495.310 Medicaid provider incentive payments.

(a) Rules for Medicaid EPs. The Medicaid EP's incentive payments are subject to all of the following limitations:

(1) First payment year. (i) For the first payment year, payment under this subpart may not exceed 85 percent of the maximum threshold of $25,000, which equals $21,250.

(ii) [Reserved]

(iii) An EP may not begin receiving payments any later than CY 2016.

(2) Subsequent annual payment years.

(i) For subsequent payment years, payment may not exceed 85 percent of the maximum threshold of $10,000, which equals $8,500.

(ii) [Reserved]

(iii) Payments after the first payment year may continue for a maximum of 5 years.

(iv) Medicaid EPs may receive payments on a non-consecutive, annual basis.

(v) No payments may be made after CY 2021.

(3) Maximum incentives. In no case may a Medicaid EP participate for more than a total of 6 years, and in no case will the maximum incentive over a 6-year period exceed $63,750.

(4) Limitation. For a Medicaid EP who is a pediatrician described in paragraph (b) of this section payment is limited as follows:

(i) The maximum payment in the first payment year is further reduced by two-thirds, which equals $14,167.

(ii) The maximum payment in subsequent payment years is further reduced by two-thirds, which equals $5,667.

(iii) In no case will the maximum incentive payment to a pediatrician under this limitation exceed $42,500 over a 6-year period.

(b) Optional exception for pediatricians. A pediatrician described in this paragraph is a Medicaid EP who does not meet the 30 percent patient volume requirements described in §§ 495.304 and 495.306, but who meets the 20 percent patient volume requirements described in such sections.

(c) Limitation to only one EHR incentive program. An EP may only receive an incentive payment from either Medicare or Medicaid in a payment year, but not both.

(d) Exception for EPs to switch programs. An EP may change his or her EHR incentive payment program election once, consistent with § 495.60.

(e) Limitation to one State only. A Medicaid EP or eligible hospital may receive an incentive payment from only one State in a payment year.

(f) Incentive payments to hospitals. Incentive payments to an eligible hospital under this subpart are subject to all of the following conditions:

(1) The payment is provided over a minimum of a 3-year period and maximum of a 6-year period.

(2) The total incentive payment received over all payment years of the program is not greater than the aggregate EHR incentive amount, as calculated under paragraph (g) of this section.

(3) No single incentive payment for a payment year may exceed 50 percent of the aggregate EHR hospital incentive amount calculated under paragraph (g) of this section for an individual hospital.

(4) No incentive payments over a 2-year period may exceed 90 percent of the aggregate EHR hospital incentive amount calculated under paragraph (g) of this section for an individual hospital.

(5) No hospital may begin receiving incentive payments for any year after FY 2016, and after FY 2016, a hospital may not receive an incentive payment unless it received an incentive payment in the prior fiscal year.

(6) Prior to FY 2016, payments can be made to an eligible hospital on a non-consecutive, annual basis for the fiscal year.

(7) A multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating payment.

(8) The aggregate EHR hospital incentive amount calculated under paragraph (g) of this section is determined by the State from which the eligible hospital receives its first payment year incentive. If a hospital receives incentive payments from other States in subsequent years, total incentive payments received over all payment years of the program can be no greater than the aggregate EHR incentive amount calculated by the initial State.

(g) Calculation of the aggregate EHR hospital incentive amount. The aggregate EHR hospital incentive amount is calculated as the product of the (overall EHR amount) times (the Medicaid Share).

(1) Overall EHR amount. The overall EHR amount for an eligible hospital is based upon a theoretical 4 years of payment the hospital would receive based, for each of such 4 years, upon the product of the following:

(i) Initial amount. The initial amount is equal to the sum of -

(A) The base amount which is set at $2,000,000 for each of the theoretical 4 years; plus

(B) The discharge-related amount for the most recent continuous 12-month period selected by the State, but ending before the federal fiscal year that serves as the first payment year. The discharge-related amount is the sum of the following, with acute-care inpatient discharges over the 12-month period and based upon the total acute-care inpatient discharges for the eligible hospital (regardless of any source of payment):

(1) For the first through 1,149th acute-care inpatient discharge, $0.

(2) For the 1,150th through the 23,000th acute-care inpatient discharge, $200.

(3) For any acute-care inpatient discharge greater than the 23,000th, $0.

(C) For purposes of calculating the discharge-related amount under paragraph (g)(1)(i)(B) of this section, for the last 3 of the theoretical 4 years of payment, acute-care inpatient discharges are assumed to increase by the provider's average annual rate of growth for the most recent 3 years for which data are available per year. Negative rates of growth must be applied as such.

(ii) Medicare share. The Medicare share, which equals 1.

(iii) Transition factor. The transition factor which equals as follows:

(A) For the first of the theoretical 4 years, 1.

(B) For the second of the theoretical 4 years, 3/4.

(C) For the third of the theoretical 4 years, 1/2.

(D) For the fourth of the theoretical 4 years, 1/4.

(2) Medicaid share. The Medicaid share specified under this paragraph for an eligible hospital is equal to a fraction -

(i) The numerator of which is the sum (for the 12-month period selected by the State and with respect to the eligible hospital) of -

(A) The estimated number of acute-care inpatient-bed-days which are attributable to Medicaid individuals; and

(B) The estimated number of acute-care inpatient-bed-days which are attributable to individuals who are enrolled in a managed care organization, a pre-paid inpatient health plan, or a pre-paid ambulatory health plan under part 438 of this chapter; and

(ii) The denominator of which is the product of -

(A) The estimated total number of acute-care inpatient-bed-days with respect to the eligible hospital during such period; and

(B) The estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during such period.

(iii) In computing acute-care inpatient-bed-days under paragraph (g)(2)(i) of this section, a State may not include estimated acute-care inpatient-bed-days attributable to individuals with respect to whom payment may be made under Medicare Part A, or acute-care inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C.

(h) Approximate proxy for charity care. If the State determines that an eligible provider's data are not available on charity care necessary to calculate the portion of the formula specified in paragraph (g)(2)(ii)(B) of this section, the State may use that provider's data on uncompensated care to determine an appropriate proxy for charity care, but must include a downward adjustment to eliminate bad debt from uncompensated care data. The State must use auditable data sources.

(i) Deeming. In the absence of the data necessary, with respect to an eligible hospital the amount described in paragraph (g)(2)(ii)(B) of this section must be deemed to be 1. In the absence of data, with respect to an eligible hospital, necessary to compute the amount described in paragraph (g)(2)(i)(B) of this section, the amount under such clause must be deemed to be 0.

(j) Dual eligibility for incentives payments. A hospital may receive incentive payments from both Medicare and Medicaid if it meets all eligibility criteria in the payment year.

(k) Payments to State-designated entities. Payments to entities promoting the adoption of certified EHR technology as designated by the State must meet the following requirements:

(1) A Medicaid EP may reassign his or her incentive payment to an entity promoting the adoption of certified EHR technology, as defined in § 495.302, and as designated by the State, only under the following conditions:

(i) The State has established a method to designate entities promoting the adoption of EHR technology that comports with the Federal definition in § 495.302.

(ii) The State publishes and makes available to all EPs a voluntary mechanism for reassigning annual payments and includes information about the verification mechanism

the State will use to ensure that the reassignment is voluntary and that no more than 5 percent of the annual payment is retained by the entity for costs not related to certified EHR technology.

(2) [Reserved]