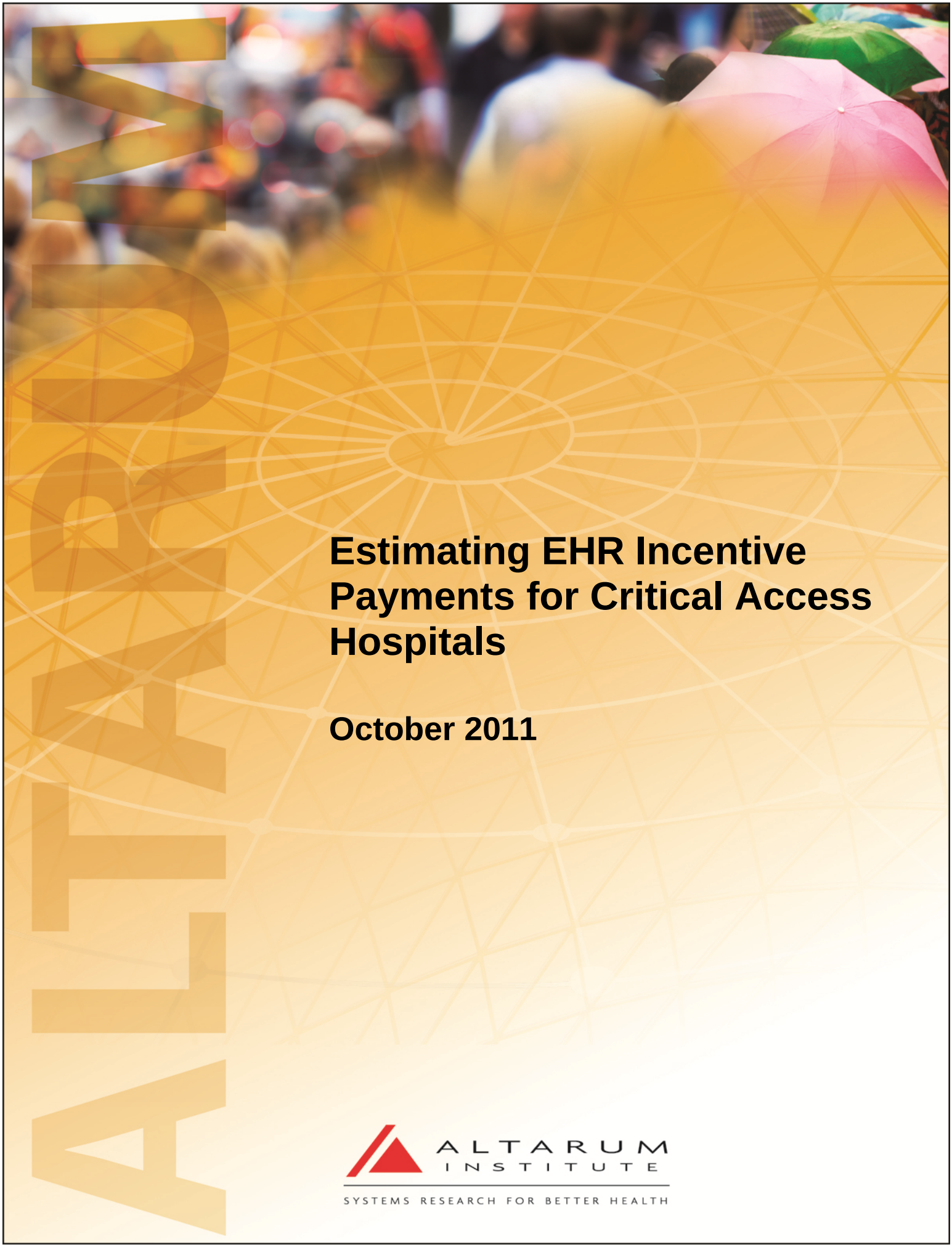

Estimating EHR Incentive Payments for Critical Access Hospitals

October 2011

ALTARUM INSTITUTE

SYSTEMS RESEARCH FOR BETTER HEALTH

The availability of incentive payments for the meaningful use of electronic health records (EHR) has lowered the financial barrier to investing in health information technology (IT) for critical access hospitals (CAHs). However, an EHR is still a significant investment, especially in comparison to the operating budget of many CAHs, and accurately estimating incentive payments is critical. While incentive payment calculators and guides are available, questions often arise among hospital administrators and boards regarding how much money they can really expect to receive. This is also true of the lenders who want to know whether a CAH will be able to pay back a loan.

Acute care hospitals, including CAHs, are eligible to receive incentives from both Medicare and Medicaid. CMS amended the definition of acute care hospital in the Final Rule as those with CMS Certification Numbers in the range of 1300-1399, which includes CAHs.[1]

Medicare Incentive Program

Medicare EHR incentive payments for CAHs are the product of the "reasonable costs" for the purchase of a certified EHR, or the remaining un-depreciated costs of the existing EHR, and the proportion of total hospital inpatient days that are paid for by Medicare (including Medicare Advantage), plus a bonus 20% (up to 100%).[2]

Medicare payments for CAHs are based on the same cost-based principles through which they normally receive 101% of the costs provided to Medicare patients. However, the incentive program adjusts normal cost-based reimbursement in two important ways:

1. A larger proportion of CAHs' costs will be reimbursed "Medicare Share" calculations.
2. CAHs can receive their entire reimbursement immediately after they attest to Meaningful Use.

Reasonable Costs

Reasonable costs, defined in the Final Rule on EHR incentive payment, are "the costs of depreciable assets purchased, such as computers and associated software, necessary to administer certified EHR technology. CMS has further clarified that reasonable costs are the costs to which purchase depreciation (excluding interest) would otherwise apply.[3] Final determination of reasonable costs is currently up to the Medicare Fiscal Intermediary/Medicare Administrative Contractors (FI/MAC).

Allowable Costs	Unallowable Costs	Gray Areas
Computers and associated hardware and software	Depreciation prior to the EHR reporting period	Vendor implementation and training
Non-depreciated cost remaining from a previous reporting period	Interest on EHR purchase	Staff training costs
Additional EHR expenses incurred after receipt of first incentive payment	Other EHR operating and maintenance costs	Costs required for a more advanced EHR
An EHR purchased for the CAH by the Home Office (i.e. the CAH is part of a health system, which purchases the EHR)	Hosted or leased solutions	EHRs for rural health clinics and provider-based clinics owned by the hospital

[1] 75 Fed. Reg. 144 at 44,460-44,461
[2] CMS FAQ Answer ID 10718.
[3] 75 Federal Register. 144 at 44463

Grey area. Determining reasonable costs is not a simple matter. There is considerable concern over the extent to which reasonable cost remains undefined, as the interpretation of the term "necessary to administer" varies. Costs for vendor implementation and training included with the implementation are likely reasonable costs, but additional training requested by the hospital may not be. Furthermore, some early adopters who have already implemented a certified EHR and have no additional non-depreciated costs may wish to add functionality, such as bedside medication verification. Such functionalities integrate with the existing EHR and create a more advanced EHR, but are not required for Meaningful Use. Thus, their allowance as a reasonable cost is unclear. While hospitals may receive incentive payments based on the eligible professionals that practice in a clinic that they own, it is not clear whether costs incurred for these settings is eligible for the incentive payment bonus.

Defining Medicare Share. The Medicare Share is based on the Medicare fee-for-service and managed care inpatient days, divided by total inpatient days, modified by charges for charity care. Medicare Share is different in several ways from Medicare utilization normally used to reimburse CAHs. The incentive bonus is based only on inpatient days (which are generally higher in Medicare utilization), includes Medicare Advantage days (which traditional reimbursement does not), and is further adjusted for charity care.

For example, a CAH with 35% Medicare Utilization would normally receive 35% in standard cost-based reimbursement (or $175,000 for a $500,000 EHR). Under the incentive program, if the same CAH has a Medicare Share of 50% and qualifies for the 20% bonus, it could receive a payment of around 70% (or $350,000, based on an EHR cost of $500,000). In addition, the CAH receives those funds as a one-time payment instead of over the life of the EHR. The required elements to calculate Medicare Share are in the Medicare cost report and the complete list of necessary data elements is listed in Appendix A.

<u>Incentive Program</u>
$500,000 (EHR Cost)
X 70% (50% Medicare Share + 20% Bonus)
= $350,000

<u>Standard Cost Reimbursement</u>
$500,000 (EHR Cost)
X 35% (Medicare Utilization)
= $175,000

Medicaid Incentives

To receive Medicaid payments, hospitals must have a Medicaid patient volume of at least 10%. CAHs may choose any representative 90-day period in the payment year to do this and does not have to coincide with the 90-day reporting period used to attest for the first year of Meaningful Use. Many states are allowing multiple ways to calculate patient volume in order to increase the likelihood of meeting the threshold. In contrast to Medicare incentives, Medicaid payments are calculated from a discharge-based formula of $2 million, with an additional $200 for each discharge between 1,150 and 2,300 discharges, factored against the hospital's Medicaid percentage. Hospitals are given 100% of this calculation in Year 1, 75% in Year 2, 50% in Year 3, and 25% in Year 4.

Examples for calculating Medicaid incentive payments are provided elsewhere[4], but some points of differentiation between the Medicare and Medicaid programs are:

1. Total incentive payments from Medicaid will likely be significantly higher than from Medicare due to payment calculations based on $2 million and receipt of four years of payments, instead of the reasonable cost of the EHR.

[4] Medicaid Hospital Incentive Payments Calculations. Available at: https://www.cms.gov/MLNProducts/downloads/Medicaid_Hosp_Incentive_Payments_Tip_Sheets.pdf

2. The "adopt, implement, or upgrade" requirement means that Meaningful Use is not required in year 1.
3. Medicaid payments are not reduced for hospitals who do not achieve Meaningful Use.

Timing and Penalties

Reporting Period. To receive the first year of Medicare payments, a hospital must demonstrate Meaningful Use of an EHR within a continuous 90-day period within a payment year. In following years, the hospital must demonstrate Meaningful Use for the entire year. The payment year refers to the Federal Fiscal Year, which begins October 1 and ends September 30. Thus, the first available payment year began October 1, 2010. In order to attest to Meaningful Use in any given year, the attestation period must begin no later than July 3.

Timing. To receive incentive payments from Medicare, a CAH submits documentation to their fiscal intermediary. While the interim payment will be based on information from the previous fiscal year, this payment is subject to reconciliation based on actual amounts at the end of the current fiscal year.

Penalties. There are no changes in Medicaid payments based on EHR use. However, CAHs will be subject to decreases in Medicare payments if they do not reach Meaningful Use by 2015. CMS will withhold one-third of one percent in Medicare reimbursements until it reaches 100% of costs.

Conclusion

CAH administrators, advisory boards, and community stakeholders are seeking to understand the implications of EHR adoption and expect EHRs to improve the quality of care and become part of health care delivery. Several important points may help CAHs understand EHR incentive payments, including:

- Eligible CAHs can simultaneously receive payments from the Medicare and Medicaid incentive programs
- Check with their state's Medicaid program to determine how to calculate Medicaid patient volume
- Work with the state FI/MAC to determine what can and cannot count as reasonable costs
- Expense, when possible, EHR costs not allowable through standard cost-based accounting in the reporting period in which they occur
- Maximize the Medicare Share by ensuring that staff accurately report charity care
- Expense the reasonable costs of the depreciable assets being included in the EHR incentive payment in their entirety in the year incurred[5]

CAHs can explore these issues further by reviewing the additional resources listed in Appendix B.

[5] CMS FAQ Answer ID 10720.

Appendix A: Data elements needed to calculate incentive payments

The current Medicare cost report, Form CMS 2552-96, will be used until the implementation of the new Medicare cost report, Form CMS 2552-10. The CMS 2552-96 data elements are as follows:[6]

- Total Discharges - Worksheet S-3 Part 1, Column 15, Line 12
- Inpatient Part A Days - Worksheet S-3 Part 1, Column 4, Line 1 + Lines 6 through 10
- Inpatient Part C Days - Worksheet S-3 Part 1, Column 4, Line 2
- Total Inpatient Days - Worksheet S-3 Part 1, Column 6, Line 1 + Lines 6 through 10
- Total Charges - Worksheet C Part 1, Column 8, Line 101
- Charity Care Charges - Worksheet S-10, Column 1, Line 30

The CMS 2552-10 data elements are as follows:

- Total Discharges - Worksheet S-3 Part 1, Column 15, Line 14
- Inpatient Part A Days - Worksheet S-3 Part 1, Column 6, Line 1 + Lines 8 through 12
- Inpatient Part C Days - Worksheet S-3 Part 1, Column 6, Line 2
- Total Inpatient Days - Worksheet S-3 Part 1, Column 8, Line 1 + Lines 8 through 12
- Total Charges - Worksheet C Part 1, Column 8, Line 200
- Charity Care Charges - Worksheet S-10, Column 3, Line 20

Appendix B: Additional Resources

- Regional Extension Centers
  http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__rec_program/1495
- Health Information Technology Toolkit for Critical Access and Small Hospitals:
  http://www.stratishealth.org/expertise/healthit/hospitals/htoolkit.html
- HRSA Rural Health IT Toolbox
  http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/index.html
- Examples of incentive payment calculations for hospitals from CMS:
  - Medicaid Incentive Calculations:
    https://www.cms.gov/MLNProducts/downloads/Medicaid_Hosp_Incentive_Payments_Tip_Sheets.pdf
  - Medicare Incentive Calculations:
    https://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_Medicare_Hosp.pdf
  - Critical Access Hospital Incentive Calculations:
    https://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_CAH.pdf

[6] CMS FAQ Answer ID 10717.