New Federal Regs Aim to Grease Health IT Wheels

BY MARY ELLEN SCHNEIDER
New York Bureau

Hospitals, health plans, and other health care organizations will soon be able to help physicians obtain health information technology without running afoul of federal fraud laws under regulations issued last month by the Department of Health and Human Services.

In two final regulations published in the Federal Register on Aug. 8, the Centers for Medicare and Medicaid Services and the HHS Office of Inspector General carved out new exceptions to the Stark physician self-referral law and the federal antikickback statute. Under these new exceptions, certain health care entities will be able to donate interoperable electronic health record (EHR) software and training. Hospitals and other health care organizations will also be able to provide hardware, software, and training that are "necessary and used solely" for electronic prescribing.

The regulations did not cap the donations to physicians for electronic prescribing technology, but the government is requiring physicians to share some of the costs of donated EHR technology. Under the rules, physicians will be required to pay 15% of the donor's cost of the EHR technology and services. The regulations go into effect in October (60 days after publication in the Federal Register). The provisions related to EHR arrangements are slated to sunset on Dec. 31, 2013.

The regulations were widely praised by physician organizations and health IT industry groups for breaking down barriers to physician adoption. But Patrick Hope, legislative counsel for the American College of Physicians, said the changes aren't likely to do a whole lot to speed physician adoption of the technologies since few hospitals will be able to afford to donate the expensive technology to physicians.

"They are operating at the margins just as physician offices are," Mr. Hope said.

ACP officials are urging members of Congress to establish an add-on payment to the Medicare reimbursement for an office visit in an effort to help offset the ongoing costs of an electronic health record system, Mr. Hope said. While the regulations are helpful in removing some barriers, he said, an add-on payment would create a better business case for physician adoption of health IT. The jury is still out as to what impact these regulations will have on physician adoption, said Chantal Worzala, senior associate director for policy at the American Hospital Association. Not all hospitals will have the financial resources to donate health IT services, she said, since only about a third of U.S. hospitals are making a profit.

Health plans may offer electronic prescribing products, but hospitals are likely to want to help physicians acquire more comprehensive EHR systems.

But the regulations will give hospital administrators more options. "Hospitals really should have flexibility in working with community physicians," she said.

Although some health plans may be interested in offering electronic prescribing products, Ms. Worzala said, hospitals are likely to want to help physicians acquire more comprehensive EHR systems.

The relaxation of the Stark physician self-referral law and the antikickback statute is a good thing, said Dr. Steven E. Waldren, assistant director of the American Academy of Family Physicians' Center for Health Information Technology, since the changes will allow more health IT resources to flow to physicians. However, he cautioned physicians not to count on getting this support.

This type of support won't be available to all physicians and in some cases may not be appropriate, he said. For example, Dr. Waldren said that some hospital electronic health record systems are not designed for the ambulatory environment and may end up costing physicians more money in the long run. The bottom line is that physicians need to continue to do their "due diligence" in researching systems, he said.

The Medicare Modernization Act of 2003 mandated that the HHS Secretary create exemptions that would allow for certain health care organizations to help furnish physician practices with electronic prescribing technology. The changes were originally outlined in a proposed

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Circumcision Pain Relief Is Taught but Underused

BY JOHN R. BELL
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A significant portion of neonates still do not receive effective pain relief when undergoing circumcision, according to the findings of a study by Dr. Daniel Yawman and his colleagues.

This is true despite the substantial increase over the last few years in the percentage of residency programs in which effective anesthesia for this procedure is taught. Moreover, the most commonly reported surgical technique taught in these programs is not the method associated in the literature with less pain, reported Dr. Yawman of the University of Rochester (N.Y.) and his colleagues (Ambul. Pediatr. 2006;6:210-4).

Following up on a 1998 study by other researchers, they found that the percentage of all family practice, ob.gyn., and pediatric residency programs in the United States that reported teaching effective (local or topical) anesthesia for the procedure rose from a previously reported 71% for the mid-1990s to 97% in 2003; however, only 84% of programs in 2003 reported actually practicing effective anesthesia in neonatal circumcision always or frequently. Overall, 82% of the programs reported teaching circumcision.

Data were collected via a survey mailed to all directors of family practice, ob.gyn., and pediatric residency programs in the United States. There was an 86% response rate involving 811 programs.

The investigators considered effective anesthesia to be either local methods (subcutaneous or dorsal penile nerve block) or topical anesthesia (a combination of lidocaine and prilocaine [EMLA] or other anesthetic cream). They also collected data on other forms of analgesia taught for and used during circumcision, such as pacifiers or parental comforting. The most commonly taught and most frequently used method was the dorsal penile nerve block; this method was taught in 81%, and used frequently in 35%, of the residency programs that teach neonatal circumcision. Overall, local anesthesia was taught in 91% of the residency programs, and topical anesthesia was taught in only 44% of the programs.

The researchers also collected data on the surgical technique used in each program. Despite the fact that the Mogen clamp "may provide a less painful procedure, compared with the Gomco clamp or the Plastibell method," use of the Mogen clamp was taught in only 38% of the programs, vs. 95% for the Gomco clamp and 37% for the Plastibell technique.

Pediatric residency programs reported teaching circumcision much less often (49%) than did family practice residencies (95%) or ob.gyn. programs (86%).

The authors concluded that although education regarding pain relief in circumcision has improved, "a significant number of newborns may not receive appropriate analgesia, despite the fact that effective analgesic techniques are taught to residents."

Dr. Yawman and his colleagues noted that since the 1998 study, the professional organizations for each of the included specialties (the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics) have issued recommendations for universal use of local or topical anesthetic. ■

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rule issued last October.

Under the provisions related to electronic prescribing technology, hospitals can donate hardware, software, and services to members of their medical staffs; group practices can donate to physician members; and Medicare prescription drug plan sponsors and Medicare Advantage plans can donate to pharmacies and prescribing physicians. The Stark law exemption and antikickback safe harbors have slightly different definitions of who can donate the comprehensive electronic health record system software and training.

The electronic prescribing safe harbors and exemptions allow organizations to donate hardware, software, Internet connectivity, and training and support services. The provisions for electronic health records are slightly different and do not include hardware. For EHRs, organizations can donate software, which must include an electronic prescribing component. Also, donated information technology and training can include Internet connectivity. ■