EHR Incentive Payments
For
Rural Hospitals and Eligible Providers

April, 2011

Tommy Barnhart, Dixon Hughes Goodman LLP
Objectives

• Health Information Technology (HIT) and Electronic Health Record (EHR) Incentive Payments
  – Incentive payments for:
    • PPS hospitals & CAH
    • Eligible providers
  – Sample calculation of CAH & PPS hospital incentive
  – Data needs for the calculation
  – EHR & reform
References and Limitations

• Based on our understanding of current policy
• Subject to further clarification by CMS and others
• Consult with your reimbursement adviser, financial auditor and Medicare Administrative Contractor
EHR Incentive Payments

- American Recovery and Reinvestment Act of 2009 (ARRA)
  - Final rule issued 7/28/10 (275 pages – small print)
  - Provides incentive payments from Medicare and Medicaid to encourage hospitals and physicians to implement EHR systems and technologies
  - Payments - available for 5 years beginning 2011
  - Unlike physicians, hospitals (including CAH) may be able to receive payments tied to both Medicare and Medicaid
PPS Hospitals and CAH
EHR Incentive Payments

• The key factor to qualifying for funding – successfully becoming a *meaningful user* of EHR

• Final rule defines Meaningful User criteria only for Stage 1 (2011 through 2012)
  – For the first qualification year, hospitals demonstrate the meaningful use criteria for 90 continuous days.
  – For every year after the first payment year, the EHR reporting period is for the entire year.
• Incentive Payment = (Initial Amount) x (Medicare Share) x (Transition)
  – Initial Amount = $2 million/hospital plus $200 per discharge 1,150 to 23,000
  – Medicare Share equals [# of Part A days plus MA beneficiary days] ÷ [Total IP days x ((Total charges minus charity care charges) ÷ by total charges)]
EHR Incentive Payments - PPS

- Incentive Payment = (Initial Amount) x (Medicare Share) x (Transition)
  - Transition factors

- Year 1: 1
- Year 2: 3/4
- Year 3: 1/2
- Year 4: 1/4
### Basic Hospital Data:

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<thead>
<tr>
<th>Data Point</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>650</td>
</tr>
<tr>
<td>Total hospital charges</td>
<td>$35,000,000</td>
</tr>
<tr>
<td>Hospital charity care charges</td>
<td>$500,000</td>
</tr>
<tr>
<td>First date to qualify as meaningful user</td>
<td>10/1/2011</td>
</tr>
</tbody>
</table>

### Basic Program Data:

<table>
<thead>
<tr>
<th>Data Point</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive amount - base</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Incentive amount - per discharge (1,150 thru 23,000)</td>
<td>$200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fiscal Year that Eligible Hospital Receives the First Incentive Payment</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year that Eligible Hospital Receives the First Incentive Payment</td>
<td>2011</td>
<td>1.00</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Fiscal Year that Eligible Hospital Receives the First Incentive Payment</td>
<td>2012</td>
<td>0.75</td>
<td>1.00</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Fiscal Year that Eligible Hospital Receives the First Incentive Payment</td>
<td>2013</td>
<td>0.50</td>
<td>0.75</td>
<td>1.00</td>
<td>-</td>
</tr>
<tr>
<td>Fiscal Year that Eligible Hospital Receives the First Incentive Payment</td>
<td>2014</td>
<td>0.25</td>
<td>0.50</td>
<td>0.75</td>
<td>1.00</td>
</tr>
<tr>
<td>Fiscal Year that Eligible Hospital Receives the First Incentive Payment</td>
<td>2015</td>
<td>-</td>
<td>0.25</td>
<td>0.50</td>
<td>0.75</td>
</tr>
<tr>
<td>Fiscal Year that Eligible Hospital Receives the First Incentive Payment</td>
<td>2016</td>
<td>-</td>
<td>-</td>
<td>0.25</td>
<td>0.50</td>
</tr>
</tbody>
</table>

### Calculated Hospital-specific Factors

<table>
<thead>
<tr>
<th>Data Point</th>
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<tbody>
<tr>
<td>Charity percentage</td>
<td>1.43%</td>
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<td>98.57%</td>
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<tr>
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</tr>
<tr>
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<td>101</td>
</tr>
<tr>
<td>Additional incentive based on discharges</td>
<td>$20,200</td>
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<tr>
<td>Medicare percentage</td>
<td>64.47%</td>
</tr>
<tr>
<td>Medicaid percentage</td>
<td>13.74%</td>
</tr>
<tr>
<td>Medicaid threshold met (yes = 1)</td>
<td>1</td>
</tr>
<tr>
<td>Eligible Medicaid percentage</td>
<td>13.74%</td>
</tr>
</tbody>
</table>

### Estimated Incentive Payment

<table>
<thead>
<tr>
<th>Hospital Fiscal Year</th>
<th>Medicare</th>
<th>Medicaid *</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$1,302,423</td>
<td>$277,575</td>
<td>$1,579,998</td>
</tr>
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<td>2013</td>
<td>976,817</td>
<td>208,182</td>
<td>1,184,999</td>
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<tr>
<td>2014</td>
<td>651,211</td>
<td>138,788</td>
<td>789,999</td>
</tr>
<tr>
<td>2015</td>
<td>325,606</td>
<td>69,394</td>
<td>395,000</td>
</tr>
<tr>
<td></td>
<td>$3,256,057</td>
<td>$693,939</td>
<td>$3,949,996</td>
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</tbody>
</table>

*Medicaid payments subject to State Plan.
EHR Medicare Payments - CAH

- CAH’s - up to 4 payment years starting with cost report periods beginning in federal FY 2011.

- 2015 - the last payment year for which a CAH can receive incentive payments. Reduction in CAH reimbursement begins for Non-EHR hospitals by 2015.
### EHR Medicare Payments - CAH

- Payment for reasonable capital costs incurred for EHR assets and technology
- Payment = reasonable capital costs for EHR times CAH Medicare share
  - Swing bed days are not in the calculation
  - Medicare share = sum of the Medicare fraction plus 20 percentage points
  - Not exceeding 100%
What is EHR Capital Cost

• Great question!
  – CMS definition – Federal Register 7/28/2010
  – CMS useful life definition
  – Financial statement definition
  – Practical thoughts
  – In the end - Subject to hospital decision and MAC interpretation
• **Page 44573 – Section 495.106** *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 this chapter, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in §495.4, excluding any depreciation and interest expenses associated with the acquisition.

• **Page 44565 – Section 495.4** *Certified electronic health record technology has the same definition as* this term is defined at 45 CFR 170.102.
Certified EHR Technology

- **Federal Register – ONC - July 28, 2010, Page 44649**
- **§ 170.102 Definitions.**
- *Certified EHR Technology means:*
  - (1) A Complete EHR that meets the requirements included in the definition of a Qualified EHR and has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary; or
  - (2) A combination of EHR Modules in which each constituent EHR Module of the combination has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary, and the resultant combination also meets the requirements included in the definition of a Qualified EHR.
  - *Complete EHR means EHR technology* that has been developed to meet, at a minimum, all applicable certification criteria adopted by the Secretary.
  - *Disclosure is defined as it is in 45 CFR 160.103.*
EHR Capital Cost - CMS

- Provider Reimbursement Manual (PRM 15-1) Section 104.17 – Useful life of Depreciable Assets:

- Purchased computer software purchased on or after August 1, 1988, is depreciated using the applicable edition of the useful life guidelines.

- The costs of initial customizing and/or modification of purchased computer software to function with the provider's computer hardware, or to put it into place for use, should be capitalized as part of the historical cost of the software. Such costs are analogous to installation costs of a moveable asset.
• Costs of computer software developed or obtained for internal use that shall be capitalized include only the following:
  – a. External direct costs of materials and services consumed in developing or obtaining internal-use computer software. Examples of those costs include but are not limited to the following:
    – 1. Fees paid to third parties for services provided to develop the software during the application development stage.
  – 2. Costs incurred to obtain computer software from third parties.
  – 3. Travel expenses incurred by employees in their duties directly associated with developing software.
  – b. Payroll and payroll-related costs (for example, costs of employee benefits) for employees who are directly associated with and who devote time to the internal-use computer software project, to the extent of the time spent directly on the project. Examples of employee activities include but are not limited to coding and testing during the application development stage.
  – c. Interest costs incurred while developing internal-use computer software. Interest shall be capitalized in accordance with the provisions of Subtopic 835-20.

• General and administrative costs and overhead costs shall not be capitalized as costs of internal-use software.
Practical Thoughts

• Section 495.106 includes “necessary to administer certified EHR technology”
  – May expand the definition beyond the “certified” modules
Practical Thoughts

• Include:
  – Hardware and software costs
  – Training & implementation costs paid to outside vendor
  – Cost of outside vendors or contractors for functions directly related to the conversion & implementation (example: scanning or digitizing prior medical records)
Practical Thoughts

• Include:
  – Costs that the CAH would normally capitalize
    – if no incentive payment were in play
  – Costs in accordance with the CAH capitalization policy for Medicare
Practical Thoughts

• Include – maybe:
  – Hospital staff salaries, benefits and expenses for training & implementation time while at the vendor’s office or location outside the hospital
  – if it is documented
  – Cost of upgrades to financial accounting and related systems if necessary for the administration of the certified EHR
Practical Thoughts

• Include – maybe:
  – Cost of upgrades or new software to hospital-based clinics, and home health, nursing facility, etc. and related systems if necessary for the administration of the certified EHR by the CAH.
  – Interest during development – if any is capitalized
Practical Thoughts

• Include – maybe:
  – Cost of hospital staff during the “development” stage: i.e. travel to look at other systems, consultant costs in evaluating needs, costs of developing an RFP – if it can be documented
Practical Thoughts

• Do not Include:
  – Software maintenance service charges
  – Hardware maintenance
  – Hospital staff salaries & benefits while at the hospital
  – Normal operating costs
• Gross annual amount based on Medicare & Medicaid percentage
  – Medicare % impacted by MA days and charity care charges (greater charity care charges yield a greater Medicare percentage)
  – Excluded unit days such as Nursery, Rehab or Psych days not included
  – MA days from the cost report
  – Medicaid includes HMO days
  – Initial amounts based on most recent 12-month cost report
  – Final amounts based on actual cost report
EHR Incentive Pmts - CAH

- Medicare & Medicaid % impacted by charity care charges
  - Data to be obtained from cost report
    - CAH will complete cost report S-10 worksheets
  - CMS definition of charity using Hospital’s policy
    - Total Patient revenue to be used in the charity care % is defined in new cost report transmittal
- Gross revenue from the cost report – excluding physician revenue
EHR Incentive Pmts - CAH

- Revised cost report forms
  - CMS Transmittal #1, December 2010
  - Cost reporting periods beginning on or after May 1, 2010
  - Important worksheets: S-2, S-10, S-3,
    - C and E-1 Part II
  - Consult your cost report preparer
## Cost Reporting After Incentive

- Depreciation is no longer allowable cost
- Financing cost:
  - During period of development (before active use) capitalize as cost of system
  - After meaningful use – not allowable & excluded from future cost reports
EHR Incentive Payments - CAH

- Medicaid payments
  - Calculation the same as Medicare computation except uses Medicaid patient days
  - Must meet threshold of 10%
  - Subject to State Plan
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### Hospital HIT Undepreciated and acquisition costs (Medicare calculation only):

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Undepreciated cost at beginning of fiscal year</th>
<th>New HIT acquisition cost during fiscal year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>500,000</td>
<td>-</td>
</tr>
<tr>
<td>2013</td>
<td>150,000</td>
<td>150,000</td>
</tr>
<tr>
<td>2014</td>
<td>150,000</td>
<td>150,000</td>
</tr>
<tr>
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<tr>
<td>Adjusted Medicare percentage</td>
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<tr>
<td>Medicaid Transition Factor:</td>
<td></td>
</tr>
<tr>
<td>Year 1</td>
<td>1.00</td>
</tr>
<tr>
<td>Year 2</td>
<td>0.75</td>
</tr>
<tr>
<td>Year 3</td>
<td>0.50</td>
</tr>
<tr>
<td>Year 4</td>
<td>0.25</td>
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### Medicaid Factors *

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<tbody>
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<td>2012</td>
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<td>$277,575</td>
<td>$699,925</td>
</tr>
<tr>
<td>2013</td>
<td>126,705</td>
<td>208,182</td>
<td>334,887</td>
</tr>
<tr>
<td>2014</td>
<td>126,705</td>
<td>138,788</td>
<td>265,493</td>
</tr>
<tr>
<td>2015</td>
<td>126,705</td>
<td>69,394</td>
<td>196,099</td>
</tr>
</tbody>
</table>

| Total       | $802,465 | $693,939   | $1,496,404|
EHR Incentive Payments

• Challenges & open issues
  – Paid to providers of record based on provider number
  – CAHs must spend money or incur cost before they are entitled
  – Home office capital purchases for CAH must be on CAH books?
EHR Incentive Payments

• Challenges & open issues:
  – CAHs related interest is not allowable cost
  – Financing may be on different basis than incentive payments
  – Cash flow of implementation costs
  – What costs can be included
EHR Incentive Payments

- Challenges & open issues:
  - Web-based systems – no capital cost
  - Operating leases – no capital cost
  - Purchase cost of clinic, nursing facility, home health and other systems
  - Subject to final audit and settlement
  - Creation of different accounting and reimbursement depreciation schedules
What if you miss some costs?

• Potential impact:
  – Still get “regular 101% cost” – either depreciation, imputed interest or operating cost
  – Medicare share (including 20%) may be higher than “regular” reimbursement after allocation – including Medicaid in cost-based states
EHR Incentive Payments – Medicaid

• Incentive Payment = (Initial Amount) x (Medicaid Share) x (Transition)

  – Initial Amount = $2 million/hospital plus $200 per discharge 1,150 to 23,000

  – Medicaid Share equals [# of inpatient paid days plus HMO days] ÷ [Total IP days x ((Total charges minus charity care charges) ÷ by total charges)]

  – Imputed average annual growth rate
EHR Incentive Payments - Medicaid

- Incentive Payment = (Initial Amount) x (Medicaid Share) x (Transition)
  - Transition factors
  - Year 1: 1
  - Year 2: \( \frac{3}{4} \)
  - Year 3: \( \frac{1}{2} \)
  - Year 4: \( \frac{1}{4} \)
Eligible Professionals
Who is an Eligible Professional?

- Doctor of:
  - Medicine or Osteopathy
  - Oral Surgery or Dental Medicine
  - Podiatric Medicine
  - Optometry
  - Chiropractor

- May be able to participate in either Medicare or Medicaid
EHR Incentive Payments - EP

• Physicians in hospital settings
  – Provider-based are eligible
    • Ineligible if 90% or more are inpatient or ED
    • Plus a 10% HPSA bonus (at least 50% of services)

• Rural health clinics/FQHC
  • Medicaid only – if more than 30% Medicaid and needy
<table>
<thead>
<tr>
<th>EHR Incentive Payments - EP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician payments made to the physician but can assign to employer</td>
</tr>
<tr>
<td>• Physicians may qualify for Medicaid payments</td>
</tr>
<tr>
<td>– May switch between programs 1 time</td>
</tr>
<tr>
<td>– Maximum payment = Medicaid schedule</td>
</tr>
<tr>
<td>• Medicaid – must adopt, implement, upgrade or demonstrate meaningful use in the first year</td>
</tr>
</tbody>
</table>
EHR Incentive Payments - EP

- Additional Medicaid EP:
  - Nurse practitioner
  - Certified Nurse mid-wife
  - Physician assistant in a PA-led RHC or FQHC
MAXIMUM EHR INCENTIVE FOR A MEDICARE EP - NOT PREDOMINANTLY IN A HPSA

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>First CY in which the EP receives an incentive payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>$18,000</td>
</tr>
<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>$2,000</td>
</tr>
<tr>
<td>Total</td>
<td>$44,000</td>
</tr>
</tbody>
</table>
# Maximum EHR Incentive Payments for a Medicare EP - Predominantly in a HPSA

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Year that an EP first receives the incentive payment for Medicare covered professional services furnished in a geographic HPSA</th>
<th>2015 and Subsequent Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$19,800</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$13,200 $19,800</td>
<td></td>
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<tr>
<td>2013</td>
<td>$8,800 $13,200 $16,500</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$4,400 $8,800 $13,200 $13,200</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>$2,200 $4,400 $8,800 $8,800 $0</td>
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</tr>
<tr>
<td>2016</td>
<td>$2,200 $4,400 $4,400 $4,400 $0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$48,400 $48,400 $42,900 $26,400 $0</td>
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## MEDICAID EP POTENTIAL PAYMENTS

<table>
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<tr>
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<th></th>
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<tbody>
<tr>
<td>2011</td>
<td>$21,250</td>
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<tr>
<td>2012</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
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<tr>
<td>2014</td>
<td>$8,500</td>
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Medicaid Threshold 30%

• Count encounters for:
  – Medicaid paid regular & managed care
  – Dual eligible patients
  – See AL definitions on website

• RHC/FQHC also count “needy”
  – CHIP
  – Uncompensated care
  – Sliding fee scale
Help & More Information

- The Alabama Regional Extension Center (ALREC) - http://onehealthrecord.alabama.gov
- CMS – http://www.cms.gov/EHRIncentivePrograms
Reform Challenges

Reform Challenges our Personal Paradigms

- **Paralyzed by Confusion**
- **Embracing the Opportunities**
- **Existing in Denial**
- **Resigned to Acceptance**

**Resiliency**

- Low
- High

**Understanding**

- Low
- High
Reform Provisions

Goal

Objectives

Prerequisites

Shift Risk & Accountability
Adopt New Delivery Models
Provide Coverage for the Uninsured
Electronic Health Records
Access...Alignment...Coordination...Integration

Source: HFMA; Dixon Hughes Goodman
Reform Impact

Volume
- Insured +32M
- Inpatient +0.5%
- Outpatient +4%
- Elective +1%

Providers
- Hospital Consolidations
- Entrepreneur Centers
- Physician Owned Ancillaries

Accountability & Risk
- $90B in Penalties
- P4P/Bundling
- Shared Savings

Reimbursement
- $240 B in Savings
- Market Basket Adjustments
- DSH Revisions
- Value Based Purchasing

Source: Sg2 Dixon Hughes Goodman
Reform Impact

Innovation & Experimentation
- Pilots and Demonstrations
- ACO’s
- CMI

EHR & Analytics
- Communication
- Performance Tracking
- CMS Reporting
- Carrots and Sticks

Source: Sg2 Dixon Hughes Goodman
Reform Implications

Risk
Payers

Risk
Providers

Alignment

Independent

Alignment

Integration

Accountability

All Providers

Payers
Reform Road Map

The Prelude (2010-2013)

Chase the Incentives, Get Ready

- Focus on performance and care transitions
- Strengthen MD relationships
- Pilot unique value creation concepts


Manage the

- Manage to Medicare margins
- Manage new incentives and risk
- Implement new clinical business models

Regulation and Restructuring (2018-2020+)

Consolidate Your Position

- Accelerate patient information and financial transactions
- Streamline and simplify SoC portfolio
- Prepare for Medicare 3.0
Shifting Risk

- Consumers
- Employers
- Health Plans
- Government Payers

Risk Shift

- Physicians
- Medical Groups
- Hospitals
- Other Providers

Source: Pricewaterhouse Coopers | Dixon Hughes
Accelerating Alignment

FFS Reimbursement Cuts → Pay-for-Performance → Value-based Purchasing → Bundled Payments → Shared Savings → Global Payments / Capitation

Independent → Alignment → Integration → Accountability

All Providers

Payers

Source: PricewaterhouseCoopers
Physician Alignment
Drivers and Models
### Hospital Drivers for Alignment

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lower Costs</strong></td>
<td>“The biggest potential income streams for both hospitals and physicians may reside in sharing savings from providers. To do that, hospitals and physicians must manage care together.” – PwC</td>
</tr>
<tr>
<td><strong>Better Quality</strong></td>
<td>“Better quality will finally pay off for hospitals but they need physicians to deliver it.” – PwC</td>
</tr>
<tr>
<td><strong>New Payment Systems</strong></td>
<td>“Hospitals need to partner with physicians as a means of participating in ACO’s and other new payment arrangements.” – PwC</td>
</tr>
<tr>
<td><strong>Expand Base, Increase Volume, Grow Market Share</strong></td>
<td>“High end expensive procedures are at risk unless we can expand the referral base.” – Michael Sachs, Sg2</td>
</tr>
</tbody>
</table>
Physician Drivers for Alignment

- Professional Fees
- Ancillary Revenue
- Payor Leverage
- Profitability & Personal Income

- Operating Expense
- Administrative Burden
- Assessment / Audit Risk
- Alignment with Hospitals
HIT/EHR & Reform

- Joined at the hip
- EHR is the base of real reform
Questions?
Contact the Speaker

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