

# Selling the subsidy: Questions remain on hospital-physician IT collaboration

**Despite changes to federal rules that allow hospitals to donate health IT to physicians, studies show neither hospitals nor physicians are jumping at the opportunity.**

By [Pamela Lewis Dolan](#), *AMNews* staff. Nov. 10, 2008.

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On an October Tuesday, Randolph, Mass., family physician Carmel Kelly, MD, was examining an elderly patient who became ill and needed to be transported to the hospital immediately. When emergency technicians arrived, Dr. Kelly handed over a summary of the patient's vitals, her most recent test results and her medical history, all printed out with the click of a button. For the next few hours, Dr. Kelly checked in on the patient, kept track of all tests and received results without leaving her practice.

Had this emergency happened four days earlier, it would have been a completely different scenario.

- [Rules of donation](#)
- [Ready for a donation?](#)
- [Getting subsidized EMRs from other sources](#)
- [Links](#)
- See [related content](#)
- Topic: [Electronic medical records](#)
- [E-mail](#) - [Print](#) [Ctrl-P if JavaScript off] - [Write a letter](#)

This seamless coordination of care is what Beth Israel Deaconess Medical Center in Boston had in mind when it made the \$20 million decision to subsidize the implementation of electronic health records for its 1,300 affiliated physicians, including Dr. Kelly, who had just gone live four days before the emergency.

"The report [delivered from the EMTs to the emergency physicians] was clear, concise and complete. There were elements that were immediately useful. In that sense, [four days before] I had nothing equivalent," Dr. Kelly said. "That was exciting."

But Beth Israel Deaconess Medical Center is one of the few hospital groups taking advantage of new exceptions to the Stark laws and safe harbors to anti-kickback rules that paved the way for hospitals to help physicians implement health IT. The exceptions are scheduled to expire in 2013.

## **Hospitals can donate up to 85% of IT costs, with the physician picking up the other 15%.**

A recent study by the Center for Studying Health System Change looked at why few projects are moving forward. Among reasons: the hospitals' unwillingness to take on additional health IT projects and a lack of interest from physicians.

According to Susan Kanvik, MPH, health care practice leader for the management consulting firm Point B, many hospitals are holding off, counting on others to test the waters. "There is a little bit of watchful waiting," she said.

Even the ones that have expressed interest have been moving slowly. But experts say patience is key in a project of this scope, which is why Beth Israel, which announced its project nearly a year ago, is still in the early phases of its pilot program.

### **Obstacles to EMR use**

Exceptions to Stark and safe harbors for anti-kickback laws went into effect in October 2006. But it wasn't until June 2007 that the Internal Revenue Service clarified that these donations wouldn't violate federal tax law.

The law says hospitals can donate up to 85% of the price for a system, with the physician picking up the other 15%. But not all aspects of the law are as clear.

Like many physicians during an EMR implementation, Dr. Kelly was and is dealing with legal, technical and logistical issues compounded by the fact that this is no simple contract between EMR vendor and client. The hospital itself also is facing questions of how to become 100% connected with its affiliated physicians even though many of them are not yet ready to adopt health IT.

Mark Cohen, MD, a gastroenterologist and internist at a two-physician practice in Milton, Mass., said one of the biggest obstacles is the financial one. Even with 85% of the tab for his EMR being picked up by Beth Israel, Dr. Cohen's investment is still \$22,000 plus service fees of \$550 per physician, per month.

Dr. Cohen also is preparing for the revenue loss due to disruption of business. He plans to go live with the system next month. "It's a big concern taking that on, but the thing is, I have to do it," Dr. Cohen said.

Picking the wrong system is a big fear for any physician adopting an EMR. And when a hospital subsidy is involved, doctors rarely have a choice in picking their own technology.

Richard Parker, MD, is medical director and internist for the Beth Israel Deaconess Physicians Organization, to which all of Beth Israel's affiliated physicians belong. He said the only doctors who will not be on the hospital-selected eClinical works system are those who already had implemented an EMR. The physicians organization is sharing implementation costs with the hospital.

"If a doctor joins a practice that is closely affiliated with [Beth Israel Deaconess Medical Center], they would have to use eClinical works. ... If we allow them to choose what system they want, we will have chaos," Dr. Parker said.

Dr. Kelly said having the hospital pick the system was a selling point for her. She didn't know what she needed, and the team of experts at the hospital evaluated the systems for her, she said.

But the practice still needs to be comfortable with the choice, said Jay Want, MD, president and CEO of Physician Health Partners, a management services organization that has an IPA in Denver with 183 primary care doctors.

Dr. Want said that group turned down an initial donation offer from a local hospital when it determined that the system the hospital offered would not meet its needs. The hospital eventually offered a different system, which the group accepted. But Dr. Want said the final negotiations took about a year.

Gerald Deloss, vice chair of the American Health Lawyers Assn.'s Health Information and Technology Practice Group, said contracts can be tricky and urged physicians to take their time. Deloss and Kanvik say physicians should pay careful attention to:

**Exit strategy.** The contract should detail how a physician would keep his data if he were to leave the practice and stop using the current system.

**Data ownership.** Under the law, the donating hospital must have access to the data. But under some arrangements, the data would be stored by the hospital, and de-identified data could be sold for other profitable purposes such as research.

**Maintenance.** Many of the maintenance contracts with vendors that cover technical issues are reached before the actual implementation. Physicians might have less leverage with vendors to whom maintenance fees are paid up front. Practices also might end up with contracts that prioritize larger groups.

**Tax issues.** There are questions on how donated IT should be handled at tax time. Deloss said some hospitals issued 1099 forms to doctors who got a donation, which required physicians to report the donation as taxable income.

**Data transfer.** The contract should spell out who will pay for electronic conversion of files. Under the law, hospitals could donate the module needed to do so, but it may require an add-on to the contract.

## **Getting off the ground**

John Halamka, MD, chief information officer at Beth Israel Deaconess Medical Center and at Harvard Medical School, said that during the initial implementation of its project, the physicians' organization will contract with the third-party support vendor. Eventually those contracts will be between each physician and vendor, using the template created during the pilot phase.

"Doctors getting started don't want the headache," Dr. Halamka said.

Dr. Kelly agreed, saying that the contract made sure she got tech support, which was key when several technical difficulties forced her to extend her initial training.

"Almost more than the cost is the assurance that there is a lot of competence," she said.

When Beth Israel first decided to launch the subsidy program, it chose doctors such as Drs. Kelly and Cohen, who had no prior health IT experience, said Leanne Harvey, EHR project director for the medical center. It also looked for practices ready to finance the project and able to reduce patient load, she said.

Deloss said doctors need to consider readiness. Many don't know that even though many hospitals call it a donation, physicians must pick up 15% as well as hardware costs, which can't be donated.

Although he realizes that "some physicians will rightly balk" at the price, Dr Parker said, implementation would cost more and be less reliable if doctors tried it on their own.

The whole idea of taking this on as a group appealed to Dr. Kelly. "It's the reassurance that I would have good technical support. I wouldn't have taken this on on my own," she said.

As more success stories are reported, Deloss said, more hospitals will become donors. That may mean more competition to attract the best doctors in areas such as Boston, which has multiple hospitals in a relatively small geographic area.

"There's no doubt these IT solutions will spawn a significant number of competitive situations," said Dr. Parker. By the end of 2011, all doctors affiliated with Beth Israel are expected to be on its EHR system.

In Denver, the race to adopt health IT has brought two competitors together to help the community, Dr. Want said. After one hospital started its donation project, its competitor was interested, too. Since most area doctors are affiliated with both hospitals, the two worked together to get all their local physicians connected to one system with both hospitals donating.

Dr. Kelly is a believer in her EMR.

During the two days her patient remained hospitalized, Dr. Kelly said she was able to coordinate care with other practitioners in real time. Not only did it improve the quality of care and eliminate duplication of tests, but it gave her more time to spend with other patients. Had the event happened before she implemented an EMR, Dr. Kelly said she would have spent valuable time on the phone and at her desk shuffling through piles of paper.

[Back to top.](#)

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## **ADDITIONAL INFORMATION:**

### **Rules of donation**

The Stark law exceptions and the anti-kickback safe harbors on technology donation to physicians include certain requirements that every agreement must include, as well as certain prohibitions.

#### REQUIRED

**Interoperability.** Not only should the system talk to the donating hospital's system, pharmacies, other physicians and labs, but it also should interface with the physician's current practice management system.

**15% contribution.** Hospitals are allowed to donate only 85% of the total cost, with the recipient picking up the rest.

**Specific cost details.** Both hospital and physician must detail what their own costs will be and the methodologies used to calculate those costs.

**CCHIT certification.** Donated systems must be certified by the Certification Commission for Healthcare Information Technology.

**E-prescribing.** The donated system must include an e-prescribing component.

#### PROHIBITED

**Hardware donation.** Only software can be donated for EMR implementations, but an e-prescribing donation by itself can include hardware.

**Practice management system donation.** The donated system can include practice management functionality, but practice management software by itself cannot be donated.

**Consideration of referrals.** The practice's volume of referrals to the donating hospital cannot be taken into consideration when determining the amount or volume of a donation.

Source: "Health information technology donations: A guide for physicians," AMA ([www.ama-assn.org/ama1/pub/upload/mm/472/hitdonate\\_physicians.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/472/hitdonate_physicians.pdf))

[Back to top.](#)

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## Ready for a donation?

The American Medical Association has published educational material to help physicians decide whether to accept a health IT donation. Among questions physicians should consider:

### Readiness

- Does the technology meet your practice needs?
- How will the new software and technology interface with key systems you use regularly (e.g., your practice management system)? If the interfacing capability is not there, what are the future consequences?

### Cost

- Are all of your costs understood and documented? What percent of the total cost are you being asked to pay? Are there additional costs beyond the required 15%?
- Will fees rise over the term of the agreement? Who will pay for system upgrades and maintenance?

### Implementation

- Who is responsible for training? How much training is included in the contract? Will you be able to consult with the trainer when problems arise?
- Will data in your current system populate the new system? Who will pay for data conversion?

## **Maintenance/termination**

- Does the contract specify who will have access to the practice's clinical data? How will the data be maintained if the relationship is terminated? What are your rights or consequences for terminating the agreement?
- Will upgrades, new features, product offerings and customer service be available to you when they arrive? How will they be communicated to you?

Source: "Health information technology donations: A guide for physicians," AMA ([www.ama-assn.org/ama1/pub/upload/mm/472/hitdonate\\_physicians.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/472/hitdonate_physicians.pdf))

[Back to top.](#)

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## **Getting subsidized EMRs from other sources**

A recent study by the Certification Commission for Healthcare IT found that 50 of the estimated 90 current health IT donation programs in the U.S. have been launched by hospitals.

The report found that at least 43,000 physicians are being offered subsidies or incentives worth at least \$700 million, some of which are being offered through government agencies, insurers, employer coalitions and public-private partnerships.

As the numbers show, physicians have options other than accepting a donation from a hospital. One option is for physicians simply to buy a license for a system already adopted by a hospital and buy the hardware and license at fair market value, said Gerald Deloss, vice chair of the American Health Lawyers Assn.'s Health Information and Technology Practice Group.

Another option is to accept a system that is used for the sole purpose of communicating with one particular entity or performing a specific task. A lab, for example, could foot the entire costs for a system on which doctors could access results. The only catch with this arrangement is that the donated system cannot be used for any other reason.

Joe Rubinsztain, MD, CEO of the technology firm gMed, said the majority of donated projects he has seen are labs donating under the Stark regulations. He said many physicians feel more comfortable accepting a donation from a lab than a hospital out of concern for how their data might be used and because they have the freedom to choose the system they want. Labs are also better equipped than hospitals to make a business case for a donation, he said.

[Back to top.](#)

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## **Weblink**

AMA on HIT donations ([www.ama-assn.org/go/hit](http://www.ama-assn.org/go/hit))

Centers for Medicare & Medicaid Services press release on regulations to facilitate adoption of health information technology, Aug. 1, 2006  
([www.hhs.gov/news/press/2006pres/20060801.html](http://www.hhs.gov/news/press/2006pres/20060801.html))

Internal Revenue Service memorandum on handling health IT donations, May 11, 2007, in pdf ([www.irs.gov/pub/irs-tege/ehrdirective.pdf](http://www.irs.gov/pub/irs-tege/ehrdirective.pdf))

[Back to top.](#)