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MEDICARE INCENTIVES FOR MEANINGFUL USE OF EHR TECHNOLOGY BY CRITICAL ACCESS HOSPITALS

Medicare incentives are available to critical access hospitals that are *meaningful users* of EHRs for inpatient services provided in 2011 through 2014. A complex formula is used to determine the incentive amounts.

1. *Meaningful user* has nearly the same requirements as previously listed for physicians:
   - Certified EHR technology; not specified yet but most likely CCHIT-certified
   - Capable of providing patient demographics and clinical health information, medical history and problem lists; capacity for clinical decision support, CPOE; ability to capture and query information relevant to healthcare quality; and to exchange health information with, and integrate such information from other sources
   - Connected to a health information exchange
   - Submit clinical quality measures in the reporting format selected by Secretary of HHS
   - No e-prescribing requirement for hospitals

2. Three factors are used to determine the hospital incentives and include:
   - Initial amount that includes base amount of $2 million and a discharge-related adjustment
   - Medicare share
   - Annual transition factor

   The initial amount multiplied by the Medicare share multiplied by the annual transition factor determines the incentive amount.

3. Initial amount is the sum of:
   Base amount of $2 million + $200 for each discharge between 1,150th and 23,000th

4. Medicare share is a fraction derived from:

   Numerator: Sum of the estimated number of inpatient-bed-days for Part A eligible patients and Part C Medicare Advantage-enrolled individuals (as established by the Secretary of HHS)

   Denominator: Quotient of estimated total inpatient-bed-days, not including charges attributable to charity care, divided by estimated total amount of charges

   Critical access hospitals add 20 percentage points to the derived Medicare share, not to exceed 100 %.

5. Transition factor is applied to each of the maximum of four payment years that hospitals can receive incentive payments in amounts shown in the table below. Hospitals that initiate *meaningful use* in 2014 use the same transition factor in 2014 as allowed for hospitals that initiated in 2013. There is no transition factor for hospitals that initiate *meaningful use* in 2016 and beyond.

Transition Factor by EHR Initiation Year and Payment Year

Payment Years	2011 Initiation	2012 Initiation	2013 Initiation	2014 Initiation	2015 Initiation	2016 Initiation
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-	0.25	0.50	0.50	0.50	
2016	-0-	-0-	0.25	0.25	0.25	-0-
2017	-0-	-0-	-0-	-0-	-0-	-0-

6. Incentive determinations specific to critical access hospitals described in the act include:

“The Secretary shall compute reasonable costs by expensing such costs in a single payment year and not depreciating such costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved.)’’

“The payment …shall be paid through a prompt interim payment (subject to reconciliation) after submission and review of such information (as specified by the Secretary) necessary to make such payment.’’

7. Hospitals that have not initiated *meaningful use* by fiscal year 2015 shall be subject to payment reductions. Critical access hospitals will see payments reduced to 100.66 percent of costs in fiscal year 2015; to 100.33 percent in fiscal year 2016; and to 100 percent in fiscal year 2017 forward.