

EHR Bonus Implementation

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In February 2009, Congress passed the American Recovery and Reinvestment Act (ARRA). This act provided framework for federal incentive payments for meaningful use of certified electronic health records (EHR).

The Center for Medicare and Medicaid Services (CMS) issued its final rule delineating the implementation of the EHR incentive program.

Also available is the certification criteria for EHR technology. These rules were determined by the Office of the National Coordinator for Health Information Technology (ONC). CMS intends this technology to allow hospitals to meet the definition of meaningful use.

ARRA allows for incentive payments for the *meaningful use of certified electronic health records*. There are two main qualifiers: the process of purchasing a system that is certified for the purpose of meaningful use and the act of becoming a meaningful user. We will discuss the act of becoming a meaningful user and reporting/applying for stimulus funds.

Medicare:

Meaningful Use

Meaningful use is based on Congress' health outcomes policy priorities. Based on these priorities, there are objectives and measures. The health outcome policy priorities, objectives, and measures are described in the final rule and summarized in a matrix format. Currently, CMS anticipates three measurement stages. In the final rule, only the first meaningful use objectives and measurements (Stage 1) are proposed. Stages 2 and 3 will be developed in future rules. The objectives and measurements for Stage 2 are anticipated by end of 2011; Stage 3 by end of 2013. The first years of meaningful use implementation entail less intense measurements than ensuing years. Therefore, the current measurements and goals will become more difficult to meet.

In the final rule, there is a core set of objectives and measures and a menu set of objectives and measures. To qualify as a meaningful user, hospitals or physicians must meet the core objectives and measures and choose five from the menu of objectives and measures. Further, each must also report clinical quality measures.

The meaningful use matrix changed from the proposed rule. Therefore, reviewing the new matrix is essential. Eligible **hospitals** must report on all 14 core measures and 5 from the menu set, for a total of 19 measures out of 24. Eligible **professionals (EPs)** report on 20 out of 25 measures.

Eligible hospitals and EPs are defined below.

It is anticipated that each menu item in Stage 1 will move to the core set in Stage 2. Remember, you get to choose from the menu set and, therefore, do not report on all. In the next stage of reporting, all menu items will be required.

EHR Bonus Implementation (Continued)

Medicare (continued):

Meaningful Use (continued)

The matrix's first column is "health outcome priorities" which are five priorities stated in ARRA:

1. Improving quality, safety, efficiency, and reducing health disparities
2. Engage patients and families in their health care
3. Improve care coordination
4. Improve population and public health
5. Ensure adequate privacy and security protections for personal health information

The matrix's next two columns are "objectives". Objectives are listed separately for hospitals and eligible professionals. For hospitals, the core objectives include items such as using computerized physician order entry (CPOE); implementing drug-drug and drug-allergy interaction checks; recording smoking status of patients 13-years-old or older, etc. The menu list includes items such as implementing drug-formulary checks, incorporating clinic lab test results into certified EHR technology as structured data, capability to submit electronic data to immunization registries, etc. One item picked from the menu set must be from the "improve population and public health" priority section.

The matrix's last column is "Stage 1 measurements". An example measure: more than 50% of all unique patients 13-years-old or older seen have smoking status recorded (this was 80%). Each objective has a specific measure listed.

There are also clinical quality measures that eligible hospitals and EPs must report. For hospitals, there are 15 quality measures to report. For 2011 and 2012, these are simply reporting requirements; there are no performance requirements in these years.

For EPs, there are three core quality measures to report. If the denominator is zero for any of these core quality measures, there are three alternate core quality measures from which to choose. For example, one core quality measure requirement is "adult weight screening and follow-up". A pediatric physician does not have any adult patients; therefore, this denominator is zero. They would move to the alternate core and pick "weight assessment and counseling for children and adolescents". Eligible professionals must also pick three from the menu set of clinical quality measures. An EP will report 6 clinical quality measures; an eligible hospital or critical access hospital (CAH) will report 15.

The meaningful use matrix and clinical quality measures are attached to this e-mail and can also be found by clicking on the "News" icon on our website: <http://www.dzacpa.com/>.

EHR Bonus Implementation (Continued)

Medicare (continued):

Meaningful Use (continued)

The year the hospital first qualifies for EHR incentive payments also determines the applicable stages of measurement. Hospitals whose first year of meaningful use falls between 2011–2014 will start by using Stage 1 measurements. Hospitals whose first year of meaningful use is 2015, may have to meet Stage 3 measurements. The proposed rule indicated 2015 would be reporting Stage 3; however, the final rule defers this decision to future rule making.

Payment years and correlating stages follow:

Stages of Meaningful Use

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD

Payment Years and Reporting Period:

Payment Year

The payment year for a **hospital is the federal fiscal year** (October 1 – September 30). The payment year for an **EP is the calendar year**. The incentive program starts in 2011 — for a hospital this is October 1, 2010 through September 30, 2011; for an EP this is January 1, 2011 through December 31, 2011. A hospital may only receive Medicare incentive payments for four years. Payment years are consecutive. If a hospital qualifies in 2011, but does not qualify in 2012; however, again qualifies in 2013, then the 2013 payment year is the third payment year.

Reporting Period

The reporting period for the *first year* of meaningful use is any 90-day continuous period that a hospital or EP meets the meaningful use reporting requirements during the payment year. For the second and all future years, the reporting period is the payment year. Therefore, for an eligible hospital the second and future reporting periods are October 1 through September 30; the 90-day continuous period must also happen within a federal fiscal year (as opposed to the hospital’s fiscal year).

Reporting Method

For 2011, the eligible hospital or professional must attest to being a meaningful user. CMS anticipates eligible hospitals or professionals can report meaningful use measure requirements directly on CMS’ website. A sample attestation is attached. In 2012 and future years, CMS may create a portal for eligible hospitals or professionals to log in and electronically submit their information in a structured format.

EHR Bonus Implementation (Continued)

Medicare (continued):

Calculation of the Incentive Payment:

Some definitions apply to both CAHs and PPS hospitals.

Days

Medicare days include paid traditional Medicare and Medicare Advantage days for acute care, ICU, NICU, and CCU. To include the Medicare Advantage days, a “no pay” bill must be submitted to the Intermediary. Only days reflected on the final processed claims summary report (PS&R) will be used in the calculation.

Timing

The prior year’s as-filed Medicare cost report is used to calculate an interim payment. The cost report beginning in the payment year is used to finalize the payment amount (must be a full year’s cost report). Law requires a prompt interim payment based on the payment year; therefore, reconciliation is necessary. For example, a June 30 fiscal year end hospital qualifying for meaningful use in 2011 would use its 2010 as filed cost report for interim payment and its 2011 finalized cost report for final payment (its 2011 cost report began July 1, 2011, which is in the federal fiscal year October 1, 2010 through September 30, 2011). Remember payments are only paid after eligible hospitals or professionals meet meaningful use reporting requirements; therefore, payments happen after the reporting period. For hospitals, this is after September 30 (after it submits its information) or after December 31 for EPs once their information is submitted.

Charity Care

The final rule requires preparation of cost report worksheet S-10. This workpaper, although currently not required for CAHs, will be required in the future. The new cost report forms will be used for cost report periods beginning on or after May 1, 2010 and will require this form. The amount of charity care charges used in the incentive calculation originates from this worksheet. For EHR purposes, charity care includes items written off under the hospital’s normal charity care policy (self-pay amount is the charge, self-pay portion of insurance is the deductibles and co-insurance). It does not include professional fees or courtesy discounts.

CAH – Medicare

CAHs are paid for most services on a cost basis. The CAH bonus amounts are Medicare’s share of cost plus 20%. This amount is capped at 100% of the EHR equipment cost. The cost-based calculation for EHR is based on inpatient days and is typically 25-35% greater than if costs were reimbursed through capital accounts on the Medicare cost report. Furthermore, an allowance for charity care exists that adds to the total amount the CAH is reimbursed. The formula follows:

$$((\text{Medicare days} + \text{Medicare Advantage days}) / (\text{total days} * (\text{total charges} - \text{charity care charges}) / \text{total charges})) + 20\% * (\text{un-depreciated cost of EHR})$$

It is Medicare utilization compared to total charges plus 20% of the undepreciated cost of EHRs. The rule stipulates that this payment is in lieu of claiming depreciation *and interest* on the hospital’s Medicare cost report. Depreciable costs are costs normally capitalized as part of a project and match generally accepted accounting principles’ definition; it does *not* include training costs. These costs are reimbursed through the normal cost report process.

EHR Bonus Implementation (Continued)

Medicare (continued):

Calculation of the Incentive Payment (continued):

CAH – Medicare (continued)

CAH payments are based on the undepreciated and unclaimed cost of EHR during a four-year-period. The first payment year, a CAH can claim EHR purchased during the year and also undepreciated EHR from previous years. The second through the fourth years are based on the purchase of EHR during those years. Therefore, timing is essential. To maximize reimbursement, CAHs should time its purchase of EHR to ensure all costs are born in payment years. Remember, the first payment year only requires a continuous 90-day period of meaningful use.

Example:

A CAH purchased \$500,000 of certified EHR hardware and software on March 10, 2011. The EHRs are put into service May 1, 2011. For the period July 1, 2011 – September 30, 2011, they can attest to meeting the meaningful use definition. On the 2010 Medicare cost report, they reported 300 Medicare days and 400 total days. The CAH had \$200,000 of charity care charges and \$10,000,000 of total charges.

The base amount for the bonus is \$500,000 (the undepreciated cost). The weighted total days is 392 ($400 - (400 * (200,000/10,000,000))$). The CAH's Medicare percentage is 76.5% ($300/392$). The bonus percentage is 96.5% ($76.5\% + 20\%$). The payment for EHR is \$482,500.

The CAH must attest to meeting Stage 1 meaningful use criteria and should run each measurement and record the results (numerator and denominator) periodically to ensure they can report a 90-day consecutive period. If the CAH meets Stage 1 measurement criteria, it should attest the results (including the numerator and denominator) on CMS' website. The payment will come from a separate contractor.

This payment is reconciled based on the 2011 finalized Medicare cost report. If the 2011 cost report reflects 350 Medicare days, 450 total days, and 2% charity care, the final payment is \$497,000.

The second payment year follows these same calculations if additional EHR equipment is purchased.

EHR Bonus Implementation (Continued)

Medicare (continued):

Calculation of the Incentive Payment (continued):

Prospective Payment System (PPS) – Medicare

PPS hospitals are paid for inpatient services based on diagnostic-related groups (DRGs). The bonus amounts for these facilities are Medicare’s share of an initial amount and a transition factor. PPS hospitals that meaningfully use EHR can be paid an incentive for up to four years. There is an allowance for charity care in the formula that adds to the total amount the PPS hospital is reimbursed (calculated the same as CAHs). The transition factor is 1, ¾, ½, ¼, for the first, second, third, and fourth payment year, respectively. The PPS formula follows:

$$(\text{Initial amount}) * ((\text{Medicare days} + \text{Medicare Advantage days}) / (\text{total days} * (\text{total charges} - \text{charity care charges}) / \text{total charges})) * (\text{transition factor})$$

$$\text{The initial amount} = \$2,000,000 + (200 \text{ per each discharge between } 1,150 \text{ and } 23,000)$$

Four years of incentives are possible for hospitals. However, to receive four years of payments, the first payment year must be in 2011 – 2013. A PPS hospital who first receives incentive payments in 2014 may have three years of incentive payments, but the transition factor for the first year is ¾ instead of 1. A table of incentive payment transition factors by first payment year follows:

PPS Transition Factor by Year

Payment Year	First Payment Year				
	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	0.75	-
2015	-	0.25	0.50	0.50	0.50
2016	-	-	0.25	0.25	0.25

EHR Bonus Implementation (Continued)

Medicare (continued):

Calculation of the Incentive Payment (continued):

Prospective Payment System (PPS) – Medicare (continued)

Example:

A PPS hospital becomes a meaningful user of certified EHR in May 2012. They prove 90-days of meaningful use from July 1, 2012 – September 30, 2012, and have 25,000 Medicare days, 100,000 total days, and 30,000 discharges. Total charges for the year were \$900,000,000 of which \$27,000,000 were written off as charity care.

The initial amount is \$6,370,000 ($\$2,000,000 + \$4,370,000$) – ($\$4,370,000 = \200 per discharges between 23,000 and 1,150 or $\$200$ times 21,850).

Medicare's share is 25.77% ($25,000/97,000$). Charity care is 3% of total charges making the base 97% of 100,000 days.

The transition factor for 2012 is 1.00 (look at the 2012 column on the table on the previous page and read down); therefore, the incentive payment for this hospital's first year is \$1,641,549 ($\$6,370,000 * .2577 * 1$).

However, if this was the hospital's second payment year, the incentive would be \$1,231,162 ($\$6,370,000 * .2577 * .75$).

The hospital must attest to meeting Stage 1 meaningful use criteria and should run each measurement and record the results (numerator and denominator) periodically to ensure they can report a 90-day consecutive period. If the hospital meets the Stage 1 measurement criteria, it should attest the results (including the numerator and denominator) on CMS' website. Payment will come from a separate contractor.

The payment will be reconciled based on the 2012 finalized Medicare cost report. If the 2012 cost report reflected 30,000 Medicare days, 100,000 total days, 3% charity care and 30,000 discharges, the final first year payment is \$1,970,241.

EHR Bonus Implementation (Continued)

Medicare (continued):

Calculation of the Incentive Payment (continued):

EPs – Medicare:

The bonus amount for EPs is based on Medicare fee schedule. EPs who qualify as meaningful users of EHR receive 75% of the Medicare fee schedule up to the following maximums:

Non-HPSA Payments for EPs

Calendar Year	First Calendar Year EP Receives 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	-
2016	-	2,000	4,000	4,000	-
Total	\$ 44,000	\$ 44,000	\$ 39,000	\$ 24,000	\$ -

Additionally, there are 10% bonus payments for EPs in a **geographic** health professional shortage area (HPSA) (primary care, dental, or mental health). An EP practicing in a HPSA during 2011 would receive up to \$19,800 the first year. To qualify for the HPSA bonus, an EP must provide more than 50% of encounters in the HPSA.

Example:

An EP billed \$40,000 in Medicare charges and received \$15,000 in Medicare reimbursement. For 2011, the bonus payment is \$11,250 (75% of \$15,000). To receive the maximum \$18,000, the EP must receive at least \$24,000 in Medicare fee-schedule reimbursement. If the base CPT code for this physician is 99213 and 99214, they potentially must see approximately 300 – 350 Medicare patients to receive the full payment.

The physician must attest to meeting Stage 1 meaningful use criteria and should run each measurement and record the results (numerator and denominator) periodically to ensure they can report a 90-day consecutive period. If the physician meets Stage 1 measurement criteria, they should attest the results (including the numerator and denominator) on CMS’ website. Payment will come from a separate contractor.

The physician should also check its Medicaid utilization, as discussed below, to determine if they may qualify for the larger Medicaid reimbursement.

EHR Bonus Implementation (Continued)

Medicare (continued):

Penalties:

The EHR incentive program starts by paying additional funds to facilities to implement and use EHR in the beginning stages. In 2015, hospitals not utilizing EHR will incur penalties.

CAH

A CAH is paid 101% of cost for most inpatient and outpatient services. CAHs not meeting EHR definitions by 2015 will instead be paid the following percentages of cost:

2015	100.66%
2016	100.33%
2017	100.00% (2017 and each year thereafter)

CMS may grant CAHs an exemption from penalties if the CAH proves utilizing EHR would “result in significant hardship”. CMS gives an example of a small CAH located in a rural area without sufficient internet access.

An exemption may only be granted for five years and few hospitals will qualify. As Medicare payments decrease to 100% of cost, hospitals will face challenges purchasing and implementing this technology. We recommend all CAHs use the additional funding to purchase and implement EHR.

PPS

PPS hospitals are paid a prospective DRG amount. PPS hospitals not qualified as a meaningful user by 2015 will have the following reduction to their base IPPS market basket updates:

2015	33 1/3
2016	66 2/3
2017	100% (2017 and each year thereafter)

PPS hospitals not reporting quality data will see an additional 1/4 reduction to the IPPS market basket updates. Hospitals may be subject to meaningful user reduction, quality reporting reduction, both reductions, or none.

EPs

EPs are paid on Medicare fee schedule. EPs not qualifying as a meaningful user by 2015 will have the following reductions to their Medicare fee schedule:

2015	99%
2016	98%
2017	97% (2017 and each year thereafter)

EHR Bonus Implementation (Continued)

Medicaid:

A state's participation in Medicaid's incentive program is voluntary. There are 100% federally matched funds for states that participate.

Acute care hospitals and CAHs may participate in both Medicare and Medicaid programs. EPs must choose one program and may switch programs only once.

Hospitals (except children's hospitals) must have at least 10% Medicaid utilization. EPs must have 30% Medicaid utilization; pediatricians need a 20% Medicaid utilization.

Hospital and EPs are not required to prove meaningful use for the first year of *Medicaid* incentive payments. The first year of the Medicaid incentive program is to adopt, implement, and upgrade EHR.

Meaningful Use

Medicare's definition of meaningful use will likely match the state's definitions. If a dual eligible entity meets Medicare's definition of meaningful use then CMS can deem that entity meets the state's definition as well. Since EPs must choose either the Medicare or Medicaid program, they must meet the respective definition. The state only has the ability to move between 1 and 4 of the menu set of meaningful use objectives and measures to the core set. The state cannot add additional measurements, but may move criteria from the menu to core objectives and measures. To accomplish this, the state must request the alternate with CMS and base it on that state's health initiatives. The state must have the infrastructure to accommodate their request.

Hospitals/CAHs

To qualify, the hospital or CAH must have at least 10% Medicaid utilization. A CAH is paid the same as a PPS hospital for Medicaid incentives.

EPs

To qualify for Medicaid incentive payments, an EP is defined as physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in an FQHC or RHC that is led by a physician assistant. These professionals cannot be provider-based – spending 90% or more of their time providing care to inpatients or patients in the emergency room. The provider-based definition is different in this scenario than in other hospital regulations.

To meet the 30% Medicaid criteria, the EP must prove that 30% of their encounters over a continuous, representative, 90-day period were provided to Medicaid beneficiaries. The definition of an encounter for an EP is “services on any one day that Medicaid paid for all or part of their service”.

Incentive payments are for individual professionals and are based on their individual tax identification number or social security number. If the professional works in more than one clinic, at least 50% of their encounters must be on EHR. For example, physician “A” works at three clinics. The first two clinics utilize EHR, the third does not. For the physician to qualify, the first two clinics must encompass 50% or more of the visits.

Payment is based on 85% of the average allowable costs for EPs that meet meaningful use and the Medicaid threshold.

EHR Bonus Implementation (Continued)

Medicaid (continued):

EPs (continued)

Payments maximums follow:

Incentive Payments Under Medicaid

Calendar Year	First Calendar Year EP Receives Incentive Payment					
	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

Penalties

There are no Medicaid penalties for non-implementation of EHR.

Miscellaneous:

The proposed rule states that CMS will conduct selected compliance reviews. Intermediaries are responsible for reviewing and settling interim payments. The proposed rule also stipulates that eligible hospitals and professionals must maintain evidence of qualification to receive the incentive payments for six years after the date they register for the incentive program (was 10 years). Therefore, if a hospital registers for the program July 2012, all records must be maintained until July 2018.

Closing:

This summary is meant to assist hospitals and physicians with implementing EHR and to inform entities on incentive monies available. If you have any questions or require additional information, please call me at 509.242.0874.