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Electronic Health Records Incentive Program: The Payment Clock is Ticking!

For Hospitals

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Electronic Health Records (EHRs) are a hot topic in the health care industry.[1] Several studies have suggested that hospitals that implement EHRs will have lower costs, improve the quality of care they offer, and see significant improvement in health outcomes of their patients. However, less than 10 percent of acute care hospitals in the U.S. have a basic EHR system (Jha et al., 2009). To encourage adoption, the American Recovery and Reinvestment Act (ARRA) of 2009, also known as the "stimulus package," provided a significant amount of funding as incentives for hospitals and individual physicians to invest in these technologies. In addition to providing incentive payments directly to hospitals and physicians, this legislation also created Regional Extension Centers whose job is to support health care providers with technical assistance in selecting a certified EHR product and demonstrating the "Meaningful Use" of that product. In Oklahoma, the Oklahoma Foundation for Medical Quality Health Information Technology (OFMQHIT) Regional Extension Center is the designated entity to help health care providers through EHR implementation. The final rules denoting official Meaningful Use definitions were released in July 2010, along with criteria regarding which hospitals qualify for the incentive program. This current report will address the most important aspects regarding the incentive payments for hospitals, including: which hospitals are eligible, the components of Meaningful Use, the types and amounts of payments (Medicare and Medicaid) available, the timeline for implementation, and several options available to hospitals in moving forward.

Inside this report:

- **Which hospitals are eligible for EHR incentive payments?**
- **What is "Meaningful Use?"**
- **Medicare and Medicaid payment structures (and examples)**
- **Incentive program timeline**
  - **Why it is important to act now**

Which Hospitals Are Eligible for EHR Incentive Payments?

There are two distinct incentive programs available – one under Medicare, and one under Medicaid. Acute care hospitals, including all Critical Access Hospitals (CAHs) and Subsection D (paid by Prospective Payment System, PPS) hospitals, are eligible for reimbursement under the Medicare incentive program. Further, if more than 10 percent of a hospital's patients are Medicaid participants, that hospital can also receive an incentive payment through Medicaid. This is different from the EHR incentive for individual physician practices, which must choose between Medicare and Medicaid incentive payments; hospitals can qualify for both. In Oklahoma, there are 62 Critical Access and Rural hospitals that qualify for assistance from OFMQHIT (those with fewer than 50 beds). Additionally, physicians in hospital-owned clinics may be eligible for technical assistance. If you are not sure if your hospital qualifies, check with OFMQHIT.

What is "Meaningful Use?"

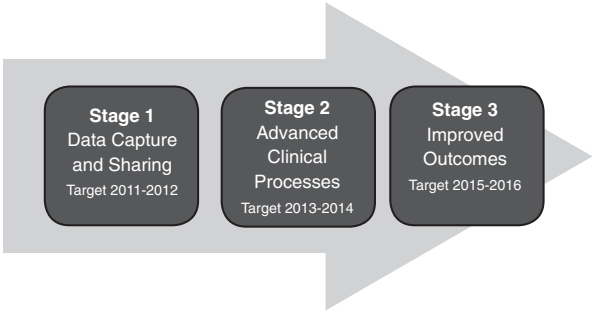
To receive Medicare or Medicaid incentive payments, hospitals are required to document that they are "meaningfully using" the EHR technology over a staggered timeframe. There are three primary components of Meaningful Use:

1. Use of a certified EHR in a meaningful manner (such as e-prescribing)
2. Use of a certified EHR for electronic exchange of health information with other healthcare entities
3. Use of a certified EHR to submit clinical quality measures (CQM)

Source: Centers for Medicare and Medicaid Servicess (www.cms.gov)

1 For more background information about Electronic Health Records, please refer to Oklahoma Cooperative Extension Service Current Report -1013, "Electronic Medical Records: What Are They?"

Figure 1. The 3 stages of EHR "Meaningful Use."



These components are then linked to three stages of "Meaningful Use" (Figure 1), with the requirements for reporting each component becoming more stringent each time. For example, to meet specific requirements under Stage 1, 80 percent of patients must have records in the certified EHR technology. While concrete rules for Stage 2 and Stage 3 have not been finalized, it is certain that requirements will become more rigorous as the stages progress.

To meet the Meaningful Use requirements for Stage 1, eligible hospitals must complete 14 core objectives, 5 out of 10 objectives from a "menu" set, and 15 total clinical quality measures (CQM). More detail into these objectives can be found in Tables 1 through 3. In Oklahoma, Meaningful Use requirements for Medicare and Medicaid incentive payments are exactly the same.

Table 1. Meaningful Use Core Set- All 14 must be met.

1. Computerized Physician Order Entry (CPOE).
2. Record demographics.
3. Maintain up-to-date problem list of current and active diagnoses.
4. Maintain active medication list.
5. Record smoking status for patients 13 years or older.
6. Provide patients with an electronic copy of their health information, upon request.
7. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically.
8. Drug-Drug and drug-allergy interaction checks.
9. Implement one clinical decision support rule.
10. Maintain active medication allergy list.
11. Record and chart changes in vital signs.
12. Report hospital clinical quality measures to CMS or States.
13. Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.
14. Protect electronic health information.

Source: Centers for Medicare and Medicaid Services (www.cms.gov)

Table 2. Meaningful Use Menu Set- five of the 10 must be met.

1. Drug-Formulary Checks.
2. Incorporate clinical lab test results as structured data.
3. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate.
4. Summary of care record for each transition of care/ referrals.

*5. Capability to provide electronic submission of reportable lab results to public health agencies.

6. Record advanced directives for patients 65 years or older.
7. Generate lists of patients by specific conditions.
8. Medication reconciliation.

*9. Capability to submit electronic data to immunization registries/systems.

*10. Capability to provide electronic syndromic surveillance data to public health agencies.

At least one of the three public health objectives (denoted by asterisk) must be selected.
Source: Centers for Medicare and Medicaid Services (www.cms.gov)

Table 3. Meaningful Use Clinical Quality Measures- All 15 must be met.

1. Emergency Department Throughput - admitted patients - Median time from ED arrival to ED departure for admitted patients.
2. Ischemic stroke - Discharge on anti-thrombotics.
3. Ischemic stroke - Thrombolytic therapy for patients. arriving within 2 hours of symptom onset.
4. Ischemic stroke - Discharge on statins.
5. VTE prophylaxis within 24 hours of arrival.
6. Anticoagulation overlap therapy.
7. VTE discharge instructions.
8. Incidence of potentially preventable VTE.
9. Emergency Department Throughput - admitted patients - Admission time from ED arrival to ED departure for admitted patients.
10. Ischemic stroke - Anticoagulation for A-fib/flutter.
11. Ischemic or hemorrhagic stroke - Antithrombotic therapy by day two.
12. Ischemic or hemorrhagic stroke - Rehabilitation assessment.
13. Intensive Care Unit VTE prophylaxis.
14. Platelet monitoring on unfractionated heparin.
15. VTE discharge instructions.

Source: Centers for Medicare and Medicaid Services (www.cms.gov)

Hospitals demonstrate these Meaningful Use measures in various ways, including attestation that certain elements are available, submission of claims with applicable data, and reporting of CQMs. It is essential for a hospital to discuss the Meaningful Use measures it plans to achieve with potential EHR vendors. This can help find the system that best fits individual needs and will also meet the requirements for Meaningful Use at the same time. OFMQHIT can help

hospitals through this decision by providing a list of certified vendors and discussing the merits of each option.

Medicare and Medicaid Payment Structures (and Examples)

As the introduction indicated, unlike physician practices which can only register and benefit from one payment program, eligible hospitals can benefit from both Medicare and Medicaid incentive programs. All CAHs and PPS hospitals are eligible for Medicare incentives. Both CAHs and PPS hospitals are also eligible to receive Medicaid incentive payments if their Medicaid patient volume is at least 10 percent of total patient volume.

Medicare payments

There are two distinct payment programs under Medicare: one for PPS hospitals, and one for CAHs. PPS hospitals can receive lump sum payments (which are not based on the EHR cost) in each of four consecutive years, while CAHs receive reimbursement payments for "reasonable costs" incurred for the purchase of certified EHR technology. The formulas for these Medicare incentive payments are summarized below, with examples of the payment a particular hospital would receive.

1. PPS - Medicare Incentive Payment.

[Initial Amount] x [Medicare Share] x [Transition Factor]

Initial Amount = $2,000,000 + [$200 per discharge for the 1,150th – 23,000th discharges]

Medicare Share =

$$\frac{\text{(\# IP Part A Bed Days + \# IP Part C Days)}}{\text{Total IP Bed Days} \times \frac{\text{Total Charges-Charity Charges}}{\text{Total Charges}}}$$

Transition Factor = Phases down incentive payments over a 4-year period as in the table below:

		Year Meaningful Use is Reached				
		2011	*2012*	*2013*	*2014*	*2015*
Year of Payout	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

Example: A PPS hospital in eastern Oklahoma meets Meaningful Use criteria and is eligible for incentive payments in 2012. They had 10,000 inpatient discharges in FY2011. This hospital had 15,000 Part A inpatient bed days and 18,000 Part C inpatient bed days, with total inpatient bed days of 50,000 in FY2011. Its total charges excluding charity were $9,000,000, with total charges of $10,000,000. The incentive payment to this hospital in 2012 is:

Initial Amount: $2,000,000 + [$200*(10,000-1,150)] = $3,770,000

Medicare Share:

$$\frac{15{,}000+18{,}000}{50{,}000 \times \frac{9{,}000{,}000}{10{,}000{,}000}} = 0.733$$

Transition Factor: 1.00 in 2012

Total Incentive Payment in 2012: $3,770,000*0.733*1.00 = $2,764,667

This hospital would also be eligible for payments in 2013, 2014, and 2015 if they continue to meet the requirements for Meaningful Use. **Note:** If hospitals delay achieving Meaningful Use until 2014 or 2015, these hospitals will not be eligible for all 4 years of incentive payments; the transition factors will then start from a lower level.

2. CAH - Medicare Incentive Payment

$$\left(\frac{\text{(\# IP Part A Bed Days + \# IP Part C Days)}}{\text{Total IP Bed Days} \times \frac{\text{Total Charges-Charity Charges}}{\text{Total Charges}}}\right)$$

+20 percentage points) x undepreciated EHR cost

Example: A CAH in northwestern Oklahoma becomes a Meaningful User beginning in FY 2014. It has 250 Part A inpatient bed days and 450 Part C inpatient bed days out of a total of 1,000 inpatient-bed-days on its most recent 12-month cost report. Its charges without charity care were $2,500,000, and its total charges were $2,700,000. This CAH incurred $600,000 for the purchase of certified EHR technology during its previous year's cost report, of which $100,000 was depreciated. This CAH will receive the following payment in 2014:

$$\left(\frac{(250+450)}{1000 \times \left(\frac{2{,}500{,}000}{2{,}700{,}000}\right)} + .20\right) \times \$500{,}000 = \$478{,}000$$

This CAH will also be eligible for reimbursement payments in later years as long as reasonable EHR costs were incurred during that year.

Medicaid payments

Similar to the Medicare PPS payment, the Medicaid incentive payment (for both CAHs and PPS hospitals) is not based on EHR cost. Rather, a formula is used to calculate an aggregate incentive amount for a theoretical four-year period. Payment is distributed on an annual basis based on Oklahoma's incentive plan, which pays out over three years. The general formula for the Medicaid incentive payment is summarized below.

3. Medicaid Incentive Payment – Both CAH and PPS Hospitals:

Aggregate EHR Amount = [Initial Amount] x [Transition Factor] x [Medicaid Share]

Initial Amount = $2,000,000 + [$200 per discharge for the 1,150th – 23,000th discharges]

Transition Factor: Phases payments down using a theoretical four-year period. These factors are used to calculate the aggregated EHR amount but do not indicate that a hospital payment will be calculated anew each year.

Year	1	2	3	4
Transition Factor	1.00	0.75	0.50	0.25

Medicaid Share =

$$\frac{\text{\# Medicaid IP Days + \# Medicaid Managed Care Days}}{\text{Total IP Bed Days} \times \frac{\text{Total Charges - Charity Charges}}{\text{Total Charges}}}$$

Example: A CAH in western Oklahoma meets the Meaningful Use criteria for certified EHR technology in FY2014. It had 500 discharges in FY2013. They also had 1,000 Medicaid inpatient bed days, 400 Medicaid managed care inpatient bed days, and a total of 2,000 inpatient days in FY2013. Their total charges excluding charity were $4,500,000 and their total charges were $5,000,000.

Initial Amount x Transition Factor:

$2,000,000 in Year 1 (no per discharge payment since they did not reach 1,150 discharges)
$1,500,000 in Year 2 ($2,000,000 x 0.75)
$1,000,000 in Year 3 ($2,000,000 x 0.50)
$500,000 in Year 4 ($2,000,000 x 0.25)
Total amount over 4 years = $5,000,000

Medicaid Share:

$$\frac{1{,}000+400}{2{,}000 \times \frac{4{,}500{,}000}{5{,}000{,}000}} = 0.777$$

Aggregate EHR Amount = $5,000,000 x 0.777 = $3,888,888

This aggregate EHR amount would be awarded over a period of three years as designated by Oklahoma's Medicaid statute. Oklahoma will use a pay-out plan of 50 percent / 40 percent / 10 percent during this three-year period, making this hospital's payout $1,944,444 in FY2014, $1,555,555 in FY 2015, and $388,889 in FY2016.

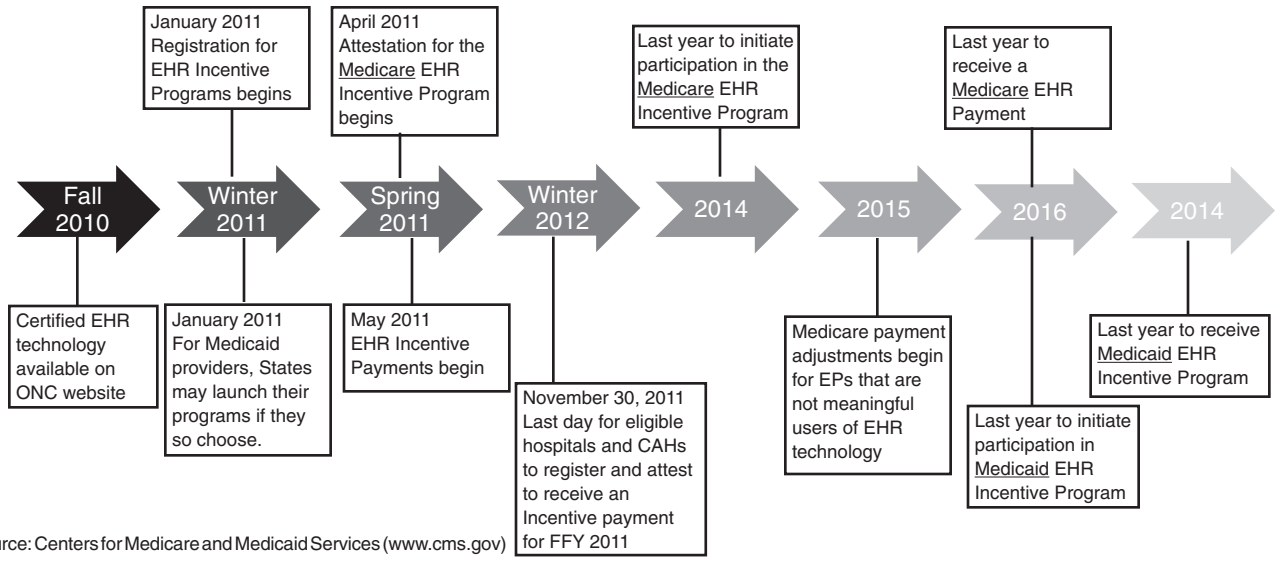
Note: The incentive payments generally use a $2,000,000 base to begin the calculation. This will likely result in a significant payment and can make up a large portion of the up-front costs faced by hospitals. Four rural hospitals in Oklahoma implemented EHRs early in 2008-2009 under a pilot program from the U.S. Department of Health and Human Services, and experienced up-front costs ranging from $300,000 to $1,700,000.

Timeline of Implementation

Since the exact specifications of Meaningful Use were not released until July 2010, EHR vendors have had to make recent adjustments to their products in order for Meaningful Use to be achieved. In addition, a certification process established for health care information and technology has been set up by the Office of the National Coordinator for Health Information Technology (ONC). A list of certified EHR products is now available on the ONC website: http://onc-chpl.force.com/ehrcert. Figure 2 displays the timeline of registration, payments, and milestones defined by CMS for this program.

The dates are quickly approaching, with registration for the EHR incentive programs starting promptly in January 2011. Note that the Medicaid timeline is significantly more lax than the timeline for Medicare. For hospitals to receive the maximum incentive payment, Meaningful Use must be reached in 2013. However, many hospitals have not started thinking about which EHR system to select, which in itself can be very time consuming. Additionally, once a vendor is selected, the EHR conversion process can take approximately 22 months (Table 4). Thus, it is essential for hospitals to start moving quickly to meet these tasks in a timely manner and receive maximum payments for EHR implementation.

Figure 2. EHR Incentive Programs Timeline for Hospitals (Medicare and Medicaid)



Source: Centers for Medicare and Medicaid Services (www.cms.gov)

Table 4. Timeframe for EHR Implementation and Reaching Meaningful Use.

Task	*Time to Accomplish**
Vendor Programming and Testing	90 to 150 days
Vendor Certification	30 to 90 days
Vendor Capacity to Implement	60 to 300 days
Vendor EHR Implementation and Testing	120 to 300 days
90 day Meaningful Use Qualification Period	90 days

* "Typical" time from vendor selection to meaningful use: 660 days (22 months)

Penalties for Failure to Achieve Meaningful Use by 2015

If a CAH has not met the criteria for Meaningful Use with a certified EHR system by 2015, the reimbursement received by the CAH from Medicare will be reduced from 101 percent to 100 percent over the course of four years according to the following schedule:

Year	*Cost-based Reimbursement*
2009 - 2014	101%
2015	100.66%
2016	100.33%
2017	100%

For Prospective Payment System hospitals (non-CAHs), the penalties are more severe. Hospitals that are not meaningful users will have their applicable Market Basket Adjustment (MBA) reduced as follows:

Year	*0.75 MBA increase reduced by:*
2015	33.33%
2016	66.66%
2017 & beyond	100%

There are no rulings in place for deductions in Medicaid reimbursements at this time.

Options for Hospitals

Many smaller hospitals are still using paper records. Looking at all the requirements associated with getting an EHR up and running can be a daunting task, particularly for rural hospitals with fewer staff members and less technical expertise. OFMQHIT has suggested that there are basically four options for rural Oklahoma hospitals facing the new EHR guidelines:

1. **Do nothing.** While continuing to use paper may seem like the best choice, one must remember there will be penalties in Medicare reimbursements for hospitals that do not "Meaningfully Use" EHRs by 2015. Further, EHRs are here to stay, so it is best to consider implementing a system - especially since monetary incentives are available.
2. **Go it alone.** There are some EHR vendors that cater specifically to CAHs or other rural and small hospitals, where the EHR requirements are often vastly different than they are for a 250 bed hospital. However, selecting one and getting to Meaningful Use remains a difficult task, especially considering that most small hospitals lack the technical expertise and dedicated information technology employees to assist with an EHR implementation and maintain those systems once deployed.
3. **Partner with a "parent" organization.** Some health care entities in Oklahoma (Saints, Integris) have shown an interest in partnering with smaller hospitals to help them implement and achieve Meaningful Use with an EHR. The benefit of this type of arrangement for a smaller "child" hospital would be to leverage the skills and resources of the "parent" organization, utilizing their professional IT staff and existing EHR expertise to efficiently extend the "parent" EHR environment to the smaller hospital partner. This not only would facilitate EHR collaboration, but would also ease transitions of care between organizations and promote continuity of care through the sharing of patient information.
4. **Band together – form a cooperative.** Similarly, groups of smaller hospitals can partner together to extend their purchasing power and leverage the economies of scale inherent to a shared EHR and technical infrastructure. Regardless of geographic location, if such rural hospitals "cooperatives" were formed (on the order of 8 to 10 hospitals) EHR vendors might be able to view them as if they functioned as a single entity, and offer EHR pricing and support in a similar arrangement as that of a larger hospital. Some vendors, such as GE, have indicated they would be willing to work with these types of groups. Both buyer and seller would benefit from this arrangement: buyers now have a degree of market power and a sounding board for questions, and sellers are ensured a reasonably sized customer base to focus their efforts.

Next Steps

Hospitals should spend some time familiarizing themselves with the Meaningful Use guidelines, what incentive payments they are eligible for, and what certified EHR systems are currently available. Several of the references listed below provide additional details on these topics. If you currently have an EHR system but are unsure about its certification status, it is best to check with the vendor about their plans for upgrading. Hospitals should also make sure that they are enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) since this is how incentive payments will be received. PECOS enrollment can be checked at http://www.cms.gov/MedicareProviderSupEnroll. Again, the OFMQHIT is Oklahoma's Regional Extension Center specifically charged with helping hospitals through this process, and their website is http://www.ofmqhit.com. Contact and interest forms are available on this website, or they can be reached at (405) 302-3318. The vast majority of the cost of this program is subsidized via the federal government; however, hospitals can generally expect to pay around $1,200 to OFMQHIT in order to participate. Given that the process can take 18 months to 22 months, can result in several million dollars in incentive payments, and provides access to EHR technology specialists, this represents an exceptional value. Keep an eye out for additional current reports on this topic, as OFMQHIT, Oklahoma Cooperative Extension Service, and the Center for

Rural Health will continue to provide information as it becomes available.

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