

HEALTHCARE₂₀₀₆

Let's Get DIGITAL

Making the case for electronic health records

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In an ideal world, all of your health information would be found in one place — a card in your wallet or a data file accessible by you and each doctor, nurse, pharmacist and hospital that cares for you. Though the technology already exists to create and update such a record, in reality our health information is scattered, incomplete, stale and, as thousands of Hurricane Katrina victims discovered, irretrievably lost if disaster strikes.

Awareness of these vulnerabilities dates back even further than last year's devastating hurricane season. A report from the Institute of Medicine published in 2000 attributed the high cost of medical errors in part to incomplete health information and prescribed a comprehensive, up to date, central health record as an obvious safety measure.

Most industries are far ahead of health care when it comes to adopting, integrating and implementing information technology. Even some industries conceived in the 19th century, such as long-haul freight railroads, have implemented 21st-century technology; meanwhile the health care industry lags behind.

To be sure, information technology is far from absent in the health care industry. Since the 1980s, billing for pharmacy services to insurers has mostly been in electronic form. Free-standing laboratories have also been leaders in applying information technology to all facets of their business operations. Notably, most pharmacy transactions occur outside the government payment system (most prescription drugs were not covered by Medicare until the implementation this year of Medicare Part D). Laboratories have enjoyed an exemption from the physician financial relationship prohibition of the federal anti-referral law — widely



known as the Stark law because it was originally sponsored by Rep. Pete Stark, a California Democrat — for items (including electronic means of communication) provided to order or communicate laboratory results. The absence of the constraints and the complex rules that are the price of participation in governmental programs have enabled the private sector in these parts of the health care industry to take the lead.

Many forces are now arrayed to push for the adoption of electronic health records and to remove the barriers that have prevented widespread adoption of electronic records in the health care industry.

These forces for change include the federal government, many state and local governments, myriad private organizations, including large employers and employer groups that pay for the bulk of private health insurance in this country, and all parts of the health care industry. Countervailing interests also have advocates. The number of pending initiatives and proposals, and the reaction to them, threaten to result in paralysis rather than meaningful change.

As with any important change to a critical part of the nation's infrastructure, barriers are numerous. Ten years ago, the first steps were taken to bring information technology to the health care industry. The federal Health Insurance Portability and Accountability Act of 1996 sought to standardize electronic billing in the Medicare program. Today, the vast majority of Medicare payments are transacted electronically. HIPAA also resulted in the creation of nationwide minimum health care privacy and security standards.

The enactment of HIPAA, however, had the unintended effect of delaying the adoption of early versions of electronic health

records. The health care industry debated whether to delay implementation of electronic health records while awaiting the development of the promised nationwide standards. Those who delayed waited for privacy rules that were issued in April 2001 (compliance was required by April 2003) and security rules in February 2003 (compliance was required by April 2005).

After 10 years, the debate over implementation of electronic health records is now focused on privacy of health records, who pays for the acquisition and implementation of electronic health records and how to address the technological and standardization barriers.

Electronic health record systems are enormously expensive and are subject to rapid financial depreciation. There are high initial costs and continuing costs for training, maintenance and replacement. A physician office system can cost anywhere from \$10,000 to \$60,000 per doctor. A hospital system in Seattle recently announced the expenditure of \$120 million over five years on an electronic health record system.

Reimbursements from payors (including governmental payors) have decreased significantly over the last 10 years. In some states, such as Massachusetts, private payors have made significant investments in the development of electronic health records systems. In most states, payors have not participated nor proposed to participate in bearing the cost of implementing electronic health records even though payors, after consumers, will reap the most immediate benefits from implementing these systems. Many hospitals and hospital systems — pushed by the development of pay-for-performance systems — have begun to implement electronic health records without waiting for third-party funding.

Physicians in private practice generally, and primary care physicians

specifically, do not receive sufficient reimbursement to purchase electronic health record technology for their practices. In the absence of government or payor funding, the only potential source is a hospital or a health care system. While many hospitals or health care systems would pay all or part of the cost for physicians practicing at their hospitals, current law prohibits such help except in the case of employed physicians (employment of physicians is limited in California by the prohibition against the corporate practice of medicine). These prohibitions are found in anti-kickback and Stark statutes and regulations.

Most industries are far ahead of health care when it comes to adopting and implementing information technology.

Under pressure from Congress, the Department of Health and Human Services and its Office of Inspector General last October proposed, respectively, exceptions to the anti-kickback and Stark statutes that would permit hospitals and others to provide certain aspects of electronic health records systems to physicians if certain conditions were met. The proposed regulations would permit only transfers of software and certain training before the HHS secretary adopts standards for certifying that software was interoperable. After adoption of certification standards, integrated software packages with other functionality that could positively affect patient care would be protected as would permitting the payor for the technology to use reasonable methods to determine which physicians receive the technology.

The proposed regulations contain a number of other provisions designed

to insure that the software is not used by the hospital to induce referrals. The Health and Human Services Department, along with the inspector general's office, also solicited comments on whether the final rules should limit the value of software that could be donated or should require recipient physicians to pay a specified percentage of the cost of the donated software. The department's inspector general's office has a longstanding belief that the provision of electronic tools will induce referrals, which dates back to a position it staked out well over a decade ago relating to fax machines and "dumb" terminals. The proposed regulations appear to be a reaction on the part of somewhat unwilling regulatory agencies that have been told by lawmakers that Congress will step in unless the agencies act on their own.

Indeed, Congress appears poised to push past HHS and the inspector general's office to resolve these issues, with several bills already in the hopper. One such bill, H.R. 4157 (the Health Information Technology Promotion Act of 2005), was approved by the House Ways and Means' health subcommittee in May. The bill is a workable compromise that advances the adoption of electronic health records systems. While the subcommittee rejected a Democratic proposal to establish funding for electronic health records systems, leaving payment for such systems to private means, H.R. 4157 contains workable exceptions to the fraud and abuse laws and Stark statutes that go beyond the proposed regulations.

H.R. 4157 is broader than the proposed regulations and would permit acquisition of hardware and software, payment for training and maintenance and the transfer of related software. The bill does not require cost sharing with physicians. It would take a step beyond the authority of any federal

regulator by pre-empting all contrary state laws. The bill includes a requirement that the purpose of the transfer would not be to induce referrals but eliminates the dichotomy found in the proposed regulations between pre-and post-interoperability.

Privacy is another critical continuing concern slowing the implementation of electronic health records. Federal and state officials are grappling with the issues presented by the fact, among others, that enormous amounts of data (which, in printed form, would fill a roomful of filing cabinets) can now be compressed and held in electronic media that is easily transportable — and easily lost or stolen.

H.R. 4157, as recommended by the Ways and Means health subcommittee, contains a provision directing

HHS to study whether differing state privacy laws present a barrier to the development of electronic health records. In a manner similar to the process under HIPAA, Congress would then be given a period of time in which to act to resolve those differences by adopting legislation. If Congress does not act, HHS would be given the authority to adopt regulations establishing a national privacy standard in place of state-by-state standards. The vast majority of health care providers are engaging in operations in a single state or have separate operations in separate states so that the resolution of this issue should not impede the adoption of electronic health records. The danger is that, as with the adoption of HIPAA, the development of electronic health records would be

slowed. (In June, this provision was removed from the version of H.R. 4157 recommended by the health subcommittee of the House Energy and Commerce Committee.) Both committees have approved a version of H.R. 4157. Action by the full House, originally expected in June, has been delayed due to a Congressional Budget Office report suggesting there are more costs associated with the bill than originally anticipated.

Congress should act promptly to remove the thicket of regulations that is preventing the adoption of electronic health record systems. Congress should not rely on resistant agencies to complete this task. H.R. 4157 represents a valuable approach to removing barriers and advancing adoption of this critical technology. ❖