the Social Security Act, 42 USC §1395jij(f).
8. 76 Fed. Reg. 67992 (Nov. 2, 2011) and 76 Fed. Reg. 67802, 67941 (Nov. 2, 2011).