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## VARIABLES OF HEALTH REFORM AND THEIR IMPACTS ON THE ELDERLY

John D. Blum\*

On Tuesday, March 22, 2010, America entered into the era of post-health care reform.<sup>1</sup> Although the 2,400 pages of new law, and the further complexities wrought by accompanying reconciliation legislation, are still being processed, the long and short of it is that the Patient Protection and Affordable Care Act (PPACA) now is the law of the land and the process of understanding and integrating this massive change to our health care system has barely just begun. Virtually all elements of the 2010 health reform touch on the future of elder care in some manner, and more specifically on Medicare, pushing the program into greater cost savings measures and expanding its focus on primary health care.<sup>2</sup>

Considerations of prevention and aging lie at the center of national health policy reform and have become foundational realities in the complex array of elements affecting America's quest to reinvent its health care delivery system. This essay, written in the new shadows of health reform, concerns five variables that link the recent legislation to the growing demands of elder care. The first variable deals with how health reform will be shaped by the realities of Medicare, as this massive

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1. See The Patient Protection and Affordable Care Act of 2010 H.R. 3590, Pub. L. No. 111-148, 124 Stat. 119, 111<sup>th</sup> Cong. (2010) (to be codified throughout 42 U.S. Code).

2. Medicare, enacted initially in 1965, is the single most significant piece of legislation in federal health policy.

program is both a backdrop to the current reform as well as the core of so many mandates in the Patient Protection and Affordable Care Act. Second, the essay will take a broad look at primary care and prevention as tools to enhance the health of elders and arrest disease processes, with the goals of promoting individual and population wellness, while at the same time reducing costs. Third, the piece will present a contextual discussion of how elder care, in the wake of health reform, will be impacted by dramatic shifts in health care markets which are both responding to and altering the landscape of health care delivery. Fourth, the essay will touch on the growing emphasis on coordinated care through the development of integrated network models such as the medical home and accountable care organizations (ACO), vehicles that may improve the health of elderly populations through a bottom-up restructuring of the delivery system. The fifth and final variable will be a consideration of how e-health applications may be used in conjunction with network delivery models as an efficient way to engage seniors in their health care by taking advantage of simple technologies which can underpin both efforts at integration and prevention.

#### AGING AND ELDER CARE OVERVIEW REMARKS

Not long ago, the Beatles icon Ringo Star turned seventy years old, a visible example that the world is getting older. The music legend's performance on his seventieth birthday was a manifestation that the aged can continue to be active.<sup>3</sup> Aging well, like Ringo, is a dream of most Americans, but the reality is that with an increased lifespan comes greater illness and thus, a higher utilization of the medical system.<sup>4</sup> The demographics of the baby boom generation present a sober reality of a bubble in the aged population. It is estimated there is somewhere in the

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3. Kate Zernike, *Turn 70. Act Your Grandchild's Age.*, N.Y. TIMES, July 11, 2010, at WK1, WK3.

4. *Id.* at WK3.

vicinity of seventy-eight million aged people who, over the coming years, will spill into the medical system.<sup>5</sup> Within the elder population there are different medical realities, which are present in the various age cohorts generically referred to as "seniors." In particular, there is a marked increase in the number of frail elderly, those individuals who are age eighty-five and older. Clearly, even with better health care, this is a population that will feel the inevitable effects of human biology, and sustaining life in its last years will require more costly and frequent health care interventions.<sup>6</sup> While we may celebrate the vital seventy year old, the health realities among younger seniors are such that a certain percentage of those sixty-five and older will experience serious health problems, marking the end, and not the beginning, of life.<sup>7</sup> Compounding the challenges for the health system will be the paradox of success in maintaining those with chronic illness from relatively early ages into elder years as the effects of lifelong conditions such as hypertension and obesity will be compounded by aging.<sup>8</sup>

Few challenges loom larger for policy makers and health providers than those presented by the striking physical and social realities of aging.<sup>9</sup> In this regard, new models of care must be crafted to meet the public obligations for the health of seniors in ways that enhance quality and are more cost-effective than the very expensive and inflationary roads followed in the past. The challenge lies beyond the rhetoric of "quality and cost," as the dark side of that politically expedient coupling is that, even

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5. For an excellent discussion on the elderly and health care, See Barbara Averde, *Being Elderly in America - What Does the Future Hold ?*, [http://www.asktheinternettherapist.com/counselingarchive\\_elderly\\_citizens\\_in\\_America.asp](http://www.asktheinternettherapist.com/counselingarchive_elderly_citizens_in_America.asp) (last visited Oct. 2, 2010).

6. Thomas Bodenheimer, *Long Term Care for the Frail Elderly*, 341 NEW ENG. J. MED. 1324, 1324-26 (1999).

7. Zernike, *supra* note 3, at WK3.

8. See ROBYN I. STONE, MILBANK MEMORIAL FUND, *LONG TERM CARE FOR THE ELDERLY WITH DISABILITIES 15-16* (2000), available at [http://www.milbank.org/reports/0008stone/LongTermCare\\_Mech5.pdf](http://www.milbank.org/reports/0008stone/LongTermCare_Mech5.pdf).

9. Karen Davis, *Health and Aging in the 21<sup>st</sup> Century*, THE COMMONWEALTH FUND (Mar. 1, 2000), <http://www.commonwealthfund.org/Content/Publications/Other/2000/Mar/Health-and-Aging-in-the-21st-Century.aspx?view=print>.

if this balance can be struck, there are times when cheaper health may not be better, just cheaper.<sup>10</sup> In addition, with government mandates being expanded to cover broader segments of the whole American population, simultaneous to growing needs in elder care, serious intergenerational equity disputes will emerge in an era of diminished resources, taxing political wills and fiscal capacity. It is noteworthy that the Patient Protection and Affordable Care Act, as broad as it is, fails to present a framework on which a new strategy for revising long term care institutional care could be based.

## MEDICARE

Arguably, the Medicare program is the single biggest element in federal health policy and is the logical jumping off point for any consideration of elder care. Medicare, established in 1965, currently enrolls over forty-five million Americans in its publicly-sponsored health insurance program, with thirty-eight million of its enrollees coming from the ranks of those sixty-five and older.<sup>11</sup> The program is divided into four major parts: Part A, Health Insurance Program (hospital); Part B, Supplementary Medical Insurance (physician and ambulatory); Part C, Medicare Advantage (managed care); and Part D, Medicare Modernization (prescription drug) and literally touches on all aspects of the delivery system from the acute care sector to the far reaches of ambulatory care.<sup>12</sup> It is anything but a static program; rather, it is a construct that has been under constant scrutiny and received numerous alterations since its inception. On the cost side, Medicare has ballooned from its early days of \$3 billion in 1966 to \$499 billion in 2009; the program is

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10. It is popular to argue that a better balance can be struck in health care between cost effectiveness and quality. No doubt there are many examples which can be cited where too much care leads to both high costs and poor outcomes. On the other hand, there are times when costly interventions can result in better outcomes.

11. KAISER FAMILY FOUND., *MEDICARE: A PRIMER, INTRODUCTION* (2009), <http://www.KFF.org/medicare/upload/7615-02.pdf>.

12. *Id.* at 1.

outstripping economic growth.<sup>13</sup> Without major changes, Medicare, as it is currently cast, is financially unsustainable. Significant fiscal reform of the program must occur as part of any national health system overhaul,<sup>14</sup> and difficult questions must be addressed concerning how Medicare can be reinvented to control costs and maintain quality. What makes Medicare even more problematic is the swell in demographics, with “baby boomers” moving into senior status, and the commensurate reduction in the number of those contributing to programmatic finances.<sup>15</sup>

The Patient Protection and Affordable Care Act (PPACA) is a signature point in the ongoing evolution of the Medicare program.<sup>16</sup> While the broader questions of system-wide structure, fiscal viability, and public equity in finances will need to be addressed over a long period, the new health insurance law presents a wide range of more immediate mandates specifically directed at the Medicare program.<sup>17</sup> Major changes in Medicare under health reform include a reduction in the size of the coverage gap for prescription drugs (the so-called “donut hole”) and payment reductions for the Medicare Advantage Program (managed care plans), hospitals, and non-physician providers. There are a variety of payment pilot projects, including bundling, value purchasing, and the creation of an Independent Payment Advisory Board for Medicare in order to achieve spending reductions.<sup>18</sup> Additional changes to Medicare

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13. KAISER FAMILY FOUND., MEDICARE FACT SHEET - MEDICARE SPENDING AND FINANCING (2009), <http://www.kff.org/medicare/upload/7305-04-2.pdf>.

14. *U.S. Health Care Costs Background Brief*, KAISER FAMILY FOUND., [http://www.kaiseredu.org/topics\\_im.asp?imID=1&parentID=61&id=358](http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358) (last updated Mar. 2010).

15. Grace-Marie Turner, *Today's Debate: Health Care Reform and Medicare* <http://argusleader.com/200719/Voicesq7/Today-C-debate-health-Care-Reform-Medicare-Will-Changes-drive-doctors-from-system>.

16. Medicare is profoundly affected by the Patient Protection and Affordable Care Act. See KAISER FAMILY FOUND., SUMMARY OF KEY CHANGES TO MEDICARE IN 2010 HEALTH REFORM LAW 1 (2010), <http://kff.org/healthreform/upload/7948-02.pdf>.

17. *Id.*

18. See The Patient Protection and Affordable Care Act, *supra* note 1, at §§ 3001-27 (2010).

by the PPACA include the expansion of income-related premiums for Parts B and D and an increase in payroll taxes for those earning higher incomes.<sup>19</sup> Of particular interest is the PPACA's authorization of Medicare coverage for personalized plan prevention services, which includes an annual comprehensive health risk assessment and mandates that the Secretary of the Department of Health and Human Services develop a model that will guide the application of such assessments.<sup>20</sup> Also of note is the development of a bonus system provision for primary care physicians, physician assistants, and nurse practitioners who deliver services to Medicare enrollees.<sup>21</sup> As far as the delivery system is concerned, the law promotes the development of a new delivery model for Medicare beneficiaries, the Accountable Care Organization, and focuses on quality improvement through both the creation of the Center for Medicare and Medicaid Innovation and a demonstration program which facilitates the provision of preventive care at home.<sup>22</sup> The sum total of the myriad of reforms required in P.L. 111-148, which are directed to Medicare, will open a new chapter for this program and no doubt will have profound impacts on elder care.<sup>23</sup>

### PRIMARY CARE AND PREVENTION

As noted in the discussion above, prevention has become a core goal of a revised Medicare program.<sup>24</sup> Historically, Medicare was locked into an acute care delivery model, but a major emphasis of the reform law is to spark a movement toward

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19. KAISER FAMILY FOUND., *supra* note 16, at 1.

20. *See* The Patient Protection and Affordable Care Act, *supra* note 1, at §§ 4001-4402.

21. KAISER FAMILY FOUND., *supra* note 16, at 4.

22. *Id.* at 5.

23. Seniors don't have a uniform view on the PPACA, and a significant number are opposed to the law. In a recent survey, seniors who had a more detailed knowledge of the law favored the legislation. *See* Drew Altman, *Pulling It Together: Seniors and Health Reform*, KAISER FAMILY FOUND. (July 29, 2010), [http://www.kff.org/pullingittogether/072710\\_altman.cfm](http://www.kff.org/pullingittogether/072710_altman.cfm).

24. KAISER FAMILY FOUND., *supra* note 16, at 1.

greater primary care and prevention, reflecting a growing consensus that health and well-being ought not to be limited to models of “sick” care.<sup>25</sup> Primary care is a collective concept which affords regular, basic medical monitoring and intervention; prevention represents a series of strategies that can be used to assist patients in maintaining their health.<sup>26</sup> The collective goal both of primary care and prevention is to foster a level of wellness that allows individuals to enjoy optimal health throughout their life.

The need for developing preventive health models has gone beyond the use of managed care and primary care case management, and has become a fundamental consideration in a restructured system of elder care.<sup>27</sup> While no one lives forever, it is estimated by The Centers for Disease Control that one third of all U.S. deaths are preventable.<sup>28</sup> The subject of prevention opens a complex array of physical, mental, and social service issues, with a long trail of health policy history attached to it.<sup>29</sup> From adherence to the old adage, “an apple a day will keep the doctor away” to the development of very sophisticated approaches to aspects of lifestyle such as physical environments, matters of prevention have evolved and, while not limited to the aged, they are clearly central to this population.<sup>30</sup> With increased longevity, chronic diseases will take their toll among

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25. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: REFORMING THE DELIVERY SYSTEM 23, 24 (2008), available at [http://www.medpac.gov/documents/jun08\\_entirereport.pdf](http://www.medpac.gov/documents/jun08_entirereport.pdf).

26. See WIS. TURNING POINT TRANSFORMATION TEAM FOR WIS. DEP’T. HEALTH & FAM. SERVS. & WIS. PUBL. HEALTH SYS. PARTNERS, HEALTHIEST WISCONSIN 2010: A PARTNERSHIP PLAN TO IMPROVE THE HEALTH OF THE PUBLIC 10 (2010). (This report deals with improving public health in Wisconsin but is very rooted in community health protection and promotion.) For a very comprehensive view of primary care, see WORLD HEALTH ORG., WORLD HEALTH REPORT 2008: PRIMARY CARE – NOW MORE THAN EVER 43 (2008), available at [http://www.who.int/whr/2008/whr08\\_en.pdf](http://www.who.int/whr/2008/whr08_en.pdf).

27. See *New Technology May Reduce Risks for Fall Prone Seniors*, AGING IN PLACE OPTIONS (Feb. 4, 2010), <http://www.aginginplaceoptions.com/archives/47>.

28. U.S. CTRS FOR DISEASE CONTROL & MERCK CO. FOUND., THE STATE OF AGING AND HEALTH IN AMERICA 2007 iii (2007).

29. See generally *id.*

30. See U.S. CTRS FOR DISEASE CONTROL & MERCK CO. FOUND., *supra* note 29, at 5.

elders in the 21<sup>st</sup> century, but effective prevention can stave off the effects of poor lifestyle choices, stem the onset of diseases, and, most significantly, improve the quality of life.

The linkages between costs and illness have sparked strong public policy interest in prevention, which relates improvements in the quality of life for elders to very strong systemic demands for pathways to health that can be pursued in the context of resource constraints.<sup>31</sup> The delivery of adequate primary care and preventive practices are, first and foremost, compelling on a wellness indices and, while they may save money, this is a tenuous foundation on which to build a case for pursuing alternatives to curative medicine. It is the quality of life which should be the catalyst for primary care and prevention: seeing it as a financial proposition is not guaranteed to be cost effective.<sup>32</sup> In addition, the provision of adequate primary care is hampered by significant human resource constraints as the numbers of primary care physicians and support personnel are far below what would be necessary to revamp the system to one oriented around routine care and prevention.<sup>33</sup> Recalibration of health care away from acute care biases will take years to achieve, and the shifts to prevention require not only a rebalancing of resources, but also a massive public reeducation about the very nature of health. In addition, policies affecting regulation and insurance must be altered to allow alternative models of health to emerge and grow, particularly in areas that can benefit from integrated approaches that spill across traditional health care boundaries, requiring considerable collaboration.<sup>34</sup> Although a new comprehensive

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31. Joshua Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates* 358 NEW ENG. J. MED. 661, 661-62 (2008).

32. *Id.*

33. Robert Steinbrook, *Easing the Shortage in Adult Primary Care – Is It All About Money?*, 360 NEW ENG. J. MED. 2696, 2696-99 (2009).

34. In particular health reforms that are integrative raise serious antitrust law problems. See, Sarah Barr, *Antitrust, DOJ Will Carefully Review Mergers to Ensure Competition, Success of Reform*, BNA HEALTH CARE DAILY REPORTS (May 25, 2010), [http://news.bna.com/hdln/HDLNWB/split\\_display.adp?fedfid=17212464&vname=hcenotallissues&fcn=1&wsn=498439000&fn=17212464&split=0](http://news.bna.com/hdln/HDLNWB/split_display.adp?fedfid=17212464&vname=hcenotallissues&fcn=1&wsn=498439000&fn=17212464&split=0).

primary care system may not emerge quickly, better health care for elders, built on wellness models, could be developed more rapidly in key silos such as in fall prevention or foot, vision, and hearing care, independent of larger systemic alterations.

## MARKETS

Joining Medicare and prevention as major variables affecting the health of the aged are many issues involving health care markets, and more specifically, considerations of how market forces are both drivers and responders to demographic shifts in aging. There has always been an interesting, and often perplexing, set of interactions among a population's health, regulation, and markets. The dynamics of health markets impact patients and providers alike and, as primary users of the system, the yin and yang of the business of health care is highly significant to the elderly population. To a large extent, the recent health reform effort has focused mostly on matters concerning either how the legislation is targeted to impact health delivery systems or, in a policy sense, how reforms themselves may be held captive to the current system. The Patient Protection and Affordable Care Act was not designed around a specific vision of health care markets. Still, there is certainly an unstated recognition in the reform law that private markets are the forum within which health will be delivered, and the success of P.L. 111-148 is tied to market responses. But the push and pull of the private sector is very much an accidental byproduct of this law and only in certain areas, such as medical networks, do elements of legislative strategy constitute deliberate interventions into private markets.

No doubt changes in regulation have profound effects on markets, but it is also true that markets often move well before regulators, and in such instances become harbingers of trends that may herald the need for alterations in legal oversight. Even a casual consideration of health markets will quickly lead to an appreciation of the remarkable fluidity in the business of health care. While the foundations of institutional acute care and

physician practices remain, much of the system, within and external to these core elements, has been altered and reinvented since its modern inception in the 1950s.<sup>35</sup> Virtually all hospitals have diversified, expanded, or specialized in some fashion in response to demand and competition. Parallel markets in primary care have emerged, such as the creation of outpatient retail clinics staffed by nurse practitioners. Other notable examples of market evolution include the shift of diagnostics beyond outpatient settings to free-standing centers and the growing availability of low cost generic drugs.<sup>36</sup> The movement toward wellness, as noted in the primary care discussion, has mushroomed and sparked a growth in complementary and alternative medicine, one which thrives in a market largely based on out-of-pocket, fee-for-service reimbursement.<sup>37</sup> The regulatory system has yet to respond to some of the changes noted, as questions arise as to how the newly enacted mandates in the Patient Protection and Affordable Care Act will be absorbed into the current system, and how those mandates will impact specific population groups such as the elderly.

In a recent analysis of health care markets, found in the book *Innovator's Prescription*, the authors review the current evolution of markets in the health sector, arguing that health care is evolving through a series of disruptive influences which have reshaped the enterprise.<sup>38</sup> Christensen et al. break health delivery into three types of entities: solution shops in which medical problems are diagnosed and treated, value-added businesses that offer new services, and retail/provider networks

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35. For an interesting timeline of the development of the American health care system, See *Healthcare Crisis: Healthcare Timeline*, PBS, <http://www.pbs.org/healthcarecrisis/history.htm> (last visited Oct. 2, 2010).

36. See generally CLAYTON M. CHRISTENSEN ET AL., *THE INNOVATOR'S PRESCRIPTION* (2009).

37. National Institutes of Health, National Center for Complementary and Alternative Medicine is a categorical institute devoted to the study and development of complimentary medicine. See *What is Complementary and Alternative Medicine?*, NAT'L CTR. FOR COMPLEMENTARY & ALTERNATIVE MED., NAT'L INST. HEALTH, (2010), <http://nccam.nih.gov/health/whatiscom/D347.pdf>.

38. See generally CHRISTENSEN ET AL., *supra* note 36.

that link together caregivers and patients.<sup>39</sup> As applied to individual markets, the analyses provided in *Innovator's Prescription* may be somewhat generic, but the overall point that health delivery is sparking new profit center arrangements is born out in markets around the country. The challenge for the regulator in reference to market evolution is to identify and understand what market developments are occurring, apply existing regulations to such developments, and craft new regulatory strategies in cases where current mandates fail to protect public interests. No doubt ongoing regulatory responses in Medicare and Medicaid have had profound impacts on inpatient and outpatient markets, but it is clear from the *Innovator's Prescription* that forces of change in health care are multi-dimensional, and cannot be controlled by one actor in a linear fashion. It is certainly too early to decipher the implications of the Obama health reform on markets, but it seems likely that not only will massive changes drive the health enterprise in new and unpredictable ways, but market forces, combined with the law of unintended consequences, will rear their heads, skewing public and private visions.

### COORDINATED CARE

A key element of health market evolution is the development of emerging network arrangements that link groups of health providers together with patients in new and creative ways. Historically, managed care plans brought physician groups and hospitals together within the context of insurance products based on prepayment and risk transfer.<sup>40</sup> Currently, new provider network developments are emerging, not based on distinct plan models, but rather crafted around care patterns that predate the creation of a specific type of plan, or are simply independent of a defined plan structure. The initial wave of

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39. See CHRISTENSEN ET AL., *supra* note 36, at xv.

40. See Lisa Donegan Shoaf, *Defining Managed Care and Its Application to Individuals with Disabilities*, 14 FOCUS AUTISM & OTHER DEV. DISABILITIES 240, 241 (1999).

integration recently was spawned by the need for more effective care coordination in child care, namely the medical homes.<sup>41</sup> The medical home concept has evolved into a tool linking various patient populations (including the elderly) to a primary care physician who acts both as a coordinator and a gatekeeper for those he or she is assigned to treat and manage.<sup>42</sup> A major focus of the medical home is to act as a bridge into a disparate system and match patient care with appropriate needs and levels of treatment. The medical home has particular value for elder care, as it addresses the critical need of coordination without disrupting existing primary care relationships, and it can function in rural areas where larger plans don't operate.<sup>43</sup> Whether there are adequate numbers of physicians to staff medical home projects and sufficient reimbursement to spark such services remains a major question, but this rather basic model of integration has viability and strength in its ease of construction, and obvious benefit in facilitating appropriate medical care.

Two other more ambitious models of integration beyond the medical home can be identified as creatures of market evolution. One development, clinical integration, is a mechanism designed to bring physicians together into a virtual network.<sup>44</sup> The concept of clinical integration was first rooted in the law and was sanctioned by the federal authorities as an exception to antitrust law.<sup>45</sup> The underlying concept in this area

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41. *Mission and Strategic Plan*, AM. ACAD. FAMILY PHYSICIANS, <http://www.aafp.org/online/en/home/aboutus/theaafp/strategicplan.html> (last visited Oct. 5, 2010).

42. Sheri Porter, *Medical Home Success Depends on Core Primary Care Attributes*, AM. ACAD. FAMILY PHYSICIANS (Mar. 30, 2010), [http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20030330\\_pcmhattributes.html](http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20030330_pcmhattributes.html).

43. *Medical Homes*, RURAL ASSISTANCE CTR., [http://www.raonline.org/info\\_guides/medicalhomes/](http://www.raonline.org/info_guides/medicalhomes/) (last visited Oct. 2, 2010).

44. Thomas J. Babbo & John P. Marren, *Collective PPO Contracting as a Catalyst for Quality Medicine*, INST. FOR CLINICAL QUALITY & VALUE, <http://www.icqv.org>, (last visited Sept. 17, 2010).

45. J. Thomas Rosch, Commissioner, Fed. Trade Comm'n, *Clinical Integration in Antitrust: Prospects for the Future*, Address at the 2007 Antitrust in Healthcare Conference (Sept 17, 2007), available at <http://www.ftc.gov/speeches>

is to allow competing physicians and hospitals to form working networks to evaluate and modify practice patterns, and to create interdependence and cooperation among physicians to control costs and enhance quality. The efficiencies of collaboration allow competing providers to formally join together to pursue common goals. In essence, for the elder patient, clinical integration, like the medical home, facilitates harmonized care and the application of best practices in diverse settings across a particular service market. It is the overlay of integration that provides a framework within which the needs of patients, who are being cared for by a mix of providers, can have their individual clinical needs better met. To a certain degree, clinical integration combines coordination with a team care concept that parallels integrated care models adopted by the Cleveland and Mayo Clinics.<sup>46</sup>

Another more recent development in market integration, specified in the Patient Protection and Affordable Care Act, can be evidenced in the increasing recognition of the network concept referred to as Accountable Care Organizations (ACOs).<sup>47</sup> Generically defined, an ACO is a collection of providers held responsible for the quality and cost of health care for a group of Medicare beneficiaries, working under a specific set of parameters. ACO entities join together hospitals and physicians based on existing patterns of care and develop various reimbursement and quality strategies dependent on levels of integration. While the regulations for Accountable Care Organizations have not yet been written, considerable legal challenges arise in this area in reference to antitrust law, as well as Medicare fraud and abuse laws.<sup>48</sup> The formality of the ACO

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/rosch/070917clinic.pdf.

46. AM. HOSP. ASS'N, CTR. FOR HEALTHCARE GOVERNANCE, HOSPITAL-PHYSICIAN CLINICAL INTEGRATION 5 (2007) [http://www.jhdgroup.com/jhd\\_pdfs/JHDgroup\\_monograph\\_Hospital\\_Physician\\_Clinical\\_Integration.pdf](http://www.jhdgroup.com/jhd_pdfs/JHDgroup_monograph_Hospital_Physician_Clinical_Integration.pdf).

47. MARC BARD & MICHAEL NUGENT, NAVIGANT CONSULTING, ACCOUNTABLE CARE ORGANIZATIONS AND PAYMENT REFORM: SETTING A COURSE FOR SUCCESS 1 (2010), [http://www.navigantconsulting.com/downloads/AcctCareWhitePaper\\_US\\_HC.pdf](http://www.navigantconsulting.com/downloads/AcctCareWhitePaper_US_HC.pdf).

48. COMM. ON RES., AM. HOSP. ASS'N, ACCOUNTABLE CARE ORGANIZATIONS

structure comes with its actual creation and assignment of Medicare patients who will be cared for, officially, within the context of these umbrella organizations. The ACO structure is in its infancy and is being tried in several settings, but has not yet crystallized into established structural models.<sup>49</sup> Beyond legal compliance, there are major challenges to create entities that balance structural oversight with flexibility, meet foundational data needs, and, in reference to elders, spark sufficient understanding and interest to encourage Medicare beneficiary enrollment.

### E-HEALTH TECHNOLOGY

The final variable for consideration in this essay concerns how technology might be harnessed to develop effective clinical networks linking elders to primary care services. The prior points of discussion: Medicare reform, primary care and prevention, recognition of market dynamics, and creation of care networks, all underscore the need for regular interactions between elders and providers in ways that both facilitate care and are cost sensitive. In the various strategies that can be identified for bringing patients and providers together, one form of technology that stands out as a facilitating such interactions is e-health. The collective term, e-health, refers to a wide array of telecommunication technologies, from single devices to telephones and computers, which can be used for an array of medical applications linking homes to doctor offices and health plans.<sup>50</sup> Developments in e-health have been rapid and a number of applications are established and fundamental to

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AHA RESEARCH SYNTHESIS REPORT 9-10 (June 2010), available at <http://www.hret.org/accountable/resources/ACO-Synthesis-Report.pdf>.

49. *Accountable Care Systems Need Appropriate Incentives to Succeed, Experts Say in Survey*, BNA HEALTH CARE DAILY REPORT (July 28, 2010) [http://news.bna.com/hdln/HDLNWB/split\\_display.adp?fedfid=17561882&vname=hcenotallissues&fcn=2&wsn=497876000&fn=17561882&split=0](http://news.bna.com/hdln/HDLNWB/split_display.adp?fedfid=17561882&vname=hcenotallissues&fcn=2&wsn=497876000&fn=17561882&split=0).

50. Pagliari et al. *What is eHealth (4): A Scoping Exercise to Map the Field*, 7 J. MED. INTERNET RES. 1, 10-11, 15-16 (2005).

medical care, particularly in rural settings.<sup>51</sup> For e-health to be widely adopted as a core of elder care, the technology involved must be both low-cost and user-friendly.

While broadly speaking, e-health has expanded, its potential to become an infrastructure technology exceeds its current applications, even in light of technical innovations in the area. The lack of a comprehensive reimbursement strategy has been a persistent impediment to proliferation of e-health, particularly outside of rural areas.<sup>52</sup> The recent health reform only references e-health in a few places, but as is the case with technological innovations generally, this area is largely beyond the pale of federal insurance reform legislation.<sup>53</sup> This is not to say that health reform and e-health aren't compatible, but rather that the recent law doesn't rest directly on this, or any other particular technological innovation, as fundamental to government reforms. Instead, it is a development which must be sparked within health care circles as is appropriate.

In an applied context, there are many current applications in the e-health technology world that link patients and medical networks in helpful ways that can serve as models for broader application. For example, the Geisinger Health System in central Pennsylvania provides patients with "virtual visits" which affords them access to their electronic records.<sup>54</sup> In addition, Geisinger has developed quick care cost estimates that allow patients to gauge their health insurance coverage and out of

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51. See CTR. FOR RURAL HEALTH, UNIV. N. DAKOTA SCH. MED. & HEALTH SCI., DEFINING THE TERM "FRONTIER AREA" FOR PROGRAMS IMPLEMENTED THROUGH THE OFFICE OF PROGRAMS FOR THE IMPLEMENTATION OF TELEHEALTH 5, 15 (2006) [http://ruralhealth.und.edu/pdf/FrontierDefinition\\_May06.pdf](http://ruralhealth.und.edu/pdf/FrontierDefinition_May06.pdf).

52. CTR. FOR TELEMEDICINE LAW, TELEMEDICINE REIMBURSEMENT REPORT (2003), <ftp://ftp.hrsa.gov/telehealth/licen.pdf>.

53. Shawn Gilman, *Is Telehealth Missing from Health Reform?*, PPACA IMPACT & OPPORTUNITIES (Aug. 26, 2009, 8:54 AM), <http://www.ppacaimpactandopportunities.com/2009/08/articles/health-information-technology/is-telemedicine-missing-from-health-reform/print.html>.

54. LISA SPRAGUE & NORA SUPER, NAT'L HEALTH POLICY FORUM, SITE VISIT REPORT: RURAL HEALTH CARE IN THE ELECTRONIC AGE, 1-2, 4 (2003) [http://www.nhpf.org/library/site-visits/SV\\_Geisinger03.pdf](http://www.nhpf.org/library/site-visits/SV_Geisinger03.pdf) (last visited Nov. 18, 2010); see also GEISINGER HEALTH SYS., 2009 SYSTEM REPORT 16, [http://www.geisinger.org/about/ar\\_09.pdf](http://www.geisinger.org/about/ar_09.pdf) (last visited Sept. 25, 2010).

pocket obligations online.<sup>55</sup> While Geisinger isn't unique in connecting patients with network providers (and providers with one another) and plan administration, their electronic linkages are enhanced through a medical home model sponsored by the Pennsylvania system. What is evident in the way Geisinger uses e-health is that it is a model that can be extrapolated in other settings and is highly compatible with senior care.<sup>56</sup>

As noted success, the use of applied e-health at the patient level (particularly for the aged) will require technology that is user friendly. Simple telecommunication applications can have major health benefits, such as the use of medical bracelets worn by patients that allow medical emergency responders access to patient data and provide linkages to family members in the event of patient emergencies. In the future, cellular phone applications maybe developed to transmit blood tests and even various types of medical imagining, in essence turning cell phones into medical devices.<sup>57</sup> Aging in place technology, reliant on e-health, is now part of a movement that is heavily based on applications that include a variety of interactive tools from social media sites to electronic coaching devices. No doubt, e-health technologies hold great potential to form patient-provider linkages, but pose challenges, not only for users, but also for providers who must incorporate telecommunications into their practices as new tools to enhance patient care planning and delivery. Technologies such as e-health, in addition, raise serious challenges for purposes of regulation and reimbursement that need to be addressed which have a long standing history, characterized by very slow resolution by regulators.<sup>58</sup>

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55. *CareCost Estimator*, GEISINGER HEALTH SYS., [http://www.geisinger.org/patients/business\\_services/estimator/index.html](http://www.geisinger.org/patients/business_services/estimator/index.html) (last visited Oct. 2, 2010).

56. GEISINGER, *supra* note 54, at 6.

57. Bradley Merrill Thompson, *FDA May Regulate Certain Mobile Phones, Accessories*, MOBIHEALTHNEWS (July 13, 2009, 10:52 AM), <http://mobihealthnews.com/3177/fda-may-regulate-certain-mobile-phones-accessories/>; see also Olga Kharif, *Medical Advances – Through Your iPhone?*, BLOOMBERG BUS. WK. (Apr. 30, 2008, 12:01 AM), [http://www.businessweek.com/technology/content/apr2008/tc20080429\\_186428.htm](http://www.businessweek.com/technology/content/apr2008/tc20080429_186428.htm).

58. AM. HOSP. ASS'N, *supra* note 48, at 15.

## CONCLUDING REMARKS

Certainly, health reform will push all facets of our delivery system in new and unpredictable ways, and those impacts will be felt perhaps most dramatically by seniors. While the implications of health reform are not yet known, statutory mandates for Medicare will usher in considerable changes, with a hard emphasis on cost control, juxtaposed with a need for innovation and quality improvement. Primary care and preventive health will take center stage, not as a matter of rhetoric, but as an essential element of a short and long-term approach to population health. It is clear that effective disease prevention and management will require care coordination, service integration, and patient engagement. No doubt, e-technology can be a valuable contributor to systemic changes for seniors, as this and other technologies can be harnessed as vehicles to enhance more efficient and timely health delivery. Considerable challenges will emerge in the context of elder care as the present demographics have the potential to overwhelm the system without ongoing, major changes in health delivery. All of the developments noted in this essay will need to pass through a legal filter and, here too, flexibility and efficiency in process must become guiding elements to a more fluid structure of health care delivery, necessary to meet the health care of elders as well as our general population.

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