

CMS Proposed EHR Bonus Implementation

*By Shar Sheaffer, CPA, Owner
Dingus, Zarecor & Associates PLLC*

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

On December 30, 2009, the Center for Medicare and Medicaid Services (CMS) issued its proposed rule delineating the implementation of the EHR incentive program. The following summarizes the proposed rule which also comes with a 60-day comment period. Comments are due to CMS by March 15, 2010. CMS anticipates a final rule after March 2010.

Also available is the proposed certification criteria for EHR technology. These rules will be 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.

Meaningful Use

Meaningful use is based on Congress' health outcomes policy priorities. Based on Congress' priorities, there are care goals and objectives. The outcomes, care goals, and objectives are described in the final rule, and summarized in a matrix format. Currently, CMS anticipates three measurement stages. In this proposed rule, only the first meaningful use measurement stage (Stage 1) is proposed. Stage 2 and Stage 3 will be developed in future rules. The first years of meaningful use implementation entail less intense measurements than the later years. The matrix is attached to this e-mail.

The priorities, goals, and objectives should be consistent while the measurements change in stages.

The matrix's first column is the "health outcome priority" which are the five priorities that Congress stated in the recovery act:

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 column is "care goals". The goals assist in meeting Congress' priorities.

The matrix's next two columns are "objectives". Objectives are listed separately for hospitals and eligible professionals (EPs). For hospitals, this includes items such as using computerized physician order entry (CPOE); maintaining active medication list; recording smoking status of patients 13-years-old or older, etc. In total, approximately 20 objectives exist.

The matrix's last column is "Stage 1 measurements". This includes using CPOE for 10% of all orders, at least 80% of all unique patients admitted to the eligible hospital have at least one entry recorded as structured data, at least 80% of all unique patients 13-years-old or older admitted to the eligible hospital have smoking status recorded, etc. Each objective has a specific measure listed.

Payment Years vs. Reporting Period

The *first payment year* is defined as “the first calendar or Federal fiscal year for which an EP or eligible hospital receives an incentive payment”. The *EHR reporting period* is any continuous 90-day period within the **first** payment year and the entire payment year for all subsequent payment years. Basically, the payment year will match the reporting period except for the first payment year. CMS’ intent is to provide flexibility for eligible hospitals to begin using EHR and still qualify for the incentive in the same year. After the first year, the flexibility is not needed as the eligible hospital should continue using the records.

So when can a hospital first qualify for payments? A hospital who is a meaningful user of electronic health records from October 1, 2011 through December 31, 2011 will qualify. They may start using the records earlier, and the rule specifies that it is any continuous 90-days within the payment year. Therefore, dates from March 13, 2011 to June 11, 2011 work, but November 1, 2011 to January 31, 2012 does not work because the 90-days must all be in the payment year.

The year that the hospital first qualifies for EHR incentive payments also determines the different stages of measurement that are applicable. Hospitals whose first year of meaningful use falls between 2011–2014, start using Stage 1 measurements. Hospitals whose first year of meaningful use is 2015 must use Stage 3 measurements. Payment years and correlating stages follow:

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3

How to Report

For each reporting period, a hospital must prove to Medicare that it is a meaningful user of certified health records. As mentioned above, the first payment year is a 90-day period and the reporting period for the remaining payment years is an entire year. In 2011, eligible hospitals will attest they meet the meaningful use measurements. All future years require data submission. CMS anticipates having the capability to accept information electronically in 2012 but will continue to use the attestation method if electronic implementation is not complete. Both meaningful use and clinical quality measures are submitted to CMS.

CMS will periodically audit information submitted and a 10-year record retention requirement exists. These requirements are also in the “miscellaneous” section in this article.

Calculation of the Incentive Payment

Some definitions apply to both critical access hospitals (CAH) and PPS hospitals. We will discuss the common definitions and then delve into specifics.

Days: Medicare days include straight Medicare and Medicare advantage days for acute care, ICU, NICU, CCU, and subproviders. On the Medicare cost report, these departments are reflected on worksheet S-3, Part I, lines 1, 6-9, 10 and 14.

Timing: The prior year's Medicare cost report is used to calculate an interim payment. The cost report falling in the payment year is used to finalize the payment amount. Law requires a prompt interim payment based on the payment year; therefore, reconciliation is necessary.

Charity care: The proposed rule requires preparation of cost report worksheet S-10. This workpaper is now required for CAHs to receive their bonus payments. The amount of charity care charges used in the calculation originates from this cost report 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: Critical access hospitals are paid for most services on a cost-basis. The amount of bonus for these facilities is Medicare's share of cost plus 20%. The cost-based calculation for EHR is based on inpatient days and is typically 20-30% 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:

$$\left(\frac{\text{Medicare days} + \text{Medicare advantage days}}{\text{total days}} \left(\frac{\text{total charges} - \text{charity care charges}}{\text{total charges}} \right) + 20\% \right) * (\text{un-depreciated cost of EHR})$$

It is Medicare utilization compared to total charges plus 20% of the un-depreciated cost of EHRs.

CAH payments are based on the undepreciated cost of EHR. Therefore, timing for these facilities is key. To maximize reimbursement, CAHs should time its purchase of EHR to ensure all costs are born in a payment year. Remember, the first payment year only requires a continuous 90-day period of meaningful use.

An 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 2009 Medicare cost report, they reported 200 Medicare days and 400 total days. The hospital 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 51% (200/392). The bonus percentage is 71% (51% + 20%). The payment for EHR is, therefore, \$355,000.

The CAH must attest to meeting Stage 1 meaningful use criteria. The CAH should run each measurement, and record the results. If the CAH meets the Stage 1 measurement criteria, it should attest the results to its Intermediary and request payment.

The payment will be reconciled based on the 2011 Medicare cost report. If the 2011 cost report reflects 250 Medicare days, 450 total days, and 2% charity care, the final payment will be \$383,400. A June 30 or September 30 hospital would settle this scenario on the 2012 Medicare cost report (the cost report that covers the reporting period).

PPS: PPS hospitals are paid for inpatient services based on DRGs. The amount of bonus for these facilities is an initial amount times Medicare’s share times a transition factor. PPS hospitals who meaningfully use certified electronic health records 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:

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

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

For these hospitals, four years of incentives is possible. 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 payments transition factor by first payment year follows:

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

An example:

A PPS hospital becomes a meaningful user of certified electronic health records in May 2012. They can prove 90-days of meaningful use from July 1, 2012 – September 30, 2012. They 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 above and read down)

Therefore, the incentive payment for this hospital's first year is \$1,641,549 ($\$6,370,000 * .2577 * 1$).

If this were 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. The hospital should run each measurement, and record the results. If the hospital meets Stage 1 measurement criteria, it should attest the results to its Intermediary and request payment.

The payment will be reconciled based on the 2012 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. A June 30 or September 30 hospital would settle this scenario on the 2013 Medicare cost report (the cost report that covers the reporting period).

Medicaid: Each state will decide how eligible hospitals and EPs will qualify for Medicaid incentive payments.

To qualify for Medicaid incentive payments, the proposed rule lists eligible provider types by provider number. It does not list the CAH provider type. PPS hospitals with provider numbers between XX-0001 and XX-0879 are eligible, but must also have at least 10% Medicaid utilization. The 10% Medicaid utilization rule does not apply to children's hospitals.

Penalties

The EHR incentive program starts by paying additional funds to facilities to implement and use EHR in the beginning stages. In 2015, a hospital that is not a meaningful user of certified electronic health records will incur penalties.

CAH: A CAH is paid 101% of cost for most inpatient and outpatient services. The CAHs who do not meet the EHR definitions starting in 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 can prove utilizing EHR would “result in significant hardship”. Remember, CMS’ definition will likely be more stringent than your own. CMS gives an example of a small CAH located in a rural area without sufficient internet access.

An exemption may only be granted for 5 years. Few hospitals will qualify. As Medicare payments decrease to 100% of cost, hospitals will likely face challenges purchasing and implementing this technology. Therefore, we recommend all CAHs use the additional funds to help purchase and use EHRs.

PPS: PPS hospitals are paid a prospective DRG amounts. PPS hospitals that do not qualify as a meaningful user starting in 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 that do not report quality data will see a ¼ reduction to the IPPS market basket updates. Hospitals may be subject to the meaningful user reduction, quality reporting reduction, both reductions, or no reduction.

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

Hospital-based Physicians

The law allows for incentive payments to eligible physicians (EPs) and eligible hospitals. The proposed rule clarifies which physicians may receive a separate payment and which must fall under the hospital’s incentive payment. The proposed rule states that hospital-based physicians are not eligible for separate incentive payments. These are physicians who furnish 90% of their Medicare covered services during the EHR reporting period in a hospital setting.

To be a provider-based department of a hospital (including provider-based clinics), the department must be integrated as part of the hospital. This includes having a seamless medical records function. Therefore, outpatient departments must be part of the EHR through the necessity of being integrated, but there is not additional payment for these outpatient services or physicians’ clinics. Rather, the incentive is based on inpatient Medicare utilization.

The proposed rule calls for comments (including alternatives) on how outpatient departments “not being part of incentive will effect hospital’s putting EHR in provider-based clinics AND how they will then continue to meet the provider-based requirements if they don’t”. This will affect some hospitals more than others, but we recommend hospitals take this opportunity to submit suggestions on how to make this work. Remember, these are physicians that are 90% or more hospital-based.

The proposed rule also states that Medicaid EPs practicing predominately in FQHCs or RHCs are not subject to the hospital-based exclusion.

Miscellaneous

The proposed rule states that CMS will conduct selected compliance reviews. The intermediaries are responsible for reviewing and settling the interim payments. The proposed rule also stipulates that eligible hospitals must maintain evidence of qualification to receive the incentive payments for 10 years after the date they register for the incentive program. Therefore, if a hospital registers for the program in July of 2012, they must retain all records until July of 2022.

Comment, questions, clarifications can be submitted at <http://www.regulations.gov/>. When submitting comments, use the file code CMS-0033-P. Comments must be received on or before 5:00 p.m. March 15, 2010.

Dingus, Zarecor & Associates PLLC (DZA) will submit a list of comments, questions, and concerns. We recommend hospitals also submit their comments.