The Financial Impact of Meaningful Use EHR

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Agenda

• Health Information Technology (HIT) Stimulus Payments
  • Critical Access Hospitals (CAH)
  • Prospective Payer Hospitals (PPS)
  • Eligible Physicians
  • Medicaid Eligible
HIT Stimulus Payments

- Payments for meaningful use of certified Electronic Health Record (EHR) technology
  - Requires meeting meaningfull use
  - This session will focus on financial impacts to an organization
HIT Stimulus Payment Years

• Defined:
  • CAH – Cost Reporting Period
    • First available payment year begins with first cost report beginning on or after October 1, 2010
  • PPS Hospital – Federal Fiscal Year
    • Year beginning on October 1 and ending September 30
    • First available payment year begins October 1, 2010
  • Eligible Providers – Calendar Year
HIT Stimulus Payment Years

• Defined:
  • EHR reporting period
    • 1st year – Continuous 90 day period within first payment year
    • Subsequent – Entire payment year
Stimulus Payments – Medicare Share

• Medicare Share
  • Based on inpatient volume
  • Numerator
    • Medicare days + Medicare Advantage patient days
      • IP, Specialty Care
        • Psych and Rehab included in proposed rule, but eliminated in final rule
        • Excludes SB
    • Medicare Advantage patient days based on no-pay bills
      • CAH impact
Stimulus Payments – Medicare Share

• Based on inpatient volume
  • Denominator
    • Total inpatient days TIMES
    • Hospital charges less charity care DIVIDED BY hospital charges
    • Worksheet C Part I Line 200 Column 8
Stimulus Payments – Medicare Share

• Based on inpatient volume
  • Denominator
    • Charity Care
      • As identified on Worksheet S-10 of the Medicare cost report for PPS Hospitals
  • New reporting requirement for CAH’s
Critical Access Hospitals – Medicare

- Payments available 2011 – 2015
- Fiscal year after FY 2010, but before FY 2016
  - Example – If December 31st year end, first year begins January 1, 2011.
- No payments after 2015
- Up to 4 consecutive payment years
Critical Access Hospitals - Medicare

- Allowed to expense their costs associated with the purchase of certified EHR technology in a single year
  - Versus depreciating these costs on the cost report
  - Current year and prior year purchases (undepreciated value)
  - Includes only purchases for hospital specific EHR technology
Critical Access Hospitals – Medicare

• Continued
  • Reimbursement based on Medicare Share + 20 percentage points (not to exceed 100%)
  • Lump sum prompt payment subject to reconciliation
    • Initial based on last filed 12 month cost report
    • Final based on final cost report
  • Deferred Revenue Issues?
Critical Access Hospitals - Medicare

• Continued
  • Payments up to 4 consecutive years
    • Stages (3 stages)
    • Replacement equipment
Allowable expense

- Reasonable cost – “computers and associated hardware and software necessary to administer EHR technology”
  - Communicate with MAC/FI with any questions
  - Impact on Trade-ins?
  - Review capitalization policies
Allowable expense

- Incentive payment in lieu of depreciation AND interest
  - “Be smart about your interest”
- MAC/FI to review cost reports to ensure the assets associated with the acquisition of certified EHR technology are expensed in a single period and that depreciation and interest expenses associated with the acquisition are not allowed
- Subject to reconciliation
Critical Access Hospital - Medicare

- Failure to become a meaningful EHR user by FFY 2015
  - Reduction in 101% of cost
  - FFY 2015 – 100.66% of cost
  - FFY 2016 – 100.33% of cost
  - FFY 2017 – 100.00% of cost
Critical Access Hospitals – Medicare

• Strategy
  • Place EHR assets in use and become meaningful user in same fiscal year
### XYZ Critical Access Hospital Example

**Calculation of Estimated EMR Incentive Payment Percentage under the American Recovery and Reinvestment Act of 2009**

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Inpatient Days</td>
<td>200</td>
</tr>
<tr>
<td>Medicare Advantage Inpatient Days</td>
<td>25</td>
</tr>
<tr>
<td>Total Days</td>
<td>375</td>
</tr>
<tr>
<td>Total Gross Revenue</td>
<td>10,000,000</td>
</tr>
<tr>
<td>Charity Care</td>
<td>12,000</td>
</tr>
<tr>
<td>Medicare Share</td>
<td>60.1%</td>
</tr>
<tr>
<td>Medicare Share with 20 percentage points add-on</td>
<td>80.1%</td>
</tr>
</tbody>
</table>

**NOTE:**
Medicare will reimburse 80.1% of outstanding depreciation cost in year facility meets "meaningful use" definition beginning in 2011. Any depreciation costs incurred prior to meeting "meaningful use" or before 2011 will be reimbursed based on current cost based Medicare utilization percentages.
PPS Hospitals – Medicare

• Does not include Puerto Rico, psychiatric, rehabilitation, long term care, children’s or cancer hospitals. Surgical and other specialty hospitals participating in IPPS are eligible for Medicare incentives.

• Multi-campus facilities treated as single facility.

• Payment based on the following:
  • Initial Amount
  • Medicare Share
  • Transition Factor
• Initial Amount
  • Base payment for each PPS hospital = $2,000,000
    • Adjusted for discharges 1,150 to 23,000
  • $200 additional per discharge in this range
  • Times Medicare Share
PPS Hospitals – Medicare

• Payment Process
  • Hospital data last filed 12 month cost report
  • Settled based on the first 12 month cost reporting period that begins after the start of the payment year
• Transition Factor (FFY 2011 – 2013)
  • Year 1 = 1
  • Year 2 = \( \frac{3}{4} \)
  • Year 3 = \( \frac{1}{2} \)
  • Year 4 = \( \frac{1}{4} \)
  • Subsequent Years = 0

• Transition Factor (FFY 2014 – 2015)
  • If the facility’s first year of eligibility is after FFY 2013, the transition factor is the same as a facility with a first payment in FFY 2013
  • If the first payment year is after FFY 2015, the transition factor is zero
<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Fiscal Year that Eligible Hospital First Receives the Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>1.00</td>
</tr>
<tr>
<td>2012</td>
<td>0.75</td>
</tr>
<tr>
<td>2013</td>
<td>0.50</td>
</tr>
<tr>
<td>2014</td>
<td>0.25</td>
</tr>
<tr>
<td>2015</td>
<td>---</td>
</tr>
<tr>
<td>2016</td>
<td>---</td>
</tr>
</tbody>
</table>
• Failure to become a meaningful EHR user by FFY 2015
  • Market Basket Adjustments reduction on $\frac{3}{4}$ of adjustment
    • FFY 2015 – 33 1/3 percent
    • FFY 2016 – 66 2/3 percent
    • FFY 2017 – 100 percent

• Net Impact
  • FFY 2015 – 25 percent
  • FFY 2016 – 50 percent
  • FFY 2017 – 75 percent
## PPS Payment Calculation Example

<table>
<thead>
<tr>
<th>Prospective Payment Example</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>Base Payment</td>
<td>2,000,000</td>
<td>2,000,000</td>
<td>2,000,000</td>
<td>2,000,000</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Discharges</td>
<td>9,600</td>
<td>9,600</td>
<td>9,600</td>
<td>9,600</td>
<td>9,600</td>
</tr>
<tr>
<td>Discharges Eligible for adjustment</td>
<td>8,451</td>
<td>8,451</td>
<td>8,451</td>
<td>8,451</td>
<td>8,451</td>
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<tr>
<td>Adjustment per Discharge</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Total Adjustment</td>
<td>1,690,200</td>
<td>1,690,200</td>
<td>1,690,200</td>
<td>1,690,200</td>
<td>1,690,200</td>
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<tr>
<td>Adjusted Base</td>
<td>3,690,200</td>
<td>3,690,200</td>
<td>3,690,200</td>
<td>3,690,200</td>
<td>3,690,200</td>
</tr>
<tr>
<td>Medicare + Medicare Advantage Days</td>
<td>19,700</td>
<td>19,700</td>
<td>19,700</td>
<td>19,700</td>
<td>19,700</td>
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<tr>
<td>Total Days</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
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<tr>
<td>Medicare Percentage</td>
<td>54.0%</td>
<td>54.0%</td>
<td>54.0%</td>
<td>54.0%</td>
<td>54.0%</td>
</tr>
<tr>
<td>Total Charges</td>
<td>400,000,000</td>
<td>400,000,000</td>
<td>400,000,000</td>
<td>400,000,000</td>
<td>400,000,000</td>
</tr>
<tr>
<td>Total Charges less Charity Care</td>
<td>395,000,000</td>
<td>395,000,000</td>
<td>395,000,000</td>
<td>395,000,000</td>
<td>395,000,000</td>
</tr>
<tr>
<td>Adjustment factor</td>
<td>1.01</td>
<td>1.01</td>
<td>1.01</td>
<td>1.01</td>
<td>1.01</td>
</tr>
<tr>
<td>Medicare Share</td>
<td>54.5%</td>
<td>54.5%</td>
<td>54.5%</td>
<td>54.5%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Transition Factor</td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>Total Payment</td>
<td>2,011,159</td>
<td>1,508,369</td>
<td>1,005,580</td>
<td>502,790</td>
<td>-</td>
</tr>
</tbody>
</table>
Stimulus Payments – Physician

• Physician defined
  • Doctor of Medicine
  • Doctor of Osteopathy
  • Doctor of Dental Surgery
  • Doctor of Podiatric Medicine
  • Doctor of Optometry
  • Chiropractor
Stimulus Payments – Physician

- Payment Year and Year of Payment defined
  - Any calendar year beginning with 2011

- Incentive
  - 75% of Secretary’s estimate of allowed charges for covered services furnished by eligible professional during relevant payment year.
    - Paid claims no later than 2 months after relevant year
  - Up to 5 years
  - No incentive after 2016
Incentives do not apply to:

- Provider based physicians
  - Substantially all professional services provided in hospital setting
    - 90% of covered services in calendar year preceding payment year
  - Place of Service 21 – Inpatient
  - Place of Service 23 – Emergency Room
- How will Medicare handle Method II providers
Stimulus Payments – Physician

• Incentives do not apply to:
  • RHCs/FQHCs
    • May qualify for Medicaid incentive if >30% of patients considered “needy”
      • Receiving medical assistance from Medicaid or CHIP
    • Furnished uncompensated care by provider
    • Furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay
# Stimulus Payments – Physician

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>First CY in which EP Receives an Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>$18,000</td>
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<tr>
<td>2012</td>
<td>$12,000</td>
</tr>
<tr>
<td>2013</td>
<td>$8,000</td>
</tr>
<tr>
<td>2014</td>
<td>$4,000</td>
</tr>
<tr>
<td>2015</td>
<td>$2,000</td>
</tr>
<tr>
<td>2016</td>
<td>---</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$44,000</strong></td>
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</tbody>
</table>
Stimulus Payments – Physician

- HPSA Incentive
  - 10% increase in incentive
    - Provides services predominately in HPSA
    - Defined as greater than 50%
    - January 1 – December 31 frequency
    - If HPSA by December 31 of prior year
      - No impact if HPSA lost during current year
      - No impact if HPSA obtained during current year
## Stimulus Payments – Physician

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>First CY in which EP Receives an Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>$19,800</td>
</tr>
<tr>
<td>2012</td>
<td>$13,200</td>
</tr>
<tr>
<td>2013</td>
<td>$8,800</td>
</tr>
<tr>
<td>2014</td>
<td>$4,400</td>
</tr>
<tr>
<td>2015</td>
<td>$2,200</td>
</tr>
<tr>
<td>2016</td>
<td>---</td>
</tr>
<tr>
<td>Total</td>
<td>$48,400</td>
</tr>
</tbody>
</table>
Stimulus Payments – Physician

- Single Consolidated Payment
  - Ascertain professional has demonstrated meaningful use
  - Reaches maximum payment limit
  - If maximum payment limit is not reached payment is processed 2 months after relevant payment year

- Multiple Employers/Contractual Arrangements
  - Assign incentive to 1 employer or entity
Stimulus Payments – Physician

- Failure to become a meaningful EHR user by 2015
  - 2015 – 99% of applicable fee schedule
  - 2016 – 98% of applicable fee schedule
  - 2017 – 97% of applicable fee schedule
  - 2018 – Additional 1% reduction if less than 75% professionals are meaningful users. Subsequent year reductions capped at 95%
Medicaid Eligible Hospitals

• Acute care hospital (including CAH) must have at least 10 percent Medicaid Patient Volume based on patient encounters
  • Inpatient
  • Emergency Room
  • Any representative continuous 90-day period in most recent fiscal year
• Like other Medicaid Eligible Hospitals, CAHs may receive both Medicare and Medicaid EHR incentive payments
Medicaid Eligible Hospitals

- PPS and CAHs reimbursed under same methodology as Medicare PPS
  - Medicaid Share versus Medicare Share
  - Calculate 4 year payment
    - Discharges based on hospital’s experience in past three years
Medicaid Eligible Hospitals

- PPS and CAHs reimbursed under same methodology as Medicare PPS
  - Payment made over 3 – 6 years
    - No more than 50% of payment in 1 year
    - No more than 90% of payment in 2 years
  - “Adopt, implement or upgrade certified EHR technology”
    - No meaningful use requirement in year 1
    - Meaningful use required for future years
Medicaid Eligible Professionals

• Eligible providers must elect (Medicare or Medicaid), with option for one change
  • Medicaid Eligible Professionals must select one state

• Medicaid EPs are the following professionals (other than hospital-based professionals):
  • Physicians and dentists
  • nurse practitioners
  • certified nurse-midwives
  • physician assistants practicing in FQHCs or RHCs that are led by a physician assistant
Medicaid Eligible Professionals

- A PA leads an FQHC or RHC under any of the following circumstances:
  - when a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA)
  - when a PA is a clinical or medical director at a clinical site of practice
  - PA is an owner of the RHC
Medicaid Eligible Professionals

• Medicaid EP must satisfy one of three Patient Volume thresholds:
  • Have $\geq 30\%$ Patient Volume attributable to Medicaid recipients
  • Have $\geq 20\%$ Patient Volume attributable to Medicaid recipients and be a pediatrician
  • practice predominantly in a FQHC or RHC and have $\geq 30\%$ Patient Volume attributable to Needy Individuals
Medicaid Eligible Professionals

- Needy Individuals are persons who:
  - received medical assistance from Medicaid or the Children’s Health Insurance Program
  - were furnished uncompensated care or
  - were furnished services either at no cost or reduced cost based on a sliding scale determined by individuals’ ability to pay
Medicaid – Eligible Providers

- Incentive payment to EP equals Net Average Allowable Costs for EHR
- NAAC is Average Allowable Costs (capped at $25K in yr 1 and $10K in yrs 2-6) net of cash payments attributable to EHR technology or support services from sources other than state and local governments, subject to 15% EP responsibility
## Medicaid – Eligible Providers

### Payments: NAAC Calculation

Average allowable costs (AAC) minus payments from other sources:

- State and local sources not considered

= Net average allowable costs (NAAC)

<table>
<thead>
<tr>
<th>$54,000</th>
<th>$29,000</th>
<th>$25,000</th>
<th>$21,250</th>
<th>$3,750</th>
</tr>
</thead>
</table>

**AAC**

- Max allowed from other sources
- Maximum incentive (example only) and also the maximum NAAC
- Reduced to 85% = actual incentive payment
- Remaining 15% responsibility of EP

**Other sources?**

- Count only cash payment to EP directly attributable to only the EHR technology. *Don’t count:* in kind, employer provided, grant to entity, etc.

**15%?**

- Count all: in kind, employer provided, grant to entity, etc.
## Medicaid – Eligible Providers

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Maximum Incentive Payment for Medicaid EPs Who Are Meaningful Users in the First Payment Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$21,250</td>
</tr>
<tr>
<td>2012</td>
<td>$8,500</td>
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<tr>
<td>2013</td>
<td>$8,500</td>
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<td>2014</td>
<td>$8,500</td>
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<td>2015</td>
<td>$8,500</td>
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<td>2016</td>
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<tr>
<td>2017</td>
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<tr>
<td>2018</td>
<td>---</td>
</tr>
<tr>
<td>2019</td>
<td>---</td>
</tr>
<tr>
<td>2020</td>
<td>---</td>
</tr>
<tr>
<td>2021</td>
<td>---</td>
</tr>
<tr>
<td>Total</td>
<td>$63,750</td>
</tr>
</tbody>
</table>
Medicaid – Eligible Providers

- Pediatricians qualifying under the 20% limit receive 2/3rds of the incentive
Attestation for Medicare FFS

- Eligible providers demonstrate MU to CMS through attestation in 2011 and attestation and electronic reporting of clinical quality information in 2012
- Providers may submit attestations as early as April 2011 to CMS
- Payment begins as early as May 2011 following attestation
Questions?