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Hospitals Giving the Gift of Technology

Relaxed regulations may spark largesse, but when it comes to I.T. donations, nothing is really free.

By Beckie Kelly Schuereberg, Senior Editor

There's usually a huge disparity between the use of I.T. in hospitals and physician practices. But the Bush administration is betting that recent revisions to federal law will help change that.

Last August, the Department of Health and Human Services published two final rules designed to ease restrictions on hospitals and other entities donating information technology to physicians and group practices.

Hospitals and other organizations have long been loath to make I.T. donations, fearing such activity would violate federal anti-kickback statutes and the Stark Act governing physician referrals. The final rules published in August made specific and conditional exceptions to those laws to permit I.T. donations, while continuing to restrict the referring of patients to facilities in which the referring physician has a financial interest.

HHS issued new exceptions to these laws to allow donations of electronic prescribing and electronic records software to help speed progress toward President Bush's goal of having substantial adoption of clinical information systems by 2014.

In response, some hospitals are using these exceptions to develop and roll out I.T. donation or data sharing initiatives.

"There are a lot of reasons why hospitals want to work with physicians for I.T. adoption," says Chantal Worzala, senior associate director for policy at the Chicago-based American Hospital Association. "The biggest one is being able to share information with them. They also feel physicians would be more willing to use technology in the hospital if they are already using it in their offices."

Health care industry experts and legislators for several years have called for the creation of I.T. donation exceptions. But whether the resulting rules will have a dramatic effect on physician I.T. adoption is uncertain. The new exceptions are somewhat unclear, which has led some hospitals to delay donation plans as they mull over legal advice on what types of technology or related services are allowed.

Additionally, the new exceptions don't address whether a not-for-profit organization would be at risk of losing its tax-exempt status for donating I.T.-something that would prevent some hospitals from creating such an initiative.

AHA requested the Internal Revenue Service make a ruling on this uncertainty. The association also issued an advisory interpretation of the new rules but is recommending each hospital consult with a lawyer before beginning a donation initiative, Worzala says.

"Having meaningful and very clear changes to the rules will facilitate hospitals' plans to share I.T. resources with physicians," she says. "But the way the rules came out, the requirements are sufficiently complex. It's not the 'bright line' guidance we would have liked. It will take time for hospitals to work through what they want to do and what the regulations say."

Interpreting the laws

The Centers for Medicare and Medicaid Services and the HHS Office of Inspector General each issued separate donation rules because there are two different regulations that govern contributions to physicians.

The Stark Act regulates the financial relationships that a hospital can have with physicians to prevent referrals for Medicare reimbursable services to facilities in which the referring physician has a financial interest. It does so by creating permissible financial relationship "exceptions", explains Mark Lutes, a partner at Epstein, Becker & Green, a Washington-based law firm. CMS last August issued an exception to the Stark Act that creates an opportunity for a permissible financial relationship for the donation of e-prescribing and electronic records technology.

The anti-kickback statute, a criminal law enforced by the HHS Office of Inspector General, calls for the review of Medicare payments to determine whether a financial relationship exists between a hospital and a referring physician. It also describes a series of "safe harbors" where the intent of such a relationship is lawful. The OIG last August issued a new set of safe harbors that now makes the donation of e-prescribing and electronic records technology a lawful financial relationship, Lutes says.

While there are slight differences in the exceptions and safe harbors created for e-prescribing and electronic records technologies, the final rules are similar on some points. For example, they both require physicians to pay for at least 15% of the I.T., with all physicians paying an equal percentage.

The new rules also require donated e-prescribing and electronic records software to be interoperable as defined by the Certification Commission on Health Care Information Technology. Training, connectivity and maintenance services are permitted in the new exemptions; hardware and staffing are not.

Further, electronic records software donations can include other functionality related to the treatment of a patient, such as scheduling, billing and other clinical support features, Lutes says. It can't, however, include other office functions, such as payroll or human resources applications.

While the rules might be ambiguous, they are a "facilitating step" toward physician adoption of I.T., Lutes says. But they aren't enough to turn on the I.T. light for many physicians, he contends.

"This could be an important step for physicians for whom the financial barriers of I.T. were paramount," he says. "But the adoption of technology is still a matter of physicians being convinced that it's worth the pain of changing workflow. The psychological barriers surrounding this transition might be stronger than the financial ones for many group practices. And in those instances, the failure to adopt technology is not attributable to a lack of safe harbors or exceptions."

Ensuring interest

Some hospitals, however, have found that physician interest in I.T. adoption is the least of their worries.

An I.T. donation program spearheaded by Oconee Memorial Hospital, for example, was proposed by some of its 50 affiliated group practices. Executives at Seneca, S.C.-based Oconee initially were hesitant to get involved because a donation program wasn't perceived as being in line with the hospital's core business strategies, says CIO and I.T. director Jay Hansen.

But Oconee executives eventually decided to financially support physicians in creating a not-for-profit organization that negotiates contracts and maintains licenses for electronic medical records and practice management software. Oconee Memorial Hospital hosts and maintains the applications, which are offered to physicians via the application service provider computing model.

FHIN, led by a physician board of trustees, contracts with McKesson Corp., San Francisco, for the Horizons Ambulatory Care EMR and Practice Plus practice management software, then sublicenses it to each practice.

Participating physicians are required to adhere to Oconee's networking and security standards because they use a virtual private network connection to the hospital to access the software. FHIN uses local I.T. consulting companies to assist physicians with such requirements.

Thirty-five group practices have indicated interest in FHIN, 10 of which have been chosen to participate in a pilot of the initiative. So far, four are live on the practice management system and two on the EMR, Hansen says.

The Foothills Health Information Network has purchased software for all the pilot practices, but is collecting fees only after they go live. While the organization isn't pushing the practices to implement the software, it does plan to push for a community-based personal health record when more physicians are using the technology, Hansen says.

"We realize that not every practice or physician will come on board with this," he says. "But as standards evolve, we will have the ability to integrate more data, so we might be able to add those other practices. It has to be a community effort."

FHIN connects each system it sublicenses to ensure data can be shared between facilities. Each participating practice, however, is set up as a private location on the network, and physicians only can access data for their own patients or patients who have been referred to them.

No interfaces necessary

The community computing model enables each practice to avoid having to buy the interfacing and networking technology required to use the software. Those savings are on top of the group rate discount they receive by purchasing the software through the FHIN.

Because the network offers the software, hosting and maintenance services at a fair market rate, the initiative adhered to the original exceptions and safe harbor requirements in the Stark and anti-kickback regulations, says Hansen at Oconee Memorial Hospital.

"Our philosophy was to make FHIN a self-supporting organization that offers software and services at a fair market value to physicians so we didn't have to worry about the Stark and anti-kickback regulations," he adds.

By offering software and I.T. services at a fair market value, Oconee and some other hospitals have managed to develop programs that were legal under the original Medicare laws. But the new exceptions and safe harbors have led some organizations to develop inventive ways to get I.T. into the hands of local physicians.

Over the past few years, 511-bed, New Haven, Conn.-based Hospital of Saint Raphael has used the fair market value exception to offer various I.T. services to some of its referring physician practices.

The hospital began by offering I.T. services to practices located in its medical office building. Services included local area network and phone system management, as well as access to the hospital's picture archiving and communication system from Philips Medical Systems, Andover, Mass.

"One of the reasons practices were coming to our medical office building is because they wanted the ability to access their office systems from our hospital and our systems at their practice," says Gary Davidson, CIO.

Thanks in part to that success, Saint Raphael is now leading a broader donation initiative, fueled by a \$3 million grant from Misys Healthcare Systems, to provide more than 200 referring physicians with electronic medical records software from the Raleigh, N.C.-based vendor.

The Misys Center for Community Health Leadership awarded the grant to the Greater New Haven area to "establish a communitywide network of connected medical organizations."

It's always good to share

The Misys donation program enables each practice to manage its own EMR data but also share it with other area physicians. It uses a "distributed" model of computing, where a third party-in this case, Saint Raphael-houses a patient locator component of the software that offers secure access to data within any of its applications. Physicians can access the patient locator via a Web-based connection to the system's server at the hospital.

Saint Raphael also will offer access to information from its own systems via the patient locator. Further, physicians not using EMR software via the program also will be able to use the locator function.

The grant program's computing model will enable information sharing without the issues of data governance that can arise in typical consolidated models, Davidson says.

Some details of Saint Raphael's involvement have yet to be determined, but the hospital's role will adhere to exceptions and safe harbors added last August to I.T. donation statues, he says. Saint Raphael will provide related I.T. services allowed under the exceptions; the laws do not apply to vendors like Misys that want to provide software free of charge to group practices, he notes.

"We don't anticipate every physician in the community will do this, but we hope that we will get a strong coalition of people to facilitate data communication," he says. "It's geared toward helping physician practices share information using electronic media. Everyone benefits from sharing information."

Many hospitals are funding I.T. donation programs because of the obvious benefits of sharing data among area caregivers. But some organizations have found data sharing initiatives can be double-edged swords.

Such initiatives often require local physicians to standardize their data and information systems, which can prevent them from customizing an EMR or other I.T.

to their needs. Additionally, data ownership issues can arise for physicians when a hospital houses their data, says Laura D. Jantos, principal at ECG Management Consultants Inc., Seattle.

"Physicians must ensure I.T. donations meet their needs," in terms of software and data sharing, she says. "They must determine whether they want to take a technology donation and use it the way a hospital wants them to or buy it on their own and customize it."

If data ownership issues are a concern, hospitals can offer EMRs via a federated computing model in which a joint software licensing agreement is created, but each practice has a separate deployment and database, Jantos says. Data sharing can be added later via separate interfaces between each system when clear-cut rules on data ownership and other business issues are hammered out, she says.

While this arrangement does offer discounted licensing costs, many physician practices are leaning toward the enterprise approach-when hospitals and practices set up data sharing networks based on standardized technology-because of the additional economic benefits in terms of hardware and maintenance, Jantos says.

Physicians' choice

In trying to appease both sides of the issue, Summa Health Network is allowing physicians to choose to use donated I.T. funds toward its preferred EMR vendor or go out on their own.

The Akron, Ohio-based physician/hospital organization for Summa Health System Hospitals created the program after receiving \$2.1 million from Anthem Inc., an Indianapolis-based payer. Summa Health Network enters contracts with payer organizations on behalf of SHSH and its affiliated physicians. It's also a member of the Cleveland Health Network, a group of regional physician/hospital organizations that enters contracts with managed care organizations.

The Anthem funding was the result of the practices meeting the payer's goals for Cleveland Health Network physicians to reduce expenditures in 2003.

In 2005, the organization researched criteria it wanted in an EMR application for the program and initiated a vendor selection process. In June 2006, it chose integrated EMR and practice management software from eClinicalWorks, Westborough, Mass., as the preferred system.

But Summa Health Network executives also realized that a single system might not fit the needs of all its 900 affiliated physicians, says Michael Maggio, M.D., chair of Summa Health Network.

"We decided if a physician or group wanted to use another EMR vendor or had another EMR in their office that they wanted us to help support, we would allow that

as long as it meets the criteria we created for EMRs," he says. Criteria includes being able to submit data to the network as well as help improve patient care and cut costs, he adds.

Maggio, however, believes most physicians will choose the preferred vendor's software because Summa Health System's I.T. department will host the system, which would enable practices to avoid having to maintain their own software. Physicians also can get I.T. hardware and networking support via other preferred vendor arrangements under the donation program.

Nice and easy

Summa Health Network wanted its I.T. donation initiative to make it easier for its physicians to evaluate and purchase I.T. as well as use it to collect and integrate disease management outcomes data to help improve care and negotiate better rates with payers.

But its funding is limited, so executives set a cap of \$7,500 grants per individual physicians, with a maximum of \$75,000 per group practice. Physicians will receive 50% of the funding at the contract signing; another 25% at go live; and the final 25% when they are able to send data from the EMR system to the network.

The reimbursement will pay about 30% to 50% of the total cost of the system's software, hardware, training and implementation.

"It's not a fortune, but it's enough to get people interested and started in this process," Maggio says. "We wanted to get physicians or groups that were interested and willing to invest the time and their own capital to make the project successful."

So far, more than 100 physicians have signed up for the initiative, and two practices are live on the software.