For-Profit Hospital Insights

Electronic Health Record Incentive Payments

Special Report

The Basics of the EHR Program

EHR Incentive Program Background: The Electronic Health Records (EHR) Program was created as a part of the American Reinvestment and Recovery Act (ARRA) of 2009. The legislation earmarked $20 billion in incentive payments for providers that adopt and demonstrate meaningful use of EHRs beginning in federal fiscal year (FFY) 2011. Hospitals are eligible to receive incentive payments through FFYs 2016 and 2021 under the Medicare and Medicaid EHR Programs, respectively.

Payments Are Not Reimbursement: It is difficult to estimate the EHR incentive payments each program participant will be able to capture, but for the Fitch-rated universe of for-profit hospital providers, the amount of payments will be substantial. However, the ARRA-funded EHR incentive payments are not meant to reimburse the cost of implementing EHR systems. Fitch expects that for most hospitals the costs associated with EHR adoption and maintenance will be greater than the amount of the incentive payments received during the life of the EHR program.

Economics of EHR Systems: The costs of EHR implementation are difficult to estimate and are likely to vary widely among hospitals. In the widest definition costs could include the initial fixed costs of software, hardware, installation and licensing fees, as well as the ongoing expense of maintaining and updating the system, staff training, and even the costs of adjusting work flow to facilitate use of the system. On the other hand, hospitals could realize savings as a result of operating efficiencies made possible by the adoption of EHR systems.

Operating Income Boost: Although lifetime costs to implement and maintain EHR systems will likely outstrip the magnitude of the incentive payments, Fitch believes the net effect of incentive payments and operating expenses will probably boost operating income in the 2013–2015 timeframe. This is because the incentive payments are "lumpier" than the EHR-related costs, much of which can be capitalized as assets on the balance sheet and depreciated over time, rather than recognized as operating expense on the income statement.

Costs Incurred Regardless of Payments: Many hospitals probably would have undertaken EHR implementation and incurred costs regardless of the incentive program. Although Fitch recognizes that the incentive payments represent a real economic benefit to the recipient, the most accurate view of underlying growth of EBITDA and cash flow is gained by backing out the entire amount of the incentive payment, without any offset for EHR-related operating expenses.

Payments Started in 2011: All the companies in the Fitch-rated group received some amount of cash EHR payments during 2011, ranging from a high of $306 million for HCA Holdings, Inc. (HCA) to $11 million for Universal Health Services, Inc. (UHS). In addition, all the companies except UHS saw some boost to EBITDA as a result of the recognition of EHR incentive payment income during the year. Fitch expects EHR incentive payment income to ramp up in 2012, with the highest amounts for most companies likely in 2013–2014.

Related Research

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2012 Outlook: U.S. Healthcare, Dec. 7, 2011

U.S. Leveraged Finance Spotlight Series: HCA, Inc. Oct. 11, 2011

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Details of the Electronic Health Records Programs

Terminology

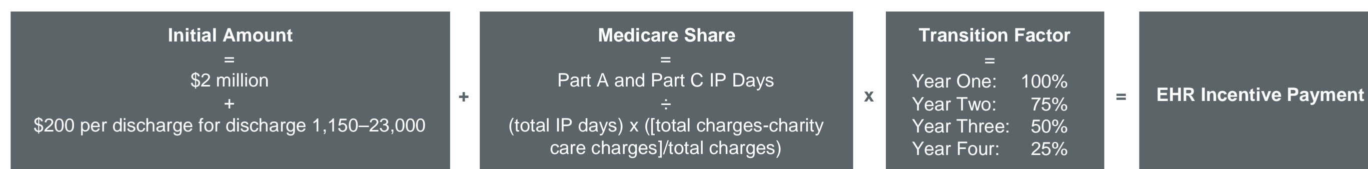
It is helpful to begin a review of this topic with a note on terminology. Different sources have referred to the EHR program by various names, which can create some confusion. The incentive payments have been called EHR, electronic medical record (EMR), HITECH, or meaningful use payments. All these terms are generally interchangeable. The Centers for Medicare and Medicaid Services (CMS) calls them The Medicare and Medicaid Electronic Health Records Incentive Programs (EHR Program) and refers to the payments as EHR incentive payments. Fitch adopts the CMS terminology in this report.

Background

The EHR Program was established under the ARRA legislation of 2009, as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The legislation earmarked $20 billion for incentive payments to hospitals and eligible medical professionals that adopt and demonstrate meaningful use of electronic health records beginning in FFY 2011, which started Oct. 1, 2010. There was some uncertainty that the incentive payments would be funded because of the escalating federal deficit reduction negotiations, but EHR program participants began to receive incentive payments during calendar 2011.

It is difficult to estimate with any certainty how much in incentive payments each program participant will be able to capture. The amount of the payments is based on rather complicated formula, illustrated in the chart below. In addition, it remains uncertain whether the full $20 billion will be funded given the evolving political and federal fiscal environment.

Medicare EHR Incentive Payment Formula



IP – Inpatient. EHR – Electronic Health Record.
Source: Centers for Medicare and Medicaid Services.

However, for the Fitch-rated universe of for-profit hospital providers, the amount of incentive payments is likely to be substantial. Based on incentive payments received under the program during 2011, some companies will collect hundreds of millions of dollars over the life of the program. Through the end of 2011, CMS reports that hospitals received $1.1 billion and $789 million of Medicare and Medicaid EHR incentive payments, respectively.

Medicare Versus Medicaid Programs

There are separate EHR programs for Medicare and Medicaid, and hospitals can receive incentive payments under both. The Medicaid program is voluntary for states to implement. According to CMS, as of Feb. 13, 2012, 43 states had launched Medicaid EHR incentive programs.

There are a few technical differences between the Medicare and Medicaid programs, mostly related to the timing requirements for demonstrating meaningful use. The most important

Related Criteria

Corporate Rating Methodology, Aug. 12, 2011

difference underlying the programs, however, is that hospitals which do not demonstrate meaningful use of a certified EHR system will receive reduced market basket updates for Medicare inpatient hospital payments starting in FFY 2015.

The penalty for failing to demonstrate meaningful use is a 25% reduction in the hospital's market basket update for FFY 2015. The penalty then escalates to a 50% reduction in FFY 2016, and a 75% reduction in FFY 2017 and after. There is no such penalty under the Medicaid program. The remainder of the report primarily focuses on the details of the Medicare EHR incentive program.

Meaningful Use

Meaningful use is a key concept underlying the EHR programs. In order to quality for incentive payments, it is not enough for a hospital to simply adopt EHRs. The hospital must also be able to demonstrate that it is meaningfully using its EHR system. CMS defines the criteria for demonstrating meaningful use, which is staged in three steps over a five-year period. Initially, Stage One of meaningful use was anticipated to be years one and two of the program (2011−2012), Stage Two was to be implemented in year three (2013), and Stage Three in year five (2015).

Stage One requires providers to set a baseline for electronic capture of medical data and information sharing. Stages Two and Three are designed to build on the baseline set in Stage One. In order to demonstrate Stage One meaningful use and qualify for incentive payments, hospitals must meet 19 of 24 objectives identified by CMS. The 19 objectives include 14 required core objectives and five menu set objectives, which hospitals can choose from a list of 10.

CMS released the proposed Stage Two criteria in late February 2012. As expected, the proposed Stage Two criteria largely build off the base established in Stage One but raises the bar with respect to the hurdles that must be met to demonstrate meaningful use. CMS expects to publish the proposed Stage Two criteria in the March 7, 2012 Federal Register, which will mark the start of a 60-day public comment period before the final criteria are published.

Attestation

Attestation refers to the process hospitals must go through to demonstrate that they are meeting the meaningful use criteria. Once a hospital successfully attests to meaningful use, it is eligible to receive incentive payments.

Attestation for the Medicare program requires hospitals to submit data to CMS indicating that they met the meaningful use criteria through use of a certified EHR program. During their first year of attestation hospitals have to demonstrate 90 consecutive days of meaningful use during the reporting period (the federal fiscal year). Starting in the first year after initial attestation hospitals must demonstrate a full 365 days of meeting the criteria in order to qualify for an incentive payment.

It is up to program participants to decide when to attest. Hospitals are eligible to receive up to four years of payments under the Medicare program through FFY 2016. Therefore, if a hospital first attests to meaningful use in FFY 2013, it will be able to capture the maximum amount of incentive payments. Hospitals that first attest in FFY 2014 or 2015 will not be able to receive the maximum potential payments; in other words, there is no "catch-up" period.

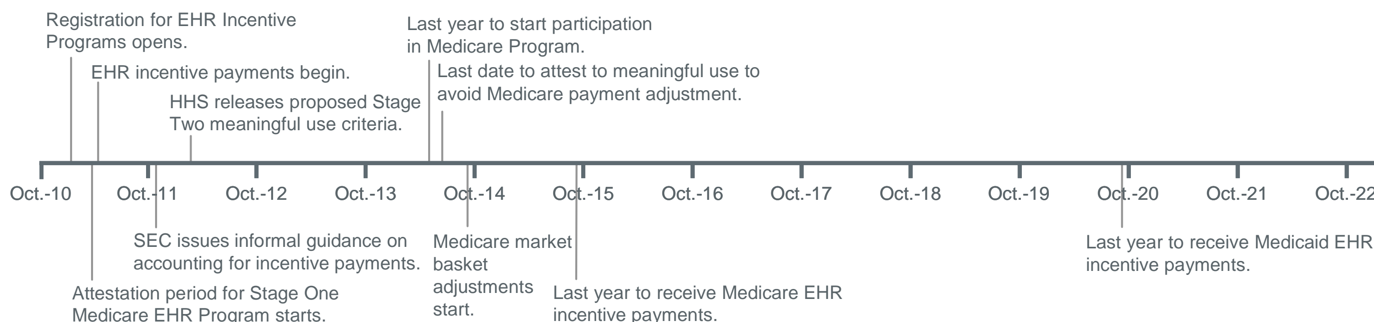
The year one attestation period initially opened April 18, 2011, and hospitals had until Nov. 30, 2011, to submit data as evidence of 90 days of consecutive meaningful use between Jan. 1, 2011, and Sept. 30, 2011. Hospitals that successfully attested to Stage One meaningful use during year one were eligible to receive incentive payments in 2011. According to CMS, hospitals should receive payments within four to eight weeks after attestation.

Initially, hospitals that attested to meaningful use in year one of Stage One were required to meet the Stage Two requirements starting in FFY 2013. This probably deterred some hospitals from attesting during year one, because the timeline to adopt Stage Two criteria was very tight, especially since CMS did not release the proposed Stage Two criteria until Feb. 23, 2012. In November 2011, CMS relaxed the standard by extending the Stage Two deadline by one year, to FFY 2014, for those that attested to Stage One during year one of the program.

Timeline

As noted in the previous section, CMS already made one major change to the timeline of the EHR program. In addition, the receipt and timing of payments could be influenced by changes in the political and government funding environment. The schedule below illustrates some key events and when they are currently anticipated to happen.

EHR Incentive Program Timeline



HHS – U.S. Health and Human Services. EHR – Electronic Health Record.
Source: Centers for Medicare and Medicaid Services.

Economics of EHR Systems

The costs to implement an EHR system are difficult to estimate and are likely to vary widely among hospitals. The estimate depends upon what is included in costs. In the widest definition costs could include the initial fixed costs of software, hardware, installation, and licensing fees, as well as the ongoing expense of maintaining and updating the system, staff training, and even the costs of adjusting work flow to accommodate use of the system.

Fitch has seen many different estimates for costs of upfront implementation as well as annual operating costs of EHR systems. CMS estimates an upfront capital cost of about $5 million per hospital to adopt an EHR system. Some companies have provided estimates of capital costs. UHS estimates a necessary capital investment of $6 million–$7 million per hospital. Tenet Healthcare Corp. (Tenet) expects to invest more than $600 million in healthcare IT through 2014, $225 million of which had been spent through Dec. 31, 2011.

Annual operating costs are likely to be offset by savings that result from the efficiencies gained through the adoption of the technology. So, estimating the net effect on annual operating costs is somewhat more difficult than estimating upfront costs.

It is important to note that the EHR incentive payments are not meant to be a reimbursement of the cost of implementing and maintaining EHR systems. Fitch expects that for most hospitals the costs associated with EHR adoption and maintenance will be greater than the amount of the incentive payments received.

Accounting Treatment

Overview

Although the costs to implement and maintain EHR systems will probably outpace the incentive payments over the long term, Fitch believes that the incentive payments net of EHR operating expenses will boost operating income in 2013–2015. This is because the incentive payments are lumpier than the EHR-related costs, much of which can be capitalized as assets on the balance sheet and depreciated over time, rather than recognized as operating expense on the income statement.

In any event, since the incentive payments are not meant to reimburse hospitals for the cost of implementing and maintaining EHR systems, the timing and magnitude of the payments are not expected to be closely correlated with EHR-related costs. In many instances hospitals probably would have undertaken EHR implementation and incurred at least a portion of the related costs regardless of the incentive program. Therefore, when assessing operating income excluding the incentive payments, adjusting by the net amount of EHR incentive payments and EHR-related operating costs is not an entirely accurate exercise.

A more conservative approach is to remove the EHR incentive payments from income, but include the operating expenses. As with any major capital project, and aside from the financial reporting implications of the EHR incentive payments, it is important to assess how companies are accounting for their EHR-related costs. This effort is complicated by the fact that financial statement disclosure of the accounting treatment of expenses related to EHR tends to be spotty. Where possible, Fitch attempts to gain more information on the topic through discussions with management. Some companies have indicated that they anticipate higher depreciation expense over the next several years, due to the relatively shorter estimated useful life of the capitalized EHR assets.

There is better visibility on the recognition of income and cash receipts of the EHR incentive payments. The biggest potential concern in this regard would be companies recognizing incentive payments as income before cash receipt of the payment, and recording an associated receivable on the balance sheet. This concern arises from the fact that Fitch believes the ultimate receipt of cash payments is questionable given the uncertain political and fiscal environment.

SEC Informal Guidance on Incentive Payment Revenue Recognition

The informal guidance issued by the SEC in November 2011 should limit the recognition of incentive payment income before cash is received. Specifically, the SEC recommended that the gain contingency method be used with respect to recognition of the incentive payments. Under this method, incentive payments are not considered to be revenue, but are recognized as other income or non-operating income.

As the name implies, the gain contingency method requires that all significant contingencies are satisfied before income is recognized on the income statement. With respect to the EHR incentive payments, these contingencies are (1) The hospital has met the meaningful use criteria; and (2) The full-year hospital cost report data, which will be used to calculate the incentive payment, is available.

This is a fairly conservative definition for when income can be recognized. This accounting method does not affect the timing of the cash receipt of the incentive payments — only the timing for recognizing income. Cash will be recorded on the balance sheet as payments are received. In some cases, companies will record a deferred income liability if the requirements for income recognition have not been met when the cash payment is received.

Similar to the positive effect of incentive payments on net income, there will be a boost to cash flow measures, including cash from operations and FCF. Fitch will assess the underlying rate of cash generation, excluding the incentive payments, when developing its cash flow projections.

There are differences in the timing of the hospital cost report data used to calculate the amount of the incentive payments under the Medicare and Medicaid EHR programs. As a result of this discrepancy, companies may recognize incentive payment income earlier under the Medicaid program. If the income is recognized before the cash payment is received, companies will record a corresponding accounts receivable on the balance sheet.

2011 Results and Outlook

All the companies in the Fitch-rated group received some amount of cash EHR payments during 2011, ranging from a high of $306 million for HCA to $11 million for UHS. In addition, all the companies except UHS saw some boost to EBITDA as a result of the recognition of EHR-related income during the year. When EHR income is excluded from EBITDA, HCA and CHS would have experienced flat growth in EBITDA; Tenet and LifePoint Hospitals, Inc. would have seen growth more than cut in half; and Health Management Associates, Inc. would have experienced 6.7% growth versus the very robust 12% growth it reported.

Based on Fitch’s review, HCA and UHS are the only companies that recorded deferred revenue with respect to cash EHR payments in 2011. This is consistent with the fact that most companies reported more Medicaid than Medicare payments during the year. Medicaid program payments do not require the same deferral of income recognition because the amount of the payment is based on the hospital’s prior year cost report data, versus the current year for the Medicare payment calculation.

Fitch anticipates that the amount of Medicare payments received will ramp up in 2012 as more hospitals attest to meaningful use. This will result in companies recording some amount of deferred revenue, depending upon the degree of the mismatch in timing between the receipt of cash payments and the end of the hospital cost report year. The highest amount of EHR income for most companies will probably be in 2013–2014.

Companies have disclosed varying amounts of information on EHR related expenses. Even where companies disclose a good amount of information, it can be difficult to determine the true net effect of EHR incentive payments and related expenses on operating income. In all cases where companies disclosed estimates of EHR operating expense in 2011, the amount of incentive payment income was higher.

HCA, Inc.

($ Mil.)	2011
EHR Incentive Payment Effect on Income Statement	
EBITDA	6,080
% Growth	3.1
EHR Incentive Payment Income — Medicare	123
EHR Incentive Payment Income — Medicaid	87
EBITDA Excluding EHR Payments	5,870
% Growth	(0.5)
EHR Incentive Payment Effect on Cash Flow Statement	
EHR Incentive Payment Contribution to Net Income	210
Operating Cash Flow Adjustments	
Deferred Income	134
Accounts Receivable	(38)
Cash EHR Incentive Payments Received	306
Cash from Operations	2,842
Less EHR Cash Payments Received	306
CFO Excluding EHR Cash Payments	2,536

Notes

Expenses

HCA's 2011 healthcare IT related operating expenses were $77 million.

2012 Outlook

HCA expects to recognize $325 million–$350 million of EHR incentive payment income in 2012 and related operating expenses of $140 million–$160 million.

EHR – Electronic health record.
Source: Company reports and Fitch calculations.

Health Management Associates, Inc.

($ Mil.)	2011
EHR Incentive Payment Effect on Income Statement	
EBITDA	851
% Growth	12.0
EHR Incentive Payment Income[a]	40
EBITDA Excluding EHR Payments	811
% Growth	6.7
EHR Incentive Payment Effect on Cash Flow Statement	
EHR Incentive Payment Contribution to Net Income	40
Operating Cash Flow Adjustments	
Deferred Income	0
Accounts Receivable	(1.7)
Cash EHR Incentive Payments Received	38.3
Cash from Operations	544
Less EHR Cash Payments Received	38
CFO Excluding EHR Cash Payments	506

Notes

Expenses

HMA does not disclose its EHR-related expenses, except to state that ongoing operating expense is fairly low, and most of the costs of implementing its EHR system were capitalized.

2012 Outlook

HMA expects to recognize $90 million–$120 million of Medicare and Medicaid incentive payments in 2012, with the bulk of the income in the second half of the year.

[a]HMA does not specify a breakdown between Medicaid and Medicare incentive payments in 2011. EHR – Electronic health record.
Source: Company reports and Fitch calculations.

Community Health Systems, Inc.

($ Mil.)	2011
EHR Incentive Payment Effect on Income Statement	
EBITDA	1,832
% Growth	3.9
EHR Incentive Payment Income — Medicare	0
EHR Incentive Payment Income — Medicaid	63
EBITDA Excluding EHR Payments	1,769
% Growth	0.3
EHR Incentive Payment Effect on Cash Flow Statement	
EHR Contribution To Net Income	63
Operating Cash Flow Adjustments	
Deferred Income	0
Accounts Receivable	(34.5)
Cash EHR Incentive Payments Received	29
Cash from Operations	1,262
Less EHR Cash Payments Received	29
CFO Excluding EHR Cash Payments	1,233

Notes

Expenses

CHS reports that operating expenses for healthcare IT were about $27 million in 2011, about half of which was depreciation expense.

2012 Outlook

In 2012 CHS expects EHR income of 0.6% to 0.8% of revenue and EHR operating expenses of 0.3% to 0.5% of revenue. The company expects that EHR-related income net of related operating expenses to contribute 1% growth in EBITDA in 2012.

EHR – Electronic health record.
Source: Company reports and Fitch calculations.

Tenet Healthcare Corp.

($ Mil.)	2011
EHR Incentive Payment Effect on Income Statement	
EBITDA	1,169
% Growth	9.0
EHR Incentive Payment Income — Medicare	0
EHR Incentive Payment Income — Medicaid	55
EBITDA Excluding EHR Payments	1,114
% Growth	3.9
EHR Incentive Payment Effect on Cash Flow Statement	
EHR Contribution to Net Income	55
Operating Cash Flow Adjustments	
Deferred Income	0
Accounts Receivable	(13)
Cash EHR Incentive Payments Received	42
Cash from Operations	564
Less EHR Cash Payments Received	42
CFO Excluding EHR Cash Payments	522

Notes

Expenses

Tenet expects to spend more than $600 million on healthcare IT investments through 2014, $225 million of which had been spent through Dec. 31, 2011.

2012 Company Guidance

Over the life of the program, Tenet projects that it will receive $320 million in EHR incentive payments, $35 million of which it expects to recognize in 2012. Tenet expects healthcare IT to be an overall $40 million headwind to EBITDA in 2012, including recognizing $20 million less in incentive payments than in 2011, plus a $20 million increase in EHR-related operating expenses.

EHR – Electronic health record.
Source: Company reports and Fitch calculations.

Universal Health Services, Inc.

($ Mil.)	2011
EHR Incentive Payment Effect on Income Statement	
EBITDA	1,210
% Growth	51.3
EHR Incentive Payment Income — Medicare	0
EHR Incentive Payment Income — Medicaid	0
EBITDA Excluding EHR Payments	1,210
% Growth	51.3
EHR Incentive Payment Effect on Cash Flow Statement	
EHR Contribution to Net Income	0
Operating Cash Flow Adjustments	
Deferred Income	11
Accounts Receivable	0
Cash EHR Incentive Payments Received	11
Cash from Operations	718
Less EHR Cash Payments Received	11
CFO Excluding EHR Cash Payments	707

Notes

Expenses

UHS expects EHR-related capital expenditures of about $6 million–$7 million for each of its 26 acute care hospitals.

2012 Company Guidance

UHS expects to recognize $12 million of EHR income in 2012 and $17 million of her-related expenses. The company states most of the EHR expenses are capitalized.

EHR – Electronic health record.
Source: Company reports and Fitch calculations.

LifePoint Hospitals, Inc.

($ Mil.)	2011
EHR Incentive Payment Effect on Income Statement	
EBITDA	560
% Growth	7.7
EHR Incentive Payment Income — Medicare	0
EHR Incentive Payment Income — Medicaid	27
EBITDA Excluding EHR Payments	534
% Growth	2.6
EHR Incentive Payment Effect on Cash Flow Statement	
EHR Contribution to Net Income	27
Operating Cash Flow Adjustments	
Deferred Income	0
Accounts Receivable	(11.7)
Cash EHR Incentive Payments Received	15
Cash from Operations	401
Less EHR Cash Payments Received	15
CFO Excluding EHR cash payments	386

Notes

Expenses

LifePoint capitalized $83 million of EHR-related expenses in 2011 and expects to capitalize about $90 million of additional costs in 2012. EHR- related operating costs were $11.7 million in 2011.

2012 and Beyond

LifePoint expects to recognize $10 million in EHR incentive payments in 2012 and an additional $80 million–$100 million in 2013–2014. In 2012 the company expects $22 million of EHR- related operating expenses and an additional $14 million of depreciation expense. Depreciation expense will run higher than historical run rate over next several years due to shorter useful life of IT related assets.

EHR – Electronic health record.
Source: Company reports and Fitch calculations.

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