

EHR Incentive Payments for Critical Access Hospitals

UNDERSTANDING EHR COST REIMBURSEMENT

An Executive Decision Guide



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Executive Summary

With each passing month, the pressure is growing for U.S. hospitals to implement electronic health records (EHR) solutions and then demonstrate Meaningful Use of their EHR technology.

Even so, some critical access hospitals (CAHs) have been slow to proceed. Their hesitation centers around a crucial question: “How much of our EHR investment can we truly recoup through Medicare reimbursements?”

The answer is not as simple as using the Medicare EHR incentive program established for inpatient prospective payment system (IPPS) hospitals. Critical access hospitals must use a different formula. Beyond that, the answer encompasses a number of variables — including some gray areas.

In this white paper, we will attempt to address the questions and concerns of critical access hospitals related to identifying which EHR costs are reimbursable through the Medicare EHR incentive program and which ones are reimbursable via the standard Medicare cost reimbursement program.

Specifically, we will cover the following topics:

- Understanding how critical access hospitals may be reimbursed for their EHR costs under the new Medicare EHR incentive program; this includes a single-year depreciation of eligible costs
- Distinguishing between costs that are reimbursable through the Medicare EHR incentive program or through the standard Medicare cost reimbursement program for critical access hospitals
- Identifying “reasonable EHR costs,” as set forth by the HITECH Act and with guidance from the Centers for Medicare & Medicaid Services (CMS)
- Clarifying how EHR costs for nontraditional deployments, such as managed hosting services, may be reimbursed by Medicare

We will devote considerable discussion to the third point (“reasonable EHR costs”), examining costs for hardware and software, of course, but also for other essential components, such as implementation services, interest on financing, staff training, maintenance, conversion and migration software/services, and interdependent software systems.

To date, CMS has not provided clear-cut guidance as to what constitutes “reasonable costs” in some areas of a hospital’s EHR investment. In these instances, we looked to Certified Public Accountants (CPAs) and other qualified professionals for their interpretation.

Ultimately, as this white paper will show, there is strong evidence that critical access hospitals may be able to recoup most of their capitalized costs for an EHR deployment through the Medicare EHR incentive program.

EHR Incentive Program for Critical Access Hospitals

Although some similarities exist, the Medicare EHR incentive program for critical access hospitals, which is part of the American Recovery and Reinvestment Act of 2009 (ARRA), is separate and different in key ways from the standard Medicare cost reimbursement program for critical access hospitals.

To qualify for EHR incentive payments, critical access hospitals must implement their EHR solution and demonstrate Meaningful Use prior to fiscal year 2015.

The Medicare EHR incentive program contains several key benefits:

- The incentive payment calculation is: “reasonable” EHR costs multiplied by the hospital’s Medicare share, plus a 20% bonus. Eligible hospitals may be reimbursed up to, but not more than, 100% of their EHR investment.
- Allowable EHR costs are not allocated across potentially non-reimbursable cost centers.
- Qualifying EHR costs are reimbursed in a single payment year (versus payment on the depreciable value of the acquisition costs over the useful life of the asset, as spelled out in the standard Medicare cost reimbursement program).

To better understand how the incentive formula works, consider the example of a hospital with a total allowable EHR cost of \$500,000:

$$\begin{array}{r} \text{Total Reasonable} \\ \text{EHR Cost:} \\ \$500,000 \end{array} \times \begin{array}{r} 60\% \\ \text{Medicare} \\ \text{Share} \end{array} + \begin{array}{r} 20\% \\ \text{Bonus} \end{array} = \begin{array}{r} \$400,000 \\ \text{Reimbursement} \\ \text{(realized in a single} \\ \text{payment year)} \end{array}$$

COMPARISON WITH STANDARD MEDICARE COST REIMBURSEMENT

Now, let’s see how much of the same \$500,000 EHR investment might be recouped under the standard Medicare cost reimbursement program for critical access hospitals:

$$\begin{array}{r} \text{Total Reasonable} \\ \text{EHR Cost:} \\ \$500,000 \end{array} \times \begin{array}{r} 35\% \text{ Medicare Utilization} \\ \text{(after reallocating costs)} \end{array} = \begin{array}{r} \$175,000 \text{ Reimbursement} \\ \text{(paid over three to five years,} \\ \text{depending on the} \\ \text{depreciation method used)} \end{array}$$

BOTTOM LINE: Standard Medicare cost reimbursement provides \$225,000 less reimbursement than the Medicare EHR incentive program, as well as a longer payback period.

At first glance, the Medicare EHR incentive program seems relatively straightforward... and very compelling. A closer examination, however, prompts this question: “What constitutes reasonable EHR costs?” After all, the costs of an EHR deployment go well beyond hardware and software.

The next section is devoted to understanding “reasonable EHR costs,” along with how a critical access hospital’s allowable EHR costs may be allocated to either the Medicare EHR incentive program or the standard Medicare cost reimbursement program.

Identifying and Allocating “Reasonable EHR Costs”

What qualifies as a “reasonable EHR cost” under the Medicare EHR incentive program for critical access hospitals? A good starting point is this CMS statement issued on March 24, 2011:

“The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply. Section 495.106(a) of the regulations states that 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 the regulations, such as computers and associated hardware and software, necessary to administer certified EHR technology, as defined in section 495.4, excluding any depreciation and interest expenses associated with the acquisition.”

Unfortunately, HITECH legislation and CMS guidance leave a lot of room for interpretation. In this section, we will outline our analysis and interpretation regarding what comprises “reasonable EHR costs” across the total scope of an EHR deployment. At the end of this paper is a quick-reference summary of the allowable costs and how they may be allocated.

We strongly encourage critical access hospitals to check with their Medicare Administrative Contractors (MACs) as to what is included in the actual calculation of their EHR incentive payment.

DEPRECIATION PRIOR TO THE EHR REPORTING PERIOD

EHR depreciation costs occurring in fiscal years prior to the EHR reporting period are not eligible for the Medicare EHR incentive program; these costs would have been recouped via the standard Medicare cost reimbursement program in previous years and cannot be claimed twice.

On the other hand, depreciation costs starting in the first fiscal year of the EHR reporting period may be counted as part of the hospital’s total EHR costs and included in the Medicare EHR incentive program payment calculation.

UN-DEPRECIATED EHR COSTS

The value of EHR assets from previous years that have yet to be depreciated will be counted toward the total EHR costs as part of the Medicare EHR incentive program; these costs would have been allowable in the ensuing depreciation periods under the standard Medicare cost reimbursement program.

CAPITALIZED ASSETS

Analyzing the CMS statement above, specifically this portion — “...such as computers and associated hardware and software, necessary to administer certified EHR technology” — it is quite clear that the costs of these capitalized assets qualify for reimbursement under the Medicare EHR incentive program.

For the time being, it is not clear what may be included within the scope of “associated hardware and software, necessary to administer certified EHR technology.” However, CMS has stated that the CAH may only include the portion of the reasonable costs of the hardware that pertains to the certified EHR technology toward the total EHR costs as part of the Medicare EHR incentive program.

INTERDEPENDENT AND INTEGRATED SYSTEMS

The CMS statement regarding software that is “necessary to administer certified EHR technology” strongly suggests that the Medicare EHR incentive program would encompass the inclusion of systems and subsystems upon which the EHR system is dependent or with which it is integrated for the purpose of the administration of electronic health records.

Many EHR solutions rely on the foundational data provided by the vendor’s financial application and, in fact, cannot function without prior installation of specific financial system components. Based on the CMS guidance for the handling of these components of an EHR acquisition, only the portion of the system that pertains to the certified EHR technology (what is required to achieve Meaningful Use) will qualify for reimbursement under the Medicare EHR incentive program. Hospitals must be able to provide documentation to the Medicare contractor to support the portion of their investment that they intend to claim. Therefore, only the cost of the requisite system components that can be identified as necessary for the achievement of Meaningful Use should be included in the Medicare EHR incentive program.

Other applications which are not essential for functioning of the EHR system (e.g., general ledger, accounts payable, payroll, personnel, fixed assets, materials management, time and attendance, and budgeting), are not eligible for incentive payments, but should be included in the standard Medicare cost reimbursement program.

VENDOR IMPLEMENTATION SERVICES

According to CMS guidance, the reasonable costs for the purchase of the certified EHR technology to which purchase depreciation would apply shall qualify for reimbursement under the Medicare EHR incentive program. Vendor implementation services are required to prepare the EHR asset for its intended use and have traditionally been a recognized part of the depreciable EHR asset; therefore, they are recorded as a capitalized cost. Following the logic of historical accounting practices and indications from CMS guidance issued to date, vendor implementation services should be considered a “reasonable EHR cost” and included in the EHR cost total for the Medicare EHR incentive program.

VENDOR EHR TRAINING

EHR training activities provided by the EHR vendor that are either requested by the EHR user or are separately identifiable as training costs, are not capitalized and therefore will not be included in the Medicare EHR incentive program. As with internal EHR training, these expenses may qualify for the standard Medicare cost reimbursement program.

INTERNAL EHR TRAINING

Costs for internal EHR training are “separately identifiable” and fall into the category of non-depreciable expenses; thus, they may not be included in the Medicare EHR incentive program. At the same time, these expenses may be allowable costs under the standard Medicare cost reimbursement program, applicable to the reporting period in which they occurred.

Some CPAs contend that the expense of training staff at a vendor location would be a capitalized cost and therefore would be eligible for the Medicare EHR incentive program. However, it is our opinion that this position falls outside the normal handling of these costs, in accordance with Generally Accepted Accounting Principles (GAAP).

CONVERSION AND MIGRATION

The purchase price of software tools for data conversion could be capitalized and therefore included in the Medicare EHR incentive program along with the cost for data conversion/migration services that are included as part of the EHR implementation services and not separately identifiable.

The cost of separately identifiable data conversion services, on the other hand, does not qualify for the Medicare EHR incentive program because it is not required to make the EHR asset ready for use; however, it is reportable under the standard Medicare cost reimbursement program.

EHR INTEREST EXPENSES

To date, CMS has not provided guidance that specifically addresses interest costs incurred on the EHR asset during the implementation period. However, most CPAs would argue that these are no longer interest costs when the EHR is placed into service; rather, they are part of the capital cost. As capital costs, they may be depreciated and included in the Medicare EHR incentive program calculation.

Interest costs incurred on the EHR asset after implementation, but prior to the Meaningful Use reporting period, are not eligible for the Medicare EHR incentive program. However, these interest expenses may be included in the standard Medicare cost reimbursement.

EHR interest costs incurred during and after the Meaningful Use reporting period are not eligible for reimbursement under the Medicare EHR incentive program, nor would they qualify for the standard Medicare cost reimbursement program.

Advisory: Critical access hospitals that finance their EHR purchase should use their incentive payment to repay the lender as quickly as possible. Doing so will help prevent substantial losses due to the inability to realize reimbursements for interest payments.

EHR MAINTENANCE COSTS

Non-depreciable expenses related to maintaining an EHR system are not eligible for the Medicare EHR incentive program. Hospitals may report reasonable maintenance costs as part of the standard Medicare cost reimbursement program, applicable to the reporting period in which they occurred.

OTHER EHR OPERATING COSTS

Information technology staff salaries, internet services, energy consumption, IT infrastructure maintenance, and other operating costs are not reimbursable under the Medicare EHR incentive program, but may be identified as allowable costs under the standard Medicare cost reimbursement program.

Reimbursements for Nontraditional EHR Deployments

Many critical access hospitals do not follow the pathway of a conventional EHR installation, which includes the purchase of hardware and software. Instead, they choose to deploy an EHR system that involves managed hosting services or leasing.

In these cases, much of the preceding discussion is not applicable. The following discussion addresses Medicare reimbursement for the most common nontraditional EHR deployments.

MANAGED HOSTING SERVICES

An alternative to the traditional EHR deployment is a managed hosting service that requires the purchase of a software license and separate payments for implementation services, hosting, and maintenance. Under this arrangement, the software purchase and implementation service fees are eligible for the Medicare EHR incentive program. However, costs for the maintenance and hosting services would be reported as part of the standard Medicare cost reimbursement program.

EHR LEASING

Costs to lease certified EHR technology does not qualify for reimbursement under the Medicare EHR incentive program. The costs allowable for the Medicare EHR incentive program are only the reasonable costs to which purchase depreciation would apply. This would not include lease costs, whether it is an “operating” or “capital” lease. However, lease costs are eligible for the standard Medicare cost reimbursement program.

QUICK-REFERENCE GUIDE TO EHR COST REIMBURSEMENTS

CATEGORY OF COST	MEDICARE EHR INCENTIVE PROGRAM	STANDARD MEDICARE COST REIMBURSEMENT PROGRAM
Depreciation prior to the EHR reporting period	NO	YES
Un-depreciated EHR costs at the time of EHR reporting period	YES	NO
Capitalized assets — computers, hardware and software associated with EHR administration	YES	NO
Vendor implementation services	YES	NO
Capitalized interest cost	YES	NO
EHR interest expenses prior to the EHR reporting period	NO	YES
EHR interest expenses after the EHR reporting period	NO	NO
Internal EHR training	NO	YES
Vendor EHR training (if separately identifiable)	NO	YES
EHR maintenance costs	NO	YES
Other EHR operating costs	NO	YES
Managed hosting services (software license & implementation services)	YES	NO
Conversion and migration (software tools)	YES	NO
Interdependent/integrated systems related to EHR	YES	NO
Interdependent/integrated systems unrelated to EHR	NO	YES
Lease costs (operational or capital)	NO	YES

Conclusions

Critical access hospitals are justifiably concerned about how they will fund their EHR investments and how much of their investments will be offset by Medicare payments, whether realized through the standard Medicare cost reimbursement program or through the Medicare EHR incentive program.

In a collaborative effort to find answers, Healthland and Eide Bailly conducted extensive analysis and consulted with many industry experts. Our key conclusions:

- Most critical access hospitals will receive a higher percentage reimbursement of their capitalized EHR costs by using the Medicare EHR incentive program.
- Many EHR costs not eligible for the Medicare EHR incentive program may be paid under the standard Medicare cost reimbursement program.
- Hospitals that finance their EHR investment should use their incentive payment to repay the lender as quickly as possible, thus avoiding a potential loss of reimbursement.
- Nontraditional EHR deployments (managed hosting services, and EHR leasing) come with a different set of reimbursement rules and need to be clearly understood before committing to an option.
- In the absence of definitive CMS guidance, critical access hospitals should consult with their MACs as to how they define “reasonable EHR costs” (i.e., reimbursable costs).
- Specific details applicable to Medicare EHR incentive program are lacking at this point. However, we expect CMS to provide further clarification as they begin issuing incentive payments to critical access hospitals.
- Many components of a typical EHR acquisition are “gray areas” with limited or no specific CMS guidance. Each should be considered with caution until such time that specific guidance is issued.
- Currently unreleased guidance and forthcoming CMS interpretations may have a significant impact on current industry interpretations and expected reimbursement under the Medicare EHR incentive program.



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For more information, visit www.healthland.com/stimulus.



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