

INCENTIVE PAYMENTS		
FAQ Number	Question	Answer
2847	We are a tribal clinic with one full-time physician, one part-time pediatrician, one part-time physicians assistant (PA). Are we going to receive Promoting Interoperability payments directly from Medicaid?	Clinics are not directly eligible for the Medicaid Promoting Interoperability Program payments, however if the practitioners at your clinic meet the eligibility criteria and successfully adopt, implement, upgrade or meaningfully use certified EHR technology, they may choose to reassign their incentive payments to your clinic. Your clinic would need to have a taxpayer identification number (TIN) that is already established with the state Medicaid agency. A PA is eligible only if your FQHC or RHC is led by a PA. Our Stage 1 final rule preamble discusses what it means for a PA to have lead role in an FQHC or RHC at page 44483. To view the Stage 1 final rule for the Medicare and Medicaid Promoting Interoperability programs, please visit: <a href="http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf">http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf</a> .
3089	Are physicians who are employed directly by a tribally-operated facility and who meet all other eligibility requirements for payments under the Medicaid Promoting Interoperability Program?	Physicians are one of the categories of eligible professionals under the Medicaid Promoting Interoperability Program. If they meet the other program eligibility requirements (they can demonstrate 30% Medicaid patient volume, they've adopted, implemented, upgraded or meaningfully used certified EHR technology, they are not hospital-based, etc.) then the fact that they are employed by a tribally-operated facility is irrelevant.
3379	How are Medicare EHR Incentive Payments Calculated for Critical Access Hospitals (CAHs)?	CAHs are currently paid based on reasonable cost principles; therefore, their EHR incentive payments are calculated differently from the incentive payments to subsection (d) hospitals. A CAH must meet the definition of a meaningful EHR user to qualify to be paid the incentive payment for a payment year. A payment year means a Federal fiscal year beginning after FY 2010 and before FY 2016. In no case are incentive payments made with respect to cost reporting periods that begin during a payment year before FY 2011 or after FY 2015, and in no case may a CAH receive an incentive payment with respect to more than 4 consecutive payment years. The incentive payment made to a qualifying CAH equals: [Allowable cost amount] * [Medicare Share]. The allowable cost amount equals the costs of depreciable assets purchased, such as computers and associated software, necessary to administer certified EHR technology. The incentive payment permits a qualifying CAH to expense the allowable cost amount in a single payment year rather than depreciating the costs over the useful life of the purchased asset. The allowable cost amount for a cost reporting period that begins in a payment year includes the reasonable cost incurred for the purchase of certified EHR technology in that payment year plus the undepreciated costs for assets purchased, prior to the CAH becoming qualified, that are also being used to administer certified EHR technology in that payment year. The Medicare Share is a fraction based on Medicare fee-for-service and managed care inpatient days, divided by total inpatient days, modified by charges for charity care: (1) The number of inpatient-bed-days which are attributable to individuals with respect to whom payment may be made under Part A, including individuals enrolled in section 1876 Medicare cost plans; and (2) The number of inpatient-bed-days which are attributable to individuals who are enrolled with a Medicare Advantage organization Denominator = Total number of acute care inpatient-bed-days; * ((Total amount of the eligible hospital's charges - charges attributable to charity care)/Total amount of the eligible hospital's charges)) For CAHs, 20 percentage points are added to the Medicare Share calculation (not to exceed 100 percent). In order for the CAH to receive its interim incentive payment, upon attestation, it must submit supporting documentation for its incurred costs of purchasing certified EHR technology to its Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor). The Medicare contractor will then calculate the allowable amount. The interim incentive payment is then subject to reconciliation to determine the final incentive payment amount. The final payment amount constitutes payment in full for the reasonable costs incurred for the purchase of certified EHR technology in the single payment year. For more information about the Medicare and Medicaid EHR Incentive Program, please visit <a href="http://www.cms.gov/EHRIncentiveProgramsKeywords">http://www.cms.gov/EHRIncentiveProgramsKeywords</a> : FAQ10718
3387	Can a Critical Access Hospital (CAH) include costs to lease/rent certified EHR technology in the Medicare EHR incentive payment?	Under the statute and the regulations, the CAHs EHR incentive payment shall only include reasonable costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply. There are two types of lease agreements that a CAH may enter into to administer their EHR system... an operating lease or a capital lease. OPERATING LEASE An operating lease is merely a lease that involves an asset that is purchased, owned, and depreciated by the lessor and the lessee (the CAH) signs the lease agreement with the lessor to use the asset by paying a lease/rental fee for the term of the lease. The asset is returned to the lessor at the end of the lease without further obligation. Generally, the CAH can claim the entire lease/rental payment under an operating lease as an operating expense, unrelated to depreciation expenses. With an operating lease, the CAH does not purchase, own, or depreciate the asset, and the lease/rental expense does not meet the intent of the statute and regulations. Therefore, operating lease/rental expenses are not included in the CAH incentive payment. The CAH may, however, continue to include the operating lease expenses on its cost report, subject to reasonable cost principles. CAPITAL LEASE A capital lease agreement is essentially the same as a virtual purchase agreement, as defined in 42 CFR 413.130(b)(8) of the regulations and the Medicare Provider Reimbursement Manual (PRM), (CMS Pub. 15-1) section 110.B.1.b. A capital lease is treated as though the CAH (lessee) purchased the asset and the capital-related costs may not exceed the amount that the lessee would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership includes straight-line depreciation, insurance and interest for computing the limitation. To be a capital lease, the agreement must satisfy at least one of the four conditions established by the Federal Accounting Standards Board (FASB). Similar to the FASB conditions, under CMS Pub. 15-1, section 110.B.1.b., a lease that meets any one of the following four conditions establishes a virtual purchase (otherwise the lease is considered an operating lease). The lease transfers title of the facilities or equipment to the lessee during the lease term, The lease contains a bargain purchase option, The lease term is 75 percent or more of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment, or The present value of the minimum lease payments (that is, payments to be made during the lease term, including bargain purchase option, guaranteed residual value, or penalties for failure to renew) equal 90 percent or more of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. The present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case, the interest rate implicit in the lease is used. Based on these criteria, a capital lease or virtual purchase meets the intent of the statute and regulation to qualify the leased asset as a purchased asset. Therefore, the CAHs' incentive payment may include the "cost" of such leased asset which must be based on the fair market value of the asset (see 42 CFR 413.134(b)(2)) at the date the lease was initiated. Other costs of ownership such as interest and insurance related to the virtual purchase lease shall not be included in the asset's cost for the purpose of the EHR incentive payment. However, the portion of the rental expense which relates to the interest and

2849	What provisions are there for tribal clinics to receive payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, rather than the physicians themselves - especially when it is a family medicine practice? I heard there were certain percentage of patients that had to be either Medicare or Medicaid and that a physician had to decide which they were going to apply for. What if their practice includes both types of patients?	Clinics are not eligible for EHR incentive payments. However, eligible professionals who qualify for an EHR incentive payment may reassign that payment to the taxpayer identification number (TIN) of their employer, if they so choose. You are correct that eligible professionals must choose either the Medicare or the Medicaid EHR Incentive Program, and may not simultaneously receive payments from both programs if they qualify for both. They may make a one-time switch after having received an incentive payment, but the switch must occur before 2015. For more information about the Medicare and Medicaid EHR Incentive Program, please visit a <a href="http://www.cms.gov/EHRIncentivePrograms">http://www.cms.gov/EHRIncentivePrograms</a> Keywords: FAQ10129
2769	If a patient is dually eligible for both Medicare and Medicaid, can they be counted twice by hospitals in their calculations if they are applying for Promoting Interoperability payments through both the Medicare and Medicaid Promoting Interoperability Programs?	For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals "described in section 1886(n)(2)(D)(i).") In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital.
3375	When will a Medicare Subsection (d) Hospital be paid under the Medicare EHR Incentive Program?	Upon submission of a successful attestation of meaningful use, the hospital will be eligible for an EHR incentive payment. The hospital will receive a preliminary, initial payment soon after attestation (usually within 4 to 6 weeks). The initial payment will be calculated based on the data reported on the hospital's latest submitted 12-month cost report. Final payment will then be determined at the time of settling the first 12-month hospital cost report for the hospital fiscal year that begins on or after the first day of the payment year. Preliminary payments will be reconciled to the actual amounts at final settlement of the cost report. Example - A hospital has a December 31 fiscal year end, and attests as a meaningful user on August 1, 2011. At the time of such attestation: The latest filed cost report will most likely be the fiscal year end December 31, 2010 cost report. Data from that cost report will be used to calculate the initial payment (subject to review by the Medicare contractor). Final payment will be based on data from the fiscal year end December 31, 2011 cost report. This is the first 12-month cost reporting period that begins in payment year 2011 (which is Federal fiscal year 2011). These data will be used to "reconcile" the initial payment, at final settlement of the cost report. The new Medicare hospital cost report, Form CMS 2552-10, will contain worksheets to accommodate the EHR incentive payments. Note - the EHR incentive payments will be made by a single payment contractor, and not by the hospitals' Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor). For more information about the Medicare and Medicaid EHR Incentive Program, please visit <a href="http://www.cms.gov/EHRIncentivePrograms">http://www.cms.gov/EHRIncentivePrograms</a> Keywords: FAQ10716
3381	When will a Critical Access Hospital (CAH) receive its Medicare EHR incentive payment?	Upon submission of a successful attestation, the CAH will be eligible for an EHR incentive payment. In order for the incentive payment to be calculated, the CAH must submit documentation to its Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor) to support the costs incurred for certified EHR technology. Once the Medicare contractor calculates the allowable amount and Medicare Share the CAH should expect its interim incentive payment within 4 to 6 weeks. The CAH will receive an interim incentive payment that will later be reconciled on the Medicare cost report. The interim payment will be calculated using the Medicare Share based on the data reported on the hospital's latest submitted 12-month cost report. The interim payment will be included on the CAH's cost report that begins during the payment year, and will be reconciled to the actual amounts at final settlement of the cost report. Example - If a hospital has a December 31 fiscal year end, and attests as a meaningful user on August 1, 2011: The latest filed cost report when the CAH attests will most likely be the fiscal year end December 31, 2010 cost report. The data on that cost report will be used to calculate the Medicare Share for the initial payment. The cost reporting period that begins during the HITECH payment year (which is the federal fiscal year) is the fiscal year ending December 31, 2011 cost reporting period (since the begin date of January 1, 2011 falls within the fiscal year 2011 HITECH year). The interim payment will be reconciled at final settlement of the cost report for this period. The new Medicare hospital cost report, Form CMS 2552-10, will contain worksheets to accommodate the EHR incentive payments. Note - the EHR incentive payments will be made by a single payment contractor, and not by the hospitals' Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor). For more information about the Medicare and Medicaid EHR Incentive Program, please visit a <a href="http://www.cms.gov/EHRIncentivePrograms">http://www.cms.gov/EHRIncentivePrograms</a> Keywords: FAQ10719
3095	Under the Promoting Interoperability Program, is there a minimum number of hours per week that an eligible professional (EP) must practice in order to qualify for an incentive payment or could a part-time EP qualify for Medicaid incentive payments if the EP meets all other eligibility criteria?	Yes, a part-time EP who meets all other eligibility requirements could qualify for payments under the Promoting Interoperability Program. There are no restrictions on employment type (e.g., contractual, permanent, or temporary) in order to be a Medicaid eligible professional.

2905	What is the definition of "reasonable cost" for critical access hospitals (CAHs) under the Medicare and Medicaid Promoting Interoperability Program?	<p>The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply. Section 495.106(a) of the regulations states that 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 the regulations, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in section 495.4 excluding any depreciation and interest expenses associated with the acquisition. This EHR incentive payment provision allows a qualifying CAH to expense the acquisition costs of a qualifying asset in a single payment year instead of depreciating the acquisition costs over the useful life of the asset. If a qualifying CAH incurs non-depreciable expenses related to implementing/maintaining its EHR system, those expenses cannot be included in the EHR incentive payment. However, those expenses may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expenses are incurred. For example, if a qualifying CAH rents its EHR technology assets, instead of purchasing the assets, the rent expense cannot be included in the EHR incentive payment. However, the rent expense may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expense is incurred. Qualifying CAHs should contact their Medicare contractor to answer questions on reasonable costs that will be included in the calculation of the Promoting Interoperability Program. Keywords: FAQ10163</p>
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