EHR Incentive Payments
For Critical Access Hospitals

RHPI
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Objectives

- Health Information Technology (HIT) and Electronic Health Record (EHR) Incentive Payments for CAH
  - Brief summary of final rule
  - What is the base amount for CAH – capital cost
  - What about financing cost?
  - Sample calculation of CAH incentive
  - Data needs for the calculation
  - Treatment of capital costs in the cost report
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
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 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.
• 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
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

- § 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.
• 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:

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total acute discharges</td>
<td>1,250</td>
</tr>
<tr>
<td>Total acute patient days</td>
<td>4,800</td>
</tr>
<tr>
<td>Traditional Medicare acute days</td>
<td>2,950</td>
</tr>
<tr>
<td>Medicare Advantage (Part C) acute days</td>
<td>100</td>
</tr>
<tr>
<td>Total Medicare days</td>
<td>3,050</td>
</tr>
<tr>
<td>Traditional Medicaid acute days</td>
<td>400</td>
</tr>
<tr>
<td>Medicaid HMO acute days</td>
<td>250</td>
</tr>
<tr>
<td>Total Medicaid days</td>
<td>650</td>
</tr>
<tr>
<td>Total hospital charges</td>
<td>$35,000,000</td>
</tr>
<tr>
<td>Hospital charity care charges</td>
<td>$500,000</td>
</tr>
<tr>
<td>First date to qualify as meaningful user</td>
<td>10/1/2011</td>
</tr>
</tbody>
</table>

### Basic Program Data (Medicaid only):

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive amount - base</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Incentive amount - per discharge (1,150 thru 23,000)</td>
<td>$200</td>
</tr>
</tbody>
</table>

### Hospital HIT Undepreciated and acquisition costs (Medicare calculation only):

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Undepreciated cost at beginning of fiscal year</th>
<th>New HIT acquisition cost during fiscal year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>500,000</td>
<td>-</td>
</tr>
<tr>
<td>2013</td>
<td>150,000</td>
<td>150,000</td>
</tr>
<tr>
<td>2014</td>
<td>150,000</td>
<td>150,000</td>
</tr>
<tr>
<td>2015</td>
<td>150,000</td>
<td>150,000</td>
</tr>
<tr>
<td>2016</td>
<td>150,000</td>
<td>150,000</td>
</tr>
</tbody>
</table>

### Calculated Hospital-specific Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity percentage</td>
<td>1.43%</td>
</tr>
<tr>
<td>Adjusted charge percentage</td>
<td>98.57%</td>
</tr>
<tr>
<td>Adjusted total patient days</td>
<td>4,731</td>
</tr>
<tr>
<td>Medicare percentage</td>
<td>64.47%</td>
</tr>
<tr>
<td>Adjusted Medicare percentage</td>
<td>84.47%</td>
</tr>
</tbody>
</table>

### Medicaid Factors *

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Charity percentage</td>
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<td>98.57%</td>
</tr>
<tr>
<td>Adjusted total patient days</td>
<td>4,731</td>
</tr>
<tr>
<td>Discharges for additional incentive</td>
<td>101</td>
</tr>
<tr>
<td>Additional incentive based on discharges</td>
<td>$20,200</td>
</tr>
<tr>
<td>Medicaid percentage</td>
<td>13.74%</td>
</tr>
<tr>
<td>Medicaid threshold met (yes = 1)</td>
<td>1</td>
</tr>
<tr>
<td>Eligible Medicaid percentage</td>
<td>13.74%</td>
</tr>
</tbody>
</table>

### Estimated Incentive Payment

<table>
<thead>
<tr>
<th>Hospital Fiscal Year</th>
<th>Medicare</th>
<th>Medicaid *</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$422,350</td>
<td>$277,575</td>
<td>$699,925</td>
</tr>
<tr>
<td>2013</td>
<td>$126,705</td>
<td>$208,182</td>
<td>334,887</td>
</tr>
<tr>
<td>2014</td>
<td>$126,705</td>
<td>$138,788</td>
<td>265,493</td>
</tr>
<tr>
<td>2015</td>
<td>$126,705</td>
<td>$69,394</td>
<td>196,099</td>
</tr>
<tr>
<td></td>
<td>$802,465</td>
<td>$693,939</td>
<td>$1,496,404</td>
</tr>
</tbody>
</table>
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 - EP

• Physicians in hospital settings
  – Provider-based are eligible
    • Ineligible if 90% or more are inpatient or ED
    • Plus a 10% HPSA bonus
  – Rural health clinics
    • Medicaid only – if more than 30% Medicaid and needy
  – Physician payments made to the physician but can assign to employer
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 \[\# \text{ of inpatient paid days plus HMO days} \div [\text{Total IP days} \times ((\text{Total charges minus charity care charges}) \div \text{by total charges})]\]
  – Imputed average annual growth rate
EHR Incentive Payments - PPS

- Incentive Payment = (Initial Amount) x (Medicare Share) x (Transition)
  - Transition factors
    - Year 1 1
    - Year 2 \( \frac{3}{4} \)
    - Year 3 \( \frac{1}{2} \)
    - Year 4 \( \frac{1}{4} \)
Questions?
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