AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

case will the applicable percent be less than 95 percent.

(4) *Exceptions.* The Secretary may, on a case-by-case basis, exempt an EP from the application of the payment adjustment under paragraph (d)(1) of this section if the Secretary determines that compliance with the requirement for being a meaningful EHR user would result in a significant hardship for the EP. To be considered for an exception, an EP must submit, in the manner specified by CMS, an application demonstrating that it meets one or more of the criteria in this paragraph (d)(4) unless otherwise specified in the criteria. The Secretary's determination to grant an EP an exemption may be renewed on an annual basis, provided that in no case may an EP be granted an exemption for more than 5 years.

(i) During any 90-day period from the beginning of the year that is 2 years before the payment adjustment year to July 1 of the year preceding the payment adjustment year, the EP was located in an area without sufficient Internet access to comply with the meaningful use objectives requiring internet connectivity, and faced insurmountable barriers to obtaining such internet connectivity. Applications requesting this exception must be submitted no later than July 1 of the year before the applicable payment adjustment year.

(ii) The EP has been practicing for less than 2 years.

(iii)(A) During the calendar year that is 2 calendar years before the payment adjustment year, the EP that has previously demonstrated meaningful use faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user. Applications requesting this exception must be submitted no later than July 1 of the year before the applicable payment adjustment year.

(B) During the calendar year preceding the payment adjustment year, the EP that has not previously demonstrated meaningful use faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user. Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year.

(iv) An EP may request an exception through an application submitted by July 1 of the year before the applicable payment adjustment year due to difficulty in meeting meaningful use based on any one of the following during the period that begins 2 calendar years before the payment adjustment year through the application deadline:

(A) The EP practices at multiple locations and can demonstrate inability to control the availability of Certified EHR Technology at one such practice location or a combination of practice locations, and where the location or locations constitute more than 50 percent of their patient encounters.

(B) The EP can demonstrate difficulty in meeting meaningful use on the basis of lack of face-to-face or telemedicine interaction with patients and lack of need for follow up with patients.

(C) The EP has a primary specialty listed in PECOS as anesthesiology, radiology or pathology 6 months prior to the first day of the payment adjustments that would otherwise apply. Such an EP may be deemed to qualify for this exception, subject to the 5-year limit that applies to all exceptions under this paragraph.

(5) *Payment adjustments not applicable to hospital-based EPs.* No payment adjustment under paragraphs (d)(1) through (3) of this section may be made in the case of a hospital-based eligible professional, as defined in §495.4.

[75 FR 44565, July 28, 2010, as amended at 77 FR 54157, Sept. 4, 2012; 77 FR 54157, Sept. 4, 2012]

§495.104 Incentive payments to eligible hospitals.

(a) *General rule.* A qualifying hospital (as defined in this subpart) must receive the special incentive payment as determined under the formulas described in paragraph (c) of this section for the period specified in paragraph (b) of this section.

(b) *Transition periods.* Subject to paragraph (d) of this section and the payment formula specified in paragraph (c) of this section, qualifying hospitals may receive incentive payments during

transition periods which comprise the following fiscal years:

(1) Hospitals whose first payment year is FY 2011 may receive such payments for FYs 2011 through 2014.

(2) Hospitals whose first payment year is FY 2012 may receive such payments for FYs 2012 through 2015.

(3) Hospitals whose first payment year is FY 2013 may receive such payments for FYs 2013 through 2016.

(4) Hospitals whose first payment year is FY 2014 may receive such payments for FY 2014 through 2016.

(5) Hospitals whose first payment year is FY 2015 may receive such payments for FY 2015 through 2016.

(c) *Payment methodology.* (1) The incentive payment for each payment year is calculated as the product of the following:

(i) The initial amount determined under paragraph (c)(3) of this section.

(ii) The Medicare share fraction determined under paragraph (c)(4) of this section.

(iii) The transition factor determined under paragraph (c)(5) of this section.

(2) *Interim and final payments.* CMS uses data on hospital acute care inpatient discharges, Medicare Part A acute care inpatient bed-days, Medicare Part C acute care inpatient bed-days, and total acute care inpatient bed-days from the latest submitted 12-month hospital cost report as the basis for making preliminary incentive payments. Final payments are 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, and settled on the basis of data from that cost reporting period. In cases where there is no 12-month hospital cost report period beginning on or after the first day of the payment year, final payments may be determined and settled on the basis of data from the most recently submitted 12-month hospital cost report.

(3) *Initial amount.* The initial amount is equal to one of the following:

(i) For each hospital with 1,149 acute care inpatient discharges or fewer, $2,000,000.

(ii) For each hospital with at least 1,150 but no more than 23,000 acute care inpatient discharges, $2,000,000 + [$200 × (n − 1,149)], where n is the number of discharges for the hospital.

(iii) For each hospital with more than 23,000 acute care inpatient discharges, $6,370,200.

(4) *Medicare share fraction*—(i) *General.* (A) CMS determines the Medicare share fraction for an eligible hospital by using the number of Medicare Part A, Medicare Part C, and total acute care inpatient-bed-days using data from the Medicare cost report as specified by CMS.

(B) CMS computes the denominator of the Medicare share fraction using the charity care charges reported on the hospital's Medicare cost report.

(ii) The Medicare share fraction is the ratio of—

(A) A numerator which is the sum of—

(*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 (as defined in § 422.2 of this chapter).

(B) A denominator which is the product of—

(*1*) The total number of acute care inpatient-bed-days; and

(*2*) The total amount of the eligible hospital's charges, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospitals charges.

(5) *Transition factor.* For purposes of the payment formula, the transition factor is as follows:

(i) For hospitals whose first payment year is FY 2011—

(A) 1 for FY 2011;

(B) ¾ for FY 2012;

(C) ½ for FY 2013; and

(D) ¼ for FY 2014.

(ii) For hospitals whose first payment year is FY 2012—

(A) 1 for FY 2012;

(B) ¾ for FY 2013;

(C) ½ for FY 2014; and

(D) ¼ for FY 2015;

(iii) For hospitals whose first payment year is FY 2013—

(A) 1 for FY 2013;

(B) ¾ for FY 2014;
(C) ½ for FY 2015; and
(D) ¼ for FY 2016.
(iv) For hospitals whose first payment year is FY 2014—
(A) ¾ for FY 2014;
(B) ½ for FY 2015; and
(C) ¼ for FY 2016.
(v) For hospitals whose first payment year is FY 2015—
(A) ½ for FY 2015; and
(B) ¼ for FY 2016.
(d) No incentive payment for nonqualifying hospitals. After the first payment year, an eligible hospital will not receive an incentive payment for any payment year during which it is not a qualifying hospital.

[75 FR 44565, July 28, 2010, as amended at 78 FR 75200, Dec. 10, 2013]

§495.106 Incentive payments to CAHs.

(a) *Definitions.* In this section, unless otherwise indicated—

Payment year means a Federal fiscal year beginning after FY 2010 but before FY 2016.

Qualifying CAH means a CAH that would meet the definition of a meaningful EHR user at §495.4, if it were an eligible hospital.

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 this chapter, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in §495.4, excluding any depreciation and interest expenses associated with the acquisition.

(b) *General rule.* A qualifying CAH receives an incentive payment for its reasonable costs incurred for the purchase of certified EHR technology, as defined in paragraph (a) of this section, in the manner described in paragraph (c) of this section for a cost reporting period beginning during a payment year as defined in paragraph (a) of this section.

(c) *Payment methodology*—(1) *Payment amount.* A qualifying CAH receives an incentive payment amount equal to the product of its reasonable costs incurred for the purchase of certified EHR technology and the Medicare share percentage.

(2) *Calculation of reasonable costs.* CMS or its Medicare contractor computes a qualifying CAH's reasonable costs incurred for the purchase of certified EHR technology, as defined in paragraph (a) of this section, as the sum of—

(i) The reasonable costs incurred for the purchase of certified EHR technology during the cost reporting period that begins in a payment year; and

(ii) Any reasonable costs incurred for the purchase of certified EHR technology in cost reporting periods beginning in years prior to the payment year which have not been fully depreciated as of the cost reporting period beginning in the payment year.

(3) *Medicare share percentage.* Notwithstanding the percentage applicable under §413.70(a)(1) of this chapter, the Medicare share percentage equals the lesser of—

(i) 100 percent; or

(ii) The sum of the Medicare share fraction for the CAH as calculated under §495.104(c)(4) of this subpart and 20 percentage points.

(d) *Incentive payments made to CAHs.* (1) The amount of the incentive payment made to a qualifying CAH under this section represents the expensing and payment of the reasonable costs computed in paragraph (c) of this section in a single payment year and, as specified in §413.70(a)(5) of this chapter, such payment is made in lieu of payment that would have been made under §413.70(a)(1) of this chapter for the reasonable costs of the purchase of certified EHR technology including depreciation and interest expenses associated with the acquisition.

(2) The amount of the incentive payment made to a qualifying CAH under this section is paid through a prompt interim payment for the applicable payment year after—

(i) The CAH submits the necessary documentation, as specified by CMS or its Medicare contractors, to support the computation of the incentive payment amount under this section; and

(ii) CMS or its Medicare contractor reviews such documentation and determines the interim amount of the incentive payment.