Washington Healthcare News®

wahcnews.com

Articles, Interviews and Statistics for the Healthcare Executive

Health Care's Digital Age: Meaningful Use Criteria and EHR Incentive Revenue

By Brian Conner
National Practice Leader, Hospitals
Moss Adams LLP

By Stacy Stelzriede, CPA
Partner, Health Care Practice
Moss Adams LLP

Hospitals have made significant progress in health information technology adoption. The American Recovery and Reinvestment Act provided Medicare and Medicaid incentive payments for the effective use of electronic health records (EHRs). As a result, the number of US hospitals with a basic EHR system has nearly tripled since 2010, according to the Robert Wood Johnson Foundation's 2013 Health Information Technology in the United States report.

Although a majority of hospitals are participating in the EHR incentive program, the number actually receiving payment is low. Hospitals—especially smaller and more rural facilities—are struggling to meet the first phase of the complex meaningful use criteria. According to the American Hospital Association, only 37 percent of hospitals met Stage 1 criteria and received payment in 2012.

With Stage 2 expected to take effect in 2014, only 5 percent of all hospitals can currently meet the standards, according to a July 2013 study in *Health Affairs*. As the EHR incentive criteria increase in difficulty, it's important to become familiar with the conditions and plan accordingly to benefit from the nearly $30 billion in incentives still available.

Meaningful Use Overview

According to the provisions of the Health Information Technology for Economic and Clinical Health Act, health care organizations must meet certain criteria to receive EHR incentive payments. The purpose is to encourage meaningful use of EHRs, which are expected to improve quality of care, safety, and efficiency and reduce health disparities.

Hospitals eligible for the Medicare EHR incentive program must initially meet meaningful use criteria by 2014. Beginning in 2015, Medicaid and Medicare providers who fail to meet the criteria will be subject to a payment reduction,

starting at 1 percent and increasing to a maximum of 5% for each year Medicare-eligible professionals don't demonstrate meaningful use.

Acute care hospitals with at least 10 percent Medicaid patient volume and children's hospitals are eligible for the Medicaid EHR incentive program. This program is administered at the state level, and requirements vary from state to state. Qualifying hospitals may participate in both the Medicare and Medicaid EHR incentive programs.

Stage 1: Data Capture and Information Sharing

The first phase of the EHR incentive lays the foundation to help advance health care and patient outcomes. The primary goal of Stage 1 is to capture health information electronically and use it to track clinical conditions.

Stage 1 includes a set of core and menu objectives that providers need to achieve to demonstrate meaningful use. Hospitals eligible for Medicare EHR incentive payments must meet the following criteria for at least a 90-day period and for the entire year thereafter:

- Fourteen core objectives
- Five out of 10 menu objectives
- Fifteen clinical quality measures

The Centers for Medicare & Medicaid Services (CMS) provides meaningful use specification sheets that highlight critical information for each objective, including:

- Meeting the measure of each objective
- Calculating the numerator and denominator for each objective
- Qualifying for an exclusion to an objective
- In-depth definitions of terms that clarify objective requirements
- Requirements for attesting to each measure

Hospitals that qualify for the Medicaid incentive payments don't need to meet the meaningful use objectives above in their first year of participation. However, Medicaid providers must either adopt, implement, or upgrade certified EHR technology or demonstrate that they've already met the meaningful use requirements.

State Medicaid programs can also add meaningful use requirements. The last year a hospital may initiate participation in the Medicaid EHR incentive program is 2016.

Stage 2: Advanced Critical Process

All hospitals must achieve meaningful use under the Stage 1 criteria before moving to Stage 2. In Stage 2 the requirements build on the objectives set in Stage 1 and include increased health information exchange, higher reporting thresholds, additional e-prescribing conditions, and more patient-controlled data. The requirements are intended to further urge providers to actively use EHRs for patient management and allow patients to become more involved in their own care. To demonstrate meaningful use in Stage 2, eligible Medicare hospitals must meet 16 core objectives and three out of six menu objectives.

New core objectives in Stage 2 augment hospitals' reporting requirements and include automatically tracking medications. Additionally, Stage 2 requires hospitals to allow patients to view, download, and transmit their health information online within four business days of the information being available. The final Stage 2 rule also modifies the EHR certification program to make the certification process more efficient.

Although the states are the administrators of the Medicaid programs, Medicaid-eligible hospitals will need to attest to 90 days of meaningful use as outlined above in Stage 2 and show meaningful use for the full year thereafter. It's also worth noting that the deadline for Stage 2 criteria has been delayed to 2014. Originally CMS required Medicare providers who first demonstrated meaningful use in 2011 to meet the Stage 2 criteria in 2013.

Stage 3: Improved Outcomes

Stage 3 is expected to further improve quality, safety, and efficiency across both Medicaid and Medicare by emphasizing clinical decision support and patient access to self-management tools. Stage 3 was originally scheduled to begin in 2015, but CMS announced earlier this year that it was delaying development of Stage 3 meaningful use rules until 2014 to assess the current implementation of existing requirements. As a result, Stage 3 rules and timing are unknown for the time being. A complete timeline of meaningful use criteria is outlined on the CMS Web site.

Recognizing Revenue from EHR Incentive Payments

As of August 2013 Medicare has distributed more than $15 billion

in incentive payments to eligible hospitals and providers. Based on an issue analysis paper published in 2011 by the Healthcare Financial Management Association's (HFMA) Principles and Practices Board, there are two primary models used to account for EHR incentive payments received: the gain contingency model and the international grant accounting model using International Accounting Standard (IAS) 20, Accounting for Government Grants and Disclosure of Government Assistance.

The SEC has commented that SEC-registered hospitals should apply the contingency model. Other hospitals—including privately held, nonprofit, or governmental facilities—may consider either model when recognizing revenue. Many choose to apply the IAS 20 grant accounting model.

Gain Contingency Model

A conservative approach, the gain contingency model requires a hospital to satisfy all the contingencies before recognizing any revenue. According to the HFMA, this model won't permit income from incentive payments to be recognized until the hospital has complied with the meaningful use criteria for the full EHR reporting period in a given year.

Additionally, the EHR reporting period is based on the federal fiscal year. If the hospital doesn't share the same fiscal year, the accumulation of certain data, such as Medicare discharges, during the cost report year may add a contingency. This method may prevent recognition of the revenue until well after the fiscal year during which meaningful use criteria was met, especially if the cost report year is different from the federal fiscal year.

IAS 20 Grant Accounting Model

The IAS 20 model is commonly used in the United States, despite its nonauthoritative status, because US GAAP doesn't currently contain specific guidance on government assistance. The IAS 20 approach allows a hospital to recognize revenue when there's reasonable assurance it will comply with the requirements during the applicable reporting period and accurate estimates of the incentive revenue can be made. This model may result in recognition of revenue over a period of time instead of at a single point in time.

Choosing a Model

The two models described briefly above and in more detail in the HFMA analysis represent two basic methods by which a hospital can recognize revenue:

- **Cliff recognition.** A hospital recognizes income after the EHR reporting period and relevant cost reporting period have ended and it has complied with the meaningful use measurements and accumulated relevant calculation data.

- **Ratable recognition.** A hospital recognizes income over the EHR reporting period once it has reasonable assurance that it will successfully comply with the minimum number of meaningful use objectives and can reasonably estimate the expected revenue for the reporting period.

Because the grant approach is based on the judgment, facts, and circumstances of each hospital, management must determine when the hospital has reasonably complied with the meaningful use requirements. The HFMA analysis suggests considering a few of the following questions when determining reasonable assurance:

- How long has the hospital been using EHR technology?
- How long has the hospital been working to meet the meaningful use criteria?
- How far along is the hospital toward implementing computerized physician order entry?
- Is the hospital doing the bare minimum to qualify for meaningful use, or is it going above and beyond?
- How reliable are the processes and controls around data entry, and how much assurance does the hospital have that the processes are working correctly?

Other Models

The HFMA analysis focuses on acute care inpatient hospitals that are paid under an inpatient prospective payment system (IPPS). Certain hospitals, such as critical access hospitals or those with particular Medicaid arrangements, are based on a reimbursement methodology other than IPPS, such as a reasonable cost basis.

The *Journal of Accountancy* published an article in April 2013 that articulated alternative reporting options for those entities not paid under an IPPS, including an option where a cost-based hospital might report the incentive payment received as net patient service or

defer the payments and amortize them into revenue over the period of depreciation of the related EHR system.

Additionally, some acute care hospitals have adopted a cash basis recognition principle where revenue is recognized upon receipt—generally after the meaningful use criteria has been demonstrated but prior to the end of the cost report year (under the assumption that the cost report data accumulation isn't a significant contingency).

Preparation Is Crucial

Only the Financial Accounting Standards Board (FASB) can promulgate US GAAP, and it hasn't specifically addressed the incentive payment revenue recognition issue (although the FASB currently has a research project on government assistance to address the lack of US GAAP guidance), which complicates the related accounting policy decisions. Meaningful use itself is also complicated and will become more so as it progresses to Stage 2 and beyond. To best prepare for upcoming regulations, contact your Moss Adams health care professional to help your hospital stay on track and appropriately account for its EHR incentive payments.

In the meantime, you can review the resources below for more information on meaningful use and EHR incentives:

- CMS
- FASB
- Healthcare Information and Management Systems Society
- HealthIT.gov
- Kaiser Health News
- Robert Wood Johnson Foundation

Brian Conner, CPA, has practiced public accounting since 1993, providing audit, tax, and consulting services to integrated health systems, hospitals, ancillary providers, mental and convalescent health facilities, and medical groups. Brian has extensive experience in providing advice and counsel in areas of audits, financial reporting and tax-exempt financings. He performs technical reviews for other health care clients in the firm and has served as an instructor and lecturer for the firm's Health Care Group. Brian holds several leadership roles including National Practice Leader for hospitals, a member of the firm's Health Care Executive Committee, and is currently one of the eight elected members of the firm's governing Executive Committee. He is the former chair of the firm's Health Care Business Assurance Committee, and is currently serving a three-year term on the Health Care Financial Management (HFMA) National Principles and Practices Board.

Stacy J. Stelzriede is an assurance partner at Moss Adams LLP, where she specializes in providing accounting and consulting services to health care systems, hospitals, acute care and specialty hospitals, medical groups, long-term care facilities and health maintenance organizations. She also has vast experience in internal control risk management, revenue cycle, regulatory compliance, tax-exempt bond offerings and debt covenant filings, and providing client education training relating to technical accounting issues.

Stacy has been in the health care industry since 1991. Prior to joining Moss Adams LLP, Mrs. Stelzriede spent 19 years at a Big 4 firm where she focused primarily on providing assurance services to health care organizations.

Mrs. Stelzriede received her Bachelor of Science in accounting from California Polytechnic University and is an executive board member and distinguished speaker for Resources for Educational and Employment Opportunities (REEO), a not-for-profit organization that is committed to empowering community college students to pursue their educations. Mrs. Stelzriede is a member of the American Institute of Certified Public Accountants, and California Society of Certified Public Accountants.

Stacy is the leader of our Los Angeles health care practice and a member of the firm's Forum_W Advisory Board which focuses on the retention and advancement of women within the profession and the firm.

Reprinted with permission from the Washington Healthcare News. To learn more about the Washington Healthcare News visit wahcnews.com.