The EHR Initiative: Cash for Compliance

Ashley Lai

MHA Candidate, University of Southern California

According to a recent report, only 37% of smaller medical practices have adopted an electronic health record (EHR) system compared to 77% of hospitals who have not (Terry, 2012). As sophisticated advances are being made in healthcare information systems, the federal government is making a push for technological integration in order to increase industry continuity and improve quality of care in the US. To facilitate this shift, lawmakers have introduced an aggressive five-year timeline with substantial monetary consequences in an effort to encourage modernization in late adopters. These changes raise grave concerns, specifically among small-scale independent practices that fear the costs of compliance and penalties of non-compliance with EHR standards will threaten the financial solvency of their businesses. In light of this national debate, the purpose of this paper is to analyze the ethics of this legislation and the financial hardship it poses on small-scale providers. Although the new federal initiative for implementation of electronic health records would streamline clinical practices and reduce medical errors, it is unethical to punish providers with heavy financial penalties to enforce industry-wide compliance by 2015. Doing so would present paralyzing financial challenges for many small-scale organizations.

There are those who believe the financial penalties under the federal EHR incentive program are a justified approach, necessary to motivate the purchase, adoption, and integration of certified EHR systems in provider practices. In support of their position, they claim monetary incentives are the most effective way to gain and reward cooperation. Policymakers believe homogeneity is essential to the improvement of healthcare in the US, and suggest uniform,
accessible records would provide that homogeneity. They claim such progress cannot be made through unstandardized EHR implementation by selective practices; changing the industry demands the participation of all providers. Furthermore, significant improvements to safety, avoiding preventable medical errors caused by unreliable paper documentation and poor inter-organizational communication, are believed to be an invaluable exchange that outweighs the collateral cost of a few smaller practices going out of business (Blumenthal & Tavenner, 2010; Pear, 2010). It is difficult to argue with the potential gains EHR implementation offers when applied to quality patient outcomes and efficient clinical workflow. Detractors suggest the program’s penalties are negligible to the profound benefits EHR adoption will bring.

What those critics fail to realize, however, is that though a financial penalty may address compliance and facilitate the widespread benefits of EHR systems, it is a shortsighted solution with compromising effects on the nation’s healthcare system. Currently, small practices account for 80% of US physicians; these independent providers remain fundamental to serving the medical needs of the public (Lee et al., 2005). The high costs of EHR systems jeopardize the ability of smaller practices to stay open. The quantifiable, basic cost of EHR implementation in the first year totals approximately $256,494 for an average smaller practice: $162,000 for hardware and software; $85,500 for maintenance expenses in the first year; $5,900 for additional hardware and network fees; and $3,094 for IT support, training, and overtime pay (McBride, 2012). Providers can also expect to spend a total of approximately 611 hours planning and preparing for EHR implementation, 134 training hours per physician and staff member, and 48 hours per week per physician on implementation (McBride, 2012). These basic costs are the same for a small practice with two or five physicians. In comparison to larger practices and hospitals, limited resources and capital in smaller practices make EHR adoption challenging.
Preoccupied with high insurance rates, small-scale organizations must prioritize their spending and be certain the purchases they make fall within their budget constraints and offer high returns. Small practices cannot afford the overhead, complexity, and decreased productivity that accompany EHR adoption, and thereby cannot justify the investment (Callahan). Many small physician practices see the technology as an irresponsible purchase. The high purchase costs and constant revisions to the initiative’s requirements are too great a risk for their practices to take.

Instability in the marketplace is another costly factor that influences the decisions of private practices to adopt an EHR system. The small nature of independent organizations unavoidably makes them more vulnerable to unpredictable shifts or changes. Each decision profoundly affects the financial position of the practice. Even if small-scale organizations are able to afford EHR implementation, physicians fear they may run into problems later if they purchase early. Further, because the initiative is new, it is continually being modified. Physicians’ concerns include the government’s ambiguous definition of “certified EHR technology” and the “meaningful uses” rewarded under the federal program (Kibbe & Klepper, 2009). The strong uncertainty surrounding reimbursement rates a year or two from now leads small practices to hold off until they have the appropriate information to make an informed decision. These unfavorable odds delay small-scale organizations from making radical purchases that may compromise their solvency.

The rules recently issued by the federal government have proposed a timeline for implementation, which determines the amount of reimbursement for which a provider qualifies. Practices whose EHR systems are operational and pass all requirements in 2011 and 2012 receive $44,000 through federal Medicare reimbursements, distributed incrementally over five years: $18,000 the first year, $12,000 the second, $8,000 the third, $4,000 the fourth, and $2,000
the fifth (Grams, 2010). Providers who begin in 2013 will receive a maximum payout of $39,000, those who begin in 2014 receive $24,000, and those who begin in 2015 receive nothing (Grams, 2010). In order for providers to qualify for this funding, their EHR systems must meet the “meaningful use” requirements laid out by the Office of the National Coordinator for Health Information Technology (ONCHIT). When the program was first implemented in January 2010, lawmakers required physicians to meet 25 “meaningful use” criteria, hospitals to meet 23 criteria, and providers to transmit at least 75% of prescriptions electronically. In July 2010, new rules required physicians to meet 15 criteria and achieve 5 of 10 objectives, hospitals to meet 14 criteria and achieve 5 of 10 objectives, and providers to transmit at least 40% of prescriptions electronically (Pear, 2010). It is unethical to hold small practices to a higher standard of “meaningful use” than larger practices and hospitals because small practices are limited by their resources. The typical small practice barely breaks even; the annual revenue of a small practice averages $500,000 compared to $13.7 billion of a large hospital system (Electronic Medical Records Deadline, 2012).

While small providers understand the value and purpose of having “meaningful use” criteria, the scope of their practices often cannot support the levels required. Even a hospital system as large as Kaiser Permanente, which has utilized EHR for decades, has difficulty meeting all the incentive program criteria and suggests it would not likely be reimbursed under “meaningful use” (Grams, 2010). Under the program, 99% completion of criteria by providers results in no reimbursements; this “all or nothing” approach presents substantial challenges for small-scale organizations. Providers’ compensation should vary directly in accordance with their relative degree of compliance. Small practices especially cannot afford to lose out on federal reimbursements of any size because they often reinvest those funds back into the business and
use them to mediate the high costs of insurance and overhead incurred when running an independent practice. That financial lifeline is what keeps the business sustainable. After practices have spent hundreds of thousands of dollars on an EHR system, it is unfair to penalize them by withholding reimbursements for only meeting most of the “meaningful use” criteria.

The federal government’s EHR incentive program unjustly dangles reimbursements, which practices are legally entitled to as a Medicare and/or Medicaid provider, as a “cash bribe” for compliance. Since the inception of the Medicare participating physician (PAR) agreement in 1966, reimbursements were created to compensate providers for treating federal program enrollees. Changing the longstanding terms of this agreement so the government can punish physicians and hospitals for lack of EHR implementation not only violates the nature of the agreement, but is also an explicit breach of contract. Similar penalties continue for organizations that have not yet adopted a certified EHR system or have failed to demonstrate “meaningful use” by 2015, under which Medicare reimbursements are set to be reduced by 1%. Deduction rates increase each subsequent year: 2% in 2016, 3% in 2017, totaling up to 95% depending on future adjustments. Based on average annual revenue, a standard small practice will lose approximately $1000 each year in reimbursement payments (Electronic Medical Records Deadline, 2012). Late adopters or noncompliant, small-scale organizations that already struggle to implement EHR will now be reprimanded twice under the program. These progressive consequences will place undue hardship on their practices, resulting in even greater danger of dissolution.

While high costs and loss of funding are the primary concerns of small independent practices, secondary challenges related to low return on investment plague providers. The program’s poorly designed timeline for EHR implementation puts small-scale organizations under high pressure to choose an EHR system without having conducted adequate research to
make an informed purchase that fits the practice’s needs and uses. Federal “meaningful use” standards are often not the same as provider “meaningful use” standards. As a result, physicians are spending thousands of additional dollars to re-engineer their clinics to meet these demands (Schneider, 2012). While the program covers $18,000 of the implementation costs, physicians are responsible for covering the remaining balance (Docs Tell Congress, 2011). Even with early provider buy-in, the cost of a certified EHR system well exceeds the maximum $44,000 distributed over 5 years. In addition, during the period of system implementation, physician and staff trainings substantially take away from time with patients.

More time training means less time with patients. Small practices experience significant decreases in patient volumes. Instead of seeing three to four patients per hour, they are only able to see one as they learn to become familiar with a new system (Docs Tell Congress, 2011). These small-scale providers are left with no options as they are unable to sustain their regular patient volumes with fewer staff members than larger practices or hospitals. For a small practice, fewer patients each day, each week, and each month have a profound impact on both patient health and the bottom-line of the practice (Docs Tell Congress, 2011). The implementation and adjustment period is reflected in increased costs and decreased revenues, which are only another factor fating them toward financial paralysis. Furthermore, even if small-scale providers can afford an EHR system, the amount of time before their practices begin to realize potential gains are far too long. Because the high costs of compliance outweigh the expected benefits, physicians of smaller organizations are unable to justify the long-term debt of such a major purchase. When making large investments, smaller practices have more to lose than larger practices. In high-stakes circumstances relating to the solvency of their organization, small practices are often unwilling to gamble when there are no guarantees of high returns. The purchase of a health information
technology system hampers the financial freedom of small practices and crushes hopes of expanding their practices in the future (Docs Tell Congress, 2011).

Small practices face devastating challenges with the aggressive push by the federal government to modernize the healthcare industry through collective use of EHR systems. EHR systems were originally designed to help large-scale organizations effectively manage health information (Callahan). It is unreasonable to expect a hospital-based system and program to translate well for small-scale providers with completely different needs and access to resources. It is only a matter of time before independent practices are no longer solvent because of crippling financial penalties set by the government’s program. Experts in the field currently see one primary policy solution for addressing the ethical dilemma of punishing small-scale providers to the point of financial insolvency to enforce information technology compliance by 2015: create an exception from the program penalty for small practices (Halvorson & Dawson, 2012). This exception should accommodate the differences in size, financial position, and needs of small practices—one that reduces the number of “meaningful use” criteria and lessens the steep drop-offs in Medicare reimbursement rates as long as they can demonstrate a clear implementation plan to be executed within a realistic timeline. If no action is taken to revise the current EHR standards and regulations, it is only a matter of time before many small practices will be forced to close their doors due to bankruptcy. With 80% of US physicians currently employed at small-scale organizations, the loss of these practices will have devastating consequences on the nation’s health.
Selected Bibliography

Docs Tell Congress EHR Adoption Presents Serious Challenge. (2011, June 8). *Information Week*.


