



**American Hospital
Association**

HIT INCENTIVE PAYMENTS: DEFINITION OF A HOSPITAL-BASED PHYSICIAN

Summary of the Issue

Under the health information technology (HIT) provisions of the *American Recovery and Reinvestment Act of 2009* (ARRA), physicians and other professionals who are meaningful users of certified electronic health records (EHRs) are eligible to receive incentive payments under Medicare Part B. However, because there are separate incentives for hospitals, physicians that are deemed “hospital-based” are not eligible to receive these payments. ARRA defines a hospital-based physician as a physician who furnishes substantially all of their services in a hospital setting (whether inpatient or outpatient), and who uses the hospital facilities and equipment, including qualified EHRs. In the Centers for Medicare & Medicaid Services’ (CMS’) recently released rule on EHR incentive payments, the agency proposes to further define a hospital-based physician as a physician who provides at least 90 percent of his/her services in an inpatient hospital, outpatient hospital, or emergency department setting. CMS proposes to define these settings broadly – as those located in the main provider or that have “provider-based” status. The agency estimates that about 27 percent of physicians will be hospital-based under this definition.

AHA’s Position

We are concerned that the broad regulatory definition of hospital-based physicians that CMS has proposed may inappropriately exclude physicians practicing in outpatient centers and clinics merely because their office or clinic is located in a facility owned by the hospital. An EHR that is used in an ambulatory setting is entirely different from an EHR that is used in an inpatient setting due to the inherent differences between the types of care provided in each. In fact, many physicians who treat patients in the ambulatory setting do not provide care in the inpatient setting, and thus, do not use the inpatient EHR. Even within the ambulatory setting, the hospital may purchase a separate physician practice EHR that is distinct from the hospital ambulatory EHR for their ambulatory physician services. Further, physicians may contribute financially to this EHR, meaning that they are not furnishing substantially all of their services using the facilities and equipment, including the EHR, of the hospital.

Implementing an EHR in the ambulatory setting requires a significant cost for the hospital above and beyond the cost of the inpatient EHR. A primary reason that hospitals make a separate investment is that the inpatient EHR technology platform does not have the needed functionality required for ambulatory care sites such as modules for appointment scheduling, office and physician workflow automation, prescription tracking and renewal, patient progress notes, patient care coordination such as preventive care reminders, and other practice management tools not included in an inpatient module.

Excluding physicians practicing in hospital ambulatory care sites from eligibility would limit the benefit of the EHR adoption in communities where hospitals have an extremely difficult time recruiting physicians and where shortages of physicians are most severe. Hospitals in these communities, most often located in inner city or rural communities that serve a disproportionate

share of low-income patients, have opened various models of ambulatory care networks that may be labeled as ambulatory care sites, affiliated physician practices, or hybrid models to ensure access to community-based physician services for their patients. These practice sites utilize an ambulatory EHR that is comparable or equivalent to the EHR platform used in traditional private practice settings and *not* the inpatient module of the hospital EHR – requiring a separate purchase and investment apart from the sponsoring hospital’s inpatient module. As highlighted above, the inpatient EHR technology platform does not have the functionality required for ambulatory care sites such as modules for appointment scheduling, office and physician workflow automation, and prescription tracking and renewal, so a separate ambulatory installation is required.

Regardless of how the ambulatory care sites are licensed or established, the care and services furnished in these settings are similar to services furnished by private physician offices in other communities that are able to attract private physicians and clearly eligible under the statute to receive HIT incentive payments. Physicians practicing in hospital ambulatory care sites, particularly those located in health shortage areas, should not be disadvantaged relative to their peers practicing in more traditional private practice settings from receiving HIT incentive payments. A broad interpretation of hospital-based physicians could inappropriately and inadvertently exclude many physicians furnishing ambulatory care services from eligibility for incentive payments and therefore, prevent patients in these communities from realizing the known benefits of EHR such as care coordination.

We recommend that, for purposes of the ARRA HIT incentives, CMS define a hospital-based physician so as to exclude physicians practicing in outpatient centers and clinics. CMS could identify such physicians using a combination of their specialty, site of service, and billed procedural codes.