Summary of Health Information Technology Incentives and Resources

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LEGISLATION

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) under Title XIII of the American Recovery and Reinvestment Act of 2009 (ARRA) created the Health Information Technology (HIT) Policy Committee, HIT Standard Committee, and process for adoption of recommendations for standards and policies from these committees, all of which is overseen by the Office of the National Coordinator for Health Information Technology (ONC). It also established provisions for workforce investments, a HIT Extension Program, HIT Research Center, and HIT Regional Extension Centers (RECs) to provide technical assistance on best practices, and to assist health care providers to adopt, implement, and effectively use certified electronic health records (EHRs). This legislation established state grants to promote HIT and assist health care providers in HIT adoption and implementation. Part IV of this legislation details Medicare and Medicaid incentives for HIT adoption for health care professionals, prospective payment system (PPS) hospitals, and critical access hospitals (CAHs). These incentives are detailed below.

For more information on a particular topic area, please click on the hyperlink to view the legislation or further information from ONC or the Centers for Medicare & Medicaid Services (CMS).

To view Title XIII, please visit: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf

DEFINITIONS

Medicare Eligible Professionals

- A physician as defined in Section 1861 (r) of the Social Security Act:
    - Doctor of Medicine or Osteopathy
    - Doctor of Dental Surgery or of Dental Medicine
    - Doctor of Podiatric Medicine
    - Doctor of Optometry
    - Chiropractor
- Eligible professionals (EPs) cannot provide more than 90% of their services with a place of service (POS) code of 21 or 23 (considered a hospital inpatient or Emergency Department). If the EP works at multiple sites, they must have certified EHR technology available for at least 50% of their patient encounters.

Medicaid Eligible Professionals

Professionals eligible to receive Medicaid EHR incentives include:

- Physicians (primarily Doctors of Medicine or Osteopathy)
- Nurse practitioners
- Certified nurse-midwife
- Dentist
- Physician assistance who furnishes services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant.

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an EP must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume
    - Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria
- Have a minimum 20% Medicaid patient volume, and is a pediatrician
    - CHIP patients do not count toward the Medicaid patient volume criteria
- Practice predominately in a FQHC or RHC and have minimum 30% patient volume attributable to needy individuals.

For further explanations of Medicare and Medicaid EPs, please see the respective sections below.

Medicare Eligible Hospitals

- A subsection (d) hospital defined in the Social Security Act, essentially an acute care facility:
    - Located in the 50 states or District of Columbia that are paid under the Inpatient Prospective Payment System (IPPS)
    - Not a psychiatric, rehabilitative, predominately pediatric, or cancer facility
    - Where average length of stay is 25 days or less
- Critical Access Hospitals (CAHs)
- Medicare-Advantage (MA-Affiliated) Hospitals
    - A subsection (d) hospital that operates under common corporate governance with a qualifying MA organization and services primarily individuals enrolled under MA plans offered by such organizations
- Individual or groups of hospitals that have the same CMS Certification Number (CCN) for cost reporting (OSCAR Number) are seen as one hospital.

Medicaid Eligible Hospitals

- Acute care hospitals (including CAHs and cancer hospitals) with at least 10% Medicaid volume

- Children's hospitals (no Medicaid patient volume requirements)

Certified EHR Technology

- Qualified EHR that is certified as meeting the standard for hospital settings as adopted by ONC
- Standards, implementation specification, and certification criteria for EHR technology have been adopted by the Secretary of the Department of Health and Human Services (HHS)
- Must be tested and certified by an ONC Authorized Testing and Certification Body (ATCB) in order for a provider to qualify for EHR incentive payments. For more information on the ONC-ATCB, please visit: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3120
- Even if you are already using EHR technology, it must be tested and certified by an ONC-ATCB specifically for the Medicare and Medicaid EHR Incentive Programs
- To view a list of product meeting the certified EHR technology definition, please visit: http://onc-chpl.force.com/ehrcert
- You do not need to have certified EHR technology in place to register for the EHR incentive programs. However, you must adopt, implement, or successfully demonstrate meaningful use of certified EHR technology under the Medicaid EHR Incentive Program and successfully demonstrate meaningful use of certified EHR technology under the Medicare EHR Incentive Program before you can receive an EHR incentive payment.

Adopt, Implement, or Update

- Pertains to the Medicaid Incentive Program
- Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or
- Expand the functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training.

MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS

A provider needs to show they are using certified EHR technology in ways that can be measures significantly in quality and in quantity. ARRA specifies three main components:

- Use of a certified EHR in a meaningful manner, such as e-prescribing;
- Use of certified EHR technology for electronic exchange of health information to improve quality of health care; and,
- Use of certified EHR technology to submit clinical quality and other measures.

Criteria for meaningful use will be staged in three steps over the course of 2011-2015:

- Stage 1 sets the baseline for electronic data capture and information sharing,
- Stage 2 and Stage 3 (expected to be implemented in 2015) will continue to expand on this baseline and be developed through future rule making.
- Stage 2 uses a core and menu structure for objectives that providers must to achieve in order to demonstrate meaningful use. Core objectives are objectives that all providers must meet. There is also a predetermined number of menu objectives that providers must select from a list and meet in order to demonstrate meaningful use.

To demonstrate meaningful use under Stage 2 criteria—

- EPs must meet 17 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 20 core objectives.
- Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 19 core objectives.

    - View the Stage 2 Tipsheet
    - View the Stage 1 vs Stage 2 Comparison Table for EPs
    - View the Stage 1 vs Stage 2 Comparison Table For EHs and CAHs

To view the meaningful use objectives for EPs, please visit:
https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

- Eligible Hospitals and CAHs
    - There are a total of 24 meaningful use objectives, 19 of 24 must be met for an incentive payment
        - 14 required core objectives
        - Remaining 5 objectives may be chosen from the list of 10 menu set objectives

To view the meaningful use objectives for Hospitals and CAHs, please visit: https://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf

PARTICIPATION IN THE PROGRAM

In order to participate in the Medicare and/or Medicaid EHR Incentive Program(s), you must register. Registration is encouraged as soon as possible and EPs and eligible hospitals can register before they have a certified EHR. For more information on registration, please click on the links below for Registration Guides provided by CMS:

- Registration Guide for Eligible Professionals in the Medicare Incentive Program: https://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicareEP_RegistrationUserGuide.pdf
- Registration Guide for Eligible Professionals in the Medicaid Incentive Program: https://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicaidEP_RegistrationUserGuide.pdf
- Registration Guide for Eligible Hospitals in the Medicare and Medicaid Incentive Programs: https://www.cms.gov/EHRIncentivePrograms/Downloads/EHRHospital_RegistrationUserGuide.pdf

Please note that although the Medicaid EHR Incentive Programs opened in January 2011, some states are not ready to participate. More information can be found at the following link: https://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp

Eligible professionals eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register. Before 2015, an EP may switch programs only once after their first incentive payment is initiated. Most EPs will maximize their incentive payments by participating in the Medicaid EHR Incentive Program.

Eligible hospitals eligible for both the Medicare and Medicaid EHR Incentive Programs may participate in both programs. Such hospitals should select "Both Medicare and Medicaid" during the registration process, even if they plan to apply for only a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire.

For more information on registration, please visit:
https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp

IMPORTANT DATES

- October 1, 2010 – Reporting year begins for eligible hospitals and CAHs.
- January 1, 2011 – Reporting year begins for EPs.
- January 3, 2011 – Registration for the Medicare EHR Incentive Program begins.
- January 3, 2011 – For Medicaid providers, states may launch their programs if they so choose.
- April 2011 – Attestation for the Medicare EHR Incentive Program begins.
- May 2011 – EHR Incentive Payments expected to begin.
- July 3, 2011 – Last day for eligible hospitals to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR Incentive Program.
- September 30, 2011 – Last day of the federal fiscal year. Reporting year ends for eligible hospitals and CAHs.
- October 1, 2011 – Last day for EPs to begin their 90-day reporting period for calendar year 2011 for the Medicare EHR Incentive Program.
- November 30, 2011 – Last day for eligible hospitals and CAHs to register and attest to receive an Incentive Payment for Federal fiscal year (FY) 2011.
- December 31, 2011 – Reporting year ends for EPs.
- February 29, 2012 – Last day for EPs to register and attest to receive an Incentive Payment for calendar year (CY) 2011.
- November 30, 2012 – Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for (FY) 2012
- December 31, 2012 – Reporting years ends for eligible hospitals
- January 1, 2013 – Reporting period begins for EPs for (CY) 2013
- February 28, 2013 – Last day for EPs to register and attest to receive an incentive payment for (CY) 2012
- July 3, 2013 – Last day for EPs to begin their 90-day reporting period to demonstrate meaningful use for (FY) 2013
- September 30, 2013 - Reporting years ends for EHs and CAHs
- October 1, 2013 – Reporting period begins for EHs and CAHs for (FY) 2014

- October 1, 2013 – Stage 2 begins for EHs. EHs and CAHs attest for a three-month reporting period regardless of when they began participation in the program. Payments decrease for hospitals that start receiving payments in 2014 and later.
- October 3, 2013 – Last day for EPs to begin 90-day reporting period for (CY) 2013
- November 30, 2013 – Last day for EHs and CAHs to register and attest to receive an incentive payment for (FY) 2013
- December 31, 2013 – Reporting period ends for EPs
- January 1, 2014 – Reporting period begins for EPs for (CY) 2014; Stage 2 begins for EPs; EPs attest for a three-month reporting period, regardless of when they began to participate in the program; Last year EPs can begin program
- February 28, 2014 – Last day EPs to register and attest to receive an incentive payment for (CY) 2013
- July 3, 2014 – Last day for EHs and CAHs to begin their 90-day reporting period to demonstrate meaningful use for (FY) 2014
- September 30, 2014 – Reporting year ends for EHs and CAHs
- October 1, 2014 – Reporting period begins for EHs and CAHs for (FY) 2015
- October 1, 2014 - Eligible hospitals and CAHs that do not successfully demonstrate meaningful use of certified EHR technology will be subject to Medicare payment adjustments beginning in FY 2015
- October 1, 2014 - ICD-10 code set implementation for full compliance. ICD-10 code sets will be required for services provided October 1, 2014 and after
- October 3, 2014 - Last day for EPs to begin 90-day reporting period for CY 2014 and last year EPs can begin program
- November 30, 2014 - Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for FY 2014
- December 31, 2014 - Reporting year ends for EPs

MEDICARE INCENTIVES FOR ELIGIBLE PROFESSIONALS

The incentive value is to be 75% of allowed Medicare charges for professional services for a payment year with yearly maximums as described in the below table if the EP is a meaningful EHR user. The program begins in 2011 and will continue through 2016. Eligible professionals can participate for up to five years throughout the duration of the program. The last year to begin participation in the Medicare EHR Incentive Program is 2014. To receive the maximum EHR incentive payment, Medicare EPs must begin participation by 2012.

Table 1. Maximum Medicare Incentives for EPs

2011	2012	2013	2014	2015	2016	2017	Incentive

							Payment
Stage 1 $18,000	Stage 1 $12,000	Stage 2 $8,000	Stage 2 $4,000	$2,000			$44,000
	Stage 1 $18,000	Stage 1 $12,000	Stage 2 $8,000	$4,000	$2,000		$44,000
		Stage 1 $15,000	Stage 1 $12,000	$8,000	$4,000		$39,000
			Stage 1 $12,000	$8,000	$4,000		$24,000
Penalty (deduction from Medicare charges) if not at Stage 3 by January 1 of that year:				**1%**	**2%**	**3%**	

Eligible professionals with more than 50% of their Medicare services in a health professional shortage area (HPSA) can receive a 10% increase in the maximum incentive payment they receive. An EP eligible for the HPSA bonus who has their first year of implementation in 2011 or 2012 could receive an incentive payment of $48,400. Those who implement in 2013 or 2014 could receive an incentive payment of $45,100. This additional 10% HPSA incentive is not available for EPs who participate in the Medicaid EHR Incentive Program.

The above incentive payment schedule does not apply to hospital-based EPs (i.e., pathologists, anesthesiologists, emergency physicians). Hospital-based professionals furnish substantially all of their services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified EHRs, of the hospital. The determination of hospital-based professionals is made by the site-of-service and without regard to employment or billing arrangement between the eligible professional and any provider.

Medicare EPs who also qualify as Medicaid EPs must choose between the Medicare and Medicaid incentive programs when they register. They cannot choose both.

Incentive payments to EPs are made either directly to the professional or the professional may reassign it to another entity. Eligible professionals who work in multiple sites and achieve meaningful use by combining the work they did at multiple site still may only assign their payment to one entity. In the first year of demonstrating meaningful use, a payment will be made when the EP reached their Medicare allowable charges limit or the end of the year, whichever comes first. Medicare EHR incentive payments to EPs will be made on a rolling basis after CMS has ascertained that he EP met meaningful use for the reporting period and the EP has met the maximum allowable charges threshold. In the event that the EP does not meet the maximum allowed charges threshold by the end of the calendar year, payment will be made following the deadline to submit claims for the period.

Payments will be made approximately 4-6 weeks after successful attestation. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments. While CMS expects that Medicare incentive payments will begin in May 2011, payments will be held for EPs until the EP meets the $24,000 threshold in allowed charges.

For more information on Medicare Incentive Payments for EPs, please visit: https://www.cms.gov/MLNProducts/downloads/CMS_eHR_Tip_Sheet.pdf

MEDICAID INCENTIVES FOR ELIGIBLE PROFESSIONALS

Medicaid EPs are defined as those professionals who are:

- Not hospital-based provider with at least 30% Medicaid patient volume;
- Not hospital-based pediatrician with at least 20% Medicaid patient volume; or,
- An EP who practices in a FQHC or RHC with at least 30% patient volume attributable to needy individuals.

Hospital-based is defined as a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnished substantially all services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including EHR, of the hospital. Determination of hospital-based status is made on the basis of site of services and without regard to any employment or billing arrangement made between the professional and any other provider.

Medicaid EHR Incentive Payments to Not Hospital-based Providers with at Least 30% Medicaid Patient Volume

Such professions include:

- Physicians (Doctor of Medicine, Doctor of Osteopathy, and in some states optometrists)
- Dentists
- Certified Nurse Mid-wives
- Nurse Practitioners
- Physician Assistants (PAs) who practice in a FQHC or RHC that is led by a PA. The PA would be leading a FQHC or RHC if:
    - The PA is the primary provider in a clinic (i.e., when there is a part-time physician and full-time PA, the PA would be considered the primary provider);

- The PA is a clinical or medical director at a clinical site of practice; or,
- The PA is an owner of a RHC.

Payments cover up to 85% of net allowable costs for EHR technology, support services, maintenance, and training for a provider to adopt and operate the EHR technology. Allowable costs for Year 1 payments are the average costs, from studying EPs, for the purchase and initial implementation or upgrade of EHR technology, including support services for training for adoption and initial operation of the technology. The net average for Year 1 cannot exceed $25,000 so if the net average cost of an EP is $25,000, they would receive a payment in Year 1 of $21,250 (85% x $25,000 = $21,250). Year 1 cannot be after 2016.

Allowable costs for subsequent year payments are the average cost, from studying EPs, for operation, maintenance, and use of technology. This excludes the initial purchase and implementation and training costs from Year 1. The net average for subsequent years cannot exceed $10,000 per year so if the net average cost of an EP in a subsequent year is $10,000, they would receive a payment of $8,500 (85% x $10,000 = $8,500). No payments are made after 2016 and subsequent year payments cannot be for more than a 5 year period.

If an EP has completed adopting, implementing, or upgrading EHR technology prior to the first year of payments, the net allowable costs for subsequent years applies for all years up to 5, including the first year of payments to such EP.

Medicaid EHR Incentive Payments to Not Hospital-based Pediatricians with at Least 20% Medicaid Patient Volume

Medicaid incentive payments to these EPs cover up to two-thirds of 85% of the net allowable costs for EHR technology, support services, maintenance, and training for a provider to adopt and operate the EHR technology. Allowable costs for Year 1 payments are the average costs, from studying EPs, for the purchase and initial implementation or upgrade of EHR technology, including support services for training for adoption and initial operation of the technology. The net average for Year 1 cannot exceed $25,000 so if the net average cost of an EP is $25,000, they would receive a payment in Year 1 of $14,166.67 (2/3 x (85% x $25,000) = $14,166.67). Year 1 cannot be after 2016.

Allowable costs for subsequent year payments are the average cost, from studying EPs, for operation, maintenance, and use of technology. This excludes the initial purchase and implementation and training costs from Year 1. The net average for subsequent years cannot exceed $10,000 per year so if the net average cost of an EP in a subsequent year is $10,000, they would receive a payment of $5,666.67 (2/3 x (85% x $10,000) = $5,666.67). No payments are made after 2016 and subsequent year payments cannot be for more than a 5 year period.

If an EP has completed adopting, implementing, or upgrading EHR technology prior to the first year of payments, the net allowable costs for subsequent years applies for all years up to 5, including the first year of payments to such EP.

Medicaid EHR Incentive Payments to EPs who practice in a FQHC or RHC with at Least 30% Patient Volume Attributable to Needy Individuals

Needy individuals are defined as those individuals:

- Receiving Medicaid;
- Receiving assistance under Title XXI;
- Who is furnished uncompensated care by a provider; or
- Who receive reduced charges by the provider on a sliding scale basis used on the individual's ability to pay.

Medicaid incentive payments to these EPs cover up to 85% of the net allowable costs for EHR technology, support services, maintenance, and training for a provider to adopt and operate the EHR technology. Allowable costs for Year 1 payments are the average costs, from studying EPs, for the purchase and initial implementation or upgrade of EHR technology, including support services for training for adoption and initial operation of the technology. The net average for Year 1 cannot exceed $25,000 so if the net average cost of an EP is $25,000, they would receive a payment in Year 1 of $21,250 (85% x $25,000 = $21,250). Year 1 cannot be after 2016.

Allowable costs for subsequent year payments are the average cost, from studying EPs, for operation, maintenance, and use of technology. This excludes the initial purchase and implementation and training costs from Year 1. The net average for subsequent years cannot exceed $10,000 per year so if the net average cost of an EP in a subsequent year is $10,000, they would receive a payment of $8,500 (85% x $10,000 = $8,500). No payments are made after 2016 and subsequent year payments cannot be for more than a 5 year period.

If an EP has completed adopting, implementing, or upgrading EHR technology prior to the first year of payments, the net allowable costs for subsequent years applies for all years up to 5, including the first year of payments to such EP.

Table 2. Maximum Medicaid Incentives for EPs with at least 30% volume

		Year of Adopt, Implement, Upgrade, or Meaningful Use Demonstration					
		2011	**2012**	**2013**	**2014**	**2015**	**2016**
ulat or	**2011**	$21,250					
	2012	$8,500	$21,250				
	2013	$8,500	$8,500	$21,250			

	2014	$8,500	$8,500	$8,500	$21,250		
	2015	$8,500	$8,500	$8,500	$8,500	$21,250	
	2016	$8,500	$8,500		$8,500	$8,500	$21,250
	2017		$8,500	$8,500	$8,500	$8,500	$8,500
	2018			$8,500		$8,500	$8,500
	2019			$8,500	$8,500		$8,500
	2020					$8,500	$8,500
	2021				$8,500	$8,500	$8,500
	Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

For more information on Medicaid incentive payments for EPs, please visit: https://www.cms.gov/MLNProducts/downloads/EHR_Final_Rule-Medicaid.pdf

MEDICARE EHR INCENTIVES FOR PROSPECTIVE PAYMENT SYSTEM HOSPITALS

The formula for the calculation of the Medicare incentive payment to prospective payment system (PPS) hospitals is as follows:

($2M + Discharge Amount) x Medicare Share x Transition %

Discharge Amount is defined as:

- 1st – 1,149th discharge = $0/discharge
- 1,150th – 23,000th discharge = $200/discharge
- 23,001st discharge or more = $0/discharge

Medicare Share is defined as:

Estimated # of inpatient-bed days with payment under Part A + Estimated # of inpatient-bed days for those enrolled in Medicare Advantage Part C

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Estimated total # inpatient days x % of an eligible hospital's total charges that are not charity care

Transition Percentage is based on the payment year and the fiscal year.

Table 3. Maximum Medicare Incentives for PPS Hospitals

2011	2012	2013	2014	2015	2016	2017	Incentive Payment
Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%				100%

	Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage TBD 25%			100%
		Stage 1 100%	Stage 1 75%	Stage TBD 50%	Stage TBD 25%		100%
			Stage 1 75%	Stage TBD 50%	Stage TBD 25%		60%
				Stage TBD 50%	Stage TBD 25%		30%
Penalty (Market basket update would be reduced by):				**-25%**	**-50%**	**-75%**	

Payments to Medicare providers will be made to the TIN selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments. Hospitals can receive their initial payment as early as May 2011. Final payment will be determined at the time of settling the hospital cost report.

For more information on Medicare incentive payments for PPS hospitals, please visit:
https://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_Medicare_Hosp.pdf

MEDICARE EHR INCENTIVES FOR CRITICAL ACCESS HOSPITALS

Critical access hospitals (CAHs) that are meaningful EHR users by 2011 are eligible for four years of enhanced Medicare payment with immediate full depreciation of certified EHR costs, including undepreciated costs from previous years.

The formula for the calculation of Medicare incentive payments for CAHs is as follows:

Total Reasonable EHR Costs x (Medicare Share + 20%)

If Medicare Share + 20% totals over 100%, the maximum amount paid will be 100%.

Medicare Share is defined as:

Estimated # of inpatient-bed days with payment under Part A + Estimated # of inpatient-bed days for those enrolled in Medicare Advantage Part C

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Estimated total # inpatient days x % of an eligible hospital's total charges that are not charity care

Reasonable EHR Costs is defined as:

- Software or hardware costs during the first payment year plus the undepreciated costs less interest from previous periods as well as software and hardware costs for other payment years.
- Only the reasonable costs for the purchase of the certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply are to be included in the CAH incentive payment.
- Currently, the CAH's Medicare contractor determines if an item purchased is a depreciable asset under Medicare principles or other accounting standards.
- The Medicare contractor also determines the CAH's reasonable cost for acquiring depreciable assets.

Table 4. Maximum Medicare Incentives for CAHs

2011	2012	2013	2014	2015	2016	2017	Payments
Payment in Stage 1	Payment in Stage 1	Payment in Stage 2	Payment in Stage 2				4
	Payment in Stage 1	Payment in Stage 1	Payment in Stage 2	Payment in Stage TBD			4
		Payment in Stage 1	Payment in Stage 1	Payment in Stage TBD			3
			Payment in Stage 1	Payment in Stage TBD			2
				Payment in Stage TBD			1
Penalty (Reasonable cost reimbursement of 101% would be reduced):				**100.66%**	**100.33%**	**100%**	

Payments to Medicare providers will be made to the TIN selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments. Hospitals can receive their initial payment as early as May 2011. Final payment will be determined at the time of settling the hospital cost report.

For more information on Medicare incentive payments for CAHs, please visit: https://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_CAH.pdf

MEDICAID EHR INCENTIVES FOR ELIGIBLE HOSPITALS

Each state must approve the demonstration of meaningful use for their state. Eligible hospitals will qualify for Medicaid incentive payments if they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology during the first participation year or successfully demonstrate meaningful use of certified EHR technology in subsequent participation years. Medicaid hospitals that qualify for EHR incentive payments may begin receiving payments in any year from FY 2011 to FY 2016. While the law defines a payment year in terms of federal fiscal year (FY) beginning with FY 2011, a hospital does not have to begin receiving incentive payments in FY 2011.

Hospitals eligible to receive Medicaid incentive payments include:

- Acute care hospitals
    - Including CAHs, cancer hospitals, and general short-term stay
    - The average length of stay must but at most 25 days with a CCN [0001-0879; 1300-1399]
    - Need to have a Medicaid patient volume of 10%
- Children's hospitals
    - 77 children's hospitals with CCN [3300-3399]
    - Does not include children's wings of larger hospitals
    - No Medicaid patient volume threshold is required

For more information on the Medicaid Incentive Payments, please visit: https://www.cms.gov/MLNProducts/downloads/EHR_Final_Rule-Medicaid.pdf

Payment for eligible hospitals is calculated, then disbursed over 3-6 years. The annual payment may not exceed 50% of the total calculation and no 2-year payment may exceed 90%. Hospital cannot initiate payments after 2016 and payment years must be consecutive after 2016. State must use auditable data sources in calculating the hospital incentive (i.e., cost report).

Medicaid Eligible Hospital Incentive Formula

The formula for incentive payments for Medicaid eligible hospitals is defined as the sum of 4 years of payment using:

$2M Base + Discharge Payment x Medicaid Share x Transition %

The Medicaid Share is calculated in the same method as the Medicare Share, but with Medicaid inpatient days and including Medicaid managed care plan.

The Transition Percent is 100% for Year 1, 75% for Year 2, 50% for Year 3, and 25% for Year 4

Table 5. Maximum Medicaid Incentives for Eligible Hospitals

		Year of Adopt, Implement, Upgrade, or Meaningful Use Demonstration					
		2011	**2012**	**2013**	**2014**	**2015**	**2016**
Calculator Year	**2011**	Y1					
	2012	Y2	Y1				
	2013	Y3	Y2	Y1			
	2014	Y4	Y3	Y2	Y1		
	2015	Y5	Y4	Y3	Y2	Y1	
	2016	Y6	Y5		Y3	Y2	Y1
	2017		Y6	Y4	Y4	Y3	Y2
	2018			Y5		Y4	Y3
	2019			Y6	Y5		Y4
	2020					Y5	Y5
	2021				Y6	Y6	Y6
	Total	Calculated Medicaid Share of EHR Cost					

RESOURCES AVAILABLE

Through the HITECH Act, several programs and projects were designated to provide assistance and technical support to providers in the adoption and implementation of meaningful use of EHRs. A brief description of such programs is provided below.

HIT State Profiles

The Technical Assistance and Services Center, a program of the National Rural Health Resource Center, collects HIT resources for each state. Information is collected on: grant funded HIT projects; health information exchanges and regional health information organizations; HIT Regional Extension Centers, telemedicine; state demographics; and, other HIT activities. Information can be accessed, by state, at: http://www.ruralcenter.org/tasc/hit-profile

HIT Web Resources

The National Rural Health Resource Center has collected many HIT-related tools and resources for you to use. Such information can be found at: http://www.ruralcenter.org/hit

Beacon Community Program

This grant program was designed for communities to build and strengthen their HIT infrastructure and exchange capabilities, while demonstrating a vision of the future

where hospitals, clinicians, and patients are meaningful users of HIT and work together with their communities. Funding was provided to 17 communities. Additional information on the Beacon Communities, their awards, and information on their project goals can be found at: http://healthit.hhs.gov/portal/server.pt?open=512&objID=1805&parentname=CommunityPage&parentid=2&mode=2&cached=true

State Health Information Exchange (HIE) Cooperative Agreement Program

A grant was provided to states, or state designated entities, to establish HIE. The program provided 56 awards with efforts for states to rapidly build capacity of HIE across the health care system both within and cross states. Additional funding was provided for the HIE Challenge Grants Program. This program provides ten awards for funding to states to encourage breakthrough innovations for HIE that can be leveraged to support national HIE efforts. For additional information, please visit: http://healthit.hhs.gov/portal/server.pt?open=512&objID=1488&parentname=CommunityPage&parentid=58&mode=2&in_hi_userid=11113&cached=true

HIT Regional Extension Center (REC) Program

The HIT REC Program seeks to provide technical assistance, guidance, and information on best practices to support and accelerate health care providers' efforts to become meaningful users of EHRs. A national HIT Research Center (HITRC) was established to gather information on effective practices and to help the RECs work with one another to identify and share best practices in EHR adoption, meaningful use, and provider support. The RECs are to: provide training and support services to assist doctors and other providers in adopting EHRs; offer information and guidance to help with EHR implementation; and, provide technical assistance as needed. The goal of the program is to provide outreach and support services to at leave 100,000 priority primary care providers within two years. Additional supplemental funding was provided to RECs who applied to provide support to eligible CAHs and rural hospitals in their efforts to adopt certified EHR technology. For more information on the RECs and HITRC, please visit: http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&parentname=CommunityPage&parentid=58&mode=2&in_hi_userid=11113&cached=true

Each REC is choosing a slightly different approach to technical support and the providers it serves. For information specific to your state, please see a list of RECs at: http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&parentname=CommunityPage&parentid=58&mode=2&in_hi_userid=11113&cached=true

Strategic Health Information Technology Advanced Research Projects (SHARP) Program

The SHARP grant program provides funds for research focused on achieving breakthrough advances to address well-documented problems that have impeded HIT adoption. Such problems include security, patient-centered cognitive support, applications and network platform architectures, and secondary use of EHR data. Four grants were awarded to address research in the above areas. For more information, please visit:
http://healthit.hhs.gov/portal/server.pt?open=512&objID=1806&parentname=CommunityPage&parentid=17&mode=2&in_hi_userid=11673&cached=true

Community College Consortia to Educate HIT Professionals Program

This grant program was established to help address the growing demand for highly skilled HIT specialists. Five regional groups of more than 70 member community colleges in all 50 states are participating in the program. The program seeks to develop or improve non-degree HIT training programs that students can complete in six months or less. It is expected that the program will annually train 10,500 new HIT professionals by 2012. For more information and a list of awardees by region, please visit:
http://healthit.hhs.gov/portal/server.pt?open=512&objID=1804&parentname=CommunityPage&parentid=14&mode=2&in_hi_userid=11673&cached=true

Program of Assistance for University-Based Training

This program was also established to help address the growing demand for highly skilled HIT specialists. It is designed to rapidly and sustainably increase the availability of role-specific HIT professionals requiring university-level training. The programs will promptly establish new and/or expanded training programs as rapidly as possible while assuring their graduates are well prepared to fulfill their chose HIT professional role. The six roles targets by this program include:

1. Clinician/Public Health Leaders
2. Health Information Management and Exchange Specialist
3. Health Information Privacy and Security Specialist
4. Research and Development Scientist
5. Programmers and Software Engineer
6. HIT Sub-specialist

Nine colleges and universities were awarded grants to participate in the program. For more information and to vie a list of the participating schools, please visit:
http://healthit.hhs.gov/portal/server.pt?open=512&objID=1808&parentname=CommunityPage&parentid=15&mode=2&in_hi_userid=11673&cached=true

Health Information Management Systems Society (HiMSS) Meaningful Use OneSource

The HiMSS Meaningful Use OneSource website has a large amount of information for organizations to use to prepare for meaningful use, certification criteria, and standards regulations. The resources, tools, and information can be found at: http://www.himss.org/ASP/topics_meaningfuluse.asp

ABBREVIATIONS

ARRA	American Recovery and Reinvestment Act of 2009
ATCB (or ONC-ATCB)	Authorized Testing and Certification Body
CAH	Critical Access Hospital
CCN	Centers for Medicare & Medicaid Services Certification Number
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
EHR	Electronic Health Record
EP	Eligible Professional
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HHS	United States Department of Health and Human Services
HIE	Health Information Exchange
HiMSS	Health Information Management Systems Society
HIT	Health Information Technology
HITECH Act	Health Information Technology for Economic and Clinical Health Act
HITRC	Health Information Technology Research Center
HPSA	Health Professional Shortage Area
IPPS	Inpatient Prospective Payment System
MA	Medicare Advantage
ONC	Office of the National Coordinator for Health Information Technology
OSCAR	Online Survey Certification and Reporting
PA	Physician Assistant
POS	Place Of Service
PPS	Prospective Payment System
REC	Health Information Technology Regional Extension Center
RHC	Rural Health Clinic
SHARP	Strategic Health Information Technology Advanced Research Projects
TIN	Taxpayer Identification Number