EHR Incentive Payments For Rural Hospitals and Eligible Providers

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Objectives

- Health Information Technology (HIT) and Electronic Health Record (EHR) Incentive Payments
  - Incentive payments for:
    - PPS hospitals & CAH
    - Eligible providers
  - Sample calculation of CAH & PPS hospital incentive
  - Data needs for the calculation
  - EHR & reform

References and Limitations

- Based on our understanding of current policy
- Subject to further clarification by CMS and others
- Consult with your reimbursement adviser, financial auditor and Medicare Administrative Contractor

EHR Incentive Payments

- American Recovery and Reinvestment Act of 2009 (ARRA)
  - Final rule issued 7/28/10 (275 pages – small print)
  - Provides incentive payments from Medicare and Medicaid to encourage hospitals and physicians to implement EHR systems and technologies
  - Payments - available for 5 years beginning 2011
  - Unlike physicians, hospitals (including CAH) may be able to receive payments tied to both Medicare and Medicaid

PPS Hospitals and CAH

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EHR Incentive Payments

- The key factor to qualifying for funding – successfully becoming a ***meaningful user*** of EHR
- Final rule defines Meaningful User criteria only for Stage 1 (2011 through 2012)
  - For the first qualification year, hospitals demonstrate the meaningful use criteria for 90 continuous days.
  - For every year after the first payment year, the EHR reporting period is for the entire year.

EHR Incentive Payments - PPS

- Incentive Payment = (Initial Amount) x (Medicare Share) x (Transition)
  - Initial Amount = $2 million/hospital plus $200 per discharge 1,150 to 23,000
  - Medicare Share equals [# of Part A days plus MA beneficiary days] ÷[Total IP days x ((Total charges minus charity care charges) ÷ by total charges)]

EHR Incentive Payments - PPS

- Incentive Payment = (Initial Amount) x (Medicare Share) x (Transition)
  - Transition factors
    - Year 1 1
    - Year 2 ¾
    - Year 3 ½
    - Year 4 ¼

Basic Hospital Data:		
Total acute discharges		1,250
Total acute patient days		4,800
Traditional Medicare acute days	2,950	
Medicare Advantage (Part C) acute days	100	
Total Medicare days		3,050
Traditional Medicaid acute days	400	
Medicaid HMO acute days	250	
Total Medicaid days		650
Total hospital charges	$ 35,000,000	
Hospital charity care charges	$ 500,000	
First date to qualify as meaningful user	10/1/2011	

Basic Program Data:	
Incentive amount - base	$ 2,000,000
Incentive amount - per discharge (1,150 thru 23,000)	$ 200

Transition factors

Fiscal Year	Fiscal Year that Eligible Hospital Receives the First Incentive Payment				
	2011	2012	2013	2014	2015
2011	1.00	-	-	-	-
2012	0.75	1.00	-	-	-
2013	0.50	0.75	1.00	-	-
2014	0.25	0.50	0.75	1.00	-
2015	-	0.25	0.50	0.75	1.00
2016	-	-	0.25	0.50	0.75

Calculated Hospital-specific Factors	
Charity percentage	1.43%
Adjusted charge percentage	98.57%
Adjusted total patient days	4,731
Discharges for additional incentive	101
Additional incentive based on discharges	$ 20,200
Medicare percentage	64.47%
Medicaid percentage	13.74%
Medicaid threshold met (yes = 1)	1
Eligible Medicaid percentage	13.74%

*Medicaid payments subject to State Plan.

Estimated Incentive Payment

Hospital Fiscal Year	Medicare	Medicaid *	Total
2012	$ 1,302,423	$ 277,575	$ 1,579,998
2013	976,817	208,182	1,184,999
2014	651,211	138,788	789,999
2015	325,606	69,394	395,000
	$ 3,256,057	$ 693,939	$ 3,949,996

EHR Medicare Payments - CAH

- CAH's - up to 4 payment years starting with cost report periods beginning in federal FY 2011.
- 2015 - the last payment year for which a CAH can receive incentive payments. Reduction in CAH reimbursement begins for Non-EHR hospitals by 2015.

EHR Medicare Payments - CAH

- Payment for reasonable capital costs incurred for EHR assets and technology
- Payment = reasonable capital costs for EHR times CAH Medicare share
  - Swing bed days are not in the calculation
  - Medicare share = sum of the Medicare fraction plus 20 percentage points
  - Not exceeding 100%

What is EHR Capital Cost

- Great question!
  - CMS definition – Federal Register 7/28/2010
  - CMS useful life definition
  - Financial statement definition
  - Practical thoughts
  - In the end - Subject to hospital decision and MAC interpretation

EHR Capital – HHS Final rule

- ***Page 44573 – Section 495.106*** *Reasonable costs incurred for the purchase of certified EHR technology for* a qualifying CAH means the reasonable acquisition costs incurred for the purchase of depreciable assets as described in part 413 subpart G of this chapter, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in § 495.4, excluding any depreciation and interest expenses associated with the acquisition.

- ***Page 44565 – Section 495.4*** *Certified electronic health record technology has the same definition as* this term is defined at 45 CFR 170.102.

Certified EHR Technology

- **Federal Register – ONC - July 28, 2010, Page 44649**
- **§ 170.102 Definitions.**
- *Certified EHR Technology means:*
  - (1) A Complete EHR that meets the requirements included in the definition of a Qualified EHR and has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary; or
  - (2) A combination of EHR Modules in which each constituent EHR Module of the combination has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary, and the resultant combination also meets the requirements included in the definition of a Qualified EHR.
  - *Complete EHR means EHR technology* that has been developed to meet, at a minimum, all applicable certification criteria adopted by the Secretary.
  - *Disclosure is defined as it is in 45 CFR* 160.103.

EHR Capital Cost - CMS

- Provider Reimbursement Manual (PRM 15-1) Section 104.17 – Useful life of Depreciable Assets:

- Purchased computer software purchased on or after August 1, 1988, is depreciated using the applicable edition of the useful life guidelines.

- The costs of initial customizing and/or modification of purchased computer software to function with the provider's computer hardware, or to put it into place for use, should be capitalized as part of the historical cost of the software. Such costs are analogous to installation costs of a moveable asset.

EHR Capital Cost – Financial Statements

- Costs of computer software developed or obtained for internal use that shall be capitalized include only the following:
  - a. External direct costs of materials and services consumed in developing or obtaining internal-use computer software. Examples of those costs include but are not limited to the following:
  - 1. Fees paid to third parties for services provided to develop the software during the application development stage.
  - 2. Costs incurred to obtain computer software from third parties.
  - 3. Travel expenses incurred by employees in their duties directly associated with developing software.
  - b. Payroll and payroll-related costs (for example, costs of employee benefits) for employees who are directly associated with and who devote time to the internal-use computer software project, to the extent of the time spent directly on the project. Examples of employee activities include but are not limited to coding and testing during the application development stage.
  - c. Interest costs incurred while developing internal-use computer software. Interest shall be capitalized in accordance with the provisions of Subtopic 835-20.

- General and administrative costs and overhead costs shall not be capitalized as costs of internal-use software.

Practical Thoughts

- Section 495.106 includes "necessary to administer certified EHR technology"
  - May expand the definition beyond the "certified" modules

Practical Thoughts

- Include:
  - – Hardware and software costs
  - – Training & implementation costs paid to outside vendor
  - – Cost of outside vendors or contractors for functions directly related to the conversion & implementation (example: scanning or digitizing prior medical records)

Practical Thoughts

- Include:
  - Costs that the CAH would normally capitalize – if no incentive payment were in play
  - Costs in accordance with the CAH capitalization policy for Medicare

Practical Thoughts

- Include – maybe:
  - Hospital staff salaries, benefits and expenses for training & implementation time while at the vendor's office or location outside the hospital – if it is documented
  - Cost of upgrades to financial accounting and related systems if necessary for the administration of the certified EHR

Practical Thoughts

- Include – maybe:
  - Cost of upgrades or new software to hospital-based clinics, and home health, nursing facility, etc. and related systems if necessary for the administration of the certified EHR by the CAH.
  - Interest during development – if any is capitalized

Practical Thoughts

- Include – maybe:
  - Cost of hospital staff during the “development” stage: i.e. travel to look at other systems, consultant costs in evaluating needs, costs of developing an RFP – if it can be documented

Practical Thoughts

- Do not Include:
  - Software maintenance service charges
  - Hardware maintenance
  - Hospital staff salaries & benefits while at the hospital
  - Normal operating costs

EHR Incentive Pmts – CAH

- Gross annual amount based on Medicare & Medicaid percentage
  - Medicare % impacted by MA days and charity care charges (greater charity care charges yield a greater Medicare percentage)
  - Excluded unit days such as Nursery, Rehab or Psych days not included
  - MA days from the cost report
  - Medicaid includes HMO days
  - Initial amounts based on most recent 12-month cost report
  - Final amounts based on actual cost report

EHR Incentive Pmts - CAH

- Medicare & Medicaid % impacted by charity care charges
  - Data to be obtained from cost report
    - CAH will complete cost report S-10 worksheets
    - CMS definition of charity using Hospital's policy
  - Total Patient revenue to be used in the charity care % is defined in new cost report transmittal
    - Gross revenue from the cost report – excluding physician revenue

EHR Incentive Pmts - CAH

- Revised cost report forms
  - CMS Transmittal #1, December 2010
  - Cost reporting periods beginning on or after May 1, 2010
  - Important worksheets: S-2, S-10, S-3,
    - C and E-1 Part II
  - Consult your cost report preparer

Cost Reporting After Incentive

- Depreciation is no longer allowable cost
- Financing cost:
  - During period of development (before active use) capitalize as cost of system
  - After meaningful use – not allowable & excluded from future cost reports

EHR Incentive Payments - CAH

- Medicaid payments
  - Calculation the same as Medicare computation except uses Medicaid patient days
  - Must meet threshold of 10%
  - Subject to State Plan

Basic Hospital Data:		
Total acute discharges		1,250
Total acute patient days		4,800
Traditional Medicare acute days	2,950	
Medicare Advantage (Part C) acute days	100	
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Total Medicaid days		650
Total hospital charges	$ 35,000,000	
Hospital charity care charges	$ 500,000	
First date to qualify as meaningful user	10/1/2011	

Basic Program Data (Medicaid only):	
Incentive amount - base	$ 2,000,000
Incentive amount - per discharge (1,150 thru 23,000)	$ 200

Hospital HIT Undepreciated and acquisition costs (Medicare calculation only):					
Hospital fiscal year	2012	2013	2014	2015	2016
Undepreciated cost at beginning of fiscal year	500,000	150,000	150,000	150,000	150,000
New HIT acquistion cost during fiscal year	-	-	-	-	-
	500,000	150,000	150,000	150,000	150,000

Calculated Hospital-specific Factors	
Charity percentage	1.43%
Adjusted charge percentage	98.57%
Adjusted total patient days	4,731
Medicare percentage	64.47%
Adjusted Medicare percentage	84.47%

Medicaid Transition Factor:	
Year 1	1.00
Year 2	0.75
Year 3	0.50
Year 4	0.25

Medicaid Factors *	
Charity percentage	1.43%
Adjusted charge percentage	98.57%
Adjusted total patient days	4,731
Discharges for additional incentive	101
Additional incentive based on discharges	$ 20,200
Medicaid percentage	13.74%
Medicaid threshold met (yes = 1)	1
Eligible Medicaid percentage	13.74%

* Medicaid payments subject to State Plan

Estimated Incentive Payment

Hospital Fiscal Year	Medicare	Medicaid *	Total
2012	$ 422,350	$ 277,575	$ 699,925
2013	126,705	$ 208,182	334,887
2014	126,705	$ 138,788	265,493
2015	126,705	$ 69,394	196,099
	$ 802,465	$ 693,939	$ 1,496,404

EHR Incentive Payments

- Challenges & open issues
  - Paid to providers of record based on provider number
  - CAHs must spend money or incur cost before they are entitled
  - Home office capital purchases for CAH must be on CAH books?

EHR Incentive Payments

- Challenges & open issues:
  - CAHs related interest is not allowable cost
  - Financing may be on different basis than incentive payments
  - Cash flow of implementation costs
  - What costs can be included

EHR Incentive Payments

- Challenges & open issues:
  - Web-based systems – no capital cost
  - Operating leases – no capital cost
  - Purchase cost of clinic, nursing facility, home health and other systems
  - Subject to final audit and settlement
  - Creation of different accounting and reimbursement depreciation schedules

What if you miss some costs?

- Potential impact:
  – Still get “regular 101% cost” – either depreciation, imputed interest or operating cost
  – Medicare share (including 20%) may be higher than “regular” reimbursement after allocation – including Medicaid in cost-based states

EHR Incentive Payments – Medicaid

- Incentive Payment = (Initial Amount) x (Medicaid Share) x (Transition)
  - Initial Amount = $2 million/hospital plus $200 per discharge 1,150 to 23,000
  - Medicaid Share equals [# of inpatient paid days plus HMO days] ÷[Total IP days x ((Total charges minus charity care charges) ÷ by total charges)]
  - Imputed average annual growth rate

EHR Incentive Payments -Medicaid

- Incentive Payment = (Initial Amount) x (Medicaid Share) x (Transition)
  - Transition factors
    - Year 1 1
    - Year 2 ¾
    - Year 3 ½
    - Year 4 ¼

Eligible Professionals

Who is an Eligible Professional?

- Doctor of:
  - Medicine or Osteopathy
  - Oral Surgery or Dental Medicine
  - Podiatric Medicine
  - Optometry
  - Chiropractor
- May be able to participate in either Medicare or Medicaid

EHR Incentive Payments - EP

- Physicians in hospital settings
  - Provider-based are eligible
    - **Ineligible** if 90% or more are inpatient or ED
    - Plus a 10% HPSA bonus (at least 50% of services)
- Rural health clinics/FQHC
    - Medicaid only – if more than 30% Medicaid and needy

EHR Incentive Payments - EP

- Physician payments made to the physician but can assign to employer
- Physicians may qualify for Medicaid payments
  - May switch between programs 1 time
  - Maximum payment = Medicaid schedule
- Medicaid – must adopt, implement, upgrade or demonstrate meaningful use in the first year

EHR Incentive Payments - EP

- Additional Medicaid EP:
  - Nurse practitioner
  - Certified Nurse mid-wife
  - Physician assistant in a PA-led RHC or FQHC

MAXIMUM EHR INCENTIVE FOR A MEDICARE EP - NOT PREDOMINANTLY IN A HPSA

Calendar year	First CY in which the EP receives an incentive payment				
	2011	2012	2013	2014	2015 and Subsequent Years
2011	$18,000				
2012	$12,000	$18,000			
2013	$8,000	$12,000	$15,000		
2014	$4,000	$8,000	$12,000	$12,000	
2015	$2,000	$4,000	$8,000	$8,000	$0
2016		$2,000	$4,000	$4,000	$0
Total	$44,000	$44,000	$39,000	$24,000	$0

MAXIMUM EHR INCENTIVE PAYMENTS FOR A MEDICARE EP - PREDOMINANTLY IN A HPSA

Calendar year	Year that an EP first receives the incentive payment for Medicare covered professional services furnished in a geographic HPSA				2015 and Subsequent Years
	2011	2012	2013	2014	
2011	$19,800				
2012	$13,200	$19,800			
2013	$8,800	$13,200	$16,500		
2014	$4,400	$8,800	$13,200	$13,200	
2015	$2,200	$4,400	$8,800	$8,800	$0
2016		$2,200	$4,400	$4,400	$0
Total	$48,400	$48,400	$42,900	$26,400	$0

MEDICAID EP POTENTIAL PAYMENTS

Calendar year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Medicaid Threshold 30%

- Count encounters for:
  - Medicaid paid regular & managed care
  - Dual eligible patients
  - See AL definitions on website
- RHC/FQHC also count “needy”
  - CHIP
  - Uncompensated care
  - Sliding fee scale

Help & More Information

- The Alabama Regional Extension Center (ALREC) - http://onehealthrecord.alabama.gov
- CMS – http://www.cms.gov/EHRIncentivePrograms

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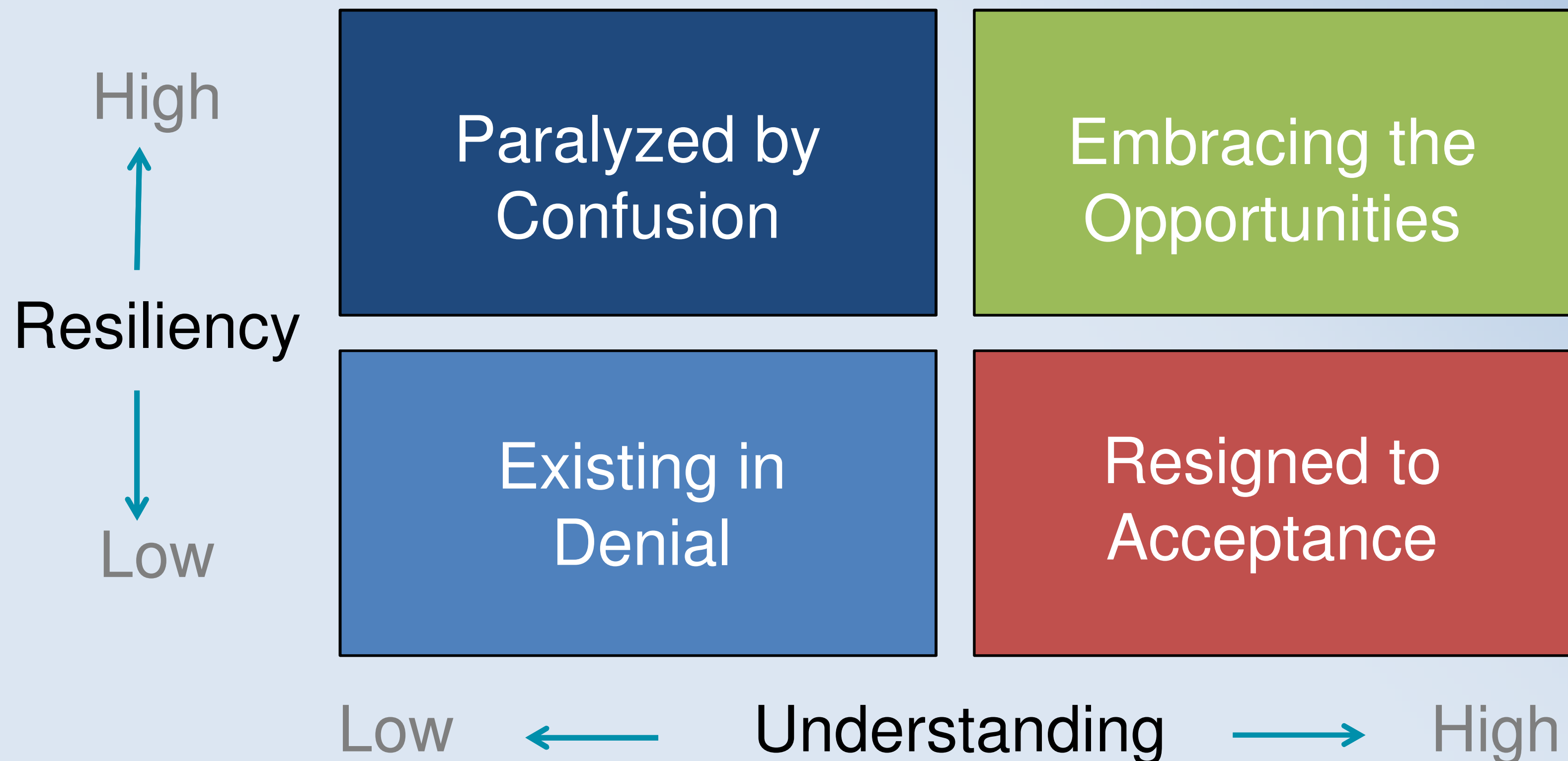
Reform Challenges

Reform Challenges our Personal Paradigms



Reform Provisions

Goal

Objectives

Prerequisites

Increase Healthcare "Value"

Improve Care

Reduce Costs

Provide Coverage for the Uninsured

Redirect and Shrink the Dollars

Shift Risk & Accountability

Adopt New Delivery Models

Electronic Health Records

Access…Alignment…Coordination…Integration

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Source: HFMA; Dixon Hughes Goodman

Reform Impact

Volume

- Insured +32M
- Inpatient +.5%
- Outpatient +4%
- Elective +1%

Providers

- Hospital Consolidations
- Entrepreneur Centers
- Physician Owned Ancillaries

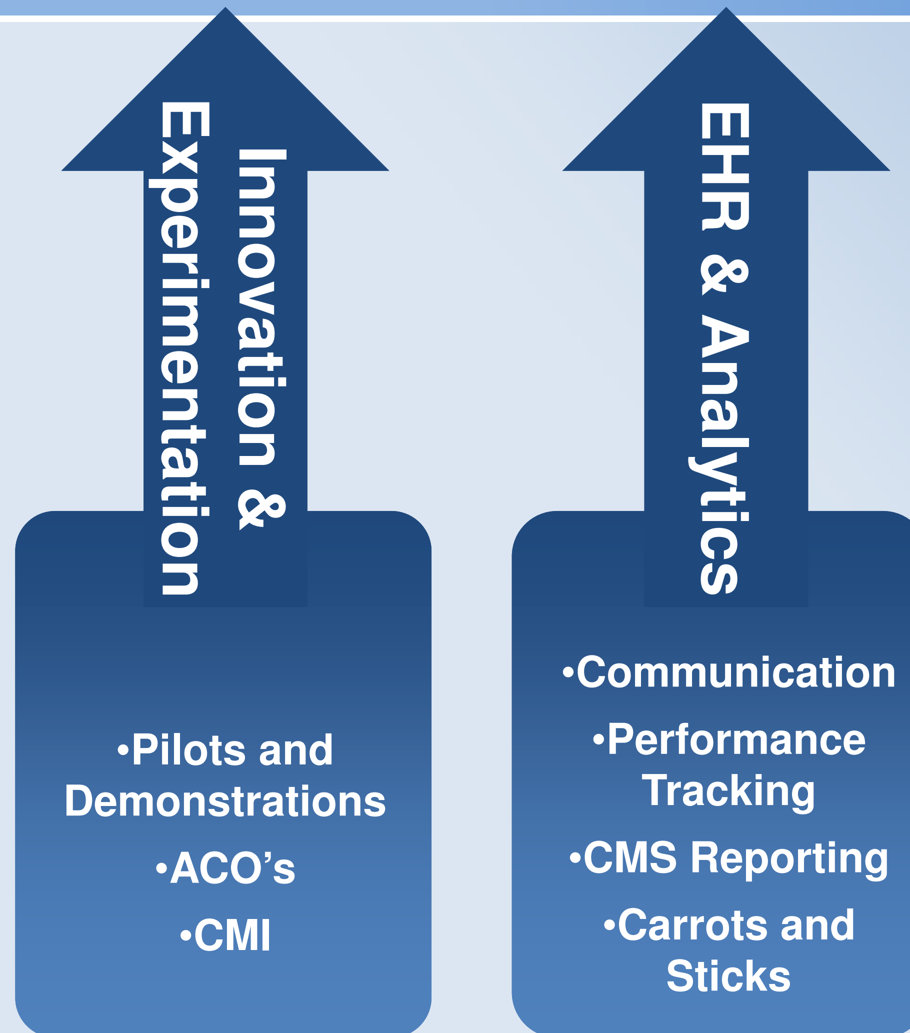
Accountability & Risk

- $90B in Penalties
- P4P/Bundling
- Shared Savings

Reimbursement

- $240 B in Savings
- Market Basket Adjustments
- DSH Revisions
- Value Based Purchasing

Reform Impact



Source: Sg2 Dixon Hughes Goodman

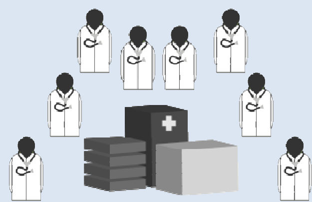
Reform Implications

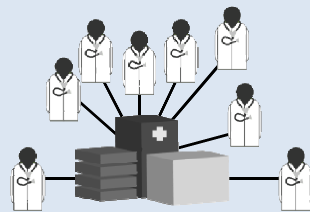
Risk

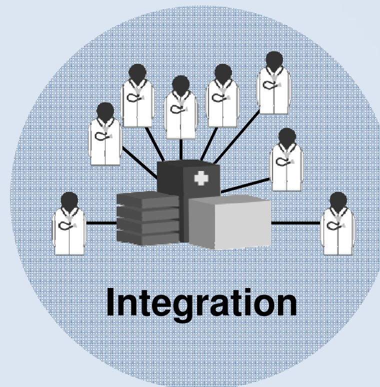
Payers   Providers

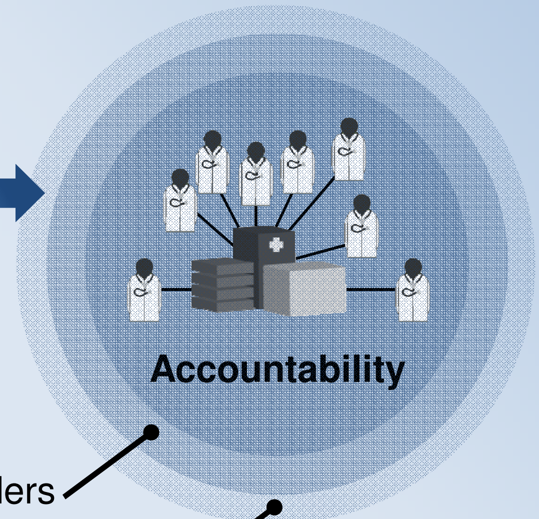
Risk

Alignment









Independent | Alignment | Integration | Accountability

All Providers

Payers

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Reform Road Map

The Prelude (2010-2013)	Market Expansion (2014-2017)	Regulation and Restructuring (2018-2020+)
Chase the Incentives, Get Ready	**Manage the**	**Consolidate Your Position**
• Focus on performance and care transitions • Strengthen MD relationships • Pilot unique value creation concepts	• Manage to Medicare margins • Manage new incentives and risk • Implement new clinical business models	• Accelerate patient information and financial transactions • Streamline and simplify SoC portfolio • Prepare for Medicare 3.0

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Source: Sg2

Shifting Risk

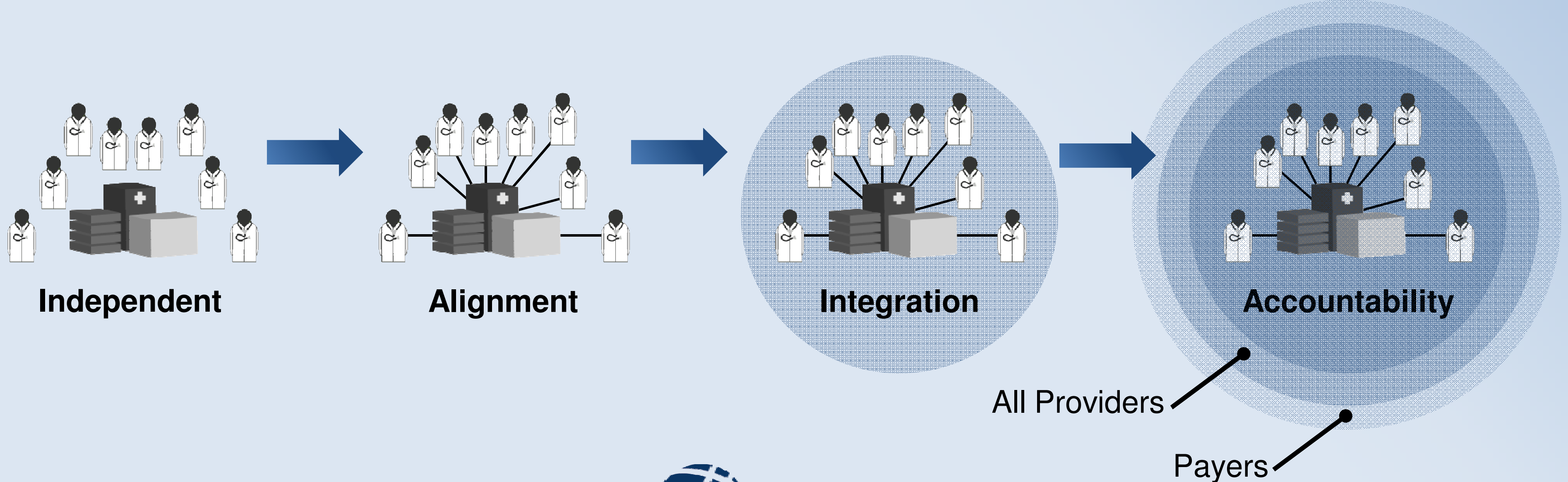
- Consumers
- Employers
- Health Plans
- Government Payers

Risk Shift

- Physicians
- Medical Groups
- Hospitals
- Other Providers

Source: Pricewaterhouse Coopers | Dixon Hughes

Accelerating Alignment



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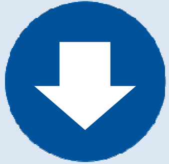
Source: PricewaterhouseCoopers

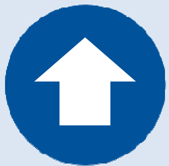
Physician Alignment Drivers and Models

Hospital Drivers for Alignment



Lower Costs

"The biggest potential income streams for both hospitals and physicians may reside in sharing savings from providers. To do that, hospitals and physicians must manage care together." – PwC

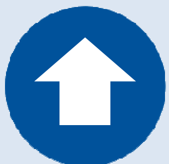


Better Quality

"Better quality will finally pay off for hospitals but they need physicians to deliver it." – PwC

New Payment Systems

"Hospitals need to partner with physicians as a means of participating in ACO's and other new payment arrangements." – PwC



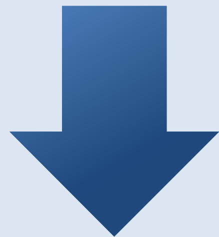
Expand Base, Increase Volume, Grow Market Share

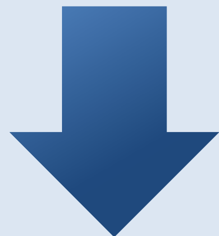
"High end expensive procedures are at risk unless we can expand the referral base." – Michael Sachs, Sg2

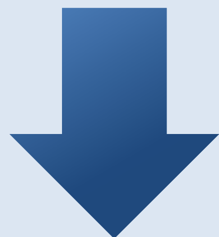
Source: PricewaterhouseCoopers | Sg2

Physician Drivers for Alignment

Professional Fees

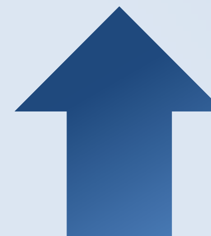

Ancillary Revenue

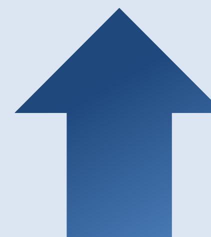

Payor Leverage


Profitability & Personal Income

Operating Expense

Administrative Burden


Assessment / Audit Risk


Alignment with Hospitals

Physician Alignment Models

High

Resources

Low

HIZ

ACO

Clinical Integration

PCMH

Foundation

Physician Enterprise

IT Deployment

Institute

Individual Employment Contracts

PSA

Co-Management

PHO

Joint Venture

IPA

MSO

Directorship / Pay for Call

Recruitment Support /
Income Guarantee

Volunteer Medical Staff

Tactical

Strategic

Transformational

Degree of Alignment

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Source: Sg2

HIT/EHR & Reform

- Joined at the hip
- **EHR is the base of real reform**

Questions?

Contact the Speaker

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