

Comparison of House and Senate Versions of HIT Stimulus Package Proposals Relating to EMR Incentive Payments for Critical Access Hospitals

House Version: F:\M11\RANGEL\RANGEL_046.XML

Senate Version: O:\ERN\ERN09386.xml (Came out of Committee on 1/30/09)

House Version

- The House version to come out of committee, identified above, effectively excludes CAHs from all incentive payments. The exclusion occurs in the below section, which identifies only “subsection (d) hospitals” as eligible. Critical Access Hospitals are a different category of provider and would need to be named separately to be included.
 - Relevant language: 4312(n)(6)(A) ELIGIBLE HOSPITAL.—The term ‘eligible hospital’ means a subsection (d) hospital.
- The House version may include some grant dollars for Critical Access Hospitals, but it is unclear how much would be available. Grant dollars for implementing EMRs in non-eligible hospitals are listed as one of 8 categories of funding to be provided. Again, it is impossible to determine how much would be available.
 - See 3011 (a) (2)

Senate Version

- The Senate version to come out of committee specifically includes CAHs, and while a \$1,000,000 per year cap was discussed in Committee, the cap was removed through an amendment vote
 - Relevant language: 3011(a)(6)(A) (6) DEFINITIONS.—For purposes of this subsection (A) ELIGIBLE HOSPITAL.—The term ‘eligible hospital’ means—(i) a subsection (d) hospital; and (ii) a critical access hospital (as defined in section 1861(mm)(1)).
 - There is no mention of a \$1,000,000 per year cap in this version.
- CAHS that became “Meaningful Users of Certified EHR Technology” by 2013 would be eligible for 4 years of incentive payments, with Year 1 full incentive payments being reduced in Year 2 to .75, Year 3 to .5, and Year 4 to .25.
 - Relevant language: Section 4202
- The formula for calculating incentive payments for CAHs can be understood as indicated below (Relevant language is in Section 4202)
 - The applicable incentive amount to meet “Meaningful Use of Certified EHR Technology” is the product of (1) initial amount (which equals [A] base payment of 2 million plus [B] discharge related calculation), (*see exact language from proposed bill below*) (2) Medicare Share, and (3) Transition Factor. (Example: A CAH with a 60% Medicare population would get 2 million X 60% X 1 = \$1.2 million the first year; and so on, with transition factor moving to .75 the second year; .5 the 3rd year, and .25 the 4th year for a total in this example of \$3 million over four years.

“(B) BASE AMOUNT.—The base amount specified in this subparagraph is \$2,000,000.

“(C) DISCHARGE RELATED AMOUNT.—The discharge related amount specified in this sub paragraph for a 12-month period selected by the Secretary shall be determined as the sum of the amount, based upon total discharges (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

“(i) For the 1,150th through the 9,200th discharge, \$200.

“(ii) For the 9,201st through the 13,800th discharge, 50 percent of the amount specified in clause (i).

“(iii) For the 13,801st through the 23,000th discharge, 30 percent of the amount specified in clause (i).

“(D) MEDICARE SHARE.—The Medicare share specified under this subparagraph for a hospital for a period selected by the Secretary for a payment year is equal to the fraction—

“(i) the numerator of which is the sum (for such period and with respect to the hospital) of—

“(I) the number of inpatient-bed days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

“(II) the number of inpatient bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

“(ii) the denominator of which is the product of—

“(I) the total number of inpatient-bed-days with respect to the hospital during such period; and

“(II) the total amount of the hospital’s charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the total amount of the hospital’s charges during such period.

- Only larger CAHs would receive the discharge/volume related added benefit; some CAHs and most Tweeners will see payments go up given a positive volume adjustment to the base.
- For example, in Wisconsin, the impact of the legislation as written will be an average of \$2,323,031 over 4 years per CAH (assuming they meet the 2013 deadline).
- Interestingly, if the \$1,000,000 per year CAH cap were reinserted, the average would only be reduced to \$2,240,191.
- The potential impact of the legislation (assuming all CAHs attain full incentive payments) for Wisconsin CAHs would be \$139,381,870. If the \$1,000,000 per year CAH cap were reinserted, the potential impact would be \$134,411,491
- CAHs that do not become meaningful EHR users would eventually be penalized: In FY 2015, reimbursements would be reduced to 100.66% of cost; In FY 2016 to 100.33% of cost; in FY 2017 to 100% of cost.
 - Relevant language: Section 4202
- Exception to the penalties would be considered under certain circumstances. The Secretary can exempt CAHs from penalties for up to 5 years beyond the FY 2015 deadline, subject to annual renewal, but in no case would a hospital be granted an exception for more than 5 years.
 - Relevant language: Section 4202