

# HIT Incentive Payments for Physicians and Hospitals in HITECH Act

*Are They Worth Pursuing?*

*Written by:*

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**NOTICEABLY  
DIFFERENT**

## Background

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The nearly \$800 billion *American Recovery and Reinvestment Act of 2009* (ARRA) made \$19 billion available for health information technology (HIT) through the *Health Information Technology for Economic and Clinical Health Act* (HITECH Act). The comprehensive stimulus package was signed into law by President Barack Obama on February 17.

Of the \$19 billion amount, \$17 billion is specifically set aside to pay incentives through Medicare and Medicaid for physicians and hospitals that implement and use HIT, such as electronic health records (EHR) and e-prescribing by 2014.

The remaining \$2 billion will be distributed through the Office of the National Coordinator for Health Information Technology (ONCIT) for a number of projects, including:

- Health information exchange (HIE) infrastructure
- Standards evaluation and development
- Grants to states for the purpose of furthering EHR adoption
- Improvements in telemedicine delivery
- The establishment of regional HIT resource centers

The ONCIT is responsible for providing counsel to the secretary of Health and Human Services (HHS) and departmental leadership for the development and nationwide implementation of an interoperable HIT infrastructure.

The intent of the new law is clear. Health care providers are strongly encouraged to take two huge steps by 2014: purchase “certified” EHR technology and use it in a “meaningful way.” Organizations that do not achieve this objective by the deadline will not only pass up available payment incentives, but will also begin incurring Medicare payment reductions.

## Qualifying for the HIT incentives

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To qualify for the incentives, a provider must demonstrate “meaningful use” of “certified” EHR technology. The HITECH Act requires the HHS Secretary, based upon recommendations from the ONCIT and a HIT Policy Committee, to adopt rules for an initial set of standards, implementation specifications, and certification criteria no later than December 31, 2009.

### Qualifications for Medicare incentive payments

Although further detail will be provided in the rules, according to the HITECH Act meaningful use of certified EHR technology:

- Is determined appropriate by the HHS secretary
- Includes [e-prescribing capabilities](#)
- Uses electronic connection in a manner that allows for (lawful) exchange of health information to improve quality of health care
- Utilizes EHR technology to report on clinical quality measures as outlined by the HHS secretary

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The HHS secretary has been charged with modifying the definition of meaningful use over time to include more stringent measures to further improve EHR usage and health care quality. In addition, determining the criteria for certified EHR technology and who will complete the certification also remains to be defined. These unanswered questions have many in the industry concerned, including David Blumenthal, M.D. and President Barack Obama's choice for national coordinator for health information technology in the Department of HHS. In a March 2009 *New England Journal of Medicine (NEJM)* article titled "[Stimulating the Adoption of Health Information Technology](#)," Blumenthal wrote that "... many certified EHRs are neither user-friendly nor designed to meet HITECH's ambitious goal of improving quality and efficiency in the health care system."

While explicit definitions are yet to be determined, it is becoming increasingly clear within the industry that the more cumbersome meaningful use is and the more stringent the certification requirements are, the less effective EHR implementation will be.

### **Qualifications for Medicaid incentive payments**

For Medicaid incentive payments, each state (with approval from the HHS secretary) will define meaningful use of EHR technology for its providers. By the end of 2009, the federal government is required to publish standards on:

- What constitutes a certified EHR
- What defines meaningful use of an EHR
- Incentive payment structure, limits, and reimbursable items
- Eligible activities for Medicaid incentive payments

### **Calculating the HIT incentive payments**

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To help you determine if implementing an EHR by the government's deadline is the right strategy for your practice or hospital, we've outlined how the separate HIT incentive payments are calculated for physicians, Prospective Payment System (PPS) hospitals, and Critical Access Hospitals (CAHs).

According to the HITECH Act, incentive payments will be available under both Medicare and Medicaid. But providers that meet the eligibility requirements for both must choose between the two incentive programs. In other words, these providers are only permitted to receive incentives through one program or the other, but not both.

### **HIT Medicare incentive payment rules and formulas for physicians**

Physicians eligible to qualify for the incentive payments include doctors of medicine or osteopathy, dental surgery or dental medicine, podiatric medicine, optometry, and chiropractors.

Each eligible physician, who can demonstrate meaningful use of certified HIT, can receive up to \$44,000 under the Medicare incentive payments over five years. Additionally, those physicians operating in a health professional shortage area will be eligible for an increase of 10 percent in their incentive payment for each year the incentives are paid.

Alternatively, physicians operating entirely in a hospital environment, such as anesthesiologists, pathologists, or emergency room physicians, are NOT eligible for the incentive payments. This is because it is anticipated hospitals will take advantage of the EHR incentives, and these hospital-based physicians will be using EHR technology that has received incentive payments and duplicate payments will not be allowed.

**Physician payments and timeline**

Qualifying physicians will be eligible for the following incentive payments through Medicare:

Yearly Amount Per Physician							
Year first filed	2011	2012	2013	2014	2015	2016	TOTAL
2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$44,000
2012	\$0	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$44,000
2013	\$0	\$0	\$15,000	\$12,000	\$8,000	\$4,000	\$39,000
2014	\$0	\$0	\$0	\$12,000	\$8,000	\$4,000	\$24,000
2015 or Later	\$0	\$0	\$0	\$0	\$0	\$0	\$0

**Penalties and rate reductions for physicians**

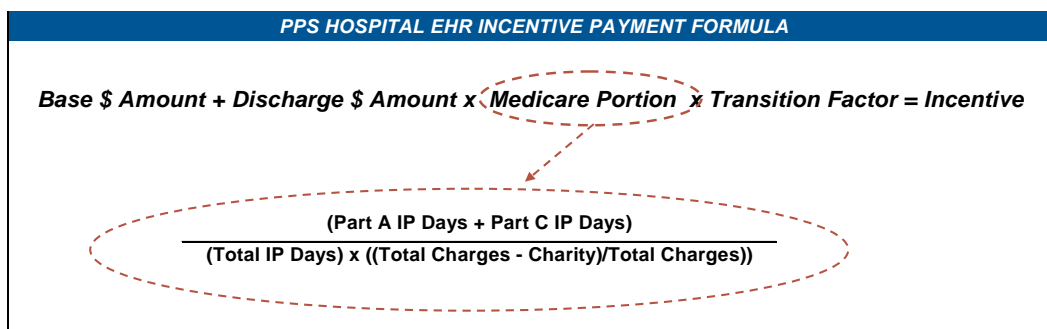
From 2015 through 2017, physicians not demonstrating meaningful use of an EHR will have their Medicare fee schedule reduced by 1 percent per year. If fewer than 75 percent of the eligible health care providers utilize EHRs in 2018 and subsequent years, the HHS secretary can reduce the fee schedule further (to a maximum of 95 percent of the fee schedule). Significant hardship exemptions related to the imposition of the penalty may be granted in some cases.

**HIT Medicare incentive payment rules and formulas for PPS hospitals**

PPS hospitals can receive incentives over a four-year period if they start using EHR technology by 2011. At this time, psychiatric, rehabilitation, long-term care, children’s, and some other specific specialty hospitals are NOT eligible.

Incentive payments will be determined from a complex formula consisting of a base dollar amount, plus a per discharge amount, multiplied by the hospitals Medicare share, times a yearly transition factor.

The complicated part of the formula is in identifying the Medicare portion, which involves a combination of Medicare days, both traditional Part A and Part C, divided by total inpatient days, multiplied by the ratio of charges less charity care to total charges. The following table illustrates the math involved in the formula.



The per-discharge amount equates to \$200 for each discharge from the 1,150<sup>th</sup> to 23,000<sup>th</sup>, with \$0 for those below or above the thresholds.

The transition factor included in the formula above essentially reduces the incentive payments over a four-year time period. The transition factors for the respective years are as follows:

First payment year	1
Second payment year	¾
Third payment year	½

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Fourth payment year	¼
Fifth payment year	0

### Calculate your PPS hospital's estimated EHR incentive payment

Download our [tool](#) to calculate your hospital's estimated EHR incentive payment.

### PPS hospital timeline

From 2011 through 2013, hospitals can receive 100 percent of their eligible incentive payments in accordance with the formula above. If the first year of meaningful EHR use is after 2013, the applicable transition factor would apply as if the first year was 2013.

### Penalties and rate reductions for PPS hospitals

If a hospital's first year of meaningful EHR use is after 2015, it will not be eligible to receive any incentive payments. The table below depicts an example of how this phase-out formula would be calculated and the potential impact it could have on an organization.

PHASE DOWN ANALYSIS *				
"Year 1" =>	2013	2014	2015	2016
2013	\$ 675,619	N/A	N/A	N/A
2014	506,714	\$ 506,714	N/A	N/A
2015	337,809	337,809	\$ 337,809	N/A
2016	168,905	168,905	168,905	\$ -
2017	-	-	-	-
<b>Total</b>	<b>\$ 1,689,047</b>	<b>\$ 1,013,428</b>	<b>\$ 506,714</b>	<b>\$ -</b>

\* Max. benefit if "Year 1" is 2011 - 2013; phase down begins in 2014 and assumes 2013 is "Year 1" with payments made according to transition schedule; incentive will equal \$0 after 2015.

In addition to risking the loss of the incentive as illustrated above, hospitals that fail to become meaningful EHR users also face potential reductions in the applicable market basket percentage increases to PPS payments. The reductions in the proposed market basket increases by year would be as follows:

- 2015 reduction: 33 1/3 percent
- 2016 reduction: 66 2/3rd percent
- 2017 and each subsequent year reduction: 100 percent

Some hospitals may be eligible for a hardship exemption as it pertains to EHR implementation, but the law limits it to a maximum of five years.

### HIT Medicare incentive payment rules and formulas for CAHs

CAHs are eligible for EHR incentives as well, and are subject to the same eligibility requirements as PPS hospitals. The formula used to arrive at estimated incentives is slightly different, and is based on the costs incurred for EHR implementation in a single year, multiplied by the Medicare share, plus 20 percent, not to exceed 100 percent. The following table illustrates the math involved in the formula.

**CAH HOSPITAL EHR INCENTIVE PAYMENT FORMULA**

$$\text{Cost of EHR} \times (\text{Medicare Portion} + 20\% *) = \text{Incentive}$$
$$\frac{(\text{Part A IP Days} + \text{Part C IP Days})}{(\text{Total IP Days}) \times ((\text{Total Charges} - \text{Charity})/\text{Total Charges})}$$

*\* Not to exceed 100%.*

There's a small twist regarding reasonable costs in that they will be based on costs incurred in a single year and not capitalized and depreciated over the useful life. This means costs associated with the purchase of certified EHR technology, excluding interest costs, incurred in a given year will be recognized as expense for incentive purposes. Any previously incurred costs not yet fully depreciated can be added to the expensed costs, but amounts already depreciated can not be added.

This treatment will create a record keeping challenge for CAHs by balancing the Generally Accepted Accounting Principles (GAAP) reporting for assets with lives over multiple years and the expense recognition criteria for incentive requirements. Most likely this will require maintenance of additional schedules to ensure both are accurately reported.

### **Calculate your CAH's estimated EHR incentive payment**

Download our [tool](#) to calculate your hospital's estimated EHR incentive payment.

### **Penalties, rate reductions, and timeline for CAHs**

Similar to PPS hospitals, CAHs will lose eligibility to receive EHR incentive payments for any cost reporting period beginning during a payment year after 2015, and they are also limited to a four-year payment period. CAH incentive payments, however, do not have a transition factor involved in the calculation.

Beginning in 2015, CAHs that are NOT meaningful users of EHR technology will experience payment reductions. Rather than receiving reimbursement at 101 percent of eligible Medicare costs, CAHs that are not meaningful EHR users will be subject to the following reimbursement rates:

- 2015: 100.66 percent
- 2016: 100.33 percent
- 2017 and each subsequent year: 100 percent

### **HIT Medicaid incentive payment rules and formulas to be determined**

Beginning in 2011, the following health care organizations will be eligible for Medicaid incentive payments:

- Non-hospital-based physicians, dentists, certified midwives, and nurse practitioners who practice in a rural health clinic or a Federally Qualified Health Center (FQHC) led by a physician assistant who has at least a 30 percent Medicaid patient volume
- Pediatricians who are not hospital based and have at least a 20 percent Medicaid patient volume
- Children's hospitals

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- Acute-care hospitals (that are not children's hospitals) that have at least a 10 percent Medicaid patient volume
- Rural health clinics or FQHCs that have at least 30 percent of patient volume from needy individuals

As mentioned earlier, each state (with approval from the HHS secretary) will define meaningful use of EHR technology for its providers and the ONCIT will further define certified technology.

### **Criteria to determine maximum HIT Medicaid incentives**

Both the federal and state governments will play a role in determining how much the maximum Medicaid incentive payments are and which providers meet the criteria to receive them. The maximum Medicaid incentive payment that a provider can receive will be set by the HHS secretary based upon the following parameters:

- It will be limited to no more than 85 percent of a provider's investment.
- For eligible, non-hospital-based Medicaid providers, such as physicians, the Centers for Medicare & Medicaid Services (CMS) will determine an average allowable cost by studying the average purchase and initial implementation costs for these Medicaid providers.
- Hospital payments will be based upon a formula similar to the Medicare one but will not include the phase down in years two through four.
- The Medicaid patient volume has yet to be defined.

Contrary to the language in the ARRA, which establishes the non-hospital-based providers payment caps at 85 percent of \$25,000 for the initial acquisition and implementation and \$10,000 for each subsequent year for five years with a cap at \$64,000, states have been informed that the limit will actually be set by the HHS secretary by the end of the 2009 calendar year.

### **Differences in HIT Medicaid incentive payments compared to Medicare**

There are a few unique features of the Medicaid incentive payments:

- Non-hospital-based providers must choose between the Medicaid and Medicare incentive programs; they cannot receive both.
- Physicians seeking Medicaid incentive payments must first demonstrate EHR usage by 2015 and will not be eligible for payments after 2021.
- Pediatricians are only eligible for 66 percent of the incentive payment because they are eligible for them at a lower threshold (20 percent Medicaid patients).
- Providers that have already invested in EHR technology are still eligible for the incentive payments.

### **HITECH Act challenges and what health care providers can do now**

There has been a lot of discussion in the past few months about whether providers should purchase EHR technology now or wait until more clarity is provided on the definitions of meaningful use and certified HIT. Although these are valid concerns, if providers wait for more direction from the government before even beginning to evaluate readiness for EHR adoption, they run the risk of not making the 2015 deadline. According to Blumenthal's *NEJM* article, it seems he would support this notion because he said, "The infrastructure to support HIT should be in place well before 2011 if physicians and hospitals are to be prepared to benefit from the most generous Medicare and Medicaid bonuses."

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Over the next two years, there will be a tremendous push for the sale and implementation of EHR technology. Undoubtedly questions will rise as to whether the HIT industry can meet the expected demand. Based on experience, it takes a typical group of five physicians approximately six months to fully implement an EHR and it takes hospitals a minimum of 18–24 months.

The federal government's goal is for 75 percent of physicians and hospitals to use certified EHR technology in a meaningful way by 2015. With fewer than 20 percent of physicians currently using it and only 1.5 percent of (non-federal) hospitals using comprehensive EHRs for all clinical departments, the potential growth in this area will not only tax the HIT industry, but may leave some providers waiting in line for implementation services.

We are also concerned whether providers can implement [electronic medical records](#) (EMRs) in this short timeline, let alone overcome the technical complications of a single health record for patients that would be accessible by multiple providers.

So, the real question to address is can providers meet the aggressive timelines for implementation given the many unanswered questions. Timing will surely become a delicate balancing act that teeters between ensuring timeliness to capitalize on incentives (and avoid future payment streams are not reductions), yet avoiding unnecessary spending associated with reworking pieces of implementation as new information emerges.

To determine if EHR implementation is the right direction for your organization, we recommend you begin evaluating your HIT strategy, including the benefits, cost, and available systems to choose from as soon as possible. Regardless of the emerging skepticism about the timeframes being too aggressive, absent official extensions on these regulations, providers that delay EHR implementation run huge risks—losing significant incentives and reducing their current revenue streams. Those are realities no provider wants to live.

### How we can help

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We can help you determine if and when you should implement an EHR. We'll assess your situation and assist you in developing a HIT strategy, from return on investment analysis to [system selection](#).

#### Contact us

Name	Contact Information
Rob Schile, Principal	612-376-4592 or <a href="mailto:rschile@larsonallen.com">rschile@larsonallen.com</a>
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#### Helpful resources

We consider the following Web sites helpful if considering the implementation of an EHR:

- [Health Information Technology for the Future of Health and Care](#)
- [U.S. Department of Health and Human Services](#)
- [Certification Commission for Healthcare Information Technology](#)
- [National eHeath Collaborative](#)
- [CMS Physician Quality Reporting Initiative \(PQRI\)](#)
- [Federal Information on the progress of the ARRA](#)