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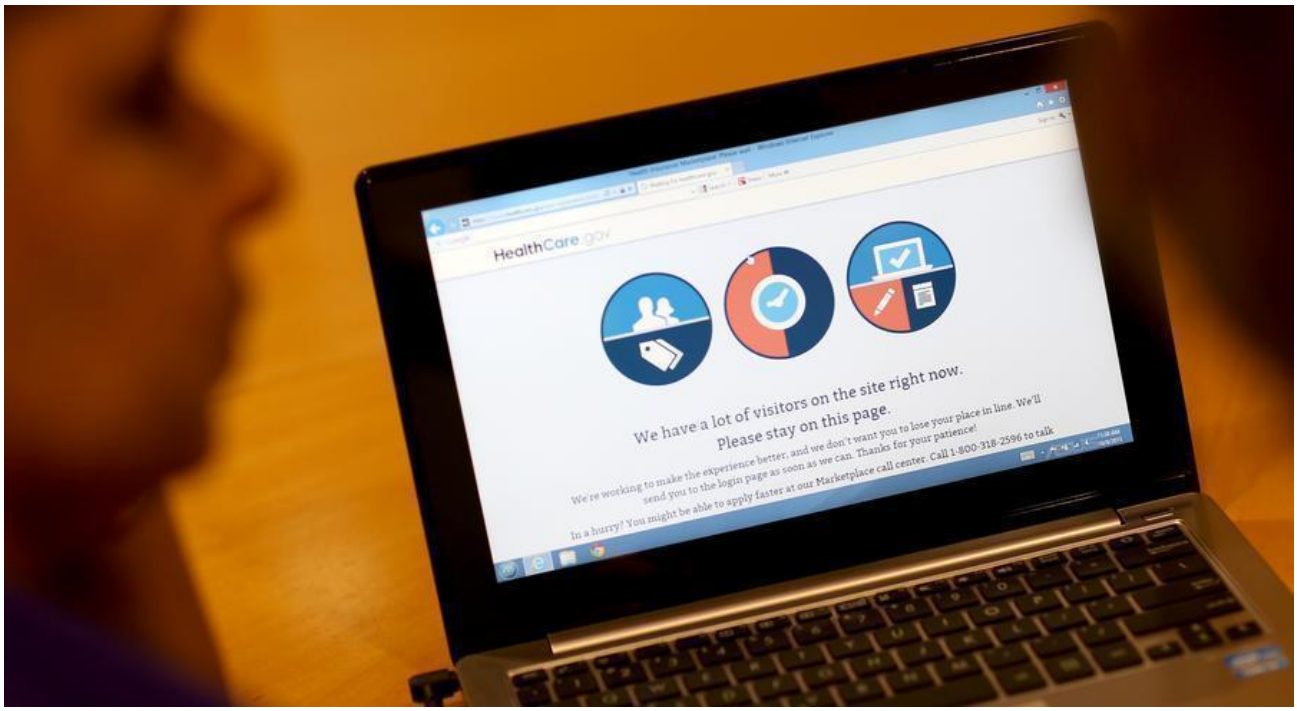

Doctors and hospitals who work in ACOs, which were created under the ACA, are finding it hard to share electronic records among themselves.

Obamacare reform effort hampered by technology

By **DAVID PITTMAN** | 01/16/15 05:00 AM EST

An Obamacare program that was supposed to spearhead movement toward prioritizing health over medical procedures is stuck with the same big problem as the rest of the health care system: The information isn't flowing smoothly, so doctors have trouble coordinating the care of their patients.

Doctors and hospitals who work in accountable care organizations, which were created under the Affordable Care Act, are finding it hard to share electronic records with each other or with other hospitals and providers. That makes it hard to track things like hospital admissions and visits with other doctors — elements for which control is key to converting health care from the current fee-for-service model to one

where quality and cost saving are rewarded.

ACOs are groups of doctors, hospitals and other providers who work together to reduce unnecessary spending. As such, they rely heavily on information technology to share knowledge on their patients. Medicare has contracts with more than 400 ACOs serving nearly 8 million beneficiaries, and several hundred more ACOs are recognized by commercial health plans like UnitedHealthcare, Cigna and Aetna.

Under the ACO model, groups of providers that lower their spending while improving care receive a slice of the savings they create.

But these organizations seem to be stuck in a catch-22 that keeps them from moving away from volume-based payments — fees charged for individual procedures, visits and the like — to care aimed at keeping patients healthy. Caregivers need good information to track their patients and coordinate their care. With little ability to exchange information, care is often uncoordinated.

Federal health officials, in a report commissioned by ONC, acknowledge the disconnect. "Interoperability challenges between electronic systems continue to inhibit progress," the October report stated.

People who follow the ACOs see a mixed picture — a range of success and failure, according to David Muhlestein, who studies ACOs for Leavitt Partners, a Salt Lake City-based consulting firm started by former HHS Secretary Mike Leavitt. "We've seen people from all the extremes do very well and very poorly and everywhere in between," he said.

Provider groups need a longer lead time to transform the way they use information technology to share and act on patient data, a much longer time frame than the typical 3-year ACO contract, he said.

Electronic records systems can help realize ACOs' goals, but vendors who build and sell systems need to do more to allow doctors to learn and share information about their patients.

"Just like a lot of things in health care, they're not there yet," said Mark McClellan, a senior fellow at the Brookings Institution. "We still have a ways to go."

A survey of 46 physician-led ACOs conducted last spring by KLAS Research graded EHR vendors an average rating of 6.3 on a 9.0 scale for meeting their needs. “Overall, EMR vendors are not ready for ACO prime time,” the report stated.

The problem of sharing information stems from the multiplicity of EHRs and the barriers to communication among them. Even if all the doctors in an ACO have the same EHR, their local hospitals will often use different systems. The issue is pronounced in ACOs that cobble together as many as a dozen different physician practices — all of whom may operate a unique records system — and are forced to build crosswalks between each one.

Less integrated ACOs were less likely to take on more risk and less reward in their ACO contracts, KLAS said.

Farzad Mostashari, who led the ONC before leaving in 2013, said ACO groups need to press vendors to give them greater capacity to share information with competing systems.

“There’s a role for policymakers, but there’s also a role for customers to be a more proactive,” he said.

It would not be fair to call the accountable care movement a failure just yet, say those who follow it.

“It’s probably best to regard the Medicare ACO program as sort of a starter step at this stage,” said McClellan, who ran the Medicare program from 2004 to 2006. It allows ACOs to start to be reimbursed for improving the quality of care and reducing costs, but “for the vast majority of ACOs in the Medicare program now, that is only a small component of their overall payment.”

Part of the problem is that Obamacare didn’t change the fundamental way in which doctors and hospitals are paid — by volume. They are still incentivized to do more tests and treatments rather than keeping patients healthy and out of hospitals, which is the goal of ACOs and the aspiration of policymakers for the health care system as a whole.

“It’s sort of a chicken-and-egg thing, which should come first,” said Josh Seidman,

director of consultant Avalere Health's Center for Payment and Delivery Innovation. "If infrastructure were in place, I think you would have seen greater success with ACOs."

Seidman, a former director of the meaningful use EHR incentive program at ONC, said that only after pressure mounted from within would it become common for the health care world to share data.

In the meantime, for ACOs to do well, they will have to become IT-savvy enough to share data between in- and out-patient services, or they risk being swallowed by larger hospital systems that are better at sharing information, said Robert Pearl, chair of the Council of Accountable Physician Practices and president of the Mid-Atlantic Permanente Medical Group.

He thinks the solution is to create large integrated systems like Kaiser Permanente of which Pearl's group is part.

Some ACO providers who are not in integrated systems like Kaiser are buying additional technology to layer on top of current electronic record systems, said Clif Gaus, president of the National Association of ACOs. Some have added population health-management tools that pool data from various records systems and analyze information to detect the sickest patients and predict who is likely to develop a chronic or serious ailment.

Others are using state information exchanges to share data, but despite nearly $600 million in federal grants, only a small number of those exchanges are functioning well.

But Mostashari, who now runs Aledade, which sets up and operates ACOs, believes IT makes all the difference. He pointed to an ACO in McAllen, Texas, that attributed a lot of its success to its ability to use health IT in an advanced way.

Other less successful ACOs, Mostashari said, are less sophisticated users of technology.

"I can tell you from personal experience and from talking to these groups they tend to not use clinical data, predictive modeling and not really have a wholesale view of

the patient," he said.