



The Affordable Care Act and the drive for electronic health records: Are small practices being squeezed?

↘ Many small practices find the expense of implementation to be a challenge, but data suggest physicians are getting on board the EHR wagon

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small practices are still feeling squeezed to keep up with the many demands of modern specialty care. The push for electronic health records (EHRs), in particular, can profoundly affect physicians in private practice.

In this article, I outline some of the challenges facing small practices when they set out to implement EHRs, as well as the potential benefits they stand to gain a little farther down the road. Before we begin, however, let's look at the latest trends in ObGyn practice, as they are related, in part, to the need to implement EHRs.

The exodus from private practice continues

A 2012 Accenture Physicians Alignment Survey shows an accelerating increase in physician employment. In 2000, 57% of all physicians were in independent practice; by the end of 2013, only 36% of physicians are projected to remain independent.²

The ObGyn specialty is a clear part of this trend, with both seasoned and incoming physicians finding hospital or other employment an attractive alternative to private practice. Fully one-third of ObGyn residents entering practice today sign hospital employment contracts. ObGyns who have made the switch from private to hospital practice, or

Two years ago, I zeroed in on the pressures straining small ObGyn practices in an article entitled, "Is private ObGyn practice on its way out?"¹ The pressures haven't eased in the interim. Today,



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who have become ObGyn hospitalists, often point to the difficulties of maintaining a solvent private practice, especially given the push toward EHRs and increasing regulatory and administrative burdens, as justification for their move.

The main reasons for the shift to employment. Top concerns influencing physicians' decisions to opt for employment include:

- business expenses (87%)
- the dominance of managed care (61%)
- the requirement for EHRs (53%)
- the need to maintain and manage staff (53%)
- the increasing number of patients needed to break even (39%).²

A 2008 socioeconomic survey from ACOG revealed that 23.6% of ObGyn practices are solo practices, and 27.1% are single-specialty group practices. Many ObGyns—especially those in solo or small practices—are hesitant to make the large capital investment that is necessary to adopt EHRs.

EHRs offer benefits—and real costs

The system-wide benefits of health information technology (HIT), including EHRs, are many. Insurers stand to save money by reducing unnecessary tests, and patients will benefit from better coordination of their care and fewer medical errors. But these advantages don't necessarily translate into savings or revenue for physician practices. Instead, physicians face payment cuts from Medicare and private insurance.

Although there's wide agreement that HIT can improve quality of care and reduce health-care costs, fewer than one-quarter (22%) of office-based physicians had adopted EHRs by 2009. We know the main reasons why:

- upfront cost and maintenance expense
- uncertain return on investment
- fragmented business model in a high proportion of small and solo practices
- changing and inconsistent information technology (IT) systems.

Some physicians are more likely to seek incentives for meaningful use of EHRs

Proportionally, more than three times as many eligible professionals participated in the Medicaid EHR incentive program in 2011 than in the Medicare incentive program, although the total payment amounts in the two programs were nearly equivalent.

Characteristics of Medicaid incentive recipients

The 45,962 professionals awarded an incentive payment for 2011 represented 33% of the estimated 139,600 professionals eligible for the program and were awarded a total of \$967 million. Almost all professionals (97%) were awarded the maximum payment amount available for the year (\$21,250).

Among the professionals who received a Medicaid EHR incentive payment for 2011, the largest percentage (37%) were located in the South, and the smallest percentage (20%) were located in the Midwest.

Four-fifths (83%) were located in urban areas.

Nearly three-quarters were physicians—either general practice physicians (23%) or specialty physicians (51%)—and the lowest percentage (1%) were physician assistants.

Almost half (47%) of incentive recipients had signed agreements to receive technical assistance from a regional extension center.

Characteristics of Medicare incentive recipients

Incentive payments were awarded to 56,585 professionals—about 9% of the estimated 600,172 professionals eligible for the program. These professionals were awarded a total amount of about \$967 million for 2011.

The largest percentage (32%) of these professionals were located in the South, and the smallest percentage (17%) were located in the West.

A significant majority (89%) practiced in urban areas.

Half (50%) of incentive recipients were specialty physicians, and more than one-third (38%) were in general practice.

Nearly three-quarters (71%) had not previously participated in the CMS incentive program for electronic prescribing.

About half were in the top third in terms of 2010 Medicare Part B charges (46%) and 2010 Medicare Part B patient encounters (51%).

General-practice physicians were 1.8 times more likely than specialty physicians to have been awarded an incentive payment.

Professionals who received technical assistance from a regional extension center, designed to increase participation by primary care physicians, especially in rural areas, were more than twice as likely to have been awarded an incentive payment.

Professionals in the top third in terms of 2010 Medicare Part B charges or number of 2010 Medicare Part B encounters were more than three times more likely to have been awarded an incentive payment, compared with those in the bottom third for charges or number of encounters.

Source: US Government Accountability Office^{8,9}

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Doctors' and hospitals' use of HIT has more than doubled since 2012

More than half of all doctors and other eligible providers have received Medicare or Medicaid incentive payments for adopting or meaningfully using EHRs, according to data released in late May 2013 by the US Department of Health and Human Services.¹⁰

Since the Affordable Care Act increased the pressures on physicians to adopt EHRs, usage has increased dramatically. According to a 2012 survey from the Centers for Disease Control and Prevention, the percentage of physicians using an advanced EHR system was just 17% in 2008. Today, more than 50% of eligible professionals (mostly physicians) have demonstrated meaningful use and received an incentive payment.

Among hospitals, just 9% had adopted EHRs in 2008, but today, more than 80% have demonstrated meaningful use.

As of April 30, 2013, more than 291,000 eligible professionals and more than 3,800 eligible hospitals had received incentive payments from the Medicare and Medicaid incentive programs.¹⁰



After 5 years of EHR use, practices reported a median operating margin 10.1% higher than that of practices in the first year of EHR use

What can a practice expect to fork over?

In 2011, the Agency for Healthcare Research and Quality (AHRQ) found that the “real-life” cost of implementing EHRs “in an average five-physician primary care practice, operating within a large physician network committed to network-wide implementation of electronic health records, is about \$162,000, with an additional \$85,500 in maintenance expenses during the first year.”³

These figures include an average of 134 hours needed per physician to prepare to use EHRs during patient visits.³

Fleming and colleagues investigated the cost associated with implementing EHRs within 26 primary care practices in Texas. They found the cost to be \$32,409 per physician through the first 60 days after the EHR system was launched, with one-time costs for hardware of \$25,000 per practice and an additional \$7,000 per physician for personal computers, printers, and scanners. The annual cost of software and maintenance was approximately \$17,100 per physician.⁴

Why physicians should hold out for the return on their investment

Despite these considerable expenses, EHRs hold promise over the long term. The Medical

Group Management Association reported, through a 2009 survey of about 1,300 primary care and specialty practice members using EHRs, that efficiency gains from the elimination of paper charts, as well as transcription savings, better charge capturing, and reduced billing errors, resulted in a median revenue increase of \$49,916 per full-time physician after operating costs.

After 5 years of EHR use, practices reported a median operating margin 10.1% higher than that of practices in the first year of EHR use.⁵

Trends in the adoption of EHRs

Private practice. An article in *Health Affairs* showed that, by 2011, only one in six office-based physicians was using an EHR system robust enough to approach “meaningful use”—that is, the use of EHRs to measurably improve the quality of health care.⁶ These robust systems offered physicians the ability to record information on patient demographics, view laboratory and imaging results, maintain patients’ problem lists, compile clinical notes, and manage prescription ordering. EHR adoption lagged among non-primary care physicians, physicians aged 55 and older, and physicians in small (1–2 providers) practices and physician-owned practices.⁶ (ObGyns were considered primary care providers in this survey.)

“Big” practice. By comparison, in 2011, 99% of physicians in health maintenance organizations, or HMOs, and 73% in academic health centers and other hospitals used EHR systems.⁶ The number of physicians in these practice settings is small but growing.

In 2011, only 17% of physicians were in large practices of 10 or more physicians; 40% were in practices of one or two physicians.⁶

Primary care. These practices lead others in the adoption of EHRs, in part because of federal assistance, including a nationwide system of regional HIT assistance centers established by the Health Information Technology for Economic and Clinical Health (HITECH) Act to help providers located in rural areas participate in the Centers for

Medicare and Medicaid Services (CMS) programs in EHR. The goal of these programs is to provide HIT support to at least 100,000 primary care providers, including ObGyns, by 2014.

The numbers cited in the *Health Affairs* article largely mirror data developed by other research organizations, including the Deloitte Center for Health Solutions.⁶

The EHR incentive

The drive for EHRs started long before the Affordable Care Act (ACA) was passed in 2010. The US Congress took a first stab at encouraging the health-care community to embrace HIT in 1996, when it passed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA created an electronic data interchange that health plans, health-care clearinghouses, and certain health-care providers, including pharmacists, are required to use for electronic transactions, including:

- claims and encounter information
- payment and remittance advice
- claims status
- eligibility
- enrollment and disenrollment
- referrals and authorizations
- coordination of benefits
- premium payment.

Congress stepped up its game in 2009, when it offered higher Medicare and Medicaid payments to physicians who adopt and “meaningfully use” EHRs. The HITECH Act included \$30 billion in new Medicare and Medicaid incentive payments—as much as \$44,000 under Medicare and \$63,750 under Medicaid—as well as \$500 million for states to develop health information exchanges.

The Act also established a government-led process for certification of electronic health records through a \$35 billion appropriation for the Office of the National Coordinator for Health IT, housed in CMS.

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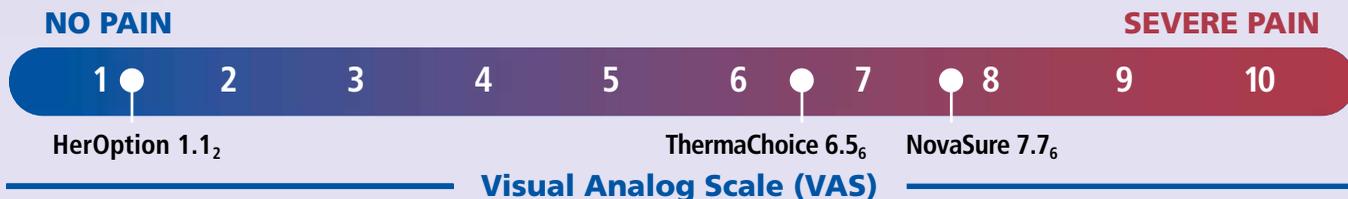
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Under the Physician Quality Reporting System, now mandatory, Medicare payments will be reduced for nonparticipating physicians

Other programs designed to encourage use of EHRs

Other federal programs include the Physician Quality Reporting System (PQRS), which, when created in 2006, was a voluntary physician electronic reporting program. Under the ACA, however, it has become a mandate. Starting in 2015, Medicare payments will be reduced for nonparticipating physicians.

The Electronic Prescribing (eRx) Incentive Program, created in 2008 under the Medicare Improvements for Patients and Providers Act, provides incentives for eligible physicians who e-prescribe Medicare Part D medications through a qualified system. This program converted to a penalty program last year for physicians who don't use eRx.

Grants were also provided under the HITECH Act to fund an HIT infrastructure and low-interest HIT loans. The AHRQ has awarded \$300 million in federal grant money to more than 200 projects in 48 states to promote access to and encourage HIT adoption. Over \$150 million in Medicaid transformation grants have been awarded to three states and territories for HIT in the Medicaid program under the 2005 Deficit Reduction Act.

The ACA carried these initiatives even further by establishing uniform standards that HIT systems must meet, including:

- automatic reconciliation of electronic fund transfers and HIPAA payment and remittance

- improved claims payment process
- consistent methods of health plan enrollment and claim edits
- simplified and improved routing of health-care transactions
- electronic claims attachments.

Clearly, a lot of effort and taxpayer dollars have been dedicated to drive efficient use of HIT and EHRs in the hopes that they can:

- help make sense of our increasingly fragmented health-care system
- improve patient safety
- increase efficiency
- reduce paperwork
- reduce unnecessary tests
- better coordinate patient care.

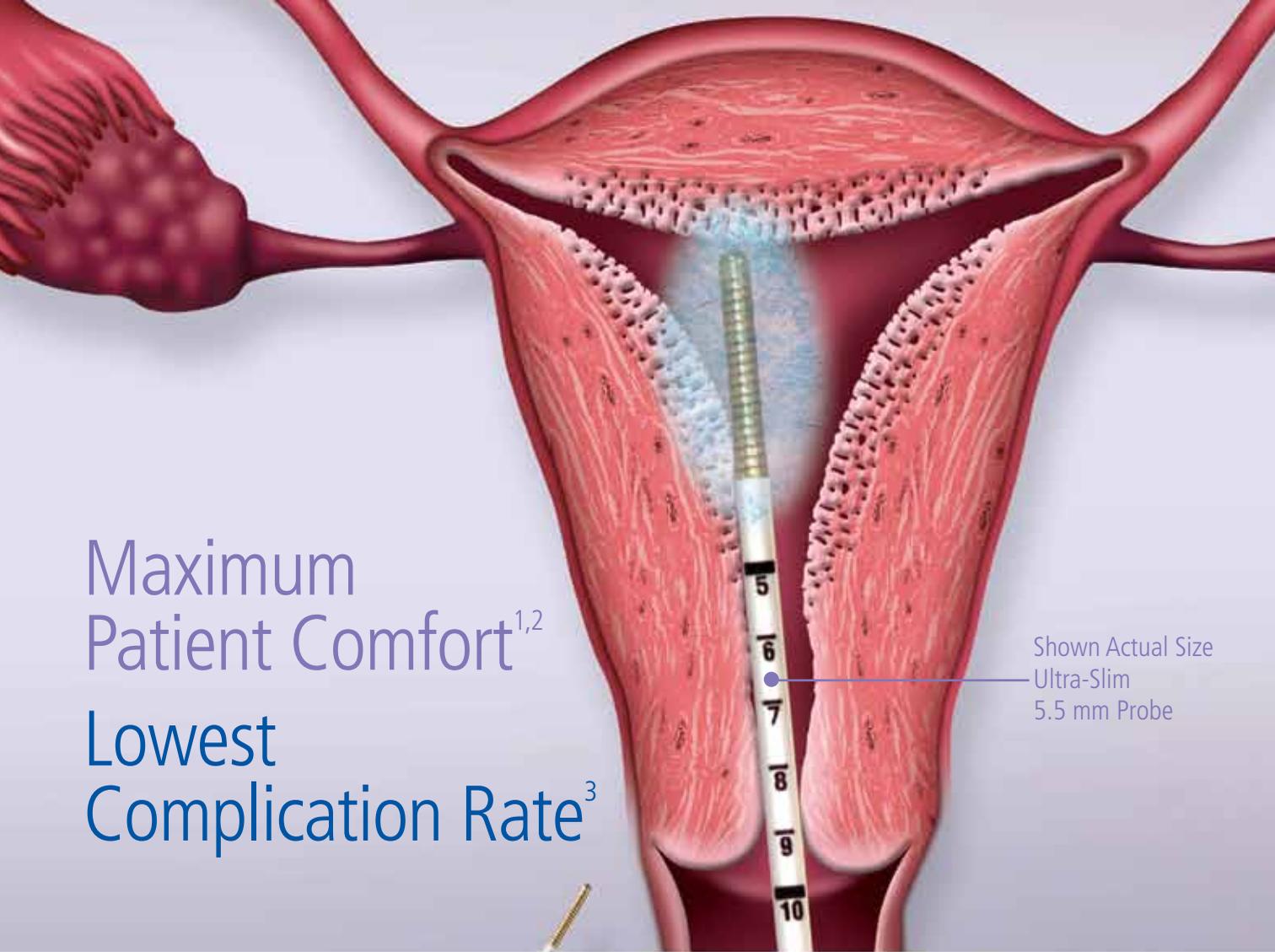
To see which providers are cashing in on the government's incentives for EHRs, see "Some physicians are more likely to seek incentives for meaningful use of EHRs" on page 37.

The long view

HIT and EHRs are here to stay. Products are maturing and improving. Acceptance by large and small practices has gained traction. Are small practices being squeezed? No doubt.

In 2011, I urged all ObGyns—especially those in private practice—to read an article written by President Barack Obama's health-reform deputies on how physicians can be

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6 Clark et al; Bipolar Radiofrequency Compared with Thermal Balloon Endometrial Ablation in the Office; Obstetrics & Gynecology; Jan 2011

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successful under the ACA.¹ It reads, in part:

To realize the full benefits of the Affordable Care Act, physicians will need to embrace rather than resist change. The economic forces put in motion by the Act are likely to lead to vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups. The most successful physicians will be those who most effectively collaborate with other providers to improve outcomes, care productivity, and patient experience.⁷ 

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